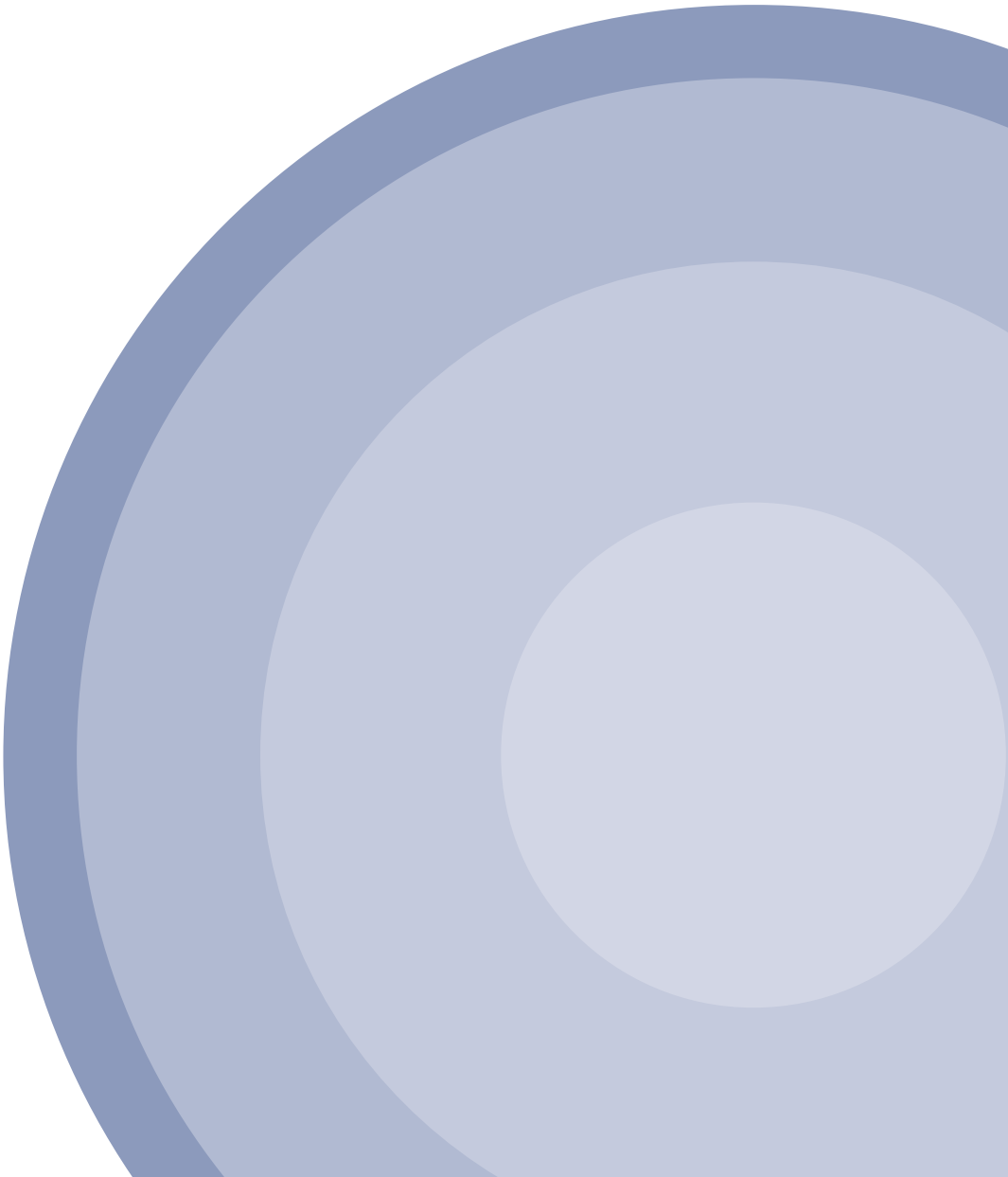
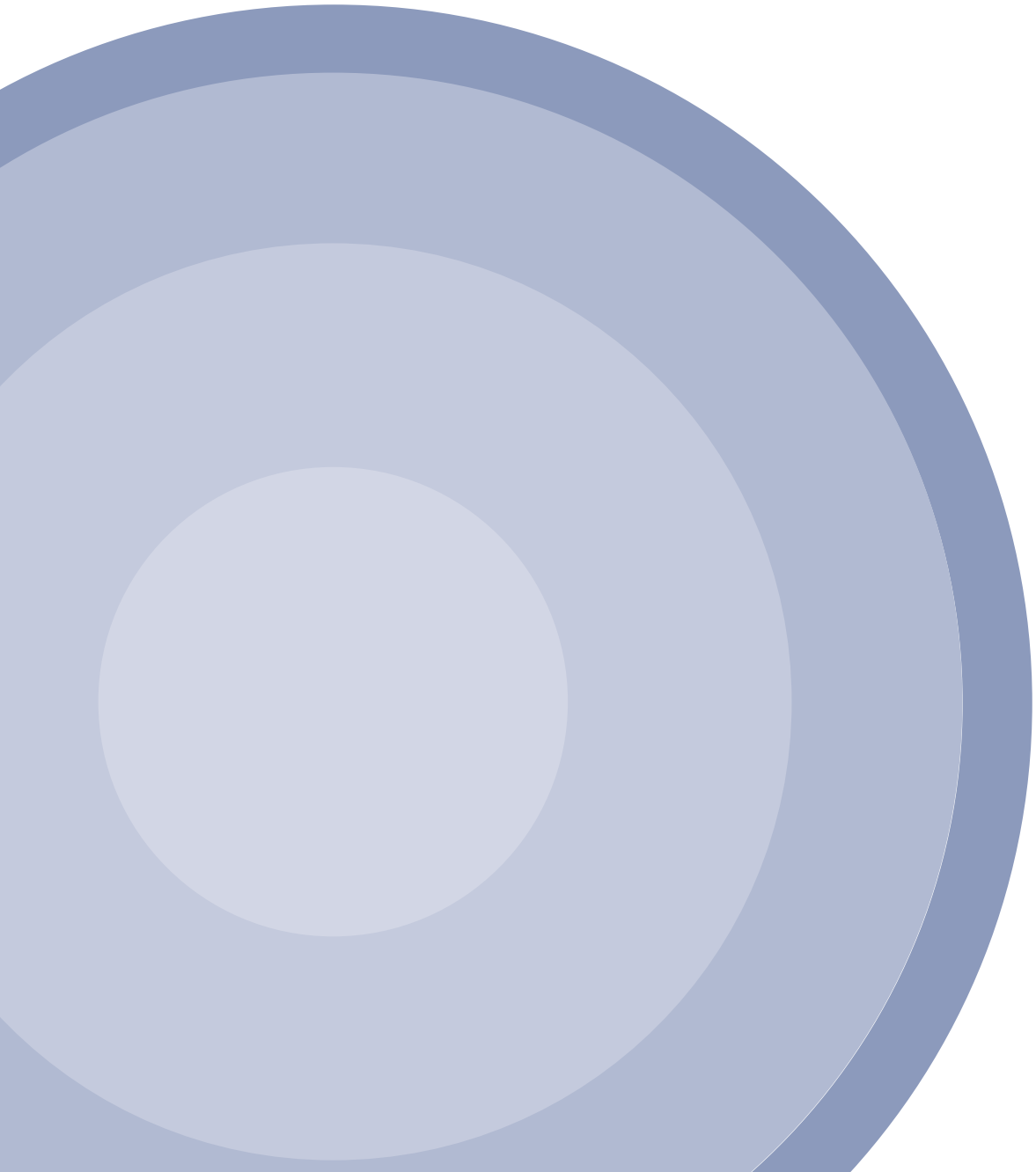
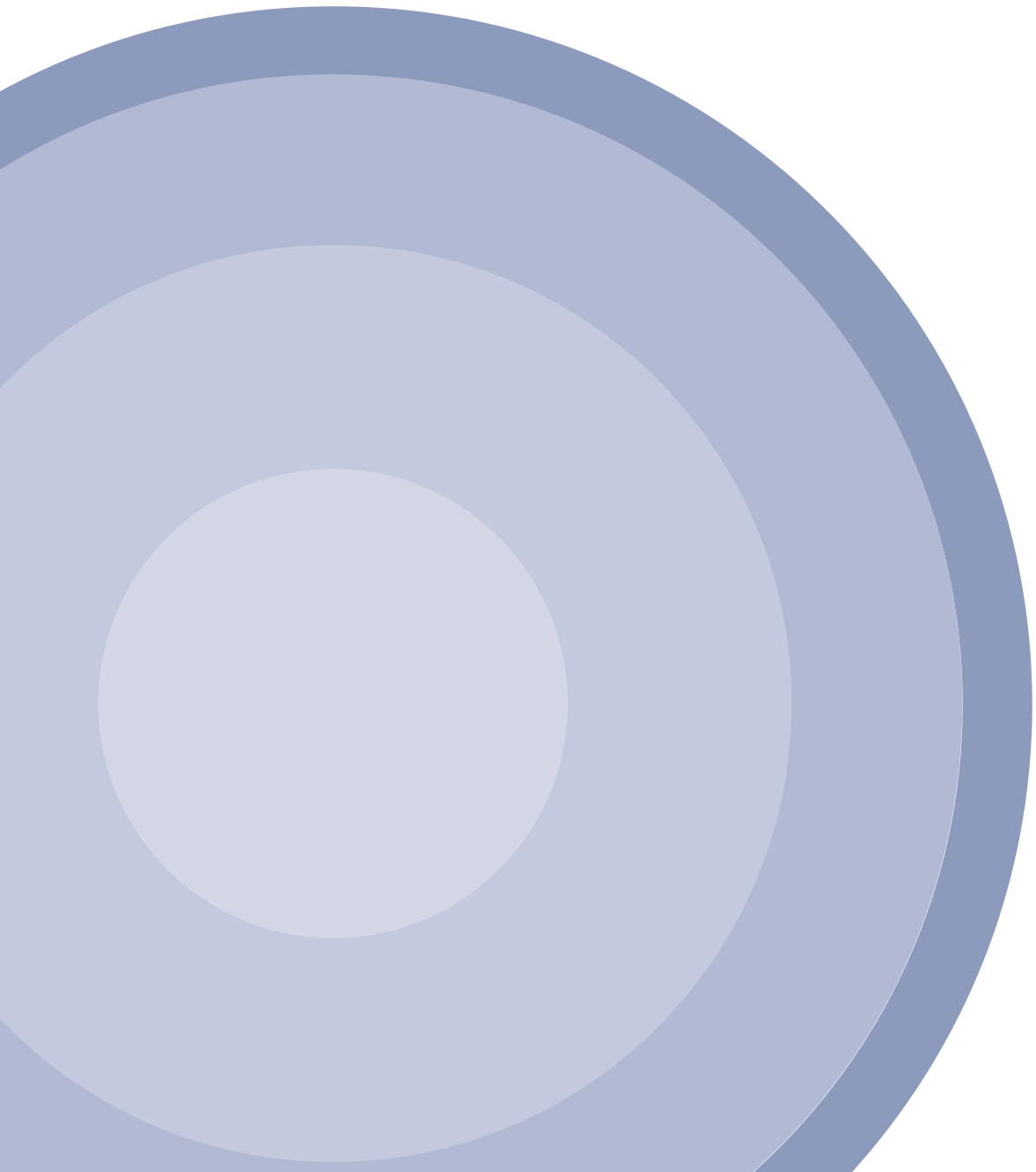
PART 2

GUIDELINES FOR OSTEOPATHS SEEKING REVALIDATION (Revalidation Pilot)

These Guidelines aim to help osteopaths taking part in the Revalidation Pilot prepare and present a portfolio of evidence that shows they are up to date and continue to meet the GOsC's requirements.





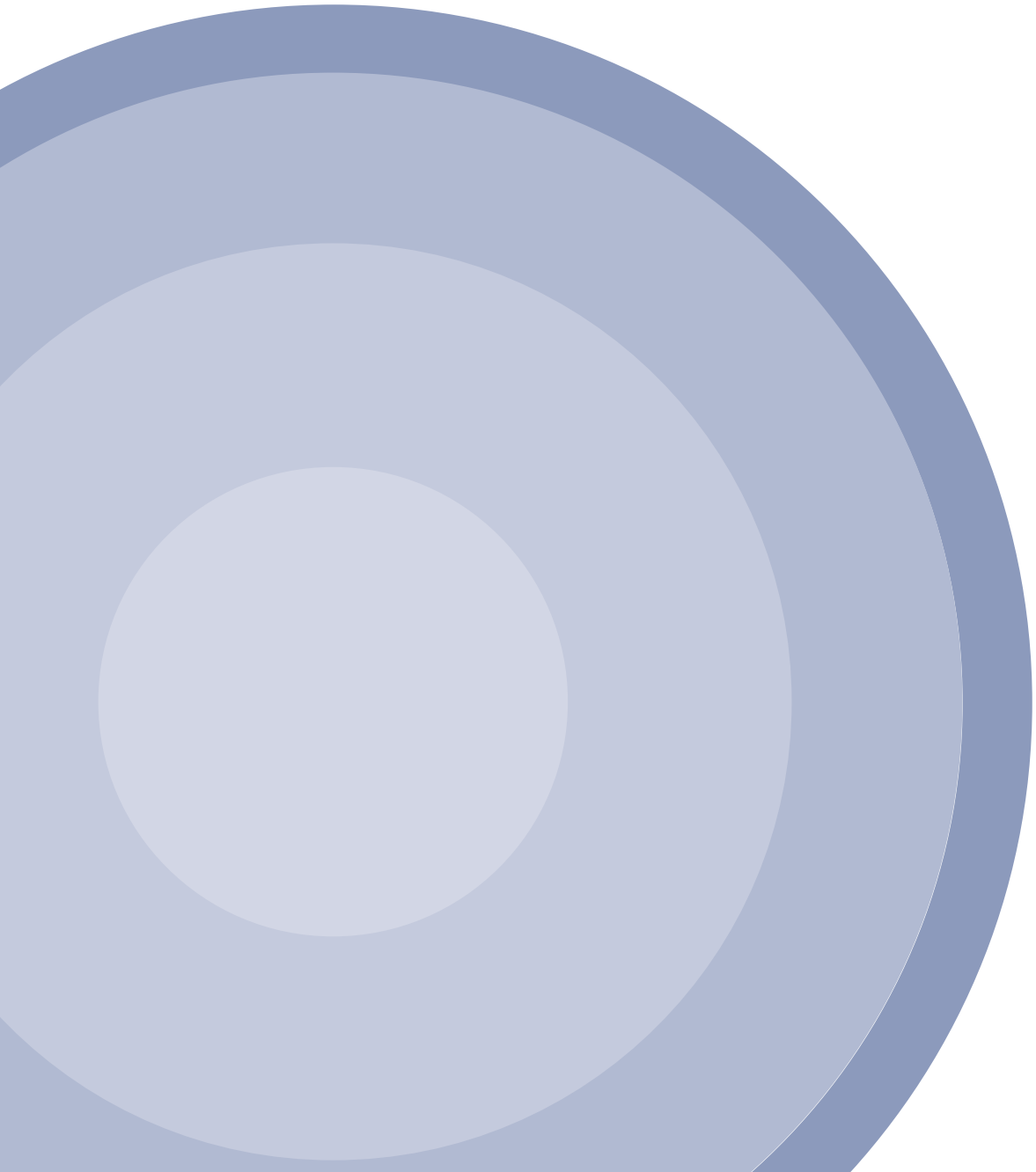


SECTION 1: OVERVIEW

This section explains the purpose of Revalidation and the Revalidation Pilot, along with its key features.

1.1 Purpose of the Guidelines

1.2 Key features of the Revalidation Pilot



1.1 Purpose of the Guidelines

These Guidelines aim to help osteopaths taking part in the Revalidation Pilot to complete a self-assessment and compile a portfolio of evidence that helps them show they are up to date and continue to meet the GOsC's *Osteopathic Practice Standards*. A portfolio is simply a collection of the evidence you have gathered to support your osteopathic practice. Throughout this guidance the term 'portfolio' means the Development Folder used to collate evidence about your practice.

The findings from the Pilot will form part of an independent evaluation of the Revalidation scheme to establish whether the scheme significantly adds value in terms of safety and quality of practice. The evaluation will take into account the costs, benefits, risks and proportionality of the scheme.

These Guidelines detail:

What is expected of you to successfully complete the Revalidation Pilot [see Section 2.1]

Ways that you may provide evidence and frameworks for presenting your evidence [see Sections 2.2 and 3]

The timescale within which your portfolio must be completed [see Section 3.4]

The support you can expect while undergoing the Revalidation Pilot [see Section 3.4]

What will happen if your portfolio does not show you have achieved the Revalidation Criteria [see Section 3.4]

1.2 Key features of the Revalidation Pilot

There are a number of key features of this Revalidation Pilot:

The Pilot will be based on your providing evidence about what you actually do in practice.

The evidence will need to show that you meet the *Osteopathic Practice Standards*; the standards are included in Part 3 this Manual and are also available on the GOsC website at: www.osteopathy.org.uk/practice/standards-of-practice.

The evidence you provide will need to be mapped against the Revalidation Criteria. These Criteria form part of the Revalidation Standards and Assessment Framework which you can find on pages 8–11.

The Revalidation Standards and Assessment Framework sets out the Themes, osteopathic practice standards, and Revalidation Criteria for assessment, as well as examples of evidence that might be suitable for each of the four Themes.

These Themes are:

A. Communication and patient partnership.

B. Knowledge, skills and performance.

C. Safety and quality in practice.

D. Professionalism.

The Revalidation Pilot is intended to be flexible to take account of the diversity of osteopathic practice: you choose what evidence you provide, how you provide it, and show how it meets the Revalidation Criteria. Osteopaths work in a range of locations and have different osteopathic approaches. The Criteria, therefore, have been written in a way that we hope will allow you to produce evidence that is appropriate to your osteopathic practice and to the context within which you work.

In the course of the Revalidation Pilot, you will be asked to:

> Collate evidence every three months, making use of one of the templates from the Guidelines or a clinical audit from NCOR's *An Introduction to Clinical Audit for Practising Osteopaths*, or using evidence collated in another way.

> Submit regular feedback to KPMG about your experience.

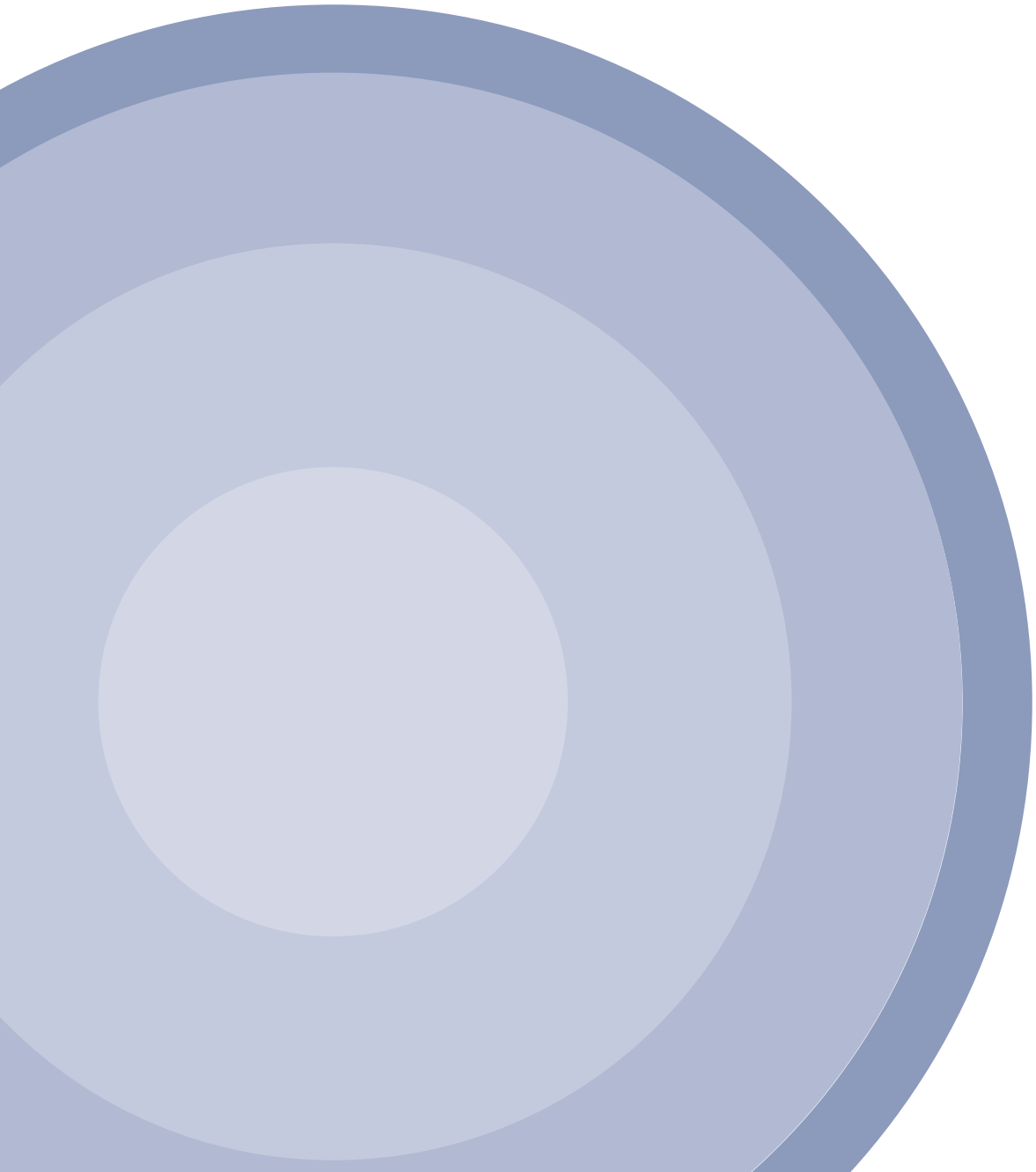
> By 30 September 2012, submit to the GOsC a completed portfolio with your pieces of evidence demonstrating your practice in accordance with the *Osteopathic Practice Standards*, a final self-assessment checklist and a mapping grid. Further information about the checklist and mapping grid can be found in Section 5.

The feedback from your Assessor on completion of the Revalidation Pilot may also help to inform your own CPD in the future.

SECTION 2: BEGINNING TO SELF-ASSESS

This section introduces the Revalidation Standards and Assessment Framework and the Revalidation Criteria. The Revalidation Criteria have been developed to show you exactly what it is you should be able to demonstrate in practice.

Guidance is offered on how to carry out an initial self-assessment of your osteopathic practice using a self-assessment tool (SAT). Support will be provided to help you complete the SAT and action plan during your training workshop.



2.1 Revalidation Standards and Assessment Framework

The Revalidation Standards and Assessment Framework shows the relationship between the four Themes in the *Osteopathic Practice Standards*, the Revalidation Criteria, and the types of evidence that you might use to support the assessment of your practice. The remainder of the Guidelines illustrates in more detail how evidence should be planned, prepared and submitted.

For the purposes of the Pilot only, you will also be required to submit information about your experience of the process to inform the independent evaluation and impact assessment conducted by KPMG.

Table 1 **The Revalidation Standards and Assessment Framework**

REVALIDATION THEMES	REFERENCES IN THE OSTEOPATHIC PRACTICE STANDARDS	REVALIDATION CRITERIA The practitioner will be able to show that he/she:	EVIDENCE Refer to the Guidelines for Osteopaths Seeking Revalidation. Possible sources of evidence
THEME 1 **Communication and patient partnership** The therapeutic relationship between osteopath and patient is built on trust and confidence. Osteopaths must communicate effectively with patients to establish and maintain an ethical relationship. Standards under this Theme focus on the following areas: > Interaction with patients. > Communication. > Consent.	A1–A6	1.1 Creates a relationship with patients that acknowledges the patient's strengths and knowledge. 1.2 Empowers patients to be involved in their healthcare. 1.3 Gains informed consent, as appropriate, in a manner that is understandable to the patient, carer or parent and that is in accordance with legal requirements for consent and the GOsC's *Osteopathic Practice Standards*. 1.4 Involves the patient in understanding the assessment and decisions about their care.	> Practice documentation. > Patient records. > Case presentations. > Case-based discussions. > Patient experience questionnaires.

REVALIDATION THEMES	REFERENCES IN THE OSTEOPATHIC PRACTICE STANDARDS	REVALIDATION CRITERIA The practitioner will be able to show that he/she:	EVIDENCE Refer to the Guidelines for Osteopaths Seeking Revalidation. Possible sources of evidence
THEME 2 **Knowledge, skills and performance** Ethically an osteopath must possess the relevant knowledge and skills required to function as a primary healthcare professional. Standards under this Theme focus on the following areas: > Clinical knowledge and skills. > An ability to recognise and work within own limits of competence.	B1–B4	2.1 Promotes high standards of osteopathic care through their educational activities. 2.2 Applies osteopathic principles, evidence-based practice, where appropriate, and health sciences in an integrated fashion in their patient care. 2.3 Uses their clinical judgement and decision-making skills to determine appropriate osteopathic management plans. 2.4 Determines the boundaries of safe osteopathic practice. 2.5 Liaises with other practising healthcare professionals as appropriate.	> Patient records. > Case presentations. > Case-based discussions. > Clinical reflections. > Personal development needs analysis. > Action plans. > Audits. > Peer review. > Multi-source feedback.

REVALIDATION THEMES	REFERENCES IN THE OSTEOPATHIC PRACTICE STANDARDS	REVALIDATION CRITERIA The practitioner will be able to show that he/she:	EVIDENCE Refer to the Guidelines for Osteopaths Seeking Revalidation. Possible sources of evidence
THEME 3 **Safety and quality in practice** Osteopaths must deliver high-quality, safe, ethical and effective healthcare through thorough evaluation and considered treatment approaches that are clearly explained to the patient and that respect patient dignity. Osteopaths are committed to maintaining and enhancing their practice to continue to deliver high-quality patient care. Standards under this Theme focus on the following areas: > Patient evaluation. > Osteopathic treatment. > Reflection on practice/clinical audit. > Patient care. > Patient modesty. > Risk assessment and risk mitigation. > Ensuring character, health and sufficient insurance cover.	C1–C9	3.1 Critically gathers and records a broad range of sufficient verbal and non-verbal evidence in a professional, patient-centred fashion. 3.2 Makes robust and safe assessments recognising the need for clinical tests when appropriate. 3.3 Applies a safe and competent osteopathic approach. 3.4 Shows critical awareness of the effectiveness and risk indicators of osteopathic management and responds appropriately. 3.5 Applies appropriate solutions in practice to issues surrounding patient modesty within current norms for assessment and effective osteopathic care. 3.6 Ensures that the environment is safe. Adheres to data collection guidelines and ensures full, accurate and timely patient records and data collection are maintained, in line with contemporary legal requirements. 3.7 Avoids, minimises and controls difficult situations. 3.8 Applies complaints procedures, when appropriate, ensuring relevant others are aware of these procedures.	> Practice documentation. > Patient records. > Case presentations. > Case-based discussions. > Management and treatment plans. > Significant event analyses. > Clinical reflections. > Personal development needs analysis. > Action plans. > Peer review. > Multi-source feedback. > Patient experience questionnaires.

REVALIDATION THEMES	REFERENCES IN THE OSTEOPATHIC PRACTICE STANDARDS	REVALIDATION CRITERIA The practitioner will be able to show that he/she:	EVIDENCE Refer to the Guidelines for Osteopaths Seeking Revalidation. Possible sources of evidence
THEME 4 **Professionalism** Osteopaths must deliver safe and ethical healthcare by interacting with professional colleagues and patients in a respectful and timely manner. Standards under this Theme focus on the following areas: > Professional and ethical responsibilities. > Healthcare environment. > Working with other healthcare professionals. > Processing information and data.	D1–D18	4.1 Understands and respects the role of other healthcare professionals and supports a climate that allows the choice of multi-professional care when appropriate. 4.2 Works within the parameters of the *Osteopathic Practice Standards*, acknowledges their own limitations and recognises when to seek advice or to refer. 4.3 Competently seeks current information to inform their osteopathic practice. 4.4 Documents all relevant information about patient management and their osteopathic practice. 4.5 Cares for and manages their patients in a manner that complies with equality and anti-discrimination laws. 4.6 Cares for and manages their patients in a manner that abides by the *Osteopathic Practice Standards*.	> Practice documentation. > Patient records. > Case presentations. > Case-based discussions. > Significant event analyses. > Clinical reflections. > Peer review. > Multi-source feedback. > Patient experience questionnaires. > Audits.

2.2 How to use the self-assessment tool

The purpose of the self-assessment tool (SAT) is to help you assess your ability to show whether you fulfil the Revalidation Criteria (see Table 1 on pages 8–11). It should be used before you start preparing and presenting your evidence.

The SAT will enable you to identify areas where you are already confident that you can provide the required evidence to successfully revalidate your practice. It will also identify at an early stage those areas of practice that might require further development. It is, basically, a quick checklist that if used at an early stage in the Revalidation Pilot will save you time and effort.

The SAT is based around the four Themes of osteopathic practice:

A. Communication and patient partnership.

B. Knowledge, skills and performance.

C. Safety and quality in practice.

D. Professionalism.

Before you start completing the SAT, you might find it useful to take some time to consider your current role:

> What does your routine work entail? What is it that you actually do in the course of your everyday practice?

> What are the common presentations that your patients consult you on? What is the common patient profile?

> What knowledge and skills are required to be an effective practitioner in your area of osteopathic practice?

> Do you feel equally confident in providing supporting evidence for each of the Themes or are there areas where you feel you may need to spend more time gathering evidence?

Step 1 Answering the self-assessment questions

The questions are based on the Revalidation Criteria (see Table 1 on pages 8–11). They are offered as a guide to self-assessment only. If you feel a question is not applicable to your role, you should disregard it. If you think there are more appropriate questions that it would be useful for you to consider, you should add these to your SAT framework.

Step 2 Assessing your ability to show whether you fulfil the Revalidation Criteria

Once you have reflected on the questions, you should indicate your level of ability to demonstrate achievement. There are three options: green, amber or red. You should work your way through the self-assessment questions and tick the colour that you feel applies.

GREEN I am confident I can provide evidence to support achieving the Revalidation Criteria.

AMBER I am not fully confident I can provide enough evidence to support achieving the Revalidation Criteria, and I may need to do some further work on this aspect of my practice.

RED I am not confident I can provide enough evidence to support achieving the Revalidation Criteria. I will definitely need to do some further work on this aspect of my practice.

Step 3 Providing evidence

If you have assessed yourself as able to show that you fulfil the Revalidation Criteria, then you should be able to produce evidence of this. In the final section of the SAT, you should note what evidence you could use to support your self-assessment. This is the first step in gathering your supporting evidence, and you can refer to your self-assessment as you progress through the Pilot.

Step 4 Action planning

Your initial self-assessment may have identified areas where you are not fully confident in your ability to provide evidence to support achieving the Revalidation Criteria. A structured action plan can help you clarify how you might develop and provide evidence on these specific areas of osteopathic practice (see pages 17–18 for further help).

The time taken to complete this initial self-assessment will be worthwhile because it will provide you with a clear structure on which to base gathering and presenting appropriate supporting evidence on. Further guidance on completing your self-assessment and action plan will be given during the regional training workshops.

Theme of osteopathic practice	Revalidation Criteria	Level of ability to provide supporting evidence
Theme 1 **Communication and patient partnership**	Can you provide evidence to show that you: 1.1 Create relationships with patients that acknowledge the patient's strengths and knowledge. 1.2 Empower patients to be involved in their healthcare. 1.3 Gain informed consent, as appropriate, in a manner that is understandable to the patient, carer or parent and that is in accordance with legal requirements for consent and the GOsC's *Osteopathic Practice Standards*. 1.4 Involve the patient in understanding the assessment and decisions about their care.	Green Amber Red

Theme of osteopathic practice	Revalidation Criteria	Level of ability to provide supporting evidence
Theme 2 **Knowledge, skills and performance**	Can you provide evidence to support that you: 2.1 Promote high standards of osteopathic care through your educational activities. 2.2 Apply osteopathic principles, evidence-based practice, where appropriate, and health sciences in an integrated fashion in your patient care. 2.3 Use your clinical judgement and decision-making skills to determine appropriate osteopathic management plans. 2.4 Determine the boundaries of safe osteopathic practice. 2.5 Liaise with other practising healthcare professionals as appropriate.	Green Amber Red

Theme of osteopathic practice	Revalidation Criteria	Level of ability to provide supporting evidence
Theme 3 **Safety and quality in practice**	Can you provide evidence to support that you: 3.1 Critically gather and record a broad range of sufficient verbal and non-verbal evidence in a professional, patient-centred fashion. 3.2 Make robust and safe assessments, recognising the need for clinical tests when appropriate. 3.3 Apply a safe and competent osteopathic approach. 3.4 Show critical awareness of the effectiveness and risk indicators of osteopathic management and respond appropriately. 3.5 Apply appropriate solutions in practice to issues surrounding patient modesty within current norms for assessment and effective osteopathic care. 3.6 Ensure that the environment is safe. Adhere to data collection guidelines and ensure full, accurate and timely patient records and data collection are maintained, in line with contemporary legal requirements. 3.7 Avoid, minimise and control difficult situations. 3.8 Apply appropriate complaints procedures, when necessary, ensuring relevant others are aware of these procedures.	Green Amber Red

Theme of osteopathic practice	Revalidation Criteria	Level of ability to provide supporting evidence
Theme 4 **Professionalism**	Can you provide evidence to support that you: 4.1 Understand and respect the role of other healthcare professionals and support a climate that allows the choice of multi-professional care when appropriate. 4.2 Work within the parameters of the *Osteopathic Practice Standards*, acknowledge your limitations and recognise when to seek advice or to refer. 4.3 Competently seek current information to inform your osteopathic practice. 4.4 Document all relevant information about patient management and your osteopathic practice. 4.5 Care for and manage your patients in a manner that complies with equality and anti-discrimination laws. 4.6 Care for and manage your patients in a manner that abides by the *Osteopathic Practice Standards*.	Green / Amber / Red

2.4 Completing an action plan

This action plan template contains guidance about how to complete it. The goal or aim is identified by your self-assessment.

You will receive help in the course of your training workshop to develop this action plan.

Action plan

Goal/aim	Objectives	Action planned (how?)	Planned completion dates (when?)
What are you aiming to achieve, and why have you identified this as an aim?	Outline the steps that you need to complete along the route to achieving your aim or aims. You may have any number of smaller objectives to help you plan, although it is better to avoid long lists of minor elements (three to six is common).	How do you intend to achieve these objectives (reading, course attendance, advertising, survey, etc.)?	Offer a reasonable time frame by when you plan to complete each objective.

Analysis of outcome	Evidence
What do you feel has changed in your practice following the completion of your action plan?	Evidence may include anything that supports your assertions in your reflection: literature for the practice, patient demographics, CPD certificates, publications, patient feedback, etc.

This is a blank action plan template for your use. Further examples of completed action plans are offered in Section 4.

Action plan template

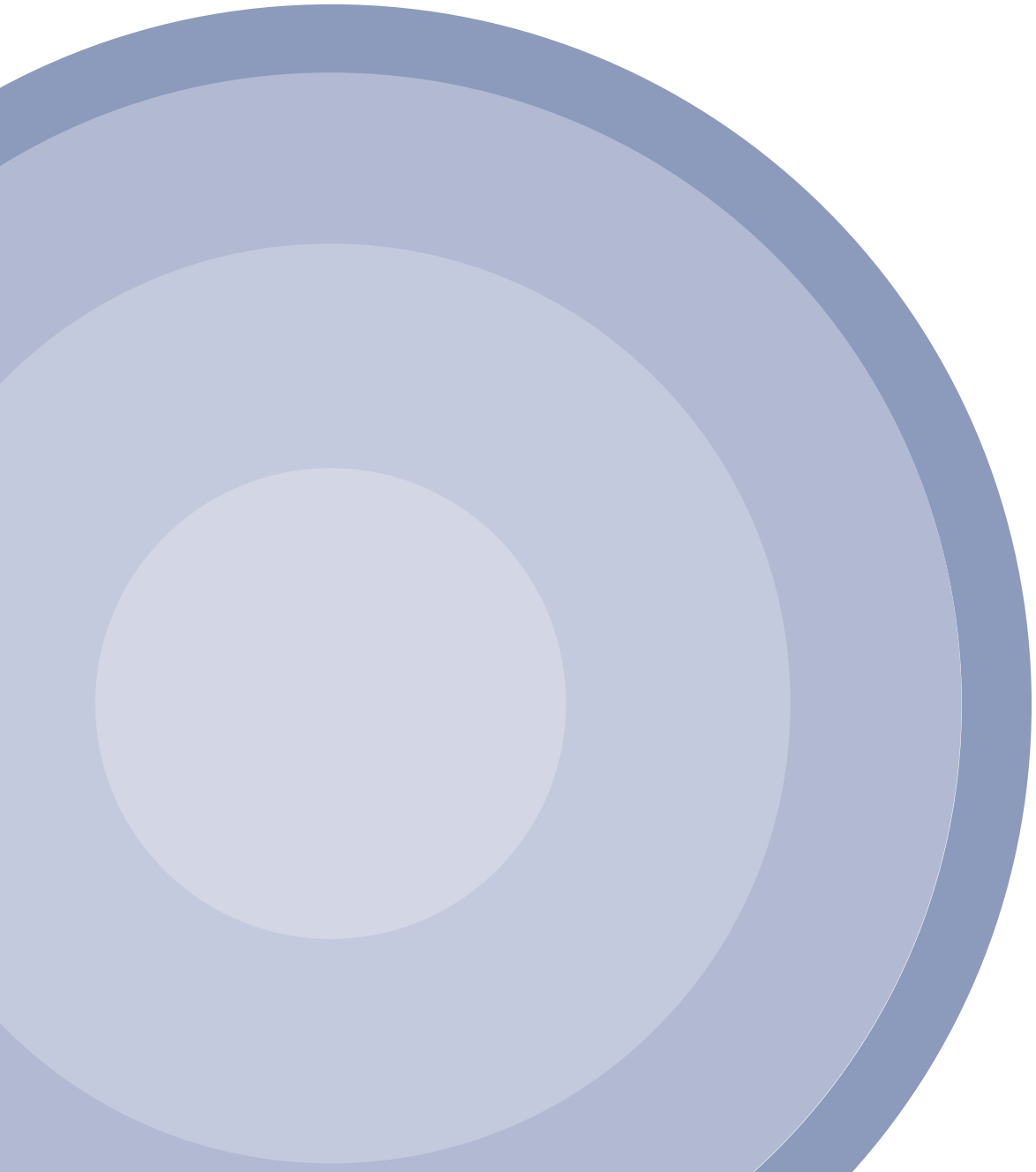
Goal/aim	Objectives	Action planned (how?)	Planned completion dates (when?)

Analysis of outcome	Evidence

SECTION 3: PROVIDING THE EVIDENCE

This section looks at the nature of evidence and offers some ideas on how you might like to prepare and present your evidence for Revalidation. It indicates the minimum requirements for your portfolio.

At first you may find the thought of completing a portfolio a bit overwhelming. But remember, you will be helped to start off the process during your training workshop and will continue to receive support throughout the Pilot.



3.1 What do we mean by evidence?

All osteopaths taking part in the Pilot will be expected to submit a portfolio of evidence, along with the final self-assessment checklist.

The portfolio is how you will show you have achieved the Revalidation Criteria. (See the Revalidation Standards and Assessment Framework on pages 8–11, which illustrates the relationship between the Themes in the *Osteopathic Practice Standards*, the Revalidation Criteria and the types of evidence you might use to support your assessment of your practice.)

Your portfolio does not have to be large or lengthy – the important thing is that it helps you to show that you continue to meet the required standards.

Preparing and presenting your evidence should allow you to show that you have met the Revalidation Criteria and may also help develop your critical thinking and reflective skills.

It will be important that anything you choose to use as evidence is relevant, authentic, sufficient and current. Descriptions of what we mean by this are set out below.

Relevant:

It should be appropriate to the Revalidation Criteria it is being used to demonstrate.

Authentic:

It must be attributable to the osteopath submitting the evidence.

Sufficient:

There must be enough evidence to infer achievement of the Revalidation Criteria.

Current:

It must be up to date (i.e., from the previous five years).

Subjective and objective evidence

Evidence can be **subjective**; i.e., written from your perspective, or **objective**; i.e., written from the perspective of someone else.

3.2 Preparing your evidence

You will find it easier to prepare your evidence if you approach it systematically and logically:

Consider each of the four Revalidation Themes.

Look at the Revalidation Criteria for each Theme and consider these in relation to your osteopathic practice.

Develop an action plan detailing how you intend to prepare your selected evidence (information on how to develop an action plan is available on pages 17–18).

Identify what you feel might be the best method of showing how you practise in relation to the Revalidation Criteria, drawing on the examples set out in these Guidelines if this is helpful.

Set yourself realistic targets and deadlines for carrying out the work detailed in your action plan. We will help you to do this. You should try to complete actions every three months.

Start compiling the evidence.

In Section 5 you will find a final self-assessment checklist and examples of evidence mapping grids. It is a good idea to keep referring to this mapping grid to ensure that you are covering all the Revalidation Themes adequately.

3.3 Presenting your evidence

There are many ways of presenting your evidence. The list below is not exhaustive, but it does represent some of the more commonly accepted ways that healthcare professionals can provide evidence of what they are doing in practice. You may find this helpful when choosing suitable methods. It is divided into three broad categories.

Table 2 **Categories of evidence**

A. Giving information and recording/discussing practice	For example: practice documentation, patient records, case presentations, case-based discussions, management plans.
B. Developing practice	For example: significant event analyses, clinical reflections, personal development needs analysis, action plans.
C. Feedback on practice	For example: peer review, multi-source feedback, patient experience questionnaires, clinical audits.

Evidence does not have to be written material – visual and recorded evidence can be included, where appropriate, so long as consent has been obtained. Where written evidence is provided, this should be typed, rather than handwritten.

It is up to you to choose how you present your evidence to show achievement of each Revalidation Theme.

In addition, research or educational activity in any of these categories could also represent acceptable evidence.

As part of the Revalidation Standards and Assessment Framework, we have included some suggestions as to the types of evidence that may be used to show achievement within the four Themes (see pages 8–11). As you will see, the same forms of evidence can be equally effective in demonstrating that different Revalidation Criteria have been met. For example, patient questionnaires or feedback can be used to successfully show that you fulfil the Criteria for both communication skills and professionalism.

Although there is no intention to prescribe the specific types of evidence needed, you should submit a range of different categories of evidence to support your practice. The range of evidence is illustrated in the final self-assessment checklist in Section 5.

Requirements for submission of evidence

A minimum of one piece of evidence relating to each of the four Themes.

Of these pieces of evidence, a minimum of one piece should come from each of the three categories in Table 2 above.

A minimum of one piece of **subjective evidence** (written from your perspective); e.g., a significant event analysis or a clinical reflection.

A minimum of one piece of **objective evidence** (written from the perspective of someone else); e.g., multi-source feedback or clinical audit.

A brief (100 words maximum) explanation of why you included each piece of evidence and an indication of which Revalidation Criteria the evidence relates to. This requires completion of the mapping grid in Section 5.

Including different categories and types of evidence will ensure that a rounded picture of your osteopathic practice, taken from different perspectives, emerges from your portfolio.

It is possible that one work-based activity may allow you to fulfil all these requirements. For example, you could (with the patient's consent) make a short film of a consultation with a patient. This would enable you to present the evidence detailed in Table 3 below.

Table 3 **Example of how evidence requirements can be met**

EVIDENCE	CATEGORY OF EVIDENCE	METHOD OF OBTAINING EVIDENCE
Review of film by peers and constructive feedback obtained.	C. Feedback on practice	Peer review (**objective evidence**)
Seeking patient's views on how they felt about the consultation.	C. Feedback on practice	Patient experience questionnaire (**objective evidence**)
Exploring your own feelings about the consultation.	B. Developing practice	Clinical reflection (**subjective evidence**)
Including anonymised records you made following the consultation.	A. Giving information and recording/discussing practice	Patient records (**objective evidence**)

Table 3 shows how one activity can provide you with a range of evidence from all three of the specified categories, using different methods to obtain your evidence.

3.4 Assessment and evaluation

You should complete one piece of evidence every three months.

You will receive an evaluation survey every three months, which should be completed and submitted to KPMG. This information will help to illustrate the benefits and costs of the process and will contribute to an independent evaluation and impact assessment.

During the Pilot, you will be provided with appropriate support from the GOsC to help you successfully show achievement of the Revalidation Criteria. Online support will be available via the **o** zone or directly from the GOsC by calling 020 7357 6655 ext 235.

You must complete and submit to the GOsC your portfolio of evidence by 30 September 2012.

Your portfolio will then be analysed by a suitably qualified Assessor who will have received training on how to assess your work. This marks the end of Stage 1 of the Revalidation scheme and the end of the Pilot.

We expect that most, if not all, osteopaths will be able to provide evidence that meets the Revalidation Criteria. If either you raise or your Assessor raises any concerns about your supporting evidence, you will be provided with feedback and the opportunity to incorporate any learning into your future CPD.

SECTION 4: CATEGORIES OF EVIDENCE

This section discusses different categories of evidence and gives examples of methods or templates through which you might obtain your evidence. It presents completed examples using evidence drawn from clinical scenarios so you can see what a submission in your portfolio might look like.

This section also suggests how these methods can be used to show that you are up to date and can show you fulfil the *Osteopathic Practice Standards* through the Revalidation Criteria.

It should be stressed again that there are many frameworks and templates that can help to guide you in presenting your evidence. Those in this section represent a small sample, and you should consider any other framework you feel might be suitable.

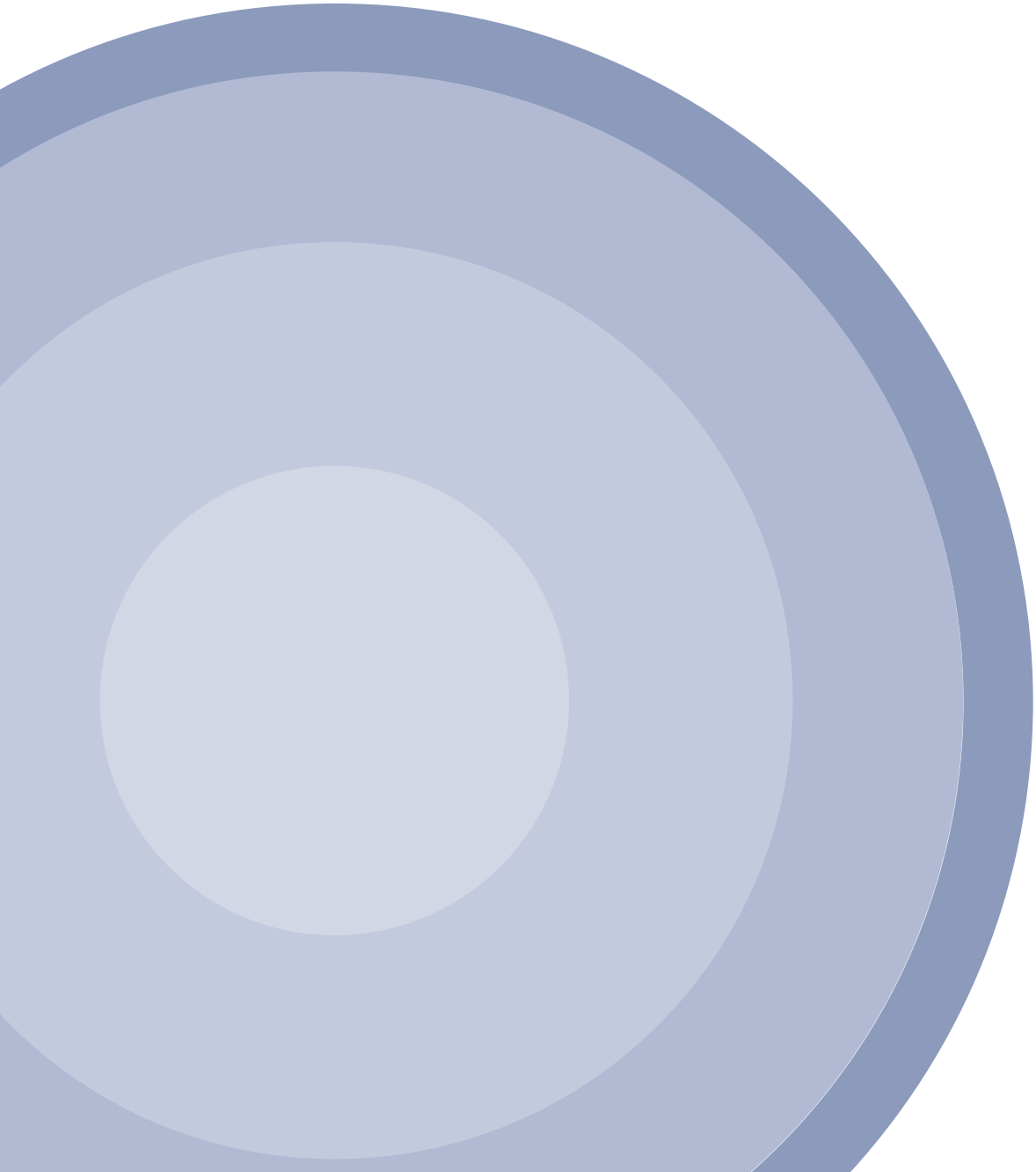
The worked examples included here illustrate how the templates can be used to present your supporting evidence. Different approaches to exploring a specific clinical scenario can allow you to evidence various aspects of your practice for the Revalidation Themes. An illustration of how each piece of evidence might look on the evidence mapping grid has been provided in Section 5.

To help you ensure your completed portfolio contains both objective and subjective evidence, each template is annotated as such.

4.1 Giving information and recording/discussing practice

4.2 Developing practice

4.3 Feedback on practice



4.1 Giving information and recording/discussing practice

Examples of the kinds of evidence you could use include:

> Practice documentation and patient records.

> Case presentation.

> Case-based discussion.

> Management plans.

Information on each of these possibilities is included in this section.

4.1.1 Practice documentation and patient records

Practice documentation and patient records can be rich sources of evidence and ones that should be readily available to you. If you are including these as evidence within your portfolio, it is essential to ensure you have anonymised all details about patients, relatives and carers, so that individuals cannot be identified.

Practice documentation could include, for example, general information sheets about osteopathy, information regarding consent, complaint forms, etc. It could also be any documentation regarding your professional practice that you are required to submit for registration; for example, insurance details.

If you are including patient records as evidence, you should highlight those sections of the records relevant to the Revalidation Criteria they are intended to meet. For example, if you are including a copy of a patient record to show that you meet the Revalidation standards in relation to Theme 1 – Communication and patient partnership – you should highlight the relevant sections of the patient record.

We have not provided examples of practice documentation or patient records in the Guidelines. These are regarded as **objective evidence** for the Pilot.

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4.1.2 Case presentation

A case presentation is where you select a specific patient you have treated and explore, in some detail, how you managed that particular case. It will, normally, be a case that has sparked your interest for some reason. Perhaps, for example, it entailed taking a different approach to care than you would normally have chosen, or perhaps it presented you with some unusual challenges.

A key aspect of a case presentation is that it illustrates your understanding of osteopathic practice and shows how you have gone about managing the case.

Your case presentation should be around 300–500 words and include:

> A clinical summary of the anonymised patient and their presentation. You should include only relevant information and should avoid listing every clinical finding and element of the patient narrative – only include information if it is key to the case.

> Anything from the case history information, examination findings, palpatory evidence or anything else that assisted you in coming to an osteopathic evaluation of your patient. Again, avoid listing everything and keep it relevant to the case.

> Your osteopathic evaluation/summary statement/diagnosis.

> The management plan, agreed with the patient. What were your aims and how did you achieve them?

> The key points that emerged from the case in relation to your individual practice.

In day-to-day practice, case presentations can illustrate a range of elements relating to what you do and allows you to show critical thinking, clinical decision-making, reflective practice and patient management. They can inform what you do and support action planning and personal development, as well as helping to define critical incidents where a significant outcome or experience has influenced your practice.

The case presentation will be regarded as **subjective evidence** for the Pilot because it is normally written from the perspective of the osteopath treating the patient.

Category: Giving information and recording/discussing practice – subjective evidence

Case presentation template

Name of osteopath:

Title of case:

Date:

Brief description/summary of the case:

What conclusions have you reached about the case from the information available to you?
What is it about the case that makes it interesting/challenging/different?

Relevant information from case history:

Include, for example, information from the patient narrative/examination findings/palpatory evidence, etc.

Management plan:

Aims/objectives/how you will achieve them.

Key points:

Draw out key points relating to the four Revalidation Themes.

Case presentation

Clinical scenario 1

JB, a 40-year-old actress and singer, presented with a 15-year history of migraine-type headaches and a seven-year history of trigeminal neuralgia, along with upper back and neck pain and stiffness that she associated with her headaches. Five years ago her GP diagnosed her headaches as being migraine-type headaches, and she reported that their severity had increased over a similar period. She was taking Naramig to help manage her symptoms.

JB experienced migraine symptoms three to four times a month, lasting anything from one to three days at a time. She described them as focused to one side of her head, though they could be left or right-sided. There was an associated aching and stiffness reported in her upper thoracic and cervical spine region bilaterally. There was no premonition of the symptoms, but there was an awareness of 'muscular tension' in the upper cervical region for some time following each episode. It was also reported that sudden extension or rotation movements through the cervical spine seemed to trigger headaches, and the patient felt very vulnerable when looking up.

JB also presented with right-sided facial pain (previously diagnosed as trigeminal neuralgia), described as 'excruciating' and at times 'crushing and burning'. At its worst she said it was 'extreme'. Symptoms were located over the lower part of her face, particularly over her 'cheek bone'.

The primary reason for JB attending the clinic was to find out if there was anything an osteopath could do to help her, particularly as she felt that there appeared to be a relationship between her headaches and her neck.

It was clear from the description of her symptoms and their effect on her life that her symptoms had significantly affected her way of life. JB appeared very anxious about her pain. She chose to wear a face mask to protect her jaw from exposure to the wind, and the debilitating nature of her migraines and facial pain had resulted in her feeling unable to work, and these prevented her from taking part in her previous social activities. Things were made more difficult in that she lived at home with her mother and sister, both of whom were registered disabled.

My examinations failed to indicate any significant abnormalities with the nervous system, although I noted a postural nystagmus when JB stood with her eyes closed. Physical examination revealed a forward head posture and poorly controlled cervical spine movements, especially into extension. JB described these as making her feel extremely vulnerable and as if she could not support her head. She also had acutely tender tissues in the upper thoracic and cervical spine that on palpation seemed to reproduce neck and head pain.

Following my examination, I felt that there were elements to her case that suggested osteopathy could help. We discussed her current treatment and the problems she faced with managing her pain. However, I was unsure precisely what I might realistically be able to achieve. I discussed with JB what I felt could be treated and explained that I did not know what effect treatment might have on her migraines. We agreed to start a course of treatment for her upper back and neck pain, which we would monitor to identify any change. I also contacted a local osteopath I knew to discuss her approach to managing complex head and neck pain.

Category of evidence

The category of evidence explored in this scenario is A – Giving information and recording/discussing practice.

Revalidation Themes

These worked examples present evidence for:

> Theme 1: Communication and patient partnership.

> Theme 2: Knowledge, skills and performance.

> Theme 3: Safety and quality in practice.

> Theme 4: Professionalism.

Examples

The tools used are:

> Case presentation.

> Case-based discussion.

> Management plan.

Worked example: Case presentation – subjective evidence

Name of osteopath: John Smith

Title of case: JB's complex head and facial pain – case presentation

Date: 15.5.11

Brief description/summary of the case:

Ms JB, a 40-year-old actress and singer. She presented with a 15-year history of migraine-type headaches and a seven-year history of trigeminal neuralgia, along with upper back and neck pain and stiffness that she associated with her headaches. One of the key elements of the case was that, as a consequence of the symptoms, the patient was unable to work consistently due to the unpredictability of her symptoms. Over time this had led her to becoming more and more isolated socially.

The patient was looking to find out if osteopathy could help her with her pain. Although she was able to control her headaches and facial pain to some extent with medication, she was interested to find out if osteopathy could help her further, particularly as she felt that movement of her head and neck affected her symptoms.

This patient was interesting because I had never treated a patient with such complex facial and head pain, and I was not sure what my role as an osteopath would be in her care. I was also conscious that there were complex psychosocial issues surrounding the case that could well be having a significant effect on her pain experience.

Relevant information from case history

15-year history of regular headaches, severity increasing over the last five years. Currently being treated with Naramig. She was diagnosed five years ago by her GP as having migraine headaches.

JB experienced her migraine symptoms three to four times a month, lasting anything from one to three days at a time. She described them as being focused to one side of her head, though they could be left or right sided. There was an associated aching and stiffness reported in the upper thoracic and cervical spine region bilaterally.

There was no premonition of the symptoms, but there was an awareness of 'muscular tension' in the upper cervical region for some time following each episode. It was also reported that sudden extension or rotation movements through the cervical spine seemed to trigger headaches, and that the patient felt very vulnerable when looking up.

JB also presented with right-sided facial pain (previously diagnosed as trigeminal neuralgia) described as 'excruciating' and at times 'crushing and burning'. At its worst she said it was 'extreme'. Symptoms were located over the lower part of her face, particularly over her 'cheek bone'.

Talking to JB, it seemed clear that she was very anxious about avoiding any triggers to her trigeminal neuralgia and migraines. She wore a face mask to cover her jaw and protect it from the elements and held a protective posture to guard the right side of her face. She described having to limit all her social activities, based around her pain. This, in particular, seemed to be quite distressing for JB because she appeared to be isolated from her 'old life' and was unable to take part in activities that she enjoyed. She had been unable to work for several years and lived at home with her sister and mother, both of whom were registered disabled.

Clinical findings

Cranial nerve examination II, III, IV, V, VII, IX normal, although it was noted that the patient struggled to stand still with her eyes shut (postural nystagmus suggestive of poor proprioceptive feedback). Upper and lower extremity reflexes, power and sensation were all normal.

Forward head posture was noted with acutely sensitive suboccipital musculature, marked tenderness through C2/3 on the left although tissue tone was relatively poor through the overlying cervical erector spinae. Tonic anterior cervical musculature was evident, specifically in relation to the hyoid.

Tenderness and acutely painful upper thoracic region, with trigger points found within the cervical extensor muscle attachments, serratus posterior superior, rhomboids and trapezius bilaterally. Palpation of these tissues seemed to reproduce some of the aching pain JB experienced following her migraines.

Active movements of the cervical spine were hesitant and poorly controlled. JB was unable to extend her head more than 10 degrees without feeling 'vulnerable', describing this as if she were unable to 'hold her head up' and being fearful of pain. However, all ranges of movement were possible, and passively there were no significant findings to suggest structural weakness.

Management plan

Having reviewed my findings and discussed the case with a colleague, there seemed to be three key issues that I felt I could help to address:

i) There appeared to be significant dysfunction in the cervical spine in relation to postural control of her head and neck.

ii) There was significant anxiety in relation to movement of the head and neck.

iii) This anxiety appeared to be influencing the patient's behaviour and seemed to be complicating her problems both functionally and psychologically.

After discussion with JB, it was agreed that the following aims and objectives would be the focus of our management.

Aims

To help JB regain confidence in being physically active:

a. To improve tissue function in the cervical and upper thoracic spine with a view to affecting her pain levels.

   i. Build trust with the patient in relation to her apprehension of pain to be able to treat her.

   ii. Work towards altering her head posture through the treatment of the anterior and posterior cervical spine musculature and associated fascia into the anterior and posterior thorax.

b. To encourage controlled exercise and simple activities to help JB control head and neck movements.

   i. Simple, focused activities to be done at home to improve proprioceptive control of the head/neck.

c. Over time, consider taking part in previously enjoyed activities (e.g., acting classes).

Key point

Theme 1: Communication and patient partnership

Although I initially felt that it was unlikely that I would be able to have much of an influence on the patient's migraine headaches, it became clear as we discussed her case that JB's focus was not so much on the treatment of her migraines but on regaining some sense of control over her life. Even simple activities, like brushing her hair or going to the cinema, were difficult because she felt she could not carry the weight of her head and was scared that extending her neck would bring on a migraine.

As I was unsure of how successful we might be in achieving the aims of treatment, I suggested a trial period for treatment that would entail weekly appointments for five weeks, accompanied by regular exercising at home. Each week we reviewed progress and reflected on what had changed. I allowed JB to consider if we were making progress and whether we should continue with treatment.

Because JB expressed a lack of control, I was keen to encourage her to take part in the management programme, and I designed some simple exercises that over time allowed her to move her neck in a controlled and pain-free manner, thus increasing her confidence and allowing her to take part in activities that in the past she was unable to do, such as helping her mother to hang new curtains and going to the theatre.

Theme 2: Knowledge, skills and performance

Owing to the unique nature of the case, I took time to review the management of headaches and reviewed some of the literature available to me regarding the osteopathic treatment and management of patients with migraine-type headaches. This was useful in that it helped me reflect on what I thought were the key issues in the case and offered management guidelines that seemed appropriate in this case. I was also able to discuss some of the theories with JB and to identify with her how we might be able to apply them in her case.

Theme 3: Safety and quality in practice

I had to ensure that JB was appropriate to treat and that there were elements of her presentation amenable to osteopathic treatment. As I was unsure of the exact relationship of my findings to the patient's migraines, I spent some time discussing the possible relevance of my findings. Although there were no obvious contra-indications to my treatment plan, there was potential for treatment to possibly trigger a migraine headache, or even induce the trigeminal neuralgia through touch. I therefore had to ensure that all my actions were well communicated and that JB consented for me to act. On a couple of occasions, JB was not feeling particularly well, so we took time to decide what I would be able to do, and I regularly monitored how JB was feeling as the treatment progressed.

4.1.3 Case-based discussion

A case-based discussion can either be a structured discussion with a colleague or colleagues about a specific patient case or it can be a more informal discussion between professionals regarding a case.

It is best to choose cases that include an element of uncertainty, conflict or dilemma (clinical or ethical) because these can provide a useful basis for reflection and discussion.

Before any discussion takes place, the osteopath should review:

- The case records.
- Information about the evidence gathered relating to the case.
- The decision-making process.
- The management of the case.
- The outcomes of the case.

For the Pilot, any case-based discussion that is presented as evidence should be structured around the Revalidation Criteria. You can find a template to facilitate this on page 34. The template can be completed either by the osteopath submitting the portfolio or by another health professional taking part in the discussion.

Case-based discussions allow you to examine your practice in relation to a specific case and to discuss with fellow professionals any issues that you found challenging or difficult. You should be able to show that you can justify any decisions taken and show understanding of the situation. Such discussions often lead to sharing of experiences and learning from the practice of others. Gaps in knowledge and skills may be identified, resulting from the discussion, and you should note any actions that you feel you need to take to address these.

For the Pilot, the case-based discussion is **objective evidence** if written from the perspective of someone else and **subjective evidence** if written as a reflection.

Category: Giving information and recording/discussing practice – subjective or objective evidence

Case-based discussion template

Title of case:
Names of osteopaths discussing:
Date:

Brief description of case (all identifying details to be anonymised):

Revalidation Theme	Points discussed	Actions to be taken
A. Communication and patient partnership		
B. Knowledge, skills and performance		
C. Safety and quality in practice		
D. Professionalism		

Case-based discussion

Clinical scenario 1

JB, a 40-year-old actress and singer, presented with a 15-year history of migraine-type headaches and a seven-year history of trigeminal neuralgia, along with upper back and neck pain and stiffness that she associated with her headaches. Five years ago her GP diagnosed her headaches as migraine-type headaches, and she reported that their severity had increased over a similar period. She was taking Naramig to help manage her symptoms.

JB experienced her migraine symptoms three to four times a month, lasting anything from one to three days at a time. She described them as focused to one side of her head, though they could be left or right sided. There was an associated aching and stiffness reported in her upper thoracic and cervical spine region bilaterally. There was no premonition of the symptoms, but there was an awareness of 'muscular tension' in the upper cervical region for some time following each episode. It was also reported that sudden extension or rotation movements through the cervical spine seemed to trigger headaches, and the patient felt very vulnerable when looking up.

JB also presented with right-sided facial pain (previously diagnosed as trigeminal neuralgia), described as 'excruciating' and at times 'crushing and burning'. At its worst she said it was 'extreme'. Symptoms were located over the lower part of her face, particularly over her 'cheek bone'.

The primary reason for JB attending the clinic was to find out if there was anything an osteopath could do to help her, particularly as she felt that there appeared to be a relationship between her headaches and her neck.

It was clear from the description of her symptoms and their effect on her life that her symptoms had significantly affected her way of life. JB appeared very anxious about her pain. She chose to wear a face mask to protect her jaw from exposure to the wind, and the debilitating nature of her migraines and facial pain had resulted in her feeling unable to work, and these prevented her from taking part in her previous social activities. Things were made more difficult in that she lived at home with her mother and sister, both of whom were registered disabled.

My examinations failed to indicate any significant abnormalities with the nervous system, although I noted a postural nystagmus when JB stood with her eyes closed. Physical examination revealed a forward head posture and poorly controlled cervical spine movements, especially into extension. JB described these as making her feel extremely vulnerable and as if she could not support her head. She also had acutely tender tissues in the upper thoracic and cervical spine that on palpation seemed to reproduce her neck and head pain.

Following my examination, I felt that there were elements to her case that suggested that osteopathy could help. We discussed her current treatment and the problems she faced with managing her pain. However, I was unsure precisely what I might realistically be able to achieve. I discussed with JB what I felt could be treated and explained that I did not know what effect treatment might have on her migraines. We agreed to start a course of treatment for her upper back and neck pain, which we would monitor to identify any change. I also contacted a local osteopath that I knew to discuss her approach to managing complex head and neck pain.

Category of evidence

The category of evidence explored in this scenario is A – Giving information and recording/discussing practice

Revalidation Themes

These worked examples present evidence for:

- Theme 1: Communication and patient partnership.
- Theme 2: Knowledge, skills and performance.
- Theme 3: Safety and quality in practice.
- Theme 4: Professionalism.

Examples

The tools used are:

- Case presentation.
- Case-based discussion.
- Management plan.

Worked example: Case-based discussion – subjective or objective evidence

Title of case: JB
Name of osteopaths discussing: Steve Paterson/Jan Oscar
Date: 26.3.11

Brief description of case (all identifying details to be anonymised):

Clinical findings

There was no premonition of the symptoms, but there was an awareness of 'muscular tension' in the upper cervical region for some time following each episode. It was also reported that sudden extension or rotation movements through the cervical spine seemed to trigger headaches and that the patient felt very vulnerable when looking up.

Cranial nerve examination II, III, IV, V, VII, IX normal, although it was noted that the patient struggled to stand still with her eyes shut (postural nystagmus suggestive of poor proprioceptive feedback).

Forward head posture. Acutely sensitive suboccipital musculature, marked tenderness through C2/3 on the left although tissue tone was relatively poor through the overlying cervical erector spinae. Tonic anterior cervical musculature, specifically in relation to the hyoid.

Tenderness and acutely painful upper thoracic region, with trigger points found within the cervical extensor muscle attachments, serratus posterior superior, rhomboids and trapezius bilaterally. Palpation of these tissues seemed to reproduce some of the aching pain JB experienced following her migraines.

Active movements of the cervical spine were hesitant and poorly controlled. JB was unable to extend her head more than 10 degrees without feeling 'vulnerable', describing this as if she were unable to 'hold her head up' and being fearful of pain. However, all ranges of movement were possible, and passively there were no significant findings to suggest structural weakness.

Personal clinical issues

I found this case particularly challenging on a number of levels:

- JB had come to me looking to find out whether osteopathy could help her, having had many years of pain and subsequent 'disability'.
- There were numerous elements in the case that appeared related to JB's neck pain and headaches, but I was not sure what role they might be playing and whether, if I treated them, it would affect JB's symptoms.
- There were complex psychosocial issues in this case relating to JB's chronic pain, her apparent fear avoidance activity (an obvious yellow flag), her apparent isolation from her previous occupation and social life, and her role supporting her relatives.
- My scope of practice limitations.

I recalled another osteopath in my local region who I knew had worked extensively with patients in a chronic pain setting, so I decided to contact her to discuss the case and to find out if she had any thoughts as to how I might manage this case, or if I should refer JB for treatment elsewhere.

The summary of our discussion and actions to be taken can be seen overleaf.

Revalidation Theme	Points discussed	Actions to be taken
A. Communication and patient partnership	**Identifying patient's expectations:** One of the first things my colleague asked me was what my patient was expecting from osteopathy. I admitted I wasn't entirely sure, but I recognised that this would be really important in my establishing if my patient's expectations were beyond my scope as well as identifying factors that I might be able to influence. We agreed that it would be essential for these expectations to be discussed with JB, so that she and I would be able to decide on the best course of action for her care.	> To spend some time with JB discussing her expectations and what she hoped to gain from osteopathic treatment. > To identify aspects of her case that I felt I could influence and to discuss with JB the possible treatment, management and likely outcomes so that she would be able to decide if she wished to proceed with treatment. > Maintain an open dialogue with JB to ensure that our aims and objectives were shared and that her expectations were being met.
B. Knowledge, skills and performance	**Develop my scope of practice:** My colleague also discussed some helpful aspects relating to the current understanding of migraine headaches. She suggested I should read a couple of papers published by an osteopath, relating to managing migraine headache patients, as well as the latest guidelines published by the Scottish Intercollegiate Guidelines Network (SIGN) for the diagnosis and management of headaches in adults.	> Search the literature online for the SIGN guidelines and review the management of migraine. > Search online for the articles suggested, and any others that might help me to better understand the issues relating to managing migraine in osteopathy and healthcare in a broader setting.
C. Safety and quality in practice	**Ensure quality of patient care:** During our discussion, we explored approaches to treatment. It was agreed that during the initial stages of treatment, patients with such symptoms would probably be somewhat nervous of treatment. Consequently it would be important to treat the patient relatively non-invasively and to continuously look for feedback in relation to pain, the patient's perceptions of the treatments and any anxiety they might be feeling. It was also agreed that there would be a need to identify objective factors in the case that could be re-assessed and reviewed with the patient, so that goals could be monitored and progress recognised.	> Plan a staged introduction of treatment, with clear instructions to the patient with regards the experience of pain. Also to be aware of possible triggers for migraines and her trigeminal neuralgia, and to ensure that if the patient has any sense of risking a trigger to stop treatment. > Identify two or three elements that can be monitored for change during the course of treatment. Agree them with the patient and retest each one at every appointment. > Begin to look towards activities that the patient realistically feels able to take part in and, assuming there are recognised improvements, to try to take up that activity again.

Revalidation Theme	Points discussed	Actions to be taken
C. Safety and quality in practice cont.	The psychosocial aspects of the case seemed significant. My colleague suggested that I might like to set goals with the patient that might begin to allow her to become more socially active. One thing I thought might be amenable to change was her lack of confidence in her neck movements. My colleague suggested some simple exercises that might be useful in practice and that could give JB something to work on whilst outside the treatment room.	
D. Professionalism	**Involve others in patient management**: My colleague also considered whether the patient might benefit from referral to a pain management specialist. She reflected that for many chronic pain sufferers there was some good evidence that learning to develop personal strategies to live with chronic pain was helpful, although my colleague was unaware of examples for migraine and trigeminal neuralgia. See also B regarding reviewing and exploring the literature surrounding migraine/headache.	> To consider this further and to investigate whether the patient has accessed such services already. Possibly consider writing to JB's GP and specialist (managing her trigeminal neuralgia) to explore these options further.

4.1.4 Management plan

A management plan is a plan devised by both the osteopath and the patient to guide the overall management of the patient's care. It should include:

- The overall aim of the osteopathic management of the patient.
- Specific objectives that will be carried out to achieve this aim.
- The actions that will be carried out by both the osteopath and the patient to achieve the objectives.
- An indication of how the management will be evaluated.

The main purpose of a management plan is to allow the patient to be managed by themselves and the osteopath in a planned, structured way. It makes managing the patient transparent and explicit and can be reviewed by the osteopath, the patient and other healthcare professionals.

For the Pilot, the management plan will normally be regarded as **subjective evidence**.

template

Category: Giving information and recording/discussing practice – subjective or objective evidence

Management plan template

Aim: Write an overall aim for the management you have agreed with your patient.

Objectives	Actions	Evaluation
Include here specific objectives agreed with your patient. These should cover all aspects of management.	Detail here the actions you and the patient have agreed to undertake to achieve the objectives. You should include timescales to complete the actions.	Detail here how you are going to evaluate whether or not the actions have been effective. If they have not, then your management plan may need to be revised.

Management plan

Clinical scenario 1

JB, a 40-year-old actress and singer, presented with a 15-year history of migraine-type headaches and a seven-year history of trigeminal neuralgia, along with upper back and neck pain and stiffness that she associated with her headaches. Five years ago her GP diagnosed her headaches as migraine-type headaches, and she reported that their severity had increased over a similar period. She was taking Naramig to help manage her symptoms.

JB experienced her migraine symptoms three to four times a month, lasting anything from one to three days at a time. She described them as focused to one side of her head, though they could be left or right sided. There was an associated aching and stiffness reported in the upper thoracic and cervical spine region bilaterally. There was no premonition of the symptoms, but there was an awareness of 'muscular tension' in the upper cervical region for some time following each episode. It was also reported that sudden extension or rotation movements through the cervical spine seemed to trigger headaches, and the patient felt very vulnerable when looking up.

JB also presented with right-sided facial pain (previously diagnosed as trigeminal neuralgia), described as 'excruciating' and at times 'crushing and burning'. At its worst she said it was 'extreme'. Symptoms were located over the lower part of her face, particularly over her 'cheek bone'.

The primary reason for JB attending the clinic was to find out if there was anything an osteopath could do to help her, particularly as she felt there appeared to be a relationship between her headaches and her neck.

It was clear from her symptoms and their effect on her life that her symptoms had significantly affected her way of life. JB appeared very anxious about her pain. She chose to wear a face mask to protect her jaw from exposure to the wind, and the debilitating nature of her migraines and facial pain had resulted in her feeling unable to work, and these prevented her from taking part in her previous social activities. Things were made more difficult in that she lived at home with her mother and sister, both of whom were registered disabled.

My examinations failed to indicate any significant abnormalities with the nervous system, although I noted a postural nystagmus when she stood with her eyes closed. Physical examination revealed a forward head posture and poorly controlled cervical spine movements, especially into extension. JB described these as making her feel extremely vulnerable and as if she could not support her head. She also had acutely tender tissues in the upper thoracic and cervical spine that on palpation seemed to reproduce her neck and head pain.

Following my examination I felt that there were elements to her case that suggested that osteopathy could help. We discussed her current treatment and the problems she faced with managing her pain. However, I was unsure precisely what I might realistically be able to achieve. I discussed with JB what I felt could be treated and explained that I did not know what effect treatment might have on her migraines. We agreed to start a course of treatment for her upper back and neck pain, which we would monitor to identify any change. I also decided to contact a local osteopath that I knew to discuss her approach to managing complex head and neck pain.

Category of evidence

The category of evidence explored in this scenario is A – Giving information and recording/discussing practice.

Revalidation Themes

These worked examples present evidence for:

- Theme 1: Communication and patient partnership.
- Theme 2: Knowledge, skills and performance.
- Theme 3: Safety and quality in practice.
- Theme 4: Professionalism.

Examples

The tools used are:

- Case presentation.
- Case-based discussion.
- Management plan.

Worked example: Management plan – subjective or objective evidence

Name of osteopath: John Smith
Title of case: JB's complex head and facial pain – management plan
Date: 15.5.11

Aim: To help JB regain confidence in being physically active.

Objectives	Actions	Evaluation
> To improve tissue function in the cervical and upper thoracic spine with a view to affecting her pain levels. > To build a trusting relationship so that JB can be confident every care will be taken to avoid triggering acute pain. > Affect tissue sensitivity in the upper thoracic and cervical spine. > Begin to alter head posture and movement control through the cervical spine.	> Communicate clearly about what is taking place during treatment and ensure that the patient is happy with what is proposed before carrying out any technique. Be particularly cautious when treating near the face and jaw (ongoing). Weeks 1-6 (treatment initially weekly for four weeks): > Introduce simple exercises that begin to address some of the poor functional control of posture: > AP glide through the cervical spine. > Controlled slow flexion and extension. > Agree with the patient the protocol for exercise and what we are trying to achieve. > Reduce the sensitivity of the erector spinae musculature throughout the thoracic and cervical spine by applying direct and indirect osteopathic techniques to the spine and soft tissues. Weeks 3-6 (possibly extend time between treatment): > Improve the mobility of the upper thoracic spine and upper ribs. > Improve flexion and extension through the thoracic spine. > Articulation with/without resistance to the OA joint and upper cervical spine. > Treatment of the anterior cervical soft tissues and fascia and thoracic diaphragm. > Introduce a simple stretching/exercise programme to begin to lengthen the anterior neck muscles.	> Monitor the patient's level of comfort throughout treatment. > Identify existing pain patterns and levels at each treatment (using a verbal analogue scale) and compare reported pain levels at each session. > Establish and agree the current limitations of movement and review them at each session to identify if there has been any change in the range and quality of movement. > Review daily activities that the patient feels are difficult or that she is anxious about (e.g., brushing her hair). > Improved passive and active range of movement of the cervical spine in extension. > Reduction in the patient's kyphotic posture. > Breathing patterns.

Objectives	Actions	Evaluation
> Enable greater control of fine movement in the upper cervical spine by improving proprioception.	Weeks 6-12 (treatment once a month): > Articulation with/without resistance to the OA joint and upper cervical spine. > Treatment of the anterior cervical soft tissues and fascia and thoracic diaphragm. > Introduction of more complex balance/proprioceptive exercises involving head position and postural control.	> Patient reported improvements. > Observation of the exercises at each appointment to identify improvement of balance. > Evaluate quality of movement.
> Approach the apparent fear avoidance and anxiety issues related to the patient's experience of pain. > To tackle the sense of social isolation.	> Combine exercises that begin to simulate difficult activities in a controlled manner. > Discuss the potential to refer the patient for further support in managing her pain (e.g., cognitive behavioral therapy). > As confidence grows in physical movements, look at activities such as acting classes.	> Discuss levels of anxiety and whether such levels diminish. > If referral needed, maintain a dialogue with the practitioner on the patient's progress.

4.2 Developing practice

Examples of the kinds of evidence you could use include:

> Significant event analyses.

> Clinical reflections.

> Personal development needs analysis.

> Action plans.

Information on each of these possibilities is included in this section.

4.2.1 Significant event analysis

A significant event analysis (SEA) is an analysis of a selected event that you have either observed or participated in and that has significance for you. It may be based on any event that happened in your osteopathic practice that has had an effect on you, and it can explore positive and negative experiences.

Because you are analysing events in depth, SEAs tend to be longer than case presentations and will normally take 500–1,000 words to complete. Your SEA should include:

> A brief description of the significant event.

> An exploration of why the event happened.

> An analysis of what you did and how you managed the event. For Revalidation, this should focus on the four Revalidation Themes.

> Consideration of what you have learned through analysing the event.

> Discussion of what you have changed as a result of the event.

Healthcare professionals have a tendency to focus on negative experiences, rather than events with a positive outcome, but it can be equally valuable to analyse why a particular incident had a favourable outcome. SEAs can be used to confirm good practice and to share it with others. By allowing you to focus on specific actions and behaviours, they can offer insight into your practice and encourage you to reflect on how you manage events.

For the Pilot, the significant event analysis will normally be regarded as **subjective evidence**.

Category: Developing practice – subjective evidence

Significant event analysis template

Name of osteopath:

Title of significant event:

Date:

DESCRIPTION OF EVENT

Provide a brief description of the event.

WHY DID IT HAPPEN?

Explore the main and underlying reasons – both positive and negative – contributing to why the event happened. Consider, for instance, lack of knowledge, the complexity or uncertainty associated with the event, the behaviour of yourself and others.

WHAT DID YOU DO?

Analyse how you managed the event. Focus on the four Revalidation Themes and reflect on your use of these areas of practice in managing the situation.

WHAT HAVE YOU LEARNED?

Demonstrate that reflection and learning have taken place and that relevant team members have been considered in the analysis of the event. Consider, for instance, a lack of education or development, the need to follow procedures or guidelines, the vital importance of effective communication.

WHAT HAVE YOU CHANGED?

Discuss the action(s) agreed and implemented, where this is relevant and feasible. Consider, in particular, where you need further learning and development in any of the four Revalidation Themes.

Significant event analysis

Clinical scenario 2

Claire, a 16-year-old girl, attended an appointment accompanied by her mother. I had previously treated her mother for persistent back and neck pain. According to her mother, Claire had been complaining of increasing 'aches and pains' in her knees, which her mother had ascribed to 'growing pains'. Apart from her knee problem, Claire was a fit, healthy adolescent who was a keen hockey player and captain of her school junior hockey team. She was hoping to be selected for the county junior team in the near future and had been attending hockey practice almost daily over the past few months.

On initial assessment, it was difficult to engage Claire in conversation because her mother insisted on answering all my questions. By the look on Claire's face, I surmised that her mother's responses did not always reflect what Claire would have said, if given the opportunity. I eventually asked Claire's mother to remain in the waiting area while I examined Claire in private. Her mother was reluctant to do this, but I felt it necessary to insist because I wanted to gain Claire's perspective on her signs and symptoms. Once alone, Claire was much more forthcoming with information and chatted readily about her pain and knee discomfort. This enabled me to take and document a full verbal history.

With Claire's consent, I carried out a physical examination on her. I had some initial concerns about examining her because I have not had a lot of experience with treating children and young people. Most of my patients are adults; most of whom are middle-aged. However, I felt that my skills and knowledge were sufficient to carry out a sound assessment, which I duly documented. Following examination, I concluded that, although osteopathic treatment might benefit her, there was also the possibility that she had knee joint abnormalities that would possibly require orthopaedic intervention. When I explained this to Claire, she was keen for me to refer her to an orthopaedic specialist for further investigation because she felt that if her knees continued to trouble her, her hockey career might be adversely affected.

However, when I explained this to Claire's mother, she expressed dissatisfaction. She had had a bad experience in the local hospital several years ago when an operation to her lumbar disc area had been unsuccessful and had resulted in chronic back pain. At first she was adamant that she would not give her consent for me to refer Claire for an orthopaedic opinion, claiming that her daughter was too young to realise the implications of possible orthopaedic surgery. Claire was equally adamant that she wanted her knee problems fully investigated. I felt that Claire was fully informed about her treatment options and that she had completely understood the implications both of further osteopathic treatment by myself and of referral. I allowed the pair to discuss the options in the privacy of my office and, eventually, Claire's mother conceded that her daughter was mature enough to make her own decisions regarding treatment.

Although I was unable to refer Claire directly for an orthopaedic opinion, I did document my assessment finding in a letter to her GP, suggesting that she be referred. When Claire's mother attended for further treatment on her back some months later, she told me that Claire had undergone a routine arthroscopy. Several pieces of loose cartilage had been removed from both knees. Claire had now fully recovered and was playing regular hockey, free of any pain and discomfort in her knees.

Category of evidence

The category of evidence explored in this scenario is B – Developing practice.

Revalidation Themes

These worked examples present evidence for:

> Theme 1: Communication and patient partnership.

> Theme 4: Professionalism.

Examples

The tools used are:

> Significant event analysis.

> Clinical reflection.

Worked example: Significant event analysis – subjective evidence

Name of osteopath: Heather Grundy
Title of significant event: Young girl with knee problems
Date: 23.5.11

Rationale for presenting a significant event analysis as supporting evidence

This event was significant for several reasons. First, I was working with a young person, and my experience of working with that age group is limited. I felt that it would be useful to explore how I had dealt with the situation and confirm, to myself and the GOsC, that I remain proficient in this area of my practice. Second, I suspected the treatment Claire needed was out of my scope of practice, and I had to acknowledge that a referral to another healthcare practitioner was required. This is not always an easy judgement to make. A third factor was informed consent, which led me to question my knowledge in this area. The final reason for choosing this event was that several difficult communication issues arose, and my analysis shows that I dealt with these very effectively.

Description of event

Claire, a 16-year-old girl, attended an appointment accompanied by her mother. I had previously treated her mother for persistent back and neck pain. According to her mother, Claire had been complaining of increasing 'aches and pains' in her knees, which her mother had ascribed to 'growing pains'. Apart from her knee problem, Claire was a fit, healthy adolescent who was a keen hockey player and captain of her school junior hockey team. She was hoping to be selected for the county junior team in the near future and had been attending hockey practice almost daily over the past few months.

On initial assessment, it was difficult to engage Claire in conversation because her mother insisted on answering all my questions. By the look on Claire's face, I surmised that her mother's responses did not always reflect what Claire would have said, if given the opportunity. I eventually asked Claire's mother to remain in the waiting area while I examined Claire in private. Her mother was reluctant to do this, but I felt it necessary to insist because I wanted to gain Claire's perspective on her signs and symptoms. Once alone, Claire was much more forthcoming with information and chatted readily about her pain and knee discomfort. This enabled me to take and document a full verbal history

With Claire's consent, I carried out a physical examination on her. I had some initial concerns about examining her because I have not had a lot of experience with treating children and young people. Most of my patients are adults; most of whom are middle-aged. However, I felt that my skills and knowledge were sufficient to carry out a sound assessment, which I duly documented.

Following examination, I concluded that, although osteopathic treatment might benefit her, there was also the possibility that she had knee joint abnormalities that would possibly require orthopaedic intervention. When I explained this to Claire, she was keen for me to refer her to an orthopaedic specialist for further investigation because she felt that if her knees continued to trouble her, her hockey career might be adversely affected.

However, when I explained this to Claire's mother, she expressed dissatisfaction. She had had a bad experience in the local hospital several years ago when an operation to her lumbar disc area had been unsuccessful and resulted in chronic back pain. At first she was adamant that she would not give her consent for me to refer Claire for an orthopaedic opinion, claiming her daughter was too young to realise the implications of possible orthopaedic surgery. Claire was equally adamant that she wanted her knee problems fully investigated. I felt that Claire was fully informed about her treatment options and that she had completely understood the implications both of further osteopathic treatment and of referral. I allowed the pair to discuss the options in the privacy of my office and, eventually, Claire's mother conceded that her daughter was mature enough to make her own decisions regarding treatment.

Although I was unable to refer Claire directly for an orthopaedic opinion, I did document my assessment finding in a letter to her GP, suggesting that she be referred. When Claire's mother attended for further treatment on her back some months later, she told me Claire had undergone a routine arthroscopy. Several pieces of loose cartilage had been removed from both knees. Claire had now fully recovered and was playing regular hockey, free of any pain and discomfort in her knees.

Why did it happen?

One of the main factors contributing to the event was the behaviour of Claire's mother. In the initial stage of the consultation, she persisted in answering questions on Claire's behalf, even when I directed my questions to Claire. It was obvious that she wanted to be present at all times during her daughter's assessment and that she felt excluded when I assessed Claire in private. When I suggested orthopaedic treatment might be a possible course of action, she was quite forceful in manner and unwilling to discuss the matter at first. I could understand the effect her personal experience had on her but did not want it to affect Claire's possible treatment in this way. Once she had been given the opportunity to discuss things more fully with Claire, she behaved in a much more rational manner and was willing to accept her daughter's decision.

I felt that Claire behaved in a very mature way throughout the event. To begin with, she allowed her mother to control the situation, but when encouraged, she expressed her opinions clearly and strongly. It was obvious to me that she understood what I was explaining to her and the implications of alternative courses of action. It would have been easy for Claire to back down and agree with her mother, but she stood her ground and insisted on making her own decision. I was very impressed that she continued to discuss things very calmly with her mother, until she managed to persuade her mother that referral was probably the best course of action. Claire's continuing ability to play hockey at a high level was obviously important to her.

I think that my behaviour had a major effect on the way the scenario evolved. Rather than allowing Claire's mother to dominate the conversation, I assessed Claire in private and encouraged her to contribute fully to her assessment. Although I had some concerns about working with a young person, I did not allow Claire to see this, and I think that I came across as confident and proficient. My assessment, which concluded that referral to an orthopaedic specialist might be an option, obviously had a significant effect on the ensuing behaviours. I supported Claire in her decision to seek an orthopaedic opinion and helped her to have a full discussion with her mother until agreement was reached. I was keen for this to happen because I was not sure of the situation with regard to informed consent and young adults, and I did not particularly want to be put in a position where my knowledge on this might be questioned. Overall, I think that my behaviour in encouraging Claire and her mother to talk things through and in referring for further assessment via a GP led to a positive outcome.

What did I do?

This analysis of what I did will focus on the Revalidation Criteria for Theme 1, Communication and patient partnership, and Theme 4, Professionalism.

The relationship I created with Claire was crucial to achieving a positive outcome. By assessing her in private, without her mother present, I could encourage her to express her feelings and opinions. Although she was relatively young, this meant she was empowered to control what happened to her and to play an active part in making decisions about her care. Once Claire decided that she wished to seek a further opinion, I supported her in explaining this to her mother.

Before excluding Claire's mother from the consultation, I confirmed with Claire that this was what she wanted. I ensured Claire was fully informed at all stages about what my assessment revealed and about what her treatment options were. She asked for further clarification on some points, and I supplied her with the relevant information. I was confident that her final decision was based on full information and understanding of all the relevant facts.

Although my priority throughout the consultation was Claire, it was important that I also communicated effectively with her mother. This required a fair degree of assertiveness on my part, particularly in excluding her from the assessment and in supporting Claire's decision to be referred. Throughout the event, I tried to be very firm whilst remaining polite. Allowing her mother to discuss matters fully, in private with Claire, made her feel involved in the final decision and allowed her to change her mind without losing her dignity.

As stated above, I initially had reservations about seeing a young person, but I tried not to let this become apparent. Once I undertook the assessment, I was more confident in my knowledge and ability to deal with the situation. I recognised that osteopathic treatment might not be the most effective course of action for Claire and was able to refer her through the most appropriate channels. At all stages, I completed full and accurate documentation of the consultation.

What have I learnt?

On reflection, I feel that I managed this event effectively. However, I did learn things during this consultation:

> My ability to communicate effectively with young people has been enhanced because of this experience. I will be more self-assured in future when working with this age group. It is, however, an area I would like to do more reading/research on.

> Although I am confident that I assessed and diagnosed Claire's knee problems accurately, I need to revisit and revise my knowledge of the anatomy of this area of the body.

> My knowledge of informed consent in young people is inadequate, and this is something I need to address.

What have I changed?

I have developed an action plan, detailing the actions I will take following the points outlined above.

4.2.2 Clinical reflection

Clinical reflection is, in some way, not dissimilar to a significant event analysis (SEA) because it requires some of the same skills of analysis. However, a clinical reflection tends to be more concerned with your thoughts and feelings, and is often more personal than a SEA.

The most common form of reflection (reflection-on-action) requires you to look back at an area of practice and to explore your actions and feelings on this, to try to make sense of these actions and feelings, and to make any changes following on from your reflection that you feel may be necessary.

Your reflection should be 1,000-2,000 words long and should include:

- A brief description of the event.
- An exploration of your thoughts and feelings on what has happened.
- An evaluation of what was good or bad about the experience.
- Analysis of what you have learnt from the experience.
- Conclusions about what you could have done differently, if anything.
- An action plan detailing what you would do if it happens again.

A clinical reflection will help you make sense of professional experiences so that you can learn from them. When you reflect on an area of osteopathic practice, you can learn valuable lessons about what did and what did not work, and you can incorporate relevant changes into your future practice.

There are many models of structured reflection that you may find helpful in guiding you if wish to submit a clinical reflection as part of your portfolio. One of the most common is Driscoll's Model for Structured Reflection on page 51.

For the Pilot, clinical reflections will normally be regarded as **subjective evidence**.

Category: Developing practice – subjective evidence

Model of structured reflection

DRISCOLL'S MODEL FOR STRUCTURED REFLECTION

1. Description of the event

WHAT? Trigger questions

a. What is the purpose of returning to the event?
b. What happened?
c. What did I see?
d. What was my reaction to it?
e. What did other people do who were involved?

2. Analysis of the event

SO WHAT? Trigger questions

f. How did I feel at the time of the event?
g. Were those feelings that I had any different from other people also involved?
h. Did I feel troubled? If so, in what way?
i. What were the effects of what I did or did not do?
j. What have I noticed about my behaviour by taking a measured look at it?
k. What positive aspects now emerge from this event?

3. Proposed actions

NOW WHAT? Trigger questions

l. What are the implications for myself and others based on what I have described and analysed?
m. What difference does it make if I do nothing?
n. Where can I get more information to face a similar situation again?
o. How can I modify my practice if a similar situation should happen again?
p. Which aspects of practice should be tackled first?
q. How will I notice whether I am any different?
r. What is the main learning that I take from reflecting on this event?

Clinical reflection

Clinical scenario 2

Claire, a 16-year-old girl, attended an appointment accompanied by her mother. I had previously treated her mother for persistent back and neck pain. According to her mother, Claire had been complaining of increasing 'aches and pains' in her knees, which her mother had ascribed to 'growing pains'. Apart from her knee problem, Claire was a fit, healthy adolescent who was a keen hockey player and captain of her school junior hockey team. She was hoping to be selected for the county junior team in the near future and had been attending hockey practice almost daily over the past few months.

On initial assessment, it was difficult to engage Claire in conversation because her mother insisted on answering all my questions. By the look on Claire's face, I surmised that her mother's responses did not always reflect what Claire would have said, if given the opportunity. I eventually asked Claire's mother to remain in the waiting area while I examined Claire in private. Her mother was reluctant to do this, but I felt it necessary to insist because I wanted to gain Claire's perspective on her signs and symptoms. Once alone, Claire was much more forthcoming with information and chatted readily about her pain and knee discomfort. This enabled me to take and document a full verbal history.

With Claire's consent, I carried out a physical examination on her. I had some initial concerns about examining her because I have not had a lot of experience with treating children and young people. Most of my patients are adults; most of whom are middle-aged. However, I felt that my skills and knowledge were sufficient to carry out a sound assessment, which I duly documented. Following examination, I concluded that, although osteopathic treatment might benefit her, there was also the possibility that she had knee joint abnormalities that would possibly require orthopaedic intervention. When I explained this to Claire, she was keen for me to refer her to an orthopaedic specialist for further investigation because she felt that if her knees continued to trouble her, her hockey career might be adversely affected.

However, when I explained this to Claire's mother, she expressed dissatisfaction. She had had a bad experience in the local hospital several years ago when an operation to her lumbar disc area had been unsuccessful and had resulted in chronic back pain. At first she was adamant that she would not give her consent for me to refer Claire for an orthopaedic opinion, claiming that her daughter was too young to realise the implications of possible orthopaedic surgery. Claire was equally adamant that she wanted her knee problems fully investigated. I felt that Claire was fully informed about her treatment options and that she had completely understood the implications both of further osteopathic treatment by myself and of referral. I allowed the pair to discuss the options in the privacy of my office and, eventually, Claire's mother conceded that her daughter was mature enough to make her own decisions regarding treatment.

Although I was unable to refer Claire directly for an orthopaedic opinion, I did document my assessment finding in a letter to her GP, suggesting that she be referred. When Claire's mother attended for further treatment on her back some months later, she told me that Claire had undergone a routine arthroscopy. Several pieces of loose cartilage had been removed from both knees. Claire had now fully recovered and was playing regular hockey, free of any pain and discomfort in her knees.

Category of evidence

The category of evidence explored in this scenario is B – Developing practice.

Revalidation Themes

These worked examples present evidence for:

- Theme 1: Communication and patient partnership.
- Theme 4: Professionalism.

Examples

The tools used are:

- Significant event analysis.
- Clinical reflection.

Worked example: Clinical reflection – subjective evidence

I have used Driscoll's Model for Structured Reflection as a framework.

DESCRIPTION OF THE EVENT

WHAT?

What is the purpose of returning to the event?

(include rationale for presenting a clinical reflection as supporting evidence)

I have chosen to present a clinical reflection as supporting evidence for several reasons. The reflection is based on a consultation that was not routine for me but that does, nevertheless, show my achievement of Revalidation Criteria for Theme 1, Communication and patient partnership, and Theme 4, Professionalism. The structured reflection allows me not only to reflect on what I did but also to analyse the personal thoughts and feelings I experienced during the consultation. This was not a particularly easy event for me to deal with, and a clinical reflection will help me to identify the positive aspects of my practice as well as areas of my practice that might need further development.

What happened?

Claire, a 16-year-old girl, attended an appointment accompanied by her mother. I had previously treated her mother for persistent back and neck pain. According to her mother, Claire had been complaining of increasing 'aches and pains' in her knees, which her mother had ascribed to 'growing pains'. Apart from her knee problem, Claire was a fit, healthy adolescent who was a keen hockey player and captain of her school junior hockey team. She was hoping to be selected for the county junior team in the near future and had been attending hockey practice almost daily over the past few months.

On initial assessment, it was difficult to engage Claire in conversation because her mother insisted on answering all my questions. By the look on Claire's face, I surmised that her mother's responses did not always reflect what Claire would have said, if given the opportunity. I eventually asked Claire's mother to remain in the waiting area while I examined Claire in private. Her mother was reluctant to do this, but I felt it necessary to insist because I wanted to gain Claire's perspective on her signs and symptoms. Once alone, Claire was much more forthcoming with information and chatted readily about her pain and knee discomfort. This enabled me to take and document a full verbal history.

With Claire's consent, I carried out a physical examination on her. I had some initial concerns about examining her because I have not had a lot of experience with treating children and young people. Most of my patients are adults; most of whom are middle-aged. However, I felt that my skills and knowledge were sufficient to carry out a sound assessment, which I duly documented. Following examination, I concluded that, although osteopathic treatment might benefit her, there was also the possibility that she had knee joint abnormalities that would possibly require orthopaedic intervention. When I explained this to Claire, she was keen for me to refer her to an orthopaedic specialist for further investigation because she felt that if her knees continued to trouble her, her hockey career might be adversely affected.

However, when I explained this to Claire's mother, she expressed dissatisfaction. She had had a bad experience in the local hospital several years ago when an operation to her lumbar disc area had been unsuccessful and had resulted in chronic back pain. At first she was adamant that she would not give her consent for me to refer Claire for an orthopaedic opinion, claiming that her daughter was too young to realise the implications of possible orthopaedic surgery. Claire was equally adamant that she wanted her knee problems fully investigated. I felt that Claire was fully informed about her treatment options and that she had completely understood the implications both of further osteopathic treatment by myself and of referral. I allowed the pair to discuss the options in the privacy of my office and, eventually, Claire's mother conceded that her daughter was mature enough to make her own decisions regarding treatment.

Although I was unable to refer Claire directly for an orthopaedic opinion, I did document my assessment finding in a letter to her GP, suggesting that she be referred. When Claire's mother attended for further treatment on her back some months later, she told me that Claire had undergone a routine arthroscopy. Several pieces of loose cartilage had been removed from both knees. Claire had now fully recovered and was playing regular hockey, free of any pain and discomfort in her knees.

What did I see?

The first thing that struck me about the situation was that, although the consultation was about Claire, it was obvious that she had not initiated the appointment. I was confronted with a very quiet teenager and her mother who was very far from quiet. Her mother was trying to dominate the conversation and to continually speak on behalf of her daughter.

My next thoughts were about the age of my presenting patient. As a teenager, she did not fit into the normal age profile of the patients that I treated.

When I took Claire into the privacy of my room, I saw a very different side to her. When she was encouraged to speak, she was articulate and confident, asking appropriate questions and participating fully in the assessment.

Once Claire told her mother that she wished to be referred to an orthopaedic specialist, I was faced with a full-blown mother-daughter stand-off. I could see that Claire's mother, given her previous experience of orthopaedic surgery, was very upset by the thought of her daughter being referred, and was expressing her feelings forcibly. Claire was refusing to be intimidated by her mother but was becoming frustrated by her mother's inability to understand or accept her decision.

The opportunity and time they were both allowed to discuss the situation without my presence further changed what I saw. Claire's mother was pleased that she had been able to talk things through with her daughter and looked relieved that she had been allowed to do so in private. Claire looked pleased and satisfied that her mother had finally accepted her decision. She had an air of self-confidence that had not been apparent when I first met her.

What was my reaction to it?

I felt a degree of concern when I discovered that I was going to be assessing a young person with possible joint problems. This was because I felt that I was inexperienced in dealing with this age group. I tried hard not to let my concern show in either my behaviour or my voice. Once I had begun the verbal and physical assessments, my confidence grew.

My reaction to Claire's mother not allowing Claire to speak for herself was to exclude her mother from the assessment. I was delighted that, once we were alone, Claire appeared to trust me enough to confide in me and to express her opinions.

I was surprised at the depth of her mother's resistance to further referral and, also, at the determination Claire showed in not bowing to her mother's wishes. It took me several moments to realise that their confrontation was unlikely to lead to a satisfactory conclusion for either of them and that I would have to intervene. I eventually persuaded them to discuss the matter in private and to share their concerns and issues with each other.

Once the final decision had been taken, I felt it was important that I dealt effectively and immediately with the referral. My written letter for the GP, suggesting an orthopaedic opinion, meant both Claire and her mother were satisfied that things would progress in a satisfactory fashion.

ANALYSIS OF THE EVENT

SO WHAT?

How did I feel at the time?

When I saw Claire's age, I was worried that my lack of experience in treating young people would affect my ability to communicate and treat her effectively. These feelings of concern lessened as the assessment progressed and I began to regain confidence in my own abilities. It can be difficult to admit that you are not best placed to provide treatment for a patient, but I recognised my own limitations. I enjoyed working in partnership with Claire because she proved to be a very mature and articulate young lady.

My feelings on the behaviour of her mother were primarily of frustration that she did not recognise her daughter's ability to speak for herself. It was difficult for me not to allow this to manifest itself in my behaviour and I had to make a conscious effort not to show the anger I was beginning to feel at the way she was behaving. I felt quite guilty for excluding her from Claire's assessment but it was the only way I could think of to ensure that a thorough and appropriate assessment was made. Once I had established a good relationship with Claire, I was then convinced that I had made the right decision.

I found the confrontation between mother and daughter quite worrying at first because I thought it looked as if no agreement was going to be reached. I could understand the mother's concerns but was worried that Claire was not going to be allowed to seek the treatment she wanted. On a personal level, I was very concerned that I would be forced to make some sort of decision on informed consent and the right of young people to make their own decisions, and I was not sure that I was fully informed on the issue.

The positive outcome to the consultation was very pleasing. I felt that I had demonstrated good communication skills in bringing things to this conclusion and that I had acted very professionally in what could have been, potentially, an unresolved situation.

Were those feelings that I had any different from other people also involved?

Yes, I think that they were.

I am sure Claire's mother was there primarily to protect her daughter and to ensure she got the best possible treatment. She was clearly used to taking charge of situations and I think that she was quite surprised when her daughter challenged her and stood up for herself.

My impression of Claire was that she enjoyed being treated as someone who was capable of participating in her care and making decisions regarding that care. She felt very passionately about her sport and was not about to let her mother adversely influence her future ability to play hockey. In confronting her mother, it was clear that Claire was determined to make her own choices but I also feel that she realised that she would have to be willing to sit down and discuss things rationally.

Did I feel troubled? If so, in what way?

I felt troubled on a number of levels. Initially, as stated above, I was troubled with having to deal with a young patient and my ability to assess and communicate with her. I was concerned with the attitude of her mother and with how I was going to get her to communicate effectively with Claire. The possibility that my lack of knowledge on informed consent in young adults definitely troubled me.

What were the effects of what I did or did not do?

The effects of what I did do are, I think, evident from the positive outcome that ensued.

By encouraging Claire to play a full role in managing her care, I feel that she grew in confidence and in her ability to question the right of other people to make decisions on her behalf.

One of the effects of this was that her mother had to accept that Claire was now mature enough to make her own decisions. I like to think that perhaps she also realised that she could not allow her personal, negative experiences to affect Claire's future.

By effectively assessing and referring Claire, I ensured that she received the most appropriate treatment for her condition and that she made a full recovery.

What have I noticed about my behaviour by taking a measured look at it?

I think my behaviour in this situation was that expected of a registered osteopath; I demonstrated effective communication skills and acted in a professional manner at all times. This is despite times during the event that I did not feel confident in my knowledge and skills.

What positive aspects now emerge from this event?

The positive aspects to emerge from this event have been presented above.

PROPOSED ACTIONS

NOW WHAT?

What are the implications for myself and others based on what I have described and analysed?

I am unable to consider the ongoing implications for Claire and her mother because I have had no further contact with Claire and am not providing her with ongoing management.

The implications for myself are that there are areas of my practice that could benefit from further development so that I can be completely confident that I can cope effectively with a similar situation in the future.

What difference does it make if I do nothing?

If I do nothing, there is the potential that areas of my osteopathic practice in the care of children and young people will become less effective, rather than develop. In this instance, I was not called on to make a judgement regarding informed consent, but this could happen in the future, and I need to make sure that I am equipped to deal with this.

Where can I get more information to face a similar situation again?

Current research and literature on the osteopathic management of children and young people and on the issue of informed consent can be accessed via professional journals, academic libraries and online.
My preferred method of obtaining information is via online professional literature.

How can I modify my practice if a similar situation should happen again?

My external behaviour in this situation was acceptable and showed the capabilities and competencies of a registered osteopath. What I would like to change, through further learning and development, is my level of knowledge and confidence in dealing with the issues that arose. In so doing, I might change my internal behaviour should a similar situation occur.

Which aspects of practice should be tackled first?

There are two areas of practice that I would wish to address:

1. The osteopathic management of children and young people, including communication.

2. The issue of informed consent in children and young people.

How will I notice that I am any different?

My intention would be to carry out further clinical reflections on situations where I have worked with children and young people. Although it is doubtful whether this situation will ever be exactly replicated, further analysis might allow me to assess whether my practice has changed in any way.

What is the main learning that I take from reflecting on this event?

I have learnt two main things through undertaking this reflection.

First, that there are areas of my osteopathic practice (as identified in this reflection) that I can develop further.

Second, this reflection has confirmed for me that my communication skills are of a high level and that I can act professionally, even when presented with difficult situations.

4.2.3 Personal development needs analysis

Personal development needs analysis (PDNA) is based around your personal evaluation of your practice and identification of aspects of your practice that you feel you may need to develop. It is important that your evaluation is supported by evidence to justify why you feel it is necessary for you to develop in that area. This could come, for example, from a SEA or a clinical reflection that you have carried out as part of the Revalidation process, from reading current literature that points to a development that you think would enhance or improve your current practice, or from feedback from others.

A PDNA may develop over time, as you reflect on what you do. It is critical that you take time to record what is taking place as you progress. A typical PDNA would be presented in table form. It should include:

- Assessment of the current situation.
- A definition of the issues. What gaps in your current practice do you perceive to be important?
- Identification of what action is needed to address the gaps, for example, training, peer feedback, self-directed study, etc.
- A plan of how you are going to take action in response to your identified needs.
- Following the implementation of this plan, you should reflect on the outcomes of your action plan and illustrate how you feel your actions have helped narrow the perceived gap.

One of the main aims of a PDNA is to encourage you to become directed in your learning and development. For Revalidation, your PDNA needs to address any areas within the four Revalidation Themes where you feel you may benefit from further development. The actions you undertake following on from your analysis should lead towards the demonstration of achievement of the Revalidation Criteria.

For the Pilot, the PDNA will normally be regarded as **subjective evidence**.

Category: Developing practice – subjective evidence

Personal development needs analysis template

Stage	Evidence	Reflection/action
Assessment	Include here evidence that you feel supports your assessment of the situation; e.g., reading an article relating to best practice and comparing it with your work, clinical observations of peers, patient feedback, etc.	Here you need to reflect on the evidence and examine why you feel there is a difference between what you perceive to be best practice and what you feel you achieve.
Definition of the issue	This is the distillation of your reflection: the conclusion to your thoughts and feelings that identify the main Theme, concept or issue that defines the perceived 'gap'.	

Action plan			
Aim	**Objective**	**How**	**By when**
Summarise your definition of the issue into one or more aims.	These are individual steps that you need to achieve along the route to achieving your aim(s).	How you intend to achieve these objectives: reading, course attendance, advertising, survey, etc).	A reasonable time frame within which you plan to complete each objective.

Analysis of outcome	Evidence
What do you feel has changed in your practice following the completion of your action plan?	Evidence may include anything that supports your assertions in your reflection: literature for the practice, patient demographics, CPD certificates, publications, patient feedback, etc.

Worked example: Personal development needs analysis – subjective evidence

This PDNA and the subsequent action plan are based on the worked example of the significant event analysis (see pages 47–49) and the worked example of the clinical reflection (see pages 53–57).

Category of evidence

The category of evidence explored in this scenario is B, Developing practice.

Revalidation Themes

These worked examples present evidence for:

Theme 1: Communication and patient partnership.

Theme 2: Knowledge, skills and performance.

Theme 4: Professionalism.

Rationale for presenting a personal development needs analysis and action plan as supporting evidence

Following my significant event analysis and my clinical reflection, it became clear to me that I required further development in some aspects of my osteopathic practice. This PDNA shows how I identified these gaps in my knowledge and what I needed to do to address them. The action plan details how I implemented this.

Stage	Evidence	Reflection/action
Assessment	My evidence for this PDNA is based on a significant event analysis and clinical reflection that I carried out before. This looked at the management of a young girl who presented with knee problems and how I managed her care.	My analysis of the case made me appreciate that, although I managed the care of my patient safely, the situation had the potential to reveal gaps in my knowledge. I need to redress these knowledge deficits so that my management of patients is based on best available evidence.
Definition of the issue	Two specific areas of my practice emerged as requiring attention. These were: > The anatomy and physiology of the knee. > The issue of informed consent in children and young people.	I decided to develop an action plan detailing how I would increase my knowledge and understanding of the two identified areas.

4.2.4 Action plans

Action plans detail how you intend to do something and can be applied to many situations. They will often be integral to other methods of showing your achievement of the Revalidation Criteria; for example, as part of a clinical reflection or a PDNA.

As with a PDNA, action plans are normally presented in table form (see page 62). Your action plan should include:

- An overall goal or aim. What exactly is it that you are trying to achieve?
- Specific objectives outlining the steps you need to take to reach your goal.
- An outline of how you intend to achieve your objectives.
- Planned completion dates.
- An analysis of the outcome of your actions.
- Supporting evidence.

Action plans can be an effective way of organising and developing solutions to address specific issues, challenges or problems that may arise for you in your osteopathic practice.

Category: Developing practice – subjective evidence

Action plan

Goal/aim	Objectives	Action planned (how?)	Planned completion dates (when?)
What are you aiming to achieve, and why have you identified this as an aim?	Outline the steps that you need to complete along the route to achieving your aim or aims. You may have any number of smaller objectives to help you plan, although it is better to avoid long lists of minor elements (three to six is common).	How do you intend to achieve these objectives (reading, course attendance, advertising, survey, etc.)?	Offer a reasonable time frame by when you plan to complete each objective.

Analysis of outcome	Evidence
What do you feel has changed in your practice following the completion of your action plan?	Evidence may include anything that supports your assertions in your reflection: literature for the practice, patient demographics, CPD certificates, publications, patient feedback, etc.

Action plan template

Goal/aim	Objectives	Action planned (how?)	Planned completion dates (when?)
Analysis of outcome		**Evidence**	

Worked example: Action plan – subjective evidence

Aim	Objective	How	By when
1. To increase my knowledge and understanding of the anatomy and physiology of the knee.	> To access current literature /research on the anatomy and physiology of the knee. > To review the literature/ information obtained. > To understand how the information obtained might affect my osteopathic practice.	> Undertake a library and online search for relevant literature/research. > Allocate dedicated study time to read and review the literature/research obtained. > Arrange to discuss osteopathic knee management with a local osteopath who specialises in joint problems. > Arrange with osteopathic partners to be given opportunity to work with any patients presenting with knee problems.	12/2/11 6/3/11 30/4/11 28/5/11 - ongoing
2. To increase my knowledge and understanding of informed consent in children and young people.	> To access current literature/ information on informed consent in children and young people. > To produce written guidelines for my practice on obtaining consent from children and young people.	> Undertake a library and online search for relevant literature/ information > Allocate dedicated time to read and review the literature/ information. > Liaise with practice partners about producing guidelines for obtaining informed consent from children and young people. > Produce written guidelines for obtaining informed consent from children and young people. > Pilot the guidelines with appropriate patient and revise according to feedback.	12/2/11 6/3/11 28/5/11 10/7/11 30/7/11

Analysis of outcome

I have successfully completed all the actions outlined in the action plan with the exception of piloting the guidelines for informed consent in children and young people. This action is ongoing.

My knowledge and understanding of the anatomy and physiology of the knee has greatly increased, and I am now more confident in my ability to manage patients presenting with knee problems. It was relatively easy to access up to date information regarding anatomy and physiology of the knee, and I dedicated some time when my practice was quiet to read over the information. Unfortunately, the evidence base for the osteopathic care of knee problems was limited, but I did manage to locate some useful articles. I spent an hour with a local osteopathic colleague who specialises in joint problems, and I found this very informative and interesting. Since completing the action plan, I have seen and managed a further four patients with knee problems.

I now feel much more informed and up to date with the issue of informed consent in children and young people. My literature search produced a wealth of material on the legal and ethical issues surrounding this. I accessed written guidelines from other healthcare professions and adapted these to suit osteopathic practice. My osteopathic partners are fully supportive of the project. Draft guidelines have now been produced and are being piloted.

Evidence

> Results of literature search on anatomy and physiology of the knee.

> Notes from meeting with osteopath specialising in joint problems.

> Results of literature search on informed consent in children and young people.

> Written guidelines for obtaining informed consent in children and young people.

4.3 Feedback on practice

Examples of the kinds of evidence you could use include:

4.3.1 Peer review

4.3.2 Multi-source feedback

4.3.3 Patient satisfaction or patient experience questionnaires, including the CARE Measure

4.3.4 Clinical audit

This section includes information on each of these possibilities.

4.3.1 Peer review

Peer review is when you ask another osteopath to assess the quality of care or service you deliver. This can be in any aspect of practice but, for Revalidation, the review should be focused on an area covered by the four Revalidation Themes.

The person undertaking the review would, normally, be an osteopath with a comparable level of training, professional credentials and experience. The most important criterion is that the peer can provide effective and constructive feedback to the osteopath under review. We have already shown how peers can take part in providing feedback to you through case-based discussions (see page 33). Another commonly used method of peer review used in healthcare is observation of practice – either through direct observation or through video recordings.

The evidence you submit in relation to peer review will depend on the area of your practice that is under review. An area of practice commonly reviewed by other healthcare professionals is consultation because this is fundamental to the effective and safe management of patients. A tool often used to assess healthcare practitioners' consultation skills is the consultation observation tool (COT), where you are required to select consultations (with the patient's permission) to be observed by the reviewer, with given criteria for discussion. Submission of a completed COT could provide acceptable evidence of achievement of several Revalidation Criteria (further information on the Revalidation Criteria can be found in the Revalidation Standards and Assessment Framework on pages 8–11).

Although peer review is frequently used as a quality assurance mechanism, it can also be useful in providing you with constructive feedback on your practice and in directing your future learning and development.

Peer review is **objective evidence**.

Category: Feedback on practice – objective evidence

Peer review: consultation observation tool (COT)

Consultation observation tool

Osteopath's surname:

Osteopath's forename:

Osteopath's registration number:

Assessor's name:

Assessor's registration number (GOsC, GMC, NMC etc.):

Assessor's position:

Setting:

Please fill in name of organisation (where appropriate):

A. Discovers the reasons for the patient's attendance

1. Encourages the patient's contribution

Insufficient evidence ☐ Needs further development ☐ Competent ☐ Excellent ☐

2. Responds to cues

Insufficient evidence ☐ Needs further development ☐ Competent ☐ Excellent ☐

3. Places complaint in appropriate psychosocial contexts

Insufficient evidence ☐ Needs further development ☐ Competent ☐ Excellent ☐

4. Explores patient's health understanding

Insufficient evidence ☐ Needs further development ☐ Competent ☐ Excellent ☐

B. Defines the presenting problem

5. Includes or excludes likely relevant significant condition

Insufficient evidence ☐ Needs further development ☐ Competent ☐ Excellent ☐

6. Appropriate physical or mental state examination

Insufficient evidence ☐ Needs further development ☐ Competent ☐ Excellent ☐

7. Makes an appropriate working diagnosis

Insufficient evidence ☐ Needs further development ☐ Competent ☐ Excellent ☐

Any additional comments:

4.3.2 Multi-source feedback

Multi-source feedback (MSF) entails obtaining a sample of attitudes and opinions, from a range of other people, on your clinical performance and/or your professional behaviour. It can be a useful way of providing data for you to reflect on your performance and for you to gain feedback on your practice. An MSF tool widely used by other healthcare professionals and adapted for use by osteopaths is available on pages 69–71.

If you decide to submit MSF as evidence, you should include a minimum of three completed tools. These should be from:

- A peer;
- A professional colleague in another healthcare discipline; and
- Some other person with whom you work, for example, a receptionist or a practice manager.

MSF can provide you with opportunities for future learning and development, and can be a useful mechanism for quality improvement.

MSF is **objective evidence**.

Category: Feedback on practice – objective evidence

Multi-source feedback template

Multi-source feedback

360 degree assessment (colleague)

Practitioner:

Completed by:

Position:

Date:

Please circle the appropriate level of performance.

History taking and examination

1 2	3 4 5 6 7	8 9
Incomplete, inaccurate, confusing history taking. Cannot get patient co-operation for examination, technique poor.	Clear history taking, appreciates the importance of clinical, psychological and social factors. Performs adequate and appropriate examinations.	Accomplished and concise history taker, including clinical, psychological and social factors. Skilled examination technique. Effective listener.

Investigations

1 2	3 4 5 6 7	8 9
Inappropriate, random, unnecessary investigations. No thought given. Often fails to perform investigations required.	Investigates appropriately, ensures all investigations requested by the team are completed, knows what to do with abnormal results	Arranges, completes and acts on investigations intelligently, economically and diligently.

Problem-solving/making a diagnosis/management plans

1 2	3 4 5 6 7	8 9
Unable to make decisions or even make a working diagnosis. Fails to engage patients in decision-making. Unaware of own limits.	Can make a sound diagnosis, and produce safe, appropriate management plans. Engages patients in decision-making. Good recognition of own limits.	Plus – shows intelligent interpretation of available data to form an effective hypothesis, understands the importance of probability in diagnosis.

Record keeping

1 2	3 4 5 6 7	8 9
Poor, confusing records. Inadequate, illegible.	Clear records made in note, medico-legally sound, others are able to understand.	Records information accurately and efficiently. Easy for others to follow.

Working within limits of competence

1 2	3 4 5 6 7	8 9
No self-confidence, seeks help all the time, does not make any decisions. Over-confident in ability, with no insight to a level that may harm patients.	Aware of own skill and competency level, seeks assistance appropriately.	An able practitioner with a clear understanding of own competency, but still seeks advice when appropriate

Attitude to and relationship with patients

1 2	3 4 5 6 7	8 9
Discourteous, inconsiderate of patients' views, dignity and privacy. Unable to reassure, subject of repeated complaints.	Courteous and polite, communicates well with patients, shows appropriate level of emotional engagement with the patient and family. Respects privacy and dignity.	Excellent bedside manner, able to anticipate patient's emotional and physical needs and plans to meet them. Explains clearly and checks understanding.

Working with colleagues

1 2	3 4 5 6 7	8 9
Unable/refuses to communicate with colleagues. Can't work to common goal, selfish, inflexible.	Listens to colleagues, accepts the views of others. Flexible – ability to change in the face of valid argument.	Able to bring together views for a common goal. Team goal is put before personal agenda.

Has a responsible and professional attitude and approach to work in the following areas: trustworthiness, honesty, confidentiality, ethics, dress code, manners, punctuality, time management

1 2	3 4 5 6 7	8 9
Poor attitude/approach in above areas, possible concerns. Fails to make care of patient first concern, own beliefs prejudice care, abuses position as a practitioner.	Reasonable attitude/ approach in above areas, a good practitioner.	Excellent attitude/approach in above areas, a credit to the profession. Patient care is the priority.

If you have any more comments, please add below

Strengths

Weaknesses

4.3.3 Patient questionnaires, including the CARE Measure

Patient satisfaction or patient experience questionnaires aim to provide you with information on what your patient expects from you and how they perceive the quality of care you have provided. These perceptions may differ from yours.

There are many available tools for measuring patient satisfaction. One has been included on page 73. The University of Glasgow's CARE (Consultation and Relational Empathy) Measure is also available on page 74 and looks at the patient experience.

If you choose to submit patient experience questionnaires as evidence, you should include a minimum of 10 submitted responses from a range of patients. If possible, these should be across the lifespan and should include questionnaires from patients with a range of different presentations.

As with MSF, patient experience questionnaires can be used to show a quality service, but they may identify areas where you need to improve or enhance your practice.

Patient experience questionnaires are regarded as **objective evidence**.

Category: Feedback on practice – objective evidence

Patient feedback template

Patient assessment

Osteopath:

Completed by:

Date:

As part of our quality assessment we need to assess how you were treated by the osteopath you have consulted with.

Please think about your consultation with the osteopath and circle the appropriate level of performance.

1. How thoroughly did the osteopath ask you about why you had attended?

Not very well ☐ Fairly well ☐ Very well ☐

2. Did you feel the osteopath listened to what you had to say?

Not very well ☐ Fairly well ☐ Very well ☐

3. How well did the osteopath put you at ease during your physical assessment and examination?

Not very well ☐ Fairly well ☐ Very well ☐

4. How well did the osteopath explain your problem?

Not very well ☐ Fairly well ☐ Very well ☐

5. How well did the osteopath engage you in your consultation?

Not very well ☐ Fairly well ☐ Very well ☐

6. Did you feel the osteopath demonstrated concern for your welfare?

Not very well ☐ Fairly well ☐ Very well ☐

Do you have any other comments about the osteopath?

You can find further examples of patient questionnaires for clinical audit in NCOR's *An introduction to Clinical Audit for Practising Osteopaths* (see www.ncor.org.uk).

Category: Feedback on practice – objective evidence

The CARE Measure

How was the osteopath at…?	Poor	Fair	Good	Very good	Excellent	Does not apply
1. Making you feel at ease ... (being friendly and warm towards you, treating you with respect; not cold or abrupt)	☐	☐	☐	☐	☐	☐
2. Letting you tell your 'story' ... (giving you time to fully describe your illness in your own words; not interrupting or diverting you)	☐	☐	☐	☐	☐	☐
3. Really listening ... (paying close attention to what you were sayings, not looking at the notes or computer as you were talking)	☐	☐	☐	☐	☐	☐
4. Being interested in you as a whole person ... (asking/knowing relevant details about your life, your situation, not treating you as 'just a number')	☐	☐	☐	☐	☐	☐
5. Fully understanding your concerns ... (communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything)	☐	☐	☐	☐	☐	☐
6. Showing care and compassion … (seeming genuinely concerned, connecting with you on a human level; not being indifferent or 'detached')	☐	☐	☐	☐	☐	☐
7. Being positive … (having a positive approach and a positive attitude; being honest but not negative about your problems)	☐	☐	☐	☐	☐	☐
8. Explaining things clearly … (fully answering your questions, explaining clearly, giving you adequate information; not being vague)	☐	☐	☐	☐	☐	☐
9. Helping you to take control … (exploring with you what you can do to improve your health yourself; encouraging rather than 'lecturing' you)	☐	☐	☐	☐	☐	☐
10. Making a plan of action with you … (discussing the options, involving you in decisions as much as you want to be involved; not ignoring your views)	☐	☐	☐	☐	☐	☐

Information about the CARE Measure

The Consultation and Relational Empathy (CARE) Measure is a consultation process measure that has been developed by Dr Stewart Mercer and colleagues in the Departments of General Practice at Glasgow University and Edinburgh University. It is based on a broad definition of empathy in the context of a therapeutic relationship within the consultation. The wording reflects a desire to produce a holistic, patient-centred measure that is meaningful to patients irrespective of their social class, and has been developed and applied in over 3,000 general practice consultations in areas of high and low deprivation in the west of Scotland.

The scoring system for each item is 'poor'=1, 'fair' = 2, 'good' = 3, 'very good' = 4, and 'excellent'= 5. All 10 items are then added, giving a maximum possible score of 50, and a minimum of 10. Up to two 'not applicable' responses or missing values are allowable, and are replaced with the average score for the remaining items. Questionnaires with more than two missing values or 'not applicable' responses are removed from the analysis.

The theoretical background and validation of the CARE Measure can be found in:

Mercer SW, McConnachie A, Maxwell M, Heaney DH, and Watt GCM. *Relevance and performance of the Consultation and Relational Empathy (CARE) Measure in general practice*. Family Practice 2005, 22 (3), 328-334.

Mercer SW, Watt, GCM, Maxwell M, and Heaney DH. *The development and preliminary validation of the Consultation and Relational Empathy (CARE) Measure: an empathy-based consultation process measure*. Family Practice 2004, 21 (6), 699-705.

Mercer SW and Reynolds W J. *Empathy and quality of care*. BJGP 2002, 52 (Supplement); S9-S12.

The CARE Measure can be used free of charge. The Intellectual Property rights rest with the Scottish Executive. The Measure may not be used on a commercial basis without the consent of the author and the Chief Scientist Office of the Scottish Executive Health Department, on behalf of the Scottish Ministers. If you would like more information, please contact:

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University of Glasgow,
1 Horselethill Road, Glasgow G12 9LX.

Email: Stewmercer@blueyonder.co.uk.

For further information, and to download the Measure please visit: www.gla.ac.uk/departments/generalpractice/caremeasure.htm.

4.3.4 Clinical audit

Clinical audit is about checking whether you are following best practice and entails improving your practice if there are any identified shortfalls in the care you deliver. It can be about any aspect of your osteopathic practice.

The National Council for Osteopathic Research (NCOR) has developed *An introduction to Clinical Audit for Practising Osteopaths* (see www.ncor.org.uk), which you might find useful if you wish to submit audit information as part of your evidence. You can also access the Handbook via the GOsC registrant website, the **o** zone.

NCOR's *An introduction to Clinical Audit for Practising Osteopaths* contains a wealth of helpful guidance about clinical audit, a selection of templates to help you undertake an audit of a variety of aspects of your practice, and some completed examples.

You should follow the suggested format in compiling your evidence and should include information on:

> A specific area of practice.

> The standard that you would like to see achieved in practice. This needs to be based on a realistic expectation of what could be achieved.

> The information that you have gathered about current practice in your selected area.

> A comparison of actual practice with ideal practice.

> Suggestions as to changes that might be needed.

> Either information on how you implemented the suggested change or an action plan outlining how you would implement the change.

Audits do not need to be large – they can relate to small, discrete areas of practice, such as patient attendance or number of referrals to other healthcare professionals. You do not have to gather all the information for the audit yourself. Where appropriate, this could be done by administrative staff, if available.

Clinical audits could usefully inform your practice as well as the Revalidation Criteria. If you choose to undertake clinical audit as part of the Revalidation Pilot, you will have the opportunity to do this over a six-month period if needed – although many of the audits can be completed within three months.

Clinical audit is regarded as **objective evidence**.

SECTION 5: SELF-ASSESSMENT – MAPPING YOUR EVIDENCE TO THE REVALIDATION THEMES

This section provides a blank mapping grid template and some completed examples drawing on the clinical scenarios introduced in Section 4. Example mapping grids are provided for the case presentation, case-based discussion, management plan, significant event analysis, clinical reflection, personal development needs analysis and action plan, to show how evidence builds up into a completed mapping grid.

Use the mapping grid to show you have fulfilled the Revalidation Criteria (as set out in the Revalidation Standards and Assessment Framework on pages 8–11). The mapping grid allows you to map the nature of the evidence you are presenting in relation to criteria for each Revalidation Theme. The mapping grid also offers a useful check to ensure that you have covered each of the Revalidation Criteria before submission to the GOsC. This will aid assessors in locating your information.

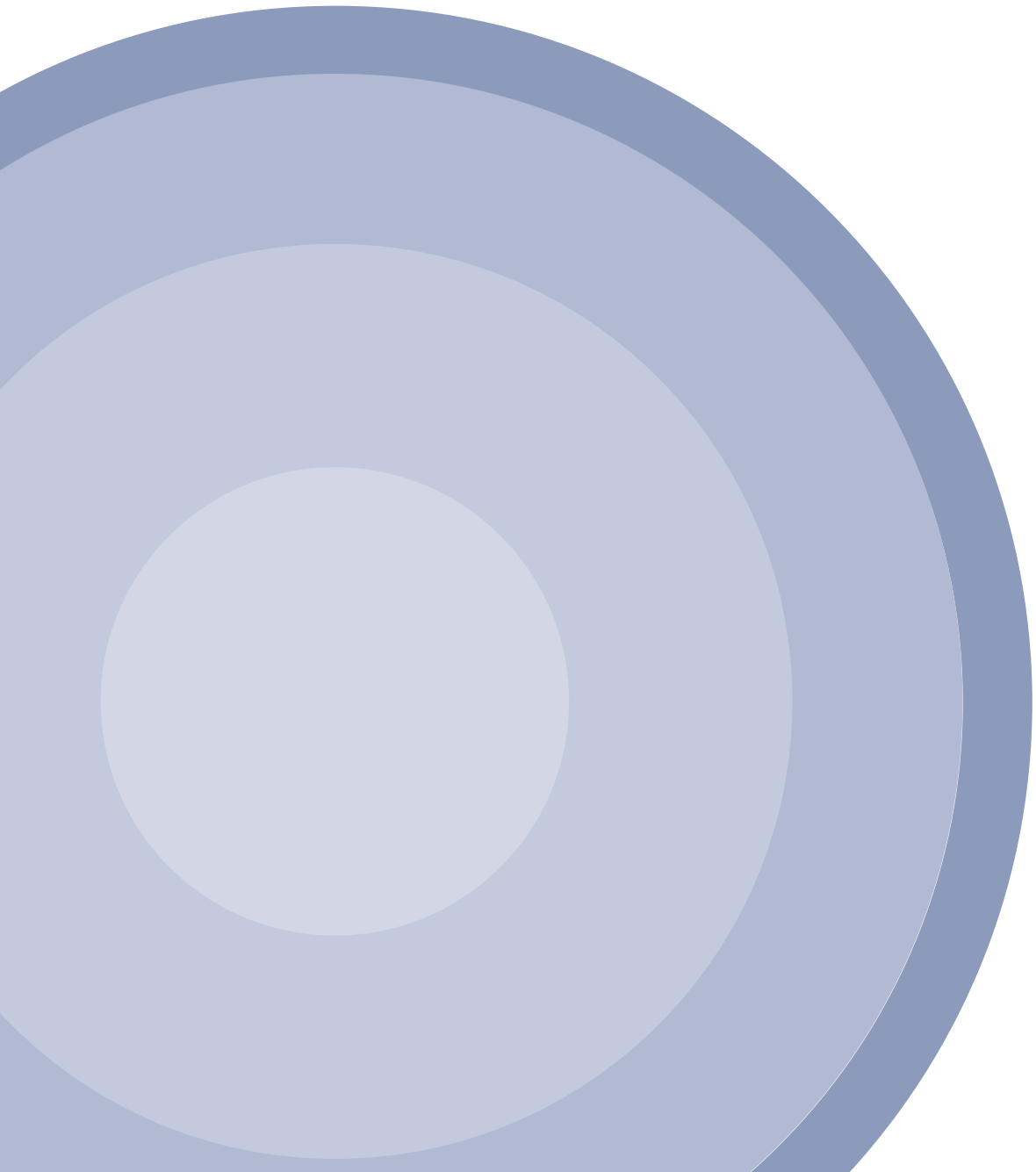
A final mapping grid template is provided on page 79.

The final self-assessment checklist helps you to ensure your evidence covers all four Revalidation Themes and meets the three categories of evidence: giving information and recording/discussing practice; developing practice; and feedback on practice.

A final self-assessment checklist template is provided on pages 87–88.

At the end of the Pilot, you should submit the following:

- **A completed final self-assessment checklist.**
- **A completed mapping grid.**
- **A completed portfolio containing the evidence that you have used to support your achieving the Revalidation Criteria.**



5.1 Mapping your evidence

Evidence mapping grid template

REVALIDATION THEME	EVIDENCE PROVIDED	MAPPING TO THE REVALIDATION ASSESSMENT CRITERIA	RATIONALE: HOW DOES THE EVIDENCE DEMONSTRATE THE REVALIDATION ASSESSMENT CRITERIA?
Theme 1 Communication and patient partnership			
Theme 2 Knowledge, skills and performance			
Theme 3 Safety and quality in practice			
Theme 4 Professionalism			

The next pages show examples of partially completed mapping grids demonstrating how each piece of evidence feeds through to a mapping grid.

Don't forget that on completion of the Pilot, you will need to consolidate all of the mapping grids into one for submission to demonstrate how your evidence meets the Revalidation Themes and Criteria.

Mapping grid example – case presentation

REVALIDATION THEME	EVIDENCE PROVIDED	MAPPING TO THE REVALIDATION ASSESSMENT CRITERIA	RATIONALE: HOW DOES THE EVIDENCE DEMONSTRATE THE REVALIDATION ASSESSMENT CRITERIA?
Theme 1 Communication and patient partnership	Case presentation	1.1, 1.2, 1.4	The case presented entailed showing my ability to communicate effectively and to work in partnership with the patient.
Theme 2 Knowledge, skills and performance	Case presentation	2.3, 2.4, 2.5	The case shows that I had the osteopathic knowledge and skills to deal with this complex case and that I liaised with an appropriate professional for further advice when needed.
Theme 3 Safety and quality in practice	Case presentation	3.1, 3.2, 3.3, 3.4	The case presentation shows that I provide safe care by making robust assessment and providing effective care within my limitations.
Theme 4 Professionalism	Case presentation	4.2, 4.6	The evidence shows an ability to act professionally and within the *Osteopathic Practice Standards* at all times.

Mapping grid example – case-based discussion

REVALIDATION THEME	EVIDENCE PROVIDED	MAPPING TO THE REVALIDATION ASSESSMENT CRITERIA	RATIONALE: HOW DOES THE EVIDENCE DEMONSTRATE THE REVALIDATION ASSESSMENT CRITERIA?
Theme 1 Communication and patient partnership	Case-based discussion	1.2, 1.4	The evidence shows that I recognise the need to work in partnership with my patient and to spend time creating an effective relationship.
Theme 2 Knowledge, skills and performance	Case-based discussion	2.1, 2.5	The discussion presented shows that I carried out appropriate educational activities to enhance my knowledge of this case and that I took an evidence-based approach to my practice.
Theme 3 Safety and quality in practice	Case-based discussion	3.3, 3.4	The evidence shows that I took a safe approach to the care of this patient and that I was aware of the risks entailed in inappropriate management.
Theme 4 Professionalism	Case-based discussion	4.2, 4.3	The evidence shows an ability to act professionally and within the *Osteopathic Practice Standards* at all times, and to engage appropriate others in the management of my patient.

Mapping grid example – management plan

REVALIDATION THEME	EVIDENCE PROVIDED	MAPPING TO THE REVALIDATION ASSESSMENT CRITERIA	RATIONALE: HOW DOES THE EVIDENCE DEMONSTRATE THE REVALIDATION ASSESSMENT CRITERIA?
Theme 1 Communication and patient partnership	Management plan	1.3, 1.4	The management plan shows that I ensured the patient was fully-informed about her treatment plan and engaged in decisions about her care.
Theme 2 Knowledge, skills and performance	Management plan	2.2, 2.3	The evidence shows that I took an evidence-based approach to care and that I used my clinical decision-making skills to plan effective care.
Theme 3 Safety and quality in practice	Management plan	3.3	The management plan shows that I applied a safe and competent approach to the care of this particular patient.
Theme 4 Professionalism	Management plan	4.2	The management plan demonstrates that I was aware of working within my limitations and that referral to another professional might be required.

Mapping grid example – significant event analysis

REVALIDATION THEME	EVIDENCE PROVIDED	MAPPING TO THE REVALIDATION ASSESSMENT CRITERIA	RATIONALE: HOW DOES THE EVIDENCE DEMONSTRATE THE REVALIDATION ASSESSMENT CRITERIA?
Theme 1 Communication and patient partnership	Significant event analysis	1.1, 1.2, 1.3, 1.4	This reflection shows my ability to communicate effectively and to work in partnership with the patient, in a complex situation.
Theme 2 Knowledge, skills and performance			
Theme 3 Safety and quality in practice			
Theme 4 Professionalism	Significant event analysis	4.2, 4.3, 4.4, 4.5, 4.6	The evidence shows an ability to act professionally and within the *Osteopathic Practice Standards* at all times.

Mapping grid example – clinical reflection

REVALIDATION THEME	EVIDENCE PROVIDED	MAPPING TO THE REVALIDATION ASSESSMENT CRITERIA	RATIONALE: HOW DOES THE EVIDENCE DEMONSTRATE THE REVALIDATION ASSESSMENT CRITERIA?
Theme 1 Communication and patient partnership	Clinical reflection	1.1, 1.2, 1.3, 1.4	This reflection shows my ability to communicate effectively and to work in partnership with the patient.
Theme 2 Knowledge, skills and performance			
Theme 3 Safety and quality in practice			
Theme 4 Professionalism	Clinical reflection	4.3, 4.4, 4.5, 4.6	The evidence shows an ability to act professionally and within the *Osteopathic Practice Standards* at all times.

Mapping grid example – personal development needs analysis (PDNA)

REVALIDATION THEME	EVIDENCE PROVIDED	MAPPING TO THE REVALIDATION ASSESSMENT CRITERIA	RATIONALE: HOW DOES THE EVIDENCE DEMONSTRATE THE REVALIDATION ASSESSMENT CRITERIA?
Theme 1 Communication and patient partnership			
Theme 2 Knowledge, skills and performance	Personal development needs analysis	2.1, 2.3	The PDNA shows how I identified gaps in my knowledge about the anatomy and physiology of the knee, and about informed consent in children and young people. It shows how I took a planned approach to addressing these gaps.
Theme 3 Safety and quality in practice			
Theme 4 Professionalism	Personal development needs analysis	4.5	By ensuring that children and young people are fully informed about their management.

Mapping grid example – action plan

REVALIDATION THEME	EVIDENCE PROVIDED	MAPPING TO THE REVALIDATION ASSESSMENT CRITERIA	RATIONALE: HOW DOES THE EVIDENCE DEMONSTRATE THE REVALIDATION ASSESSMENT CRITERIA?
Theme 1 Communication and patient partnership	Action plan	1.3	The action plan shows that appropriate informed consent is gained from children and young people who are managed within my osteopathic practice.
Theme 2 Knowledge, skills and performance	Action Plan	2.1	The action plan details the educational activities that were undertaken to achieve the outcomes detailed in the action plan.
Theme 3 Safety and quality in practice			
Theme 4 Professionalism	Action plan	4.3, 4.5	The educational activities outlined in the action plan show that I can access and retrieve current information about consent.

5.2 Final self-assessment checklist

The following is a final checklist to ensure you have met the Revalidation self-assessment requirements before you submit your portfolio.

Please circle the types of evidence you have used to support your submission and confirm yes to all questions. You have then successfully completed the Revalidation Pilot. Thank you.

Giving information and recording/discussing practice

1. Patient documentation
2. Patient records
3. Case presentation
4. Case-based discussion
5. Management plans

Other – please describe:

Developing practice

1. Significant event analyses
2. Clinical reflections
3. Personal development needs analysis
4. Action plans

Other – please describe:

Feedback on practice

1. Peer review
2. Multi-source feedback
3. Patient satisfaction/experience questionnaires
4. Clinical audit

Other – please describe:

Have you submitted evidence for each of the following Themes, showing that you meet the Revalidation Criteria?

(Please circle all Themes to confirm that you have submitted evidence for each)

A. Communication and patient partnership
B. Knowledge, skills and performance
C. Safety and quality in practice
D. Professionalism

Have you submitted a piece of subjective evidence?

1. Case presentation
2. Case-based discussion (if completed by Pilot Participant)
3. Management plan
4. Significant event analysis
5. Clinical reflections
6. Personal development needs analysis
7. Action plans

Other – please describe:

Have you submitted a piece of objective evidence?

1. Case-based discussion (if completed by someone other than the osteopath)
2. Practice documentation
3. Patient's records
4. Peer review
5. Multisource feedback
6. Patient satisfaction/experience, questionnaires
7. Clinical audit

Other – please describe:

Have you completed and enclosed the evidence mapping grid explaining how you have met each of the Revalidation Criteria?

☐ Yes ☐ No

Have you completed and enclosed your supporting evidence for the Revalidation Pilot?

☐ Yes ☐ No

Have you identified any learning needs from completing this exercise that may help to inform your CPD next year?

☐ Yes ☐ No

APPENDIX

The Assessment Expert Team

The Revalidation Standards and Assessment Framework was developed by an independent expert team. We are grateful to all members of the Assessment Expert Team for their contribution to the Guidelines for Osteopaths Seeking Revalidation (Revalidation Pilot).

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