Professional practice for exercise referral instructors

LO: Understand the role and importance of exercise referral and related policies and key documents

Assessment criteria

1. Explain the role of exercise referral in both the fitness industry and the health sector.

2. Evaluate the general role of exercise in disease risk reduction and condition management.

3. Outline the key points of government policies relating to exercise referral schemes.

4. Outline key points from the Professional and Operational Standards for exercise referral.

Activity

- What is exercise referral?

Exercise referral schemes

- Exercise referral schemes evolved in the late 1990s and early 2000's.
- They were developed to enable people with chronic health conditions to take part in structured exercise.
- The original guiding document for scheme set up was the National Quality Assurance Framework (NQAF. Department of Health, 2001).

National Quality Assurance Framework (NQAF)

The NQAF (Department of Health, 2001) was a published report which:

- Outlined key medico-legal guidance
- Guided scheme operation and management procedures
- Outlined instructor qualifications and competence
- Provided the risk stratification pyramid to assess risk

The report was written by a number of forward-thinking experts.

It was written to enable professional collaboration between the fitness and health sectors.

Various schemes evolved throughout the UK.

Exercise referral process

- The General Practitioner (GP) or health professional
  - Refer their patient(s) to an exercise referral scheme
  - Gain patient consent
  - Transfer agreed information
- The scheme:
  - Contact the client (GP's patient)
  - Assess the client
- The client:
  - Takes part in supervised and structured exercise for set time period.
  - Exits the scheme

Exercise referral schemes in the UK

- Schemes are usually overseen and managed by central and/or local co-ordinator
- Some small local schemes, e.g. local authority/council
- Some large National schemes, e.g. Welsh National Exercise Referral Scheme (NERs)
- Linked with local health services, e.g. GP
- Usually operate from community and leisure services
- Offer different activities
- Different inclusion and exclusion criteria
- Work with different conditions and level of risk
- Offer planned intervention for around 12-16 weeks
- Offer post intervention exit routes and follow-up

Activity

- Who is exercise referral for?
- Why is exercise referral important?

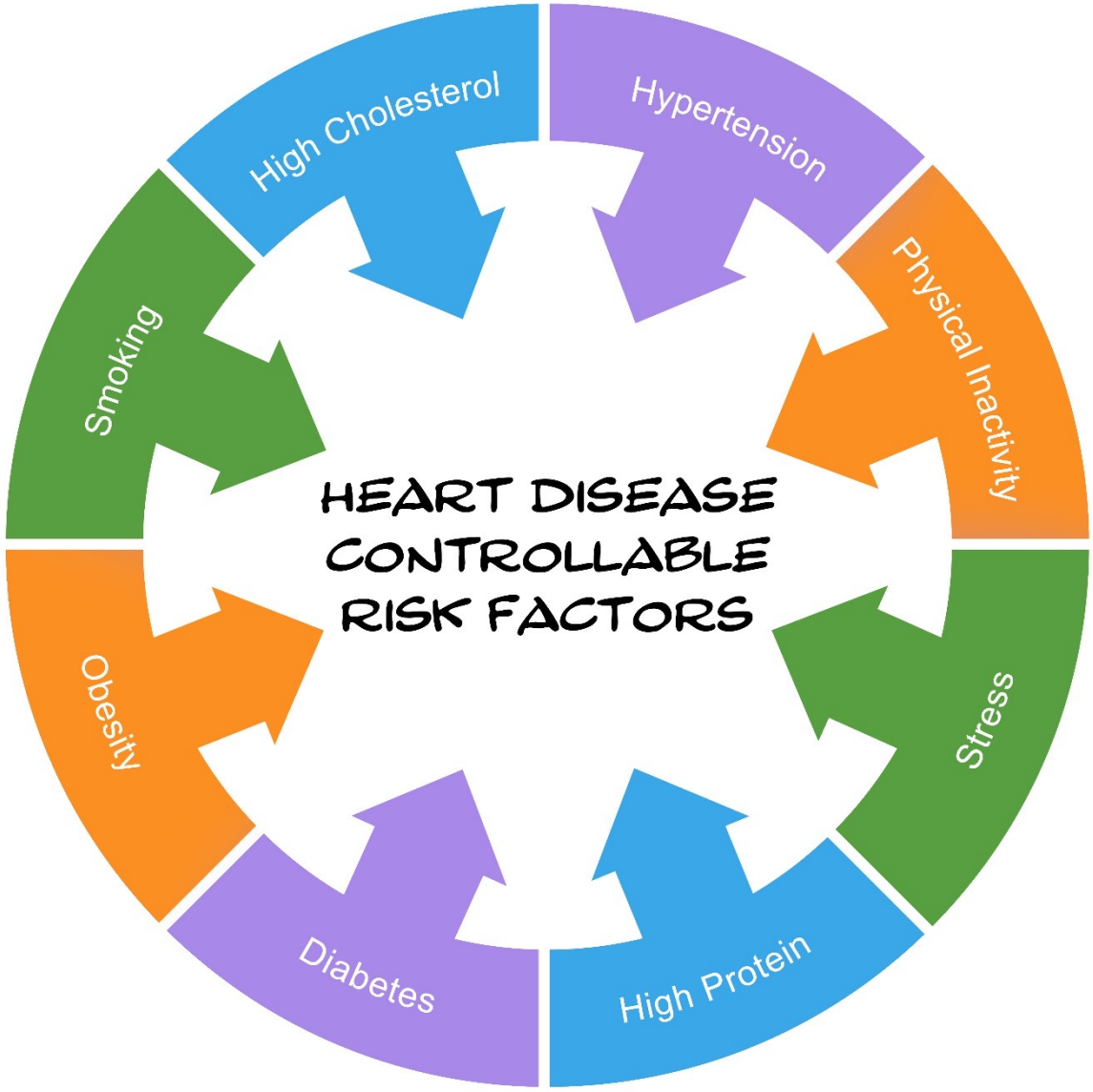
Who is exercise referral for?

For sedentary and inactive individuals who would benefit from supervised and structured exercise, including:

- At risk of cardiovascular disease (CVD)
- Mild to moderate depression, stress and/or anxiety
- Low to moderate risk medical condition(s), e.g. asthma, COPD, osteoporosis, osteoarthritis, low back pain

Who is exercise referral for?

- For people at risk of cardiovascular disease (CVD)
- Two 2 or more risk factors



Who is exercise referral for?

- For people with Mild to moderate depression, stress and/or anxiety.

Why is exercise referral important?

Exercise referral schemes enable the person to take part in structured exercise under the supervision of an appropriately qualified exercise professional.

Vtct

Why is exercise referral important?

- To assist with the prevention and management of chronic health conditions
- To enable participation in supervised and structured exercise
- To promote long term adherence to physical activity and exercise
- To promote healthy living and change of other lifestyle behaviours

Activity

- What is the role of exercise referral for the fitness industry?

Exercise referral for the fitness industry

Exercise referral has the potential to:

- Build a professional sector
- Enable the sector to contribute to the health agenda
- Build the reputation of the fitness industry
- Develop career opportunities for exercise and fitness professionals

  Increase physical activity levels
- Promote long term adherence to activity
- Support clients with other lifestyle and behaviour changes
- Enable participation in structured/supervised exercise

Activity

- What is the role of exercise referral for the health sector?

The role of exercise referral for the health sector

Exercise referral has the potential to:

- Assist and support the health and well-being of communities
- Help to reduce inactivity and associated health risks
- Assist with the prevention and management of chronic health conditions
- Help to reduce the financial burden of chronic health conditions on the NHS and UK economy.

Activity

- How can exercise referral help with disease risk reduction?

The role of exercise in disease risk reduction

Chief medical officer reports *('At Least Five a Week' and 'Start active, Stay Active')* promote the role of physical activity for reducing the risk of:

- Premature death
- Developing cardiovascular disease (CVD), hypertension, stroke, diabetes
- Developing some types of cancer
- Obesity
- Clinical depression
- Stress and anxiety
- Osteoporosis
- Falls and fractures in frail older adults
- Low back pain

The role of exercise in disease risk reduction

Regular physical activity:

- Improves general and psychological wellbeing
- Improves quality of life
- Assists with weight management
- Improves efficiency of cardiovascular system
- Maintains and improves bone density
- Maintains independence in older adults
- Improves functional capacity and maintains mobility

Source: Chief medical officer reports: At least five a week, 2004; Be active, be healthy, 2009; Start Active, Stay Active, 2011.

Risks of inactivity

Depression

Coronary heart disease

Falls and fractures

Diabetes

Hypertension

Obesity

Some cancers

Angina

Anxiety and stress

Stroke

Osteoporosis

Loss of independence

Inactive populations

- Women and girls are less active than men and boys.
- Older people - activity levels decline with increasing age.
- South Asian, Chinese and Bangladeshi men and women reported as least physically active
- Low income households
- Lower social classes
- Lower educational attainment
- Non-professional and non-managerial work

Source: Chief medical officer reports: At least five a week, 2004; Be active, be healthy, 2009; Start Active, Stay Active, 2011.

Activity levels in UK

- Only 40% of men and 28% of women (over 18) meet recommended activity levels

- Only 61% of boys and 42% of girls (aged 7 to 18) meet recommended activity levels

Source: Chief medical officer reports: 'At least five a week, 2004; Be active, be healthy, 2009; Start Active, Stay Active, 2011.

Factors affecting activity levels

- Sedentary work
- Sedentary leisure, e.g. television
- Technology, e.g. computers, transport
- Inactive travel
- No or fewer ‘sport’ role models from some population groups
- Fewer opportunities for sport and exercise at school or work
- Negative past exercise experiences, e.g. PE
- Psychological factors, e.g. low self-esteem, low confidence, low motivation

Source: Chief medical officer reports: ‘At least five a week, 2004; Be active, be healthy, 2009; Start Active, Stay Active, 2011.

Revision activity

What are some of the key points of government policies and reports that relate to exercise referral schemes?

What other Government legislation and policies may be relevant for exercise referral?

Government reports

Chief medical officer reports: At least five a week, 2004; Be active, be healthy, 2009; Start Active, Stay Active, 2011.

- Benefits of activity
- Health risks associated with inactivity

National Institute for Health and Clinical Excellence (NICE)

- 2006 report on the effectiveness of exercise referral
- Guidance for treatment and management of specific conditions

Other policies and legislation

- Health and safety at work
- First aid
- Safeguarding.
- Five stages of risk assessment
- Manual handling
- Equality and diversity
- Data protection and confidentiality
- Freedom of information
- Information transfer
- Employment

British Heart Foundation National Centre (BHFNC)

Published a tool kit in 2010.

Toolkit outlined:

- Scheme set up and operation
- Roles and responsibilities of all involved
- Medico-legal requirements
- Client consultation and assessment protocols
- Risk stratification
- Scheme evaluation
- Transferring information
- Record keeping
- Examples of paperwork

Exercise referral advisory group

- Established in 2011
- To produce operational standards and guidance for exercise referral
- Reviewed existing practice
- Developed professional operational standards for exercise referral
- Report produced by not published
- Draft document available from: *www.bases.org.uk*

Professional operational standards

- Report outlined:
  - Roles and responsibilities of all involved
  - Patient selection, risk stratification and Inclusion criteria
  - Screening, consultation and assessments
  - Recording, reporting, monitoring and evaluation
  - Instructor competence - qualifications and insurance
  - Medico-legal considerations
  - Quality assurance procedures

Learning check

1. Explain the role of exercise referral in both the fitness industry and the health sector.

2. Evaluate the general role of exercise in disease risk reduction and condition management.

3. Outline the key points of government policies relating to exercise referral schemes.

4. Outline key points from the Professional and Operational Standards for exercise referral.

Professional practice for exercise referral instructors

LO: The roles and responsibilities within an exercise referral scheme

Assessment criteria

1. Explain the roles of the medical, health, and fitness professionals in an exercise referral scheme.
2. Define the fitness professional's scope of practice and the inter-professional boundaries within an exercise referral scheme.
3. Describe how to deal with a patient who has a medical condition outside the scope of practice of the exercise referral instructor.
4. Explain when to refer to other professionals including the original referrer.
5. Explain how to determine 'inappropriate referrals'.
6. Explain the importance of not accepting a patient who has been declined a referral for exercise from their medical practitioner or health professional.
7. Explain the importance of effective inter-professional communication.

Activity

What is the role of each of the following within an exercise referral scheme?

- Referring health professional, e.g. GP
- Referral scheme manager
- Scheme co-ordinator
- Exercise referral instructor(s)
- Clients

The referral process

Patient visits GP

GP suggests exercise referral (if patient meets criteria)

Informed consent gained and information transferred

Scheme coordinator - Receives information

Incomplete records returned to GP

Complete records – client contacted and appointment booked with exercise referral instructor (ERI)

Exercise referral instructor - Client consultation

Motivational interview and initial assessment

Programme planned, delivered, monitored (12-16 weeks)

Exit strategies and follow up monitoring (6 /12 months) Scheme evaluation

Healthcare professional role

- Maintain clinical responsibility for client (their patient)
- Diagnose condition and discuss treatment options
- Check client meets inclusion criteria
- Recommended exercise referral, if appropriate
- Prescribe medications
- Gain client informed consent
- Transfer relevant information to scheme
- Refer clients to other services, e.g. counsellor, smoking cessation, dietician

Scheme coordinator role

- Responsible for the overall management of the scheme (usually for larger schemes)
- The coordinator is responsible to receiving and checking client information from the GP
- They check client records are complete and that the clients meet inclusion criteria
- Incomplete records are returned to GP
- Clients who meet criteria are assigned to an exercise referral instructor for consultation
- The coordinator is also responsible for instructor recruitment and management

Exercise referral instructor role

Responsibilities include:

- Hold relevant qualifications
- Hold professional indemnity insurance
- Member of professional body (Register of Exercise Professionals (REPs))
- Have knowledge of scheme procedures
- Work with low-moderate risk clients
- Conduct client consultations
- Plan and instruct safe programmes they are qualified to deliver (e.g. Aqua, gym, yoga, Pilates)
- Maintain accurate and current records
- Report regularly to the scheme co-ordinator and healthcare professional
- Maintain client confidentiality

Exercise referral instructor boundaries

The exercise referral Instructor is NOT qualified to:

- Instruct exercise sessions they are not qualified to instruct
- Instruct clients with conditions they are not qualified to manage (e.g. higher risk, or specialist level 4)
- Diagnose conditions
- Provide medical advice
- Provide advice on nutrition or diets (qualified dietician)
- Breach client confidentiality

Inter-professional boundaries

- Professional practice
- Sign of respect
- Risks of not respecting boundaries:
  - May put the client at risk
  - Breach duty of care
  - Potential for prosecution - instructor and scheme
  - Negative impact on reputation – instructor, scheme and sector
  - Reduce trust and negatively impact future collaboration between fitness and health sectors

Activity

When would it be necessary to signpost a client back to the referring professional or other professionals?

Refer back to health professional

- Any uncertainty regarding the client's suitability (client or instructor)
- Medical conditions outside scope of practice (Level 4)
- High risk
- Inappropriate referrals
- To refer to other services, e.g. dietitian
- Any change in the client's health status:
  - Presentation of new symptoms
  - Deterioration in an existing condition
- Contraindications:
  - Cardiac conditions
  - Stage 3 hypertension
  - Tachycardia
  - Unstable conditions, not controlled with medication

Conditions outside scope of practice

High risk stratification

All level 4 groups:

- Cardiac, e.g. angina, MI, heart failure
- Falls risk, frail older adults
- Low back pain, e.g. prolapsed disc
- Obesity and diabetes, e.g. morbid obesity
- Neurological, e.g. Parkinson's, stroke, Mulitiple Sclerosis
- Mental health, e.g. severe depression, eating disorders, substance-misuse, bipolar, schizophrenia

Referral Instructor action: Report to co-ordinator and sign-post client back to GP

Inappropriate referrals

- Contra-indications
- Level 4 conditions
- High risk stratification

- Clients must meet the specific scheme inclusion criteria
  - Listed conditions only
  - Low to moderate risk (according to scheme criteria)

Referral Instructor action: Report to co-ordinator and signpost client back to GP

Patients declined a referral by GP

- Never accept clients declined a referral by a GP (NQAF, 2001)
- Breach inter-professional boundary
- Breach duty of care
- Client most likely to be high risk stratification

Referral Instructor action: Report to co-ordinator and sign-post client back to GP

Signposting to other servicess

- An exercise referral instructor may discuss and recommend other services, e.g. smoking cessation, talking therapies
- Instructors should signpost the client to their GP to gain referral to another service, e.g. dietitian
- The GP will refer the client

Activity

- Why is effective inter-professional communication important?
- When would an exercise referral instructor need to communicate with healthcare professionals?
- What methods of communication may be used?

Importance of inter-professional communication

- Clear and accurate information transferred between services
- Accurate records
- Accurate information
- Appropriate client care at all times
- Health and safety
- Professional practice
- Scheme evaluation and monitoring
- Build relationships with other professionals

Purpose of Interprofessional communication

Communication between services will be required if:

- Incomplete transfer records
- Information provided by the client conflicts with information on transfer records
- The client does not meet the inclusion criteria
- Contra-indications identified
- A client identifies a change in their health
- Any other safety concerns
- Notification required of client attendance and progress

Written communication

Use agreed communication mode, e.g. letter, secure email.

Use appropriate language.

Must include:

- Headed paper – referral scheme.
- Sender's address and delivery address
- Concise description of proposals or concerns
- Correct spelling and grammar
- The Exercise Professional's qualifications and insurance
- Date and signature

Consideration

- Written records are legal documents
- Can be presented as evidence in a court of law
- Follow Data Protection Act and confidentiality guidelines
- Secure storage essential
- Maintain for appropriate duration

Learning check

1. Explain the roles of the medical, health, and fitness professionals in an exercise referral scheme
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3. Describe how to deal with a patient who has a medical condition outside the scope of practice of the exercise referral instructor
4. Explain when to refer to other professionals including the original referrer
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6. Explain the importance of not accepting a patient who has been declined a referral for exercise from their medical practitioner or health professional
7. Explain the importance of effective inter-professional communication

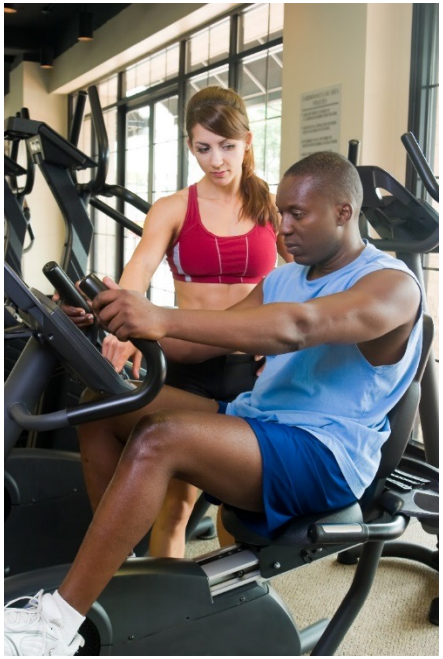
Professional practice for exercise referral instructors

LO: The current healthcare systems in the UK

Assessment criteria

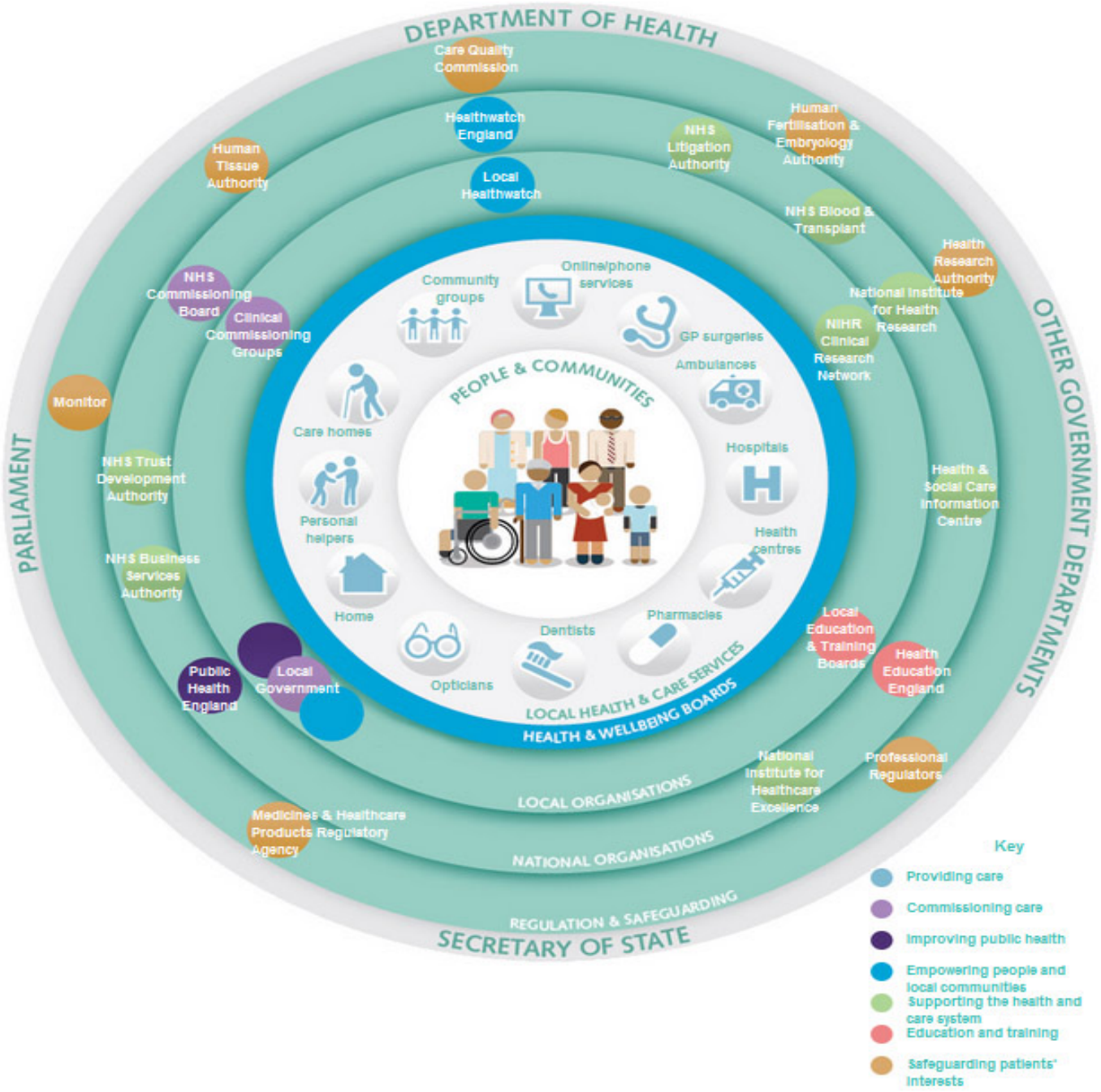
1. Describe the role of Clinical Commissioning Groups.

2. Identify key health service documents/policies and their impact on the health care system in relation to exercise referral.



Healthcare systems (2015)

- 2012 reform.
- Health and Social Care Act (2012)
- Public Health moved from the NHS
- Moved back to the Local Authorities (where originated)
- Changes implemented from April 1st 2013
- New structure
- GPs hold the majority of the NHS budget
- Other budget allocations to:
  - Clinical Commissioning Groups (CCGs)
  - Public Health in the Local Authorities


DEPARTMENT OF HEALTH
Care Quality Commission
Healthwatch England
Local Healthwatch
Human Tissue Authority
NHS Litigation Authority
Human Fertilisation & Embryology Authority
NHS Blood & Transplant
Health Research Authority
National Institute for Health Research
NIHR Clinical Research Network
NHS Commissioning Board
Clinical Commissioning Groups
Monitor
NHS Trust Development Authority
NHS Business Services Authority
Public Health England
Local Government
PARLIAMENT
OTHER GOVERNMENT DEPARTMENTS
Health & Social Care Information Centre
Local Education & Training Boards
Health Education England
Professional Regulators
National Institute for Healthcare Excellence
Medicines & Healthcare Products Regulatory Agency
SECRETARY OF STATE
REGULATION & SAFEGUARDING
NATIONAL ORGANISATIONS
LOCAL ORGANISATIONS
HEALTH & WELLBEING BOARDS
LOCAL HEALTH & CARE SERVICES
PEOPLE & COMMUNITIES
Community groups
Online/phone services
GP surgeries
Ambulances
Hospitals
Health centres
Pharmacies
Dentists
Opticians
Home
Personal helpers
Care homes
Key
Providing care
Commissioning care
Improving public health
Empowering people and local communities
Supporting the health and care system
Education and training
Safeguarding patients' interests

Healthcare layers

Centre:

- **Clients & Communities** (service users) at the centre
- **Local health services** (services visited daily), e.g.GP surgeries, pharmacies, hospitals, opticians etc.
- **Health and Wellbeing boards** oversee all local services.
- **Local authorities and Clinical Commissioning Groups** - ensure services meet community health needs
- **National Organisations** - Public Health England and NHS Commissioning boards
- **Regulation and Safeguarding organisations**, e.g. Care Quality Commission (CQC) and various authorities
- **Department of Health**, **Parliament and Government departments**

Outer layer

Health and Wellbeing Boards

- Every authority
- Operate to improve community health and well-being and reduce health inequalities
- Legally required to consist of at least:
    - One local elected representative
    - A local representative - client or community voice
    - A representative from each local clinical commissioning group (if more than one)
    - The local authority director for adult social services
    - The local authority director for children's services
    - The director of public health for the local authority
    - Local Councillors

Clinical Commissioning Groups (CCG)

- Responsible for local health services
- Clinically led
- Statutory organisations
- All GP groups within a local geographic area
- Commission appropriate services to meet needs
- Mainly clinical (e.g. elective hospital care)
- Opportunities to bid into:
  - Community health services (e.g. exercise referral)
  - Mental health services

Joint Strategic Needs Assessment (JSNA)

- Available from local authority websites
- Identifies local health needs
- All decision making regarding local health provision will be based on the needs identified in the JSNA

JSNA's, informed by

Public Health reports informed by

Chief medical officer reports

JSNA reports

Reflect key messages from CMO reports:

- Move more often
- Sit down less
- Quit smoking
- Sensible drinking - alcohol within guidelines
- Maintain a healthy weight
- Eat more fruit and vegetables (5 a day)

Activity

1. What are some of the key messages from various CMO reports?

2. How may these impact on the health care system in relation to exercise referral?

Chief medical officer reports

'At Least Five a Week' and 'Start active, Stay Active'

Promoted the role of physical activity for reducing the risk of:

- Premature death - 20 – 30%
- Developing cardiovascular disease (CVD), hypertension, stroke, diabetes and certain cancers - 50%
- Obesity
- Clinical depression
- Stress and anxiety
- Osteoporosis
- Falls and fractures
- Low back pain

Chief medical officer reports

'At Least Five a Week' and 'Start active, Stay Active'

Identified most Inactive populations:

- Women and girls are less active than men and boys
- Older people - activity levels decline with increasing age
- South Asian, Chinese and Bangladeshi men and women reported as least physically active
- Low income households
- Lower social classes
- Lower educational attainment
- Non-professional and non-managerial work

CMO England (2009)

Key points:

- Inactivity increases the risk of developing more than six major diseases
- Inactivity affects 60–70% of the adult population - more people than obesity, alcohol misuse and smoking combined
- Physical fitness of children is declining up to 9% per decade
- Physical activity tends to decline with age
- If a medication existed which had a similar effect to physical activity, it would be regarded as a ‘wonder drug’

CMO Wales (2009)

Key points:

- More actions needed to reduce:
  - Health inequalities in deprived areas
  - Alcohol and drug misuse
  - Smoking

- Interventions and treatments must be evidence-based.
  - National Institute for Health and Clinical Excellence (NICE)
  - Cochrane Library

CMO Scotland (2007)

Key points:

- Avoid tobacco smoking
- Eat a healthy diet
- Be physically active most days
- Drink alcohol within recommended limits
- Don’t inject drugs

CMO Northern Ireland (2009)

Key health concerns:

- Physical activity
- Obesity
- Alcohol misuse
- Mental health
- Self-harming
- Sexual health
- Managing infection
- Positive parenting
- Bowel cancer

Start Active, Stay Active (2011)

- Collaborative effort by CMOs for each Home Country
- Focus on physical activity and health
- Physical activity guidelines prescribed across the lifespan
  - Early years (under 5's) to older adults (65+)
- Inactivity is a silent killer
- Sets guidance for action

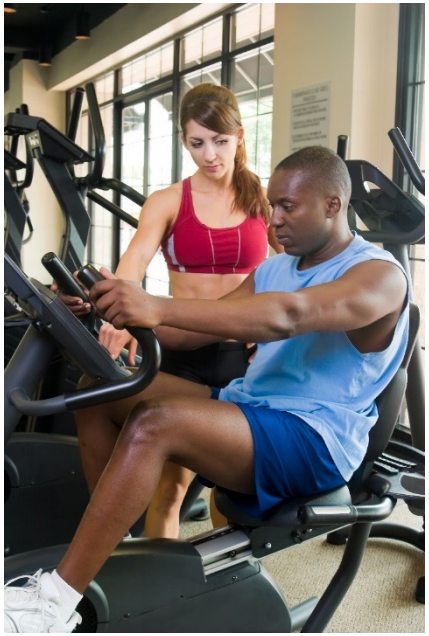
Public health reports

- Monitor community health.
- Identify community health priorities
- Make recommendations to improve services
- Transfer policy into practice

Learning check

1. Describe the role of Clinical Commissioning Groups

2. Identify key health service documents/policies and their impact on the health care system in relation to exercise referral



Professional practice for exercise referral instructors

LO: The exercise referral process

Assessment criteria

1. Explain the process of receiving a referred patient from a healthcare professional.

2. Describe the protocol for an initial patient consultation with the exercise referral instructor.

3. Describe the principles of patient monitoring and data collection.

4. Outline the medico-legal requirements relevant to the exercise referral instructor job role.

Activity

- How are clients referred from a GP or healthcare professional and how do they proceed through an exercise referral scheme?

The referral process

The start of the process is a client visiting their GP.

The GP will have a contracted agreement to work with the named referral scheme.

GP has copies of referral schemes:

1. Risk stratification model.
2. Inclusion and exclusion criteria.
3. Transfer of information records.
4. Main contact for transferring information.

Inclusion/exclusion criteria

Determined by:

- Instructor qualifications and experience
- Level 3 exercise referral = low to moderate risk
  - Low risk only schemes
  - Low to moderate risk schemes
- Access to clinical specialists
- Wider range of populations and conditions may be managed
- Risk stratification tool used by scheme
- Absolute contra-indications – exclusion

Inclusion = Clients who can be referred

Exclusion = Clients who cannot be referred

Information transferred

- GP name
- Client name
- Date
- Reason for referral
- Client contact details
- Summary of medical history – past and current
- Medications or other treatments
- Risk stratification - PARmedX and other tools
- Other relevant information, e.g. cultural needs, language spoken, etc.
- Health measurements, e.g. blood pressure, heart rate, BMI (usually taken by practice nurse)
- Clients preferred method of contact

Receiving a referred client

- Information is passed to named contact - scheme co-ordinator
- Contact receives and checks records
- Incomplete or inaccurate records returned to GP for more information
- Complete and accurate records:
  - Client contacted by co-ordinator
  - First appointment with exercise referral instructor booked
  - Client information passed to instructor

The referral process

Patient visits GP

GP suggests exercise referral (if patient meets criteria)

Informed consent gained

Information transferred to referral scheme

Scheme coordinator

Receives and checks information transferred.

Incomplete records are returned to GP.

Complete records – client is contacted and appointment booked with exercise referral instructor.

Exercise referral instructor

Consultation with client.

Motivational interview and initial assessments.

Programme planned, delivered, monitored (12-16 weeks)

Exit strategies and follow up monitoring (6 /12 months)
Scheme evaluation

Activity

1. What are the appropriate protocols to follow to conduct an initial patient consultation and assessment?

Consultation protocols

- Welcome client
- Build rapport
- Discuss information transferred to check accuracy
- Explain initial assessments and their purpose, e.g. blood pressure, heart rate, BMI, EQ-5D, IPAQ, physical assessments
- Obtain clients informed consent to participate in assessment
- Conduct assessments
- Record all information

Consultation protocols

- Use motivational interviewing and client-centred approach to assess:
  - Client readiness to participate
  - Motivation and barriers
  - Goals - short, medium and long term
  - Activity likes and dislikes
- Discuss possible programme (FITT principles) with consideration to client needs
- Obtain clients informed consent to participate in the structured exercise
- Develop programme
- Appropriate inductions (where relevant, e.g. gym)

Informed consent

- Explain the purpose of the assessment or programme
- Describe the benefits
- Explain any possible risks, discomforts and actions to minimise
- Explain client responsibilities
- Discuss and emphasise that participation is voluntary
- Discuss confidentiality and privacy
- Provide the opportunity for client questions
- Record all questions and answers
- Sign and date the informed consent record
- Ask the client to sign and date the informed consent record

Activity

What skills build rapport?

Building rapport

Listen.

Motivational Interviewing - **OARS**

- Open questions , e.g. ‘How are you you?’
- Affirming statements, e.g. ‘Thank you for joining the scheme’
- Reflective listening, e.g. ‘So you hope that exercise will help to improve your mood?’
- Summarising, e.g. ‘Your main concern is a lack of fitness and being pushed to work too hard?’

Listen

Their motivation - Change talk (reasons to make changes):

- *'I really want to be able to play with my grandchildren'*
- *'I will be able to climb stairs without getting so breathless'*
- *'I know I will feel better'*

Their barriers - Sustain talk (reasons to not make any changes):

- *'I can't do that because I'm too old.'*
- *'I've never liked exercise'*
- *'I'm scared I will fail'*

Psychological readiness scale

Example question:

Using the 1-10 scale, how ready do you feel to be more active on a regular basis?

Not ready

Why?

100% ready

Why?

Example questions:

- Why have you indicated you are at level 6 and not a 4?
- What would you need to score 8?
- What score would you like to be?
- How could you move from score 6 to score 7?

Can help to elicit further change talk.

Activity

1. Describe the principles of patient monitoring and data collection.

Professional & Operational standards

Client data to collect:

- Personal - age, gender, ethnicity
- Measurements - height, weight and BMI, waist circumference
- Health measures - pre-exercise heart rate, blood pressure
- Questionnaires - physical activity levels (using IPAQ or 7 day recall) quality of life (using EQ-5D)
- Physical - range of joint movement
- Other - any other measurements requested by the referring health professional

Professional & Operational standards

Purpose of collecting information/data:

- Baseline information
- Develop exercise programme
- Assist planning of other activities
- Monitor client progress
- Assist motivation of client
- Client education
- Identify progression and regression needed
- Identify progress and development
- Support scheme outcomes
- Support funding applications

Monitoring

When to collect:

- Initial consultation – baseline
- Mid-term review – progress check (6-8 weeks)
- End-term review – outcome check

- Follow up – post-scheme reviews
  - 6 month post review – any sustained change?
  - 12 month post review – any sustained change?

Monitoring

Pre-session checks:

- Any changes in health or symptoms
- Any changes in medication
- Response to previous exercise session, e.g. tiredness, chest pain
- The results/outcomes of any GP appointments and tests

Exercise referral instructor actions:

- Temporarily defer client from activity
- Explain why and be sensitive
- Inform coordinator
- Signpost client back to the GP

Activity

- What are the medico-legal requirements relevant to the exercise referral instructor job role?

Medico-legal requirements

General:

- Work within boundary of role and responsibilities (REPs, EHFA)
- Comply with codes of practice.
  - Only deliver programmes for which qualifications held
  - Only work with conditions for which qualifications held
- Comply with legislation, e.g. health and safety, equality, data protection, etc.
- Follow scheme protocols and professional operational standards
- Be qualified
- Be insured; be members of appropriate professional organisations

Medico-legal considerations

- GP is responsible for the overall management of the patient
- Referral by GPs governed by General Medical Council
- GP may only *refer* a patient to professionals who:
  - Are accountable to a statutory regulator.
  - Work in an environment where there is appropriate supervision, audit and performance review

These criteria are under review.

Unless these criteria are met the transfer of care is considered *delegation* NOT referral.

Learning check

1. Explain the process of receiving a referred patient from a healthcare professional.

2. Describe the protocol for an initial patient consultation with the exercise referral instructor.

3. Describe the principles of patient monitoring and data collection.

4. Outline the medico-legal requirements relevant to the exercise referral instructor job role.

Professional practice for exercise referral instructors

LO: The principles and procedures of record keeping

Assessment criteria

1. Explain how patient confidentiality is maintained in an exercise referral scheme.

2. Explain the concept of data protection.

3. Explain the meaning of validity and reliability in relation to measurement of techniques and outcomes.

4. Explain how to evaluate the quality and reliability of evidence.

Activity

- What client information is gathered as part of the exercise referral process?
- Why is this information needed?

Client information

Professional & Operational standards (2011):

- Personal - age, gender, ethnicity
- Measurements - height, weight and BMI, waist circumference
- Health measures - pre-exercise heart rate, blood pressure
- Questionnaires - physical activity levels (using IPAQ or 7 day recall)
- quality of life (using EQ-5D)
- Physical - joint range of movement
- Other - any other measurements requested by the referring health professional

Purpose of information

- Baseline measures
- Client safety
- Develop exercise programme and assist planning of other activities
- Monitor and report on client progress
- Support scheme outcomes
- Support funding applications

Monitoring

When to collect:

- Initial consultation – baseline
- Mid-term review – progress check (6-8 weeks)
- End-term review – outcome check (12-16 weeks)
- Follow up – post-scheme reviews (6 and 12 months)
    - 6 month post review – any sustained change?
    - 12 month post review – any sustained change?

Activity

- Why is confidentiality important?
- How can client confidentiality be maintained in an exercise referral scheme?
- Why is data protection important?
- How can data be protected?

Confidentiality

- Maintaining confidentiality is one component of professional and ethical practice
- If confidentiality is breached clients can complain and may take legal action

For further information refer to the industry ‘Code of Ethical Practice’

Maintaining confidentiality

- Follow data protection guidelines
- Ensure clients know why specific information is needed and how it is used
- Ensure client consent is obtained before transferring information
- Only transfer essential information
- Only transfer to people who need to receive it and for specific issues, e.g. risk of harm or non-compliance with medication
- Keep all records secure
- If discussing client case studies, remove client personal details that may reveal their identity, e.g. name, age.

Data protection

Data Protection Act (DPA) 1998 (reviewed May 2013)

- All personal information is legally protected
- Failure to comply with the DPA is a criminal offence
- Non-compliance can be prosecuted in a court of law

Government's portal: https://www.gov.uk/data-protection/the-data-protection-act

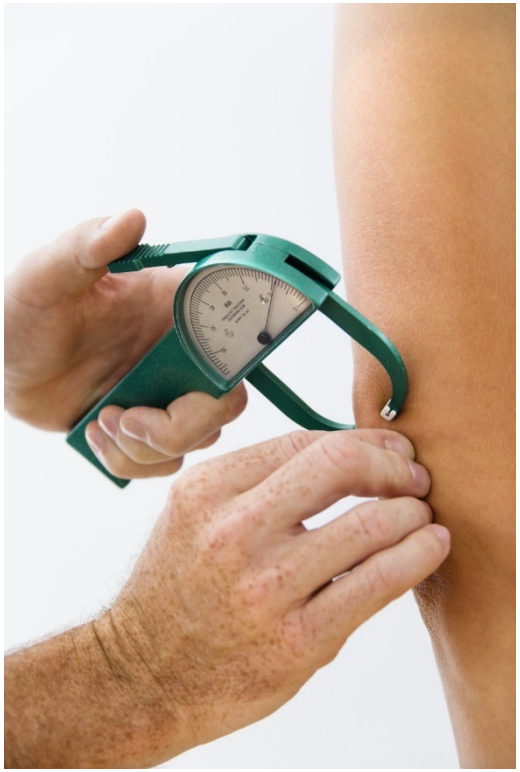
Guidelines for data protection

- Information recorded should be factual and supported by evidence
- Information should only be used for the purpose for which it was obtained
- Information must be transferred securely
- Information must be stored securely
- Information should only be seen by relevant persons
- Information must not be passed to other services
- Information should only be retained for an established timeframe
- Information must be destroyed once it has no further use

Activity

1. What is the meaning of validity and reliability in relation to measurement of techniques and outcomes?

2. How can the quality and reliability of evidence be evaluated?



Validity of measurements and techniques

Valid techniques and measures collect the data or information they are supposed to collect.

- Readiness to exercises – PAR-Q or PARmedX
- Waist circumference – tape measure
- Heart rate – take pulse
- Blood pressure - ambulatory device
- Body weight – weighing scales

Reliability of measurements and techniques

- Reliable measurements and techniques provide accurate and consistent information
- Different testers should get the same result
- The same tester would get the same result, if they repeat the test
- Standardised protocols should be followed
- Reliable recording instruments should be used (evidence-based)
- Testers/exercise referral instructors should be trained and qualified to conduct assessments

Quality and reliability

- Gather nationally agreed information, e.g. heart rate, blood pressure, height, weight, BMI
- Use valid and reliable assessment tools, e.g. IPAQ, EQ-5D
- Use standardised protocols to ensure reliability
- Ensure testers are trained and follow appropriate protocols
- Collect both qualitative and quantitative data

Quality and reliability

- Use professional researchers to monitor and evaluate scheme
- Consider issues that impact data collection, e.g. drop out, time
- Consider issues relating to group sampled
  - Sample size - how big is the sample (number of people)
  - How they were selected? e.g. are they representative of local population?
  - Any bias?
- Compare information with other studies and research, e.g. literature reviews, evaluations of other schemes

Learning check

1. Explain how patient confidentiality is maintained in an exercise referral scheme.

2. Explain the concept of data protection.

3. Explain the meaning of validity and reliability in relation to measurement of techniques and outcomes.

4. Explain how to evaluate the quality and reliability of evidence.

Professional practice for exercise referral instructors

LO: The concept of a patient-centred approach

Assessment criteria

1. Explain how verbal and non-verbal communication, appearance and body language can influence patients' perception.

2. Describe a range of consulting skills.

3. Explain the term 'health behaviours'.

4. Explain locus of control.

Activity

1. What communication skills would needed when consulting with clients?

2. How may verbal and non-verbal communication, appearance and body language influence patients' perception.

Communication skills

Eye contact

Personal space

Summaries

Open questions

Probing questions

Active listening

Consultation room

Language and terminology

Body language

Client centred

Facial expressions

Affirming statements

Motivational interviewing

Gestures

Closed questions

Reflective statements

Empathy

Non-judgement

Dress and appearance

Verbal communication

Verbal communication is used to:

- Communicate with clients
- Ask questions and gather information, e.g. lifestyle behaviours and reason for attending, and type of support they may need
- Respond to client
- Show empathy
- Motivate and affirm, e.g. ‘well done’

Examples:

- Words
- Language
- Tone and pitch
- Volume
- Pace
- Audibility

Non-verbal communication

Non-verbal communication:

- Is also used to communicate with clients
- May be conscious (in awareness)
- May be unconscious (out of awareness)
- Can often reflect and reveal true feelings and what is really meant

Examples:

- Body language
- Facial expressions
- Space and proximity
- Eye contact
- Gestures
- Posture
- Appearance
- Clothing

Activity

1. How do you think verbal and non-verbal communication, appearance and body language influence perception? Share some examples.

Client centred approach

Carl Rogers, 1960s.

Core conditions:

- Empathy - seeing things from the other person's perspective
- Unconditional positive regard - accepting and valuing the person without judgement
- Congruence - being genuine, 'real' and honest

R U L E

Motivational interviewing

Stephen Rollnick and William Miller.

Foundations in client-centred working.

RULE:

R – resist the righting reflex and need to change someone's behaviour

U – explore the person's motivations and barriers (change and sustain talk)

L – listen with empathy

E – empower the person - hold hope and be optimistic

Motivational interviewing

O A R S

- **O**pen questions – '*How does that feel?'*
- **A**ffirming statements – '*It took a lot of courage to attend today'*
- **R**eflective listening – 'You say you feel a bit more confident now'
- **S**ummarising statements – *'It took courage to attend, but you are feeling more confident now and it inspires you to see other people like you'*

Open questions

'*How are you?*'

'What is your reason for attending?

'What would you like to see happen as result of attending?'

Activity:

Make a list of a range of open questions that could be used with clients.

Closed questions

'What is the name of your GP?'

'Do you smoke?'

'Do you currently take part in any exercise or physical activity?'

Activity:

Make a list of a range of closed questions that could be used with clients.

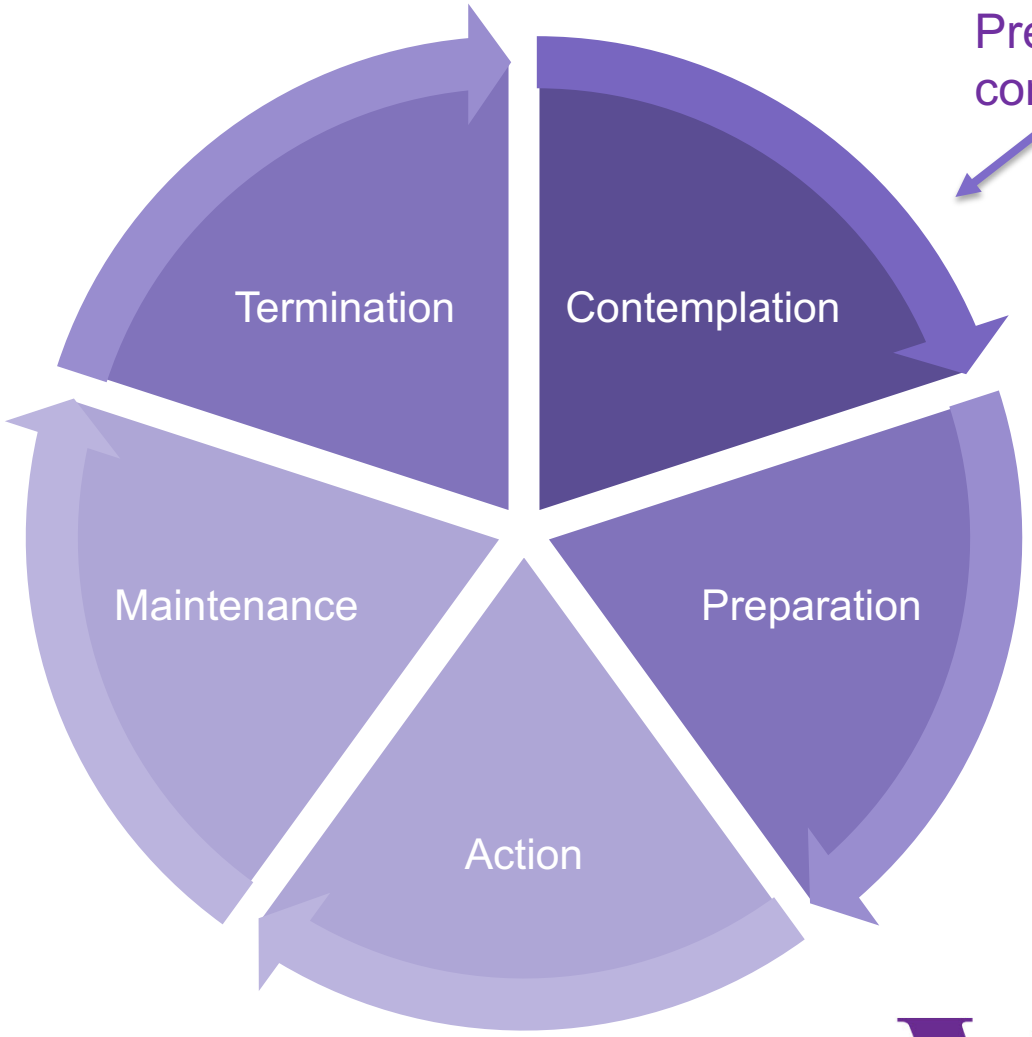
Active listening

- Facilitate conversation to enable the person to make their own choice and decisions.
- Listen more than speaking.
- Hear the motivations and barriers – change and sustain talk.
- Remember, too many questions block the flow of communication.

Stages of change

1. Pre-contemplation – not thinking about making a change
2. Contemplation – weighing up the possibilities (change and sustain talk)
3. Preparation – starting to prepare for change, e.g. gym membership.
4. Action – already made small changes (within 6 months)
5. Maintenance – change has been maintained for 6 months
6. Lapse – minor slip-up
7. Relapse – major slip-up - return to old behaviour
8. Termination – change permanent

Stages of change



Relapse – can happen at any stage

Activity

1. What are health behaviours?
2. What may influence behaviour choices?

Health behaviours

- Physical activity and exercise versus inactivity and sedentary behaviour
- Healthy eating versus unhealthy eating
- Not smoking versus smoking
- Sensible drinking versus alcohol misuse
- Healthy sleep versus unsettled sleep/insomnia
- Attending health screening checks versus non-attendance

Factors influencing behaviour choices

Socio-economic background

Culture

Ethnicity

Age

Gender

Role models

Religious beliefs

Peer group pressure

Family and friends

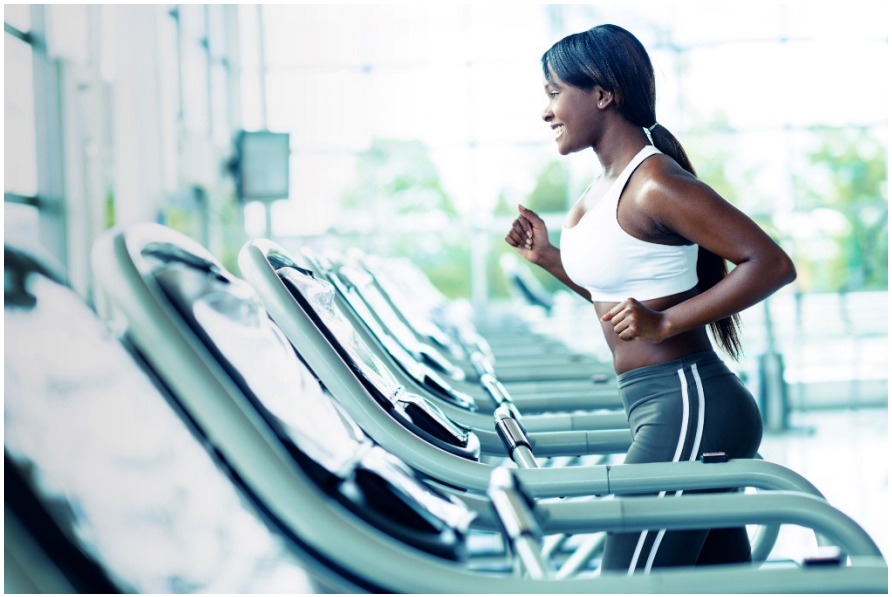
Personal beliefs, e.g. ‘I am, I can, I cant’

Media and advertising

Education

Activity

What is locus of control?



Locus of control

- The extent to which a person believes they are able to influence their lives through their own actions.
- Can be a guide to identifying an individuals determination and potential to make changes, e.g.
  - How much they want something?
  - Their self-belief and extent to which they think they can achieve something
  - The support they may need in making a change

Internal locus of control

- Believe in their own the power and ability to assert control to affect their life.
- Self-motivated, determined and will persevere to achieve their goal.
- Generally, need less external encouragement and fewer external rewards.

External locus of control

- Fatalistic, believe they have no control and life is a matter of luck
- Lower motivation and determination
- Often give quickly or modify their goal.

Considerations for working:

- Provide more one-to-one support and motivation
- Set goals (SMART)
- Use affirming statements
- Provide positive feedback and encouragement

Learning check

1. Explain how verbal and non-verbal communication, appearance and body language can influence patients' perception.

2. Describe a range of consulting skills.

3. Explain the term 'health behaviours'.

4. Explain locus of control.

Professional practice for exercise referral instructors

LO: How to monitor a successful exercise referral scheme

Assessment criteria

1. Describe techniques to monitor success for the patient and the scheme.

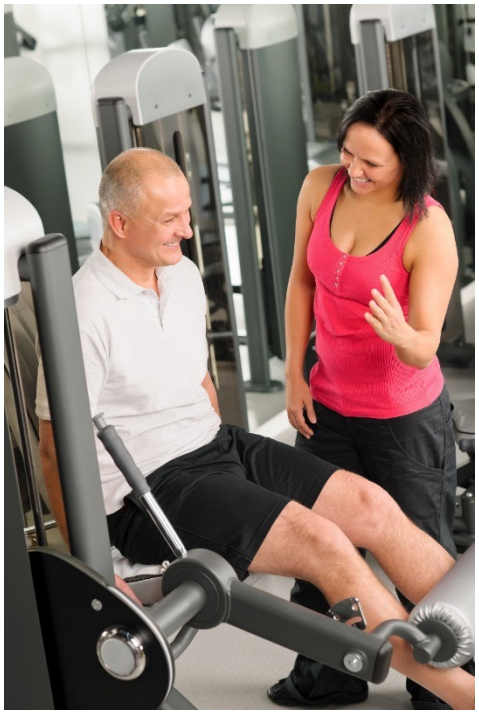
2. Describe the importance of monitoring and evaluation in exercise referral.

Activity

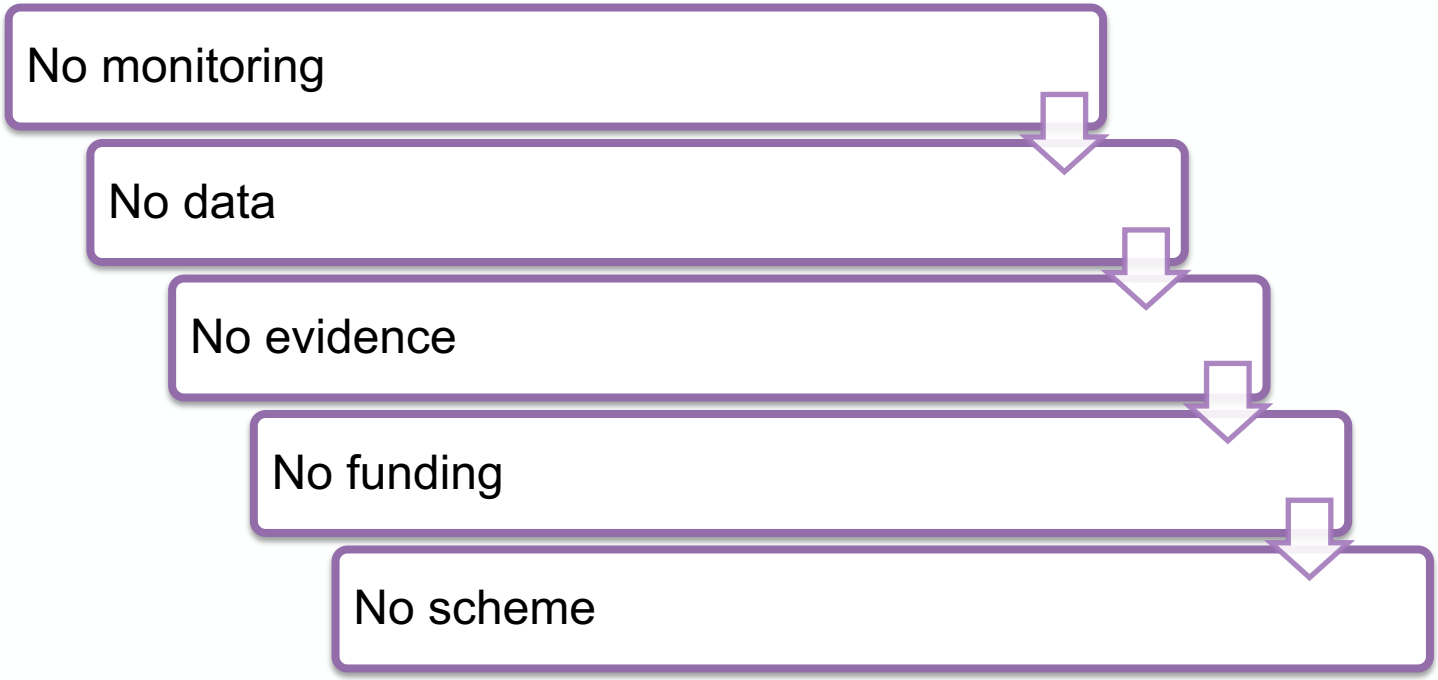
- Why is monitoring and evaluation important?
- What techniques can be used to monitor success for the client and the scheme?

Importance of monitoring and evaluation

- Check client progress
- Offer client motivation
- Provide evidence-base
- Review scheme success
- Identify strengths
- Identify weaknesses
- Identify areas to develop
- Support funding applications
- Enable continued provision of service



Importance of monitoring and evaluation



Activity

- What information can be gathered to monitor scheme effectiveness?

Techniques – client data

- Personal - age, gender, ethnicity
- Measurements - height, weight and BMI, waist circumference
- Health measures - pre-exercise heart rate, blood pressure
- Questionnaires - physical activity levels (using IPAQ or 7 day recall) and quality of life (using EQ-5D)
- Physical - joint range of movement
- Other - any other measurements requested by the referring health professional
- Interview and consultation data

Other records

- Number of GPs referring clients
- Number of clients being referred
- Attendance records – adherence
  - Clients referred
  - Clients attending first visiting
  - Clients completing
  - Drop-outs
  - Longer term adherence – 6-12 months
- Programme cards – progression/regression
- Client feedback and evaluations – subjective and personal
- Post service follow-up records – long term change 6 & 12 months
- Diaries and logs - lifestyle changes
- Client evaluations
- Instructor feedback
- GP feedback

Data collection intervals

- Initial consultation – baseline information and measures
- Every session – check readiness to exercise and health changes
- Mid-term review – progress check (6-8 weeks)
- End-term review – outcome check (12-16 weeks)
- Follow up – post-scheme reviews (6 and 12 months)
  - 6 month post review – any sustained change?
  - 12 month post review – any sustained change?

Learning check

1. Describe techniques to monitor success for the patient and the scheme.

2. Describe the importance of monitoring and evaluation in exercise referral.

Professional practice for exercise referral instructors

LO: The principles of risk stratification in exercise referral

Assessment criteria

1. Describe the principles of risk stratification.

2. Explain the current use of risk stratification tools used in exercise referral.

Activity

- What is risk stratification?
- Why is it needed?
- How is ‘risk’ assessed in exercise referral?

Risk stratification

An approach to assess risk.

Assess client readiness and suitability to be more active.

- PAR-Q
- PARmedX
- Risk stratification tools

Identify clients who may be at an increased risk during exercise and the level of risk.

- Low risk
- Moderate risk
- High risk

Assist exercise prescription and recommendations.

Assist identification of appropriate levels of supervision.

Risk stratification

Benefits of exercise

- Cardiovascular efficiency.
- Psychological well-being.
- Mobility.
- Independence
- Increase bone density
- Quality of life.
- Reduce risk of chronic disease.
- Weight management.

- Immediate increase in blood pressure and heart rate.
- Angina, heart attack.
- Asthma attack.
- Strains and sprains.
- Fainting.
- Hyperthermia.
- Hypoglycaemia.
- Hyperglycaemia.

Risks of exercise

Risk stratification

- All lifestyle behaviours present risks – exercise, alcohol, smoking, inactivity, diet
- The key is to identify the level of risk
- A start point is the health and safety executive risk assessment

Risk stratification

HSE risk assessment:

- What is the likelihood of an incident happening?
  - Unlikely to occur 1 – 2 – 3 – 4 – 5 Highly likely to occur.
- How severe would the outcome be?
  - Minor injury 1 – 2 – 3 – 4 – 5 Major injury, disability, death.
- Calculate the score by multiplying likelihood x severity

Risk stratification

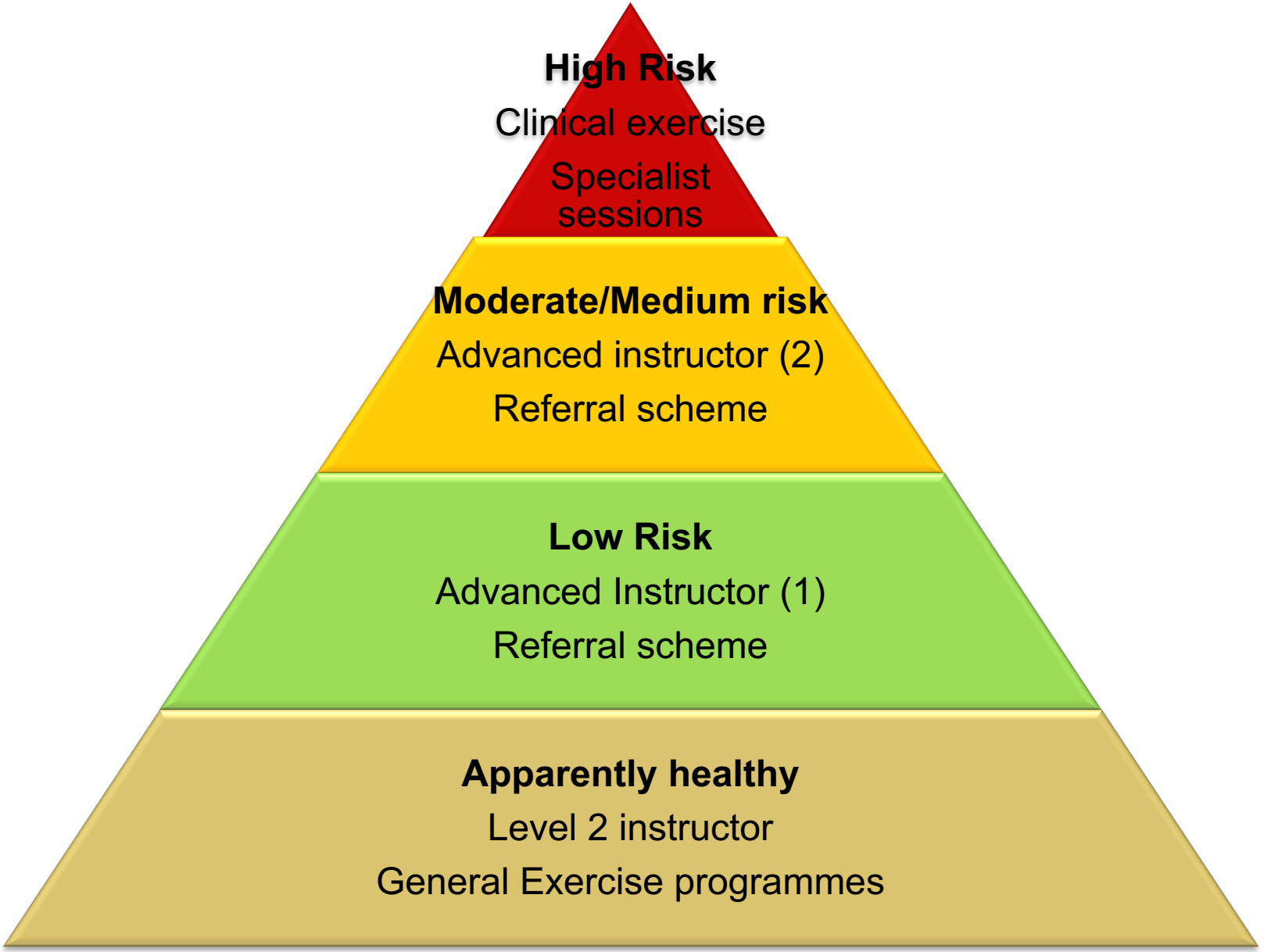
The risk of exercise and becoming more active is higher for people who:

- Are sedentary and inactive
- Are not sufficiently active
- Are deconditioned
- Are unused to exercise
- Have diagnosed health conditions, e.g. hypertension, angina etc.
- Have contra-indications, e.g. unstable conditions, stage 3 hypertension

Risk stratification models

- NQAF - Risk stratification pyramid
- ACSM - Logic model
- Irwin and Morgan - Risk Stratification Tool

NQAF. 2001 Risk stratification pyramid



ACSM. 2015. Logic model

1. Known Condition (CV, pulmonary or metabolic)
CVD/PVD/Stoke/COPD/Asthma/Cystic fibrosis/Diabetes/Thyroid disorders

YES

HIGH RISK

Clinically supervised programme

NO

2. Signs and Symptoms
Angina pain or discomfort/shortness of breath at rest or mild exertion, dizziness, ankle oedema, palpitations or tachycardia, intermittent claudication, known heart murmur, unusual fatigue or shortness of breath with usual activities

YES

HIGH RISK

Clinically supervised programme

NO

3. CVD Risk factors
Age, family history, smoking, sedentary, obesity, hypertension, dyslipidaemia, pre-diabetes

More than 2

Supervised programme - Level 3 Exercise Referral

Less than 2

Moderate risk

Low Risk

Unsupervised programme

Irwin and Morgan - Low risk	
Overweight	No complications
High normal blood pressure	Systolic 130-139 Diastolic 85-89 No medication
De-conditioned	Due to age or inactivity
Type 2 diabetes	Diet controlled
Older adults – 65+	No more than 2 CHD risk factors and not at risk of falls
Ante natal	No symptoms of PIH or pre-eclampsia, no history of miscarriage
Post natal	Provided 6 week post natal check complete and no complications
Osteoarthritis	Mild. Exercise will provide symptomatic relief
Osteopenia	BMD -1 and 2.5 SD DEXA reading
Exercise induced asthma	No other symptoms
Smoker	One other CHD risk factor, no respiratory impairment
Stress/mild anxiety	No other psychiatric diagnosis
Seropositive HIV	Asymptomatic (appropriate instructor qualification needed)

Irwin and Morgan - Medium risk	
Hypertension stage 1	Systolic 140-159; Diastolic 90-99; Medication controlled
Type 2 diabetes	Medication controlled
Type 1 diabetes	Competent in modification of insulin dosage/exercise implications
Physical disability	No other risk factors or conditions
Moderate OA/RA	Mild intermittent mobility problems, not in flare up
Osteoporosis	BMD -2.5 at spine, hip or forearm or > 4 on fracture index, no history or minor trauma fracture
Surgery pre and post	General or orthopaedic – NOT CARDIAC
Intermittent claudication	No other cardiac conditions or dysfunction
Stroke/TIA	Over one year ago, stable, no mobility issues
Asthma	Mild, medication present
COPD/COAD	No ventilatory limitations
Neurological conditions	Stable. In remission (Parkinson's, Multiple sclerosis)
Early symptomatic HIV	Moderately diminished CD4 cells. Intermittent or persistent signs and symptoms (fatigue, weight loss, fever)
Chronic fatigue syndrome, fibromyalgia, Lupus (SLE)	Significant de-conditioning due to longstanding symptoms, neuroendocrine or autonomic system dysfunctions
Depression	Mild to moderate
Moderate/severe anxiety	No other psychiatric or physical conditions

Irwin and Morgan - High risk	
Older adults 65+, falls risk, frail, OP+#	REFER DIRECTLY TO FALLS SERVICE
Unstable/uncontrolled cardiac disease, PVD with cardiac dysfunction	REFER DIRECT TO CARDIAC PHASE IV
Orthostatic hypotension	Fall in SBP >30mmHg or DBD >10mmHg within 3 minutes of standing
Stroke/TIA	Recent (less than three months)
Severe OA/RA	With immobility or flare up
Type 1 or type 2 diabetes	With autonomic neuropathy, advanced retinopathy
Moderate/severe asthma	Ventilator function limits sub-maximal exercise
COPD/emphysema	With ventilator limitation
Advanced HIV/AIDS	With neuromuscular complications, severe depletion of CD4 cells, malignancy or opportunist infection
Severe psychiatric illness/dementia	AMT score < 8

Activity

Discussion:

- What may be the strengths and weaknesses of different models?
- How would clients with co-morbidities be risk stratified?
- What action would a referral scheme instructor need to take if a client is of high risk?

Learning check

1. Describe the principles of risk stratification.

2. Explain the current use of risk stratification tools used in exercise referral.