Level 3 Diploma in Exercise Referral
Qualification Structure

Six units:
1. Professional practice for exercise referral instructors
2. Understanding medical conditions for exercise referral
3. Planning exercise referral programmes with patients
4. Instructing exercise with referred patients
5. Applying the principles of nutrition to a physical activity programme
6. Anatomy and physiology for exercise and health
Learner Support

• Home study does not mean no support

• Manuals

• Learner Assessment Record (LAR)

• Please call us on 03302231302

• Email us on support@puretraininganddevelopment.co.uk

• If you would like this training in a different format please contact us
Assessment Element 1

• Worksheet
• Relates to the unit ‘professional practice for exercise referral instructors’
• Content covered on Day 1 of course too
• Aim to complete prior to course
  • However, your deadline for ALL worksheets will be 30 days after the last day of the course
Unit 1

Professional Practice for Exercise Referral Instructors
Importance of Exercise Referral

Role & Importance:

- Prevention and management of chronic health conditions for inactive individuals with medical conditions
- Supports those with CHD risk factors (2 or more) or mild to moderate mental health conditions who need structured and supported exercise
Importance of Exercise Referral
Role in risk reduction & management

Benefits of exercise:
• Reduced risk of CHD
• Hypertension
• Stroke
• Diabetes
• Obesity
• Osteoporosis
• Depression
• Anxiety
Importance of Exercise Referral

Benefits of exercise:
• Potential prevention and management of chronic conditions
• Improved health and well-being (physical, mental, social and emotional)
• Increased independence
• Weight management
• Reduced risk of premature death
• Reduced risk of falls
Government Policies and Documents

- Employment – must be professional qualified
- Health and safety – risk management
- Human rights
- Equality
- Freedom of information
  - Gives the public a general right of access to official information held by most public authorities
  - We discuss this more during course
Professional & Operational Standards

• Patient selection
  • Risk stratification (nature and severity of primary condition)
  • Health and fitness assessments

• Inclusion
  • Differs between schemes
  • Refers to medical condition and PA levels

• Screening

• Exit strategies
Professional & Operational Standards

• Professional competence
  • Must have L3 Exercise Referral Qualification
  • Adequately insured
  • Signed up to REPs ethical code of conduct
  • Committed to CPD
  • If working with children need L2 PA and children
  • Do not answer any questions related to conditions or medications
  • Avoid being influenced by personal opinions
Professional & Operational Standards

• Recording, reporting, monitoring and evaluation
  • Attendance
  • Baseline assessment/measurements
  • 6 and 12 months after completion data

• Quality assurance

• Medico-legal issues
  • HP has clinical responsibility
  • Exercise referral instructor has responsibility with pre screening, design and delivery of programme
  • Meaningful information must be passed onto the instructor from referrer
  • Participant is responsible for consenting to participate in designed programme
Roles and Responsibilities

• GP or health professional
  • Identify and refer patients into a quality assured scheme
  • Maintain clinical responsibility
  • Checks absolute contra-indications to exercise
  • Be responsible for the transfer of relevant and meaningful information (patients signed agreement and informed consent) to the exercise professional

• **Boundaries:** Do NOT take responsibility of the exercise sessions or administration of referral programme *(NQAF, 2001)*

Lawrence (2013) adapted from BHF toolkit, ERAG and REPS
Roles and Responsibilities

• Scheme manager
  • Sets up the scheme
  • Responsible for policy development and administration
  • Networking with health professionals and GPs
  • Responsible for risk stratification and proper management of client

• **Boundaries:** NOT responsible for medical diagnosis. NOT responsible for delivering the sessions but accountable for staff.
Roles and Responsibilities

• Scheme co-ordinators
  • Processes information from GP
  • Identifying any inappropriate referrals and referring back
  • Forwards appropriate referrals to exercise professional
  • Organises/conducts initial assessments
  • Maintains the records throughout
  • Complies with legislation (H&S, human rights & data protection)

• **Boundaries:** Are NOT responsible for medical diagnosis. Should NOT take responsibility for clients until all relevant clinical data has been received (NQAF, 2001)
Roles and Responsibilities

• Exercise professional:
  • Work with clients
  • Initial assessment and informed consent
  • Refer patient back if required
  • Design safe and effective sessions
  • Motivate
  • Monitor progress
  • Understand operational procedures, policies and legislation
  • Appropriately qualified, competent and insured
  • Report back to the co-ordinator
Roles and Responsibilities

• **Boundaries:**
  - NOT responsible for medical diagnosis
  - NOT responsible for client until all relevant clinical data has been received
Roles and Responsibilities

• Do not provide the following services which are outside of your scope of practice:
  • Psychological (counsellor role)
  • Nutritional (dietician role)
  • Medical (GP)
  • Contraindications (GP role)
  • Smoking (cessation team)
  • Substance misuse (substance addiction service)
  • Higher risk conditions (Level 4 instructors or clinical supervision)

• Write/refer to original referrer explaining why they have been denied entry
Inappropriate Referrals

• Clients condition is listed as contra-indicated
• Inadequate/insufficient qualifications for that client
• Outside of the scope of the scheme
• Referral does not contain all relevant medical information
• High risk stratification
• Any referral not recommended by health professional
• Client has not given their consent to be referred
• The referral has not been signed by health professional
Inappropriate Referrals

• Absolute contraindications:
  • A recent significant change in a resting ECG, recent myocardial infarction or other acute cardiac event
  • Symptomatic severe aortic stenosis
  • Acute pulmonary embolus or pulmonary infarction
  • Acute myocarditis or pericarditis
  • Suspected or known dissecting aneurysm
  • Resting systolic blood pressure >180mmHg/diastolic blood pressure >100mmHg

BHF Toolkit 2010
Inappropriate Referrals

- Absolute contraindications continued:
  - Uncontrolled/unstable angina
  - Acute uncontrolled psychiatric illness
  - Unstable or acute heart failure
  - New or uncontrolled arrhythmias
  - Other rapidly progressing terminal illness
  - Experiences significant drop in BP during exercise
  - Uncontrolled resting tachycardia >100bpm
  - Febrile illness
  - Experiences pain, dizziness or excessive breathlessness during exertion
  - Any unstable, uncontrolled condition

BHF Toolkit 2010
Inappropriate Referrals

• Important not to accept a patient that has been declined by a MP as:
  • There is the potential to do harm
  • Medico-legal boundary infringement
  • Health and safety issues
  • Standards of professionalism drop
Importance of Effective Inter-Professional Communication

Why is effective communication important?
- Professionalism
- Multi-disciplinary working
- Respecting boundaries
- Legal and ethical (confidentiality)

Purpose of effective communication?
- Transfer of information
- Reporting on progress
Importance of Effective Inter-Professional Communication

Methods of effective communication:

• Formal versus informal
• Letter
• Telephone
• Email
• Other
Clinical Commissioning Groups

• Budget holders
• Decision makers for local health service
  • They decide on care for patients, location choices, provisions of treatment and provide funding for the selected treatment.
  • Formed from GP practices, nurses, consultants and local management teams
Health Service Documents/Policies:

• Allied Dunbar National Fitness Survey (1992)
• CMO reports – At Least Five a Week (2005), Start Active, Stay Active (2011)
• NICE (2006) A rapid review of exercise referral schemes to promote activity in adults
• Foresight document on obesity (2007)
• Public Health Outcomes Framework (2011)
• Including policies covered earlier (professionally qualified, equality, human rights)
Health Service Documents/Policies:

Impact of documents/policies:

• Activity recommendations
• Allows an insight into the priorities commissioners may focus on
• Health promotion
• Evidence reporting
  • Helps planning, delivering and commissioning services
• Read pages 27 and 28 for specific overview of each document
Exercise Referral Process

1. **Client visits GP or HP**
   - They clinically assess them

2. **GP or HP transfers the information to Co-ordinator**
   - Check information & refers forward or back

3. **Exercise Professional**
   - Completes initial assessment & paperwork

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If information is suitable

If information is not suitable
Exercise Referral Process

Initial Consultation Process:

- Check the form records
- Gather informed consent and authority to share confidential information
- Medical and surgical history and medications
- Physical activity history and preferences, current fitness
- Lifestyle behaviours
- Motivations and barriers
- Readiness and goals
- Physical measurements
- Assessments/measurements
- Patient centred approach
- Records maintained
Exercise Referral Process

Physical measurements & assessments/measurements:

- Age
- Gender
- Ethnicity
- Height, weight and BMI
- Waist circumference
- Pre exercise heart rate
- Blood pressure
- Physical activity using IPAQ
- Quality of life using EQ-5D
- Range of joint movement
- Other measurements requested by referring health professional

(ERAG, 2011)
Patient Monitoring and Data Collection

When should a patient be monitored?

- On entry to the programme/scheme
- During programme
- Exit
- Follow up
Patient Monitoring and Data Collection

Routine Data Collection:

• Attendance at sessions
• Services should be a minimum of 12 weeks
• Baseline assessment/measurement repeated after 6 weeks and at end
• 6 and 12 months after completing the programme
  – Patients should complete the physical activity and quality of life questionnaires
    • physical activity using IPAQ
    • quality of life using EQ=5D

(ERAG, 2011)
Patient Monitoring and Data Collection

Other outcomes to monitor:

• Physical changes (weight, improved strength)
• Medical changes (reduced reliance on medication – pain relief, diabetics medication)
• Health changes (increased ability to carry out activities of daily living (ADL’s), increased PA levels)
• Psychological changes (improved mood, confidence, self esteem)
• Social changes (interactions with others, changes to routines)
Monitoring a Successful Exercise Referral Scheme

• Success monitors
  • Adherence
  • Targets achieved
  • Patient satisfaction surveys
• Retention rates
• Techniques and methods
  • Questionnaires
  • Observation
  • Physical and health assessments
• Follow up records
• Possible outcomes
  • Physical, medical, health, psychological, social
Monitoring a Successful Exercise

Referral Scheme

• Others from the ERAG(2011):
  • Sources of referral
  • Percentage of potential referrers who refer e.g. the percentage of general practices in a given locality
  • Extent to which target populations have been reached
  • Overall cost of the service and cost per patient
  • Recruitment, retention and training of staff
Monitoring a Successful Exercise Referral Scheme

- Evaluation is necessary for the maintenance of standards
- Important to monitor success
- You can review the impact on local health outcomes
- Improvement/developments that need to be addressed
- Ongoing funding/cost effectiveness assessed by commissioners
- Inform evidence base
Procedures of Record Keeping

Confidentiality is maintain by:

• Only allowing access to relevant parties
• Do not discuss patient details with anyone other than designated staff.
• Storing factual information
• Storing data using secure methods as well as secure methods of data transfer
• Human Rights Act (1998)

BHF toolkit (guidance for exercise professionals 2010), NQAF (2001)
Procedures of Record Keeping

Data Protection

- All personal information is legally protected (Data Protection Act 1998)
- Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information.
  - IG provide a framework to bring together all legal rules, guidance and best practice that maintain confidentiality and security of information to organisations

“It is essential that the personnel delivering exercise to referred patients on an exercise referral scheme are bound by confidentiality.”

p.15 NQAF (2001)
Validity and Reliability of Measurements

Validity: does it measure what is was intended to measure?

Reliability: same result obtained elsewhere or on separate occasions

- Are the measurement repeatable?
- Are protocols followed?
- Standardised methods used?
- What type of research has been used?
  - Meta analysis
  - Randomised
  - Controlled
Patient Centred Approach

• Albert Mehrabian communication model:
• Suggests we receive and process information based on:
  • Words (7%)
  • Intonation (38%) – the way the words are said
  • Body language (55%)
Patient Centred Approach

• Perception influenced by:
  • Level of rapport
  • Extent to which client feels understood
  • Similarities and differences between client and instructor

• Strands of equality
  • Age
  • Race
  • Sex
  • Sexual orientation
  • Gender reassignment
  • Disability
  • Beliefs
  • Culture
  • Class
  • Education
  • Language
Patient Centred Approach

• Use a range of consulting skills
  • Verbal checks and types of questioning (open and closed)
  • Written questionnaires
  • Observation
  • Listening
• Core conditions
  • Empathy
  • Genuineness
  • Positive regard
Patient Centred Approach

• Health Behaviours:
  • Physical activity/inactivity
  • Health screening checks (regular or infrequent)
  • Healthy/unhealthy diet
  • Not smoking/smoking
  • Alcohol or substance consumption (use/misuse)
Patient Centred Approach

Locus of control (Wallston et al, 1976)

- Believes health is controlled by both internal and external factors
- Internal factors: belief that behaviour is guided by personal decisions and efforts
- External factors: belief that behaviour is guided by luck, powerful others or other external circumstance
- Main belief is a client has control of their own situation
  - Positive or negative impact on motivation
- Motivations affect commitment
- Level of supervision
Patient Centred Approach

![Diagram of Locus of Control]

- Small locus of control
- Large locus of control

Life

Personal control

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Risk Stratification

• There are different tools available for risk stratification

• PAR-Q should be used as initial screening tool
  • If the patient answers ‘no’ to all questions, BP is less than 140/90mmHg and heart rate is regular and less than 100bpm then

  Risk of exercise is low
Risk Stratification

• If the patient answers ‘yes’ to one or more questions, the instructors then uses the **Irwin and Morgan assessment**

• Traffic light system
  • Green = low risk (remain exercising, unsupervised)
  • Amber = medium risk (individualised and supervised programmes for condition)
  • Red = high risk (cardiac disease – referred back to healthcare professional)
Risk Stratification

• Other risk stratification tools include:
  • Pyramid: NQAF/DoH 2001
  • Logic model for the ACSM risk stratification scheme
Review medical history and perform physical examination

Known CVD, pulmonary disease or metabolic disease?

Yes → High Risk Category

No → Major signs and symptoms suggestive of CVD, pulmonary disease or metabolic disease?

Yes → High Risk Category

No → Number of CVD risk factors

≥2 → Moderate Risk Category

<2 → Low Risk Category
Assessment Element 1

Worksheet

Relates to the unit ‘professional practice for exercise referral instructors’

Learners will complete as a home study task
Thank you for completing Unit 1 training

Any Questions?

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