The Standard of Proficiency and Code Compared

The current Standard of Proficiency (SoP) sets out what is required for the competent and safe practice of chiropractic and forms part of the criteria for the recognition of chiropractic degrees.

We are well aware that many chiropractors are very familiar with the current SoP, and the table below shows where the existing Standards of Proficiency appear in the new Code:-

Standard of Proficiency (2010)	The Code (2016)
S1.1. Information on practice matters You must ensure that patients can readily get hold of information on: a) fees and any related structures b) the type of information that will be entered in their records and who is allowed to have access to their records c) the procedures for making a complaint if the patient wants to do this d) the arrangements that are in place when you are unavailable	**F2**: have visible and easy-to-understand information on patient fees, charging policies and systems for making a complaint. These policies must include the patient's right to change their mind about their care, and, their right to refer any unresolved complaints to the GCC. **F6:** provide information to patients about all individuals responsible for their care, distinguishing, if needed, between those responsible for delegated aspects and for their day-to-day care. This must include the arrangements for when you are not available.
S1.2. Information on joint working arrangements If you work with other healthcare professionals, you must make clear information readily available to patients on: a) the healthcare professional who is responsible for their day-to-day care b) the chiropractor accountable for their overall care if this is different (than for day-to-day care), and the parts of their care that have been delegated c) who will be responsible for their patient records d) who to approach if there is any problem with their care.	**F6:** provide information to patients about all individuals responsible for their care, distinguishing, if needed, between those responsible for delegated aspects and for their day-to-day care. This must include the arrangements for when you are not available.
S2.1. Information about assessment and care You must explain clearly to patients: a) what will happen during assessments b) the care to be provided, the foreseeable risks and proposed benefits, and when the care will be reviewed c) the findings from assessments and reassessments d) any need to refer the patient to another healthcare professional to meet their health needs.	**C2:** when carrying out a physical examination of a patient use diagnostic methods and tools that give due regard to patient health and dignity. You must document the results of the examination in the patient's records and fully explain these to the patient.

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S2.2. Obtaining case histories You must obtain and document the case history of the patient, using appropriate methods to draw out the necessary information.	**C1:** obtain and document the case history of each patient, using suitable methods to draw out the necessary information.
S2.3. Physical examination If you want to gain more information on the patient's health and health needs by physically examining the patient, you must use appropriate methods and give due regard to the patient's health.	**C2:** when carrying out a physical examination of a patient use diagnostic methods and tools that give due regard to patient health and dignity. You must document the results of the examination in the patient's records and fully explain these to the patient.
S2.4. Obtaining further information and carrying out further investigations on patients You must: a) be able to identify when further investigations are needed and act on this need in the patient's best interests and without delay b) use further investigations only when the information gained from the investigations will benefit the management of the patient c) be competent to carry out the investigations and/or interpret the results d) carry out further investigations in keeping with relevant legislation and existing good practice guidelines for those investigations e) record the outcomes of investigations.	**C8:** ensure that investigations, if undertaken, are in the patient's best interests and minimise risk to the patient. All investigations must be consented to by the patient. You must record the rationale for, and outcomes of, all investigations. You must adhere to all regulatory standards applicable to an investigation which you perform.
S2.5. Ceasing assessment You must halt assessments when: a) a patient asks you to or b) the information obtained means that it is inadvisable to proceed.	**C6:** cease care, or aspects of care, if this is requested by the patient or if, in your professional judgment, the care will not be effective, or if, on review, it is in the patient's best interest to stop. You must refer the patient to another healthcare professional where it is in their best interests.
S2.6. Clinical decision making You must: a) evaluate the patient's health and health needs b) arrive at and document a working diagnosis or rationale for care, based on the evaluation of the information. When drawing up the working diagnosis or rationale for care, you must consider: a) relevant information about the natural history and prognosis of any complaint the patient has b) the potential benefits and risks of care, including contraindications	**C3:** use the results of your clinical assessment of the patient to arrive at a working diagnosis or rationale for care which you must document. You must keep the patient fully informed.

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c) the likelihood of recurrence or need for long-term management. You must keep the working diagnosis or rationale for care under review while you care for the patient.	
S2.7. Meeting the patient's health needs You must involve other healthcare practitioners in the patient's care if this means that the patient's health needs will be met more effectively, either by referral or by arranging co-management of the patient.	**C7:** follow appropriate referral procedures when making a referral or a patient has been referred to you; this must include keeping the healthcare professional making the referral informed. You must obtain consent from the patient to do this.
S2.8. Advice on other forms of care and treatment You must not act in isolation and advise a patient to stop medication that has been prescribed by another healthcare professional.	**F3:** involve other healthcare professionals in discussions on a patient's care, with the patient's consent, if this means a patient's health needs will be met more effectively.
S3.1. Planning care You must develop and record a plan of care for the patient and do this in discussion with the patient. You must continually review a patient's state of health and health needs as you provide care for the patient, and modify the plan of care accordingly.	**C4:** develop, apply and document a plan of care in full agreement with the patient. You must check the effectiveness of the care and keep the plan of care under review. A more formal reassessment of the effectiveness of the plan of care must be undertaken at intervals that suit the patient and their needs. All subsequent modifications to the plan of care must be discussed and agreed with the patient and properly documented.
S3.2. Applying appropriate care The care you select and provide must: a) be informed by the best available evidence, the preferences of the patient and the expertise of practitioners b) be appropriate to the patient's current state of health and health needs and c) minimise risks to that patient. You must be knowledgeable about the particular forms of care that you select for a patient and be competent to apply those forms in practice. The patient must have consented to the form of care.	**C5:** select and apply appropriate evidence-based care which meets the preferences of the patient at that time.
S3.3. Review You must: a) evaluate the benefit of care to the patient and identify whether the original diagnosis or rationale for care, or the plan of care, should be modified b) review with patients the effectiveness of the plan of care in meeting its agreed aims c) reach agreement with patients on any changes that need to be made	**C4:** develop, apply and document a plan of care in full agreement with the patient. You must check the effectiveness of the care and keep the plan of care under review. A more formal reassessment of the effectiveness of the plan of care must be undertaken at intervals that suit the patient and their needs. All subsequent modifications to the plan of care must be discussed and agreed with the patient and properly documented.

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d) make a record of these agreements	
S3.4. Working with other healthcare professionals – provision of care If you receive a formal referral from another healthcare professional to provide chiropractic assessment or care for a patient, you must report back to the professional who referred the patient once you have gained the patient's consent for this to happen.	**C7:** follow appropriate referral procedures when making a referral or a patient has been referred to you; this must include keeping the healthcare professional making the referral informed. You must obtain consent from the patient to do this.
S3.5. Reports for third parties You must: a) gain the consent of the patient before providing any information b) reply to requests for information from other health professionals and third parties.	**E7:** obtain and record the express consent (i.e. orally or in writing) from the patient regarding sharing information from their patient record. You must not disclose personal information to third parties unless the patient has given their prior consent for this to happen
S3.6. Public health interventions If you are engaged in public health interventions, you must ensure that your interventions: a) are based on the best available evidence b) are appropriate for the populations concerned c) do not undermine the efforts of other health professionals who specialise in this area.	-

The remaining standards within The Code have been taken from the 2010 Code of Practice and like the standards in the above table have been re worded or merged as appropriate.