



British Association of Prosthetists and Orthotists

GUIDELINES FOR BEST PRACTICE

*No 3: Clinical Records
(Orthotics and Prosthetics)*

BEST CLINICAL PRACTICE IN ORTHOTICS AND PROSTHETICS

General Guidelines

The following guidelines are intended to reflect current best practice in clinical orthotics and prosthetics in order that the individual practitioner achieves and maintains the highest standards of professionalism and effectiveness in patient care. They are intended to be a general guide to recommended professional behaviour in all routine daily employment activities.

Your professional body has a vital role in setting and promoting standards that must have quality at their core. With healthcare standards subject to continuous quality improvements these guidelines will undergo monitoring and periodic revision.

The British Association of Prosthetists and Orthotists (BAPO) is committed to the following quality principles in professional practice:

- The pursuit of evidence-based practice.
- Involvement in quality improvement processes (e.g. clinical audit).
- Professional development programmes which reflect clinical governance principles.
- Dissemination of (evaluated) good practice ideas and innovations.
- The systematic learning of lessons for clinical practice from patient complaints.
- The promotion of universal validated clinical guidelines and their systematic controlled implementation.

BAPO, in liaison with appropriate bodies, will approve the development of the guidelines to produce national or local standards. The Association may also issue individual Guidelines or Recommendations on specific areas of prosthetic and orthotic practice.

These guidelines are critical to current arrangements which allow BAPO to build on and strengthen the existing system of professional self-regulation.

This document is subject to revision by the Professional Affairs Committee of BAPO and enquiries regarding its contents should be addressed in the first instance to its chairperson.

Other Guidelines in this Series:

1. The Role of the Prosthetist/Orthotist
2. Communication and Teamwork
3. Clinical Records
4. Assessment and Review
5. The Clinical Environment
6. Clinical Effectiveness

Clinical Records

(Orthotics and Prosthetics)

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1. Statement

The British Association of Prosthetists and Orthotists (BAPO) maintains that record keeping is an integral part of orthotic and prosthetic practice. The making of a clinical record is mandatory for all patient episodes. Adherence to the 'Minimum Requirements for Note Keeping' issued by the Health Professions Council (HPC) is mandatory for all State Registered members. Failure to comply with this requirement will be considered infamous conduct in a professional respect and may lead to disciplinary action. Record keeping is a professional tool which should aid the rehabilitation and care process. It should never be considered as separate from this process, to be fitted in only when circumstances allow. Hospital clinical records and imaging results should always be accessible to orthotists and prosthetists.

2. Introduction

The aim of this document is to provide clinicians with a useful tool in their clinical environment. The guidelines are not exhaustive in their coverage of a 'correct' method and will need regular updating. The recommended essential information is intended to be comprehensive but could be subject to revision at a local level. The guidelines are based upon a number of key principles which should underpin good records and record keeping. They are designed to help you reflect upon your current record keeping practice and how you can improve it for the benefit of your patients. All clinical records and imaging results should always be accessible.

3. The Purpose of Documentation

BAPO recommends the use of formal documentation to:

- meet statutory requirements
- encourage logical thinking
- encourage critical analysis in decision-making
- enable records to be considered legal documents
- provide standardised quality information to team members
- form the basis for future medical decisions
- support clinical audit and quality assurance
- support clinical effectiveness studies
- assist retrospective and prospective research
- provide reliable statistical evidence for service development

4. Format of Records

BAPO recommends that the decision on the format of records be taken at local hospital/clinic/company level. The best record is one which is the product of consultation at a local level with all the members of the multi-disciplinary team and includes administrative and document handling considerations. The format should be evaluated and adapted in response to the needs of the patient.

5. Content and Style

A clinical record must be made by the clinician for every patient contact. Records of the SOAP (Subjective, Objective, Analysis, Plan) type or POMR (Problem Oriented Medical Records) may be used if appropriate

In particular, patient records should:

- be factual, consistent and accurate
- be signed off as soon as possible after the event has occurred. This will normally be on the same day or within 24 hours. You are advised to check local policies.
- provide current information on the care and condition of the patient
- be written legibly in black ink and in such a manner that they cannot be erased
- be written so that any alterations or additions are dated, timed and signed in such a way that the original entry can still be read clearly. Alterations should be scored out with a single line.
- be accurately dated, timed and signed, with the signature and status of writer being printed alongside the first entry
- be contemporaneous. Records are not added to after the time of writing. Any genuine omissions are recorded at the time the omission is identified.
- not include abbreviations, jargon, meaningless phrases or offensive subjective statements. A glossary of locally-agreed abbreviations and specialised terminology is advised for your record-keeping protocol.
- be readable on any photocopy
- be consecutive, preferably with numbered pages
- be written in terms that the patient also can understand
- be headed with concise patient details such as those on hospital adhesive labels
- include all relevant letters, prescriptions and order paperwork
- clearly document where an entry is made following telephone contact

6. Essential Information

A clinical record must be raised and maintained for all patients referred for assessment and/or treatment. BAPO recommends that the following essential information be documented at the first patient episode. This information is in accordance with International Standards and Department of Health directives.

A system for the recording of clinical outcomes in patient documentation needs careful preparation and is commended, though not an essential requirement at this time.

7. Recommended Essential Information for Clinical Records

7.1 Patient Administrative Details.

- 7.1.1 Name, address and telephone number
- 7.1.2 Date of birth and gender
- 7.1.3 Hospital number
- 7.1.4 General Practitioner name and practice

7.2 Initial Referral.

- 7.2.1 Name of referrer
- 7.2.2 Status of referrer
- 7.2.3 Date of referral
- 7.2.4 Enclose copy of referral (Response necessary?)

7.3 Personal Information.

- 7.3.1 Height and weight
- 7.3.2 Vocational activity
- 7.3.3 Recreational activity

7.4 Transfer Method.

7.5 General Medical Condition.

- 7.5.1 Primary diagnosis
- 7.5.2 Significant medical history, including **infection precautions**

7.6 Clinical Condition and Pathology.

- 7.6.1 Physical Assessment: Affected body segment(s), pain location and intensity, abnormalities of shape, dimensions, motion, sensation, joint stability, muscle strength/endurance and control, stump volume and stability, amputation level (see ISO 8548-1,2,3 Method of describing amputation stumps and limb deficiencies, for guidance)
- 7.6.2 Impairment stable/changing

7.7 Notes.

- 7.7.1 The problem
- 7.7.2 Subjective notes
- 7.7.3 Objective notes
- 7.7.4 Analysis
- 7.7.5 Plan of treatment

7.8 Clinical Objectives of Treatment and/or Care Plan.

7.9 Biomechanical Requirement of Orthosis/Prosthesis.

7.10 Category of Orthosis/Prosthesis.

As defined in ISO 8549:1989 Prosthetics and Orthotics-Vocabulary Parts 2 and 3

7.11 Device Specification Number and Date supplied.

Compliance with 93/42/EEC

7.12 Date and Time of Review Appointment.

7.13 Signature, Name (in block capitals), Date and Time.

7.14 Designation: SRPros/Orth, SROrth, SRPros

8. Audit

Audit should be applied to the record keeping process and can play an important role in ensuring the continuous delivery of high quality healthcare. Through audit, the standard of the record is assessed and areas of improvement and staff development identified. Audit methods can be determined by local needs but should always address the patient's interests and not organisational requirements. A system of peer review can be included in the process. Strict patient confidentiality applies to the whole recording process including audit. See *Appendix 1: Sample Audit Checklist*.

9. Legal Implications

Patient records can be called in evidence before a court of law, by the Health Service Commissioner, or in order to investigate a complaint at a local level. As a state-registered orthotist, prosthetist or prosthetist/orthotist you have both a professional and a legal duty of care. Your record keeping should therefore be able to demonstrate:

- a full account of your assessment, treatment planned and treatment provided
- relevant information about the condition of the patient
- the measures you have taken to respond to the patient's needs
- evidence that you have understood and honoured your duty of care and that any actions or omissions on your part have not compromised their safety in any way
- a record of any arrangements you have made for the continuing care of the patient

You will use your professional judgement to decide what is relevant and what should be recorded. Courts of law tend to adopt the view that 'if it is not recorded, it has not been done'. This applies particularly to situations such as chronic or permanent disability, where the condition of the patient is apparently unchanging and no record has been made of the care delivered. Local standards should be agreed with team members to define what is a reasonable time lapse if this is the case.

If record keeping is delegated to pre-registration students, you must ensure that they are competent and are supervised and that you countersign their entries. You are strongly advised never to use initials only as a signature.

You must ensure at all times that you comply with manufacturers' instructions regarding the fitting and/or adjustment of components or devices. You must ensure that verbal and/or written instructions intended for patient use are given and that this is documented in the notes.

10. Ownership and Access

You should assume that patient records will be scrutinised at some point. Patients not only have a legal right to see their records but are increasingly participating in writing and holding them.

10.1 Access Legal Implications:

The *Access to Health Records Act 1990* gives patients the right of access to manual health records about themselves which were made after 1 November 1991. The *Data Protection Act 1984* gives patients access to their computer held records. It also regulates the storage and protection requirements of computerised patient information. The system for dealing with applications for access is explained in the *Guide to the Access to Health Records Act 1990*. See also: *Data Protection Act 1998*, *Human Rights Act 1998*, *Access to Medical Reports Act 1988*.

10.2 Inter-Disciplinary Access To Records:

Shared records, to which all members of the healthcare team contribute, may be used in some situations in accordance with an agreed local protocol.

10.3 Retention:

The period for which patient records must be kept depends upon the relevant legislation or NHS policy statements issued by the Department of Health. Your employer should have the appropriate protocols. If you are self-employed, then retain any record you have made relating to the care of a patient for at least 8 years for an adult and until the date of a child's 21st birthday.

10.4 Ownership:

Organisations which employ professional staff who make records are the legal owners of those records. You do, however, have a duty to protect the confidentiality of those records. Where a professional is contracted to provide a clinical service to another organisation, contractual conditions will normally specify the legal owner of any records kept.

10.5 Patient-Held Records:

Patients and parents may hold their own or their childrens' health care records. This is determined at a local level and may be appropriate following team consultation.

10.6 Research And Education:

Patient records may be used for research, teaching purposes and clinical supervision. Access and confidentiality rules are the same and the right of a patient to refuse access to their records should be respected. Use of records in research normally requires the approval of the local ethics committee.

11. Computer Held Records

Computer held records tend to be easier to read, require less clerical input, reduce the need for duplication and can improve inter-professional communications. You do not need to keep manual duplicates, but the same basic principles apply and you will still need to keep other hard copies pertaining to the patient such as letters. Detailed guidance is available in HSC 1999/053.

You are professionally accountable for ensuring the security of whatever information technology is used, and that clear local staff access protocols exist. You are accountable for any entry you make to the electronically held record and you must ensure that any entry you make is clearly identifiable.

Patient rights of access are defined in *The Data Protection Act 1984*, *the Access Modification (Health) Order 1987*, *the Access to Health Records Act 1990* and the *Access to Health Records (Northern Ireland) Order 1993*.

12. Further Information

We hope that you have found these guidelines helpful and that they will aid your own assessment of your current practice. BAPO strongly recommends that you attend post-graduate training courses held on this subject. The Chief Executive Officer of BAPO may be able to assist with more specific enquiries. For local guidance contact the Clinical Governance Lead or Clinical Effectiveness Department of your local NHS Trust. See Health Service Circular (HSC) 1999/053 *'For the Record'*

This guidance is regularly reviewed and we welcome your comments.

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APPENDIX 1: SAMPLE AUDIT CHECKLIST (ORTHOTICS AND PROSTHETICS)

Date of Audit: _____ Auditor (s): _____
 Ward/Department: _____ Patient Name and No. _____ Study No. _____

Use of the document

For each question a 100% compliance is required for the total number of notes audited.
 If 100% compliance is achieved, write YES (Y) in the finding box.
 If 100% non-compliance is found, write NO (N) in the finding box.
 If a mixture of compliance and non-compliance is found, write PARTIAL (P) in the finding box. Following this then document the % of **non** compliance found in relation to the **total** number of notes audited. Write this in the “% of non-compliance if P” box.

LEGIBILITY

Ref	Criteria-Legibility	Finding Y, N or P	% of non compliance if P	Comments	Action	By whom/date
1.1	Are all records written in black ink?					
1.2	Are all records in clear handwriting?					
1.3	Is there a note written for every patient episode (cross-check with appointing system).					

IDENTIFIABLE

Ref	Criteria-Identifiable as to the patient	Finding Y, N or P	% of non compliance if P	Comments	Action	By whom/date
2.1	Are all the sheets in date order?					
2.2	Are all the sheets dated?					
2.3	Is the patients name and number on each sheet?					

ATTRIBUTABLE TO THE AUTHOR

Ref	Criteria-Attributable as to the author	Finding Y, N or P	% of non compliance if P	Comments	Action	By whom/date
3.1	Is each entry signed and dated by the author? (except copy letters)					

Identify, where possible, the designation of the authors who did NOT sign each entry.

Ref	Criteria-Attributable as to the author	Finding Y, N or P	% of non compliance if P	Comments	Action	By whom/date
3.2	Did the authors clearly print their surname?					

Identify, where possible, the designation of the authors who did NOT print their surname.

Ref	Criteria-Attributable as to the author	Finding Y, N or P	% of non compliance if P	Comments	Action	By whom/date
3.3	Is the position held by the author clearly identifiable? e.g. SROrth,SRPros,SRPros/Orth					

Identify, where possible, the designation of the authors who did NOT clearly identify themselves.

CORRECTIONS OR ALTERATIONS TO ORIGINAL ENTRY (where applicable)

Ref	Criteria-Alterations to original text	Finding Y, N or P	% of non compliance if P	Comments	Action	By whom/date
4.1	Were all corrections, additions and alterations - a) signed? b) dated? c) legible? (ie single line through deletions)					

CONTENTS

Ref	Criteria-Contents of case notes	Finding Y, N or P	% of non compliance if P	Comments	Action	By whom/date
5.1	Is there a discharge summary, or referral letter					
5.2	Can you see what the diagnosis was?					
5.3	Is an initial assessment documented? (when appropriate)					
5.4	Is a treatment plan documented? (when appropriate)					
5.5	Can you tell from the notes what the next stage will be in the patient's treatment? (e.g. Follow-up in OPD, discharge to GP, further diagnostic test, referred to another consultant, to be readmitted, referral to physio, OT etc.)					

STRUCTURE

Ref	Criteria-Structure of case notes	Finding Y, N or P	% of non compliance if P	Comments	Action	By whom/date
6.1	Can you see evidence of a filing structure?					
6.2	Does the filing structure include a) contents index/filing order? b) section dividers? c) multiple spines?					
6.3	Are all the sheets in the case notes securely attached? (no loose sheets?)					
6.4	Do the notes appear to be tidy?					
6.5	Is the case note folder in a good state of repair? (e.g. no tears or excessive use of sellotape)					
6.6	Can the file be seen to be confidential? (e.g. is it marked "confidential – not to be removed from the hospital")					
6.7	Can you say there are no personal details about the patient recorded on the outside of the case note? (e.g. allergies, blood group, deaf)					
6.8	SECTION 1 MEDICAL HISTORY Entries filed chronologically, most recent at the back of the first section. GP referral letter, clinical letters, incoming information relating to episode of care, clear notation of MRSA positive if appropriate					
6.9	SECTION 2 RESULTS Pathology results, x ray reports, consent forms and ECGs. All results filed on mount sheet chronologically.					
6.10	SECTION 3 NOTES Orthotist/Prosthetist treatment notes.					
6.11	Back pocket of folder used for patient identification labels only.					