

**Prosthetist/Orthotist Record Keeping**

**Audit Checklist**

**Audit Name/No.:**

**Directorate:**

**Service:**

**Location:**

**Clinic Type:**

**Clinician:**

**Auditor:**

**NB:** This Checklist is intended to be used alongside the *‘BAPO Guidance for Record Keeping’*. Completed checklists can be transposed into the adjunctive *‘BAPO Record Keeping Audits Spreadsheet’* to help analysis of note keeping across an entire service or centre. Similarly, use of the spreadsheet will help analysis across a staff group.

This checklist comprises several sections:

1. **Identification of the Service User**
2. **Identification of the Clinician**
3. **Technical Compliance of Record Keeping**
4. **Profiling of the Service User**
5. **Documentation of Consent**
6. **Recording of Clinical Assessment, Procedure and Treatment Plans**
7. **Use of Outcome Measures**
8. **Logging of Prescriptions**
9. **Working within Episodes of Care**
10. **Identification and Management of Risk**
11. **Questions to the Auditor**

## Section A: Identification of the Service User

1. NHS Number Yes  No 
2. Forename(s)  Yes  No 
3. Surname  Yes  No 
4. Date of Birth  Yes  No 
5. Patient Number  Yes  No 
6. Apart from the above, are there any other personal details Yes  No 

about the patient on the outside cover?

If yes, please indicate in the Comments Section

1. Patient contact details *(Address, telephone number)* Yes  No 
2. Is the patient’s title recorded? Yes  No 
3. Is the patient’s gender recorded? Yes  No 
4. Does the record state the patient’s GP detail? Yes  No 
5. Are other relevant contact details recorded in the record? Yes  No 

*(e.g., Next of Kin, Carers, Lasting Power of Attorney)*?

1. Where applicable, are the patient details recorded on a Yes  No  n/a 

paper record the same as recorded on the electronic clinical

administration system. (i.e., any alterations made by pen on

the Front Sheet updated on to the computer record and vice versa)

Comments for Section A *(continue on additional page if required)*

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## Section B: Identification of the Clinician

1. Signed *(identifiable signature)* Yes  No 
2. Printed Full Name Yes  No 
3. Designation of staff in record or on signature list in record Yes  No 
4. Are all student entries counter signed by a

qualified/supervising staff member? Yes  No  n/a 

Comments for Section B *(continue on additional page if required*)

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## Section C: Technical Compliance of Record Keeping

1. Are the records correctly filed (*secure/safe location*

*and in correct order*)? Yes  No  n/a 

1. Is there a record tracing/tracking system in place? Yes  No 
2. Is the folder in a good state of repair? Yes  No 

*(e.g., no tears or excessive use of sticky tape or staples,*

*badly folded and/or damaged pages etc)*

1. Is the patient’s name on every page? Yes  No 
2. Is the patient’s Hospital/NHS number on every page? Yes  No 
3. Is the patient’s date of birth on every page? Yes  No 
4. Are the record contents in chronological order? Yes  No 
5. Do all the records in the folder belong to the correct patient? Yes  No 
6. Are all papers filed securely in the notes? *(i.e., nothing loose)*Yes  No  n/a 

**Note:** If there are loose items, please list in comments

section below

1. Dated *(day, month, year)* Yes  No 
2. Timed *(hour and minute, 24hr clock or am/pm specified*) Yes  No 
3. Are all notes written contemporaneously (within 24 hours)? Yes  No 
4. Are the entries in the record consecutive with pages

numbered? Yes  No 

1. Are all entries written for every episode of care/contact? Yes  No 

(Review against appointing records)

1. Are Clinical Assessment Record, Medical History and Yes  No 

Progress Note sheets numbered?

1. Are the entries in the record clearly written/legible? Yes  No 
2. Are the entries made in permanent/black ink and readable Yes  No 

when photocopied?

1. Are there any abbreviations in entries? Yes  No 
2. If yes, is the abbreviation written in full at first entry? Yes  No  n/a 
3. Or, if no, is it a service approved abbreviation? Yes  No  n/a 
4. If applicable is there a list of approved abbreviations Yes  No  n/a 

available and accessible to each clinician?

1. Are all alterations scored out with a single line? Yes  No  No alterations 
2. Are small errors signed with the clinician’s initials? Yes  No  No alterations 
3. Are any significant alterations readable, dated, timed Yes  No  No alterations 

and signed?

1. Has any correction fluid been used to make alterations? Yes  No  No alterations 
2. Is the file free from jargon, meaningless phrases, Yes  No 

 subjective or offensive statements?

1. Are all entries factual, consistent, and accurate? Yes  No 
2. Are all relevant forms completed fully? Yes  No  n/a 
3. Was location of consultation recorded

*(e.g., clinic, home visit)*? Yes  No 

1. Was there a record made of other people present Yes  No 

during the consultation *(e.g., chaperone,*

*carer, other healthcare professional)*?

1. Are the notes written in terms that a patient and/or Yes  No 

parent/carer can understand?

1. Are the notes written in terms that another professional Yes  No 

involved in the care of the patient can understand?

Comments for Section C *(continue on additional page if required)*

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## Section D: Profiling the Service User

1. Is the patient’s race and ethnicity recorded? Yes  No 
2. Is the patient’s religion recorded? Yes  No 
3. Is the patient’s gender recorded? Yes  No 
4. Are other protected characteristics of the patient recorded? Yes  No 
5. Does the record state the patient’s occupation/school? Yes  No 
6. Is the patient’s activity level recorded? Yes  No 
7. Is use of walking aids recorded? Yes  No 
8. Is the patient’s height recorded? Yes  No 
9. Is the patient’s weight recorded? Yes  No 
10. Is the patient’s smoking and drinking habits recorded? Yes  No 
11. Is there the need to record the patient’s cognition level? Yes  No 
12. Is there a Medicine Log or Prescription Card in the records? Yes  No  n/a 
13. Significant/pertinent medical history and current diagnoses? Yes  No 
14. Is the patient’s past orthotic history logged Yes  No  n/a 
15. If appropriate, has the patient’s anxiety and depression Yes  No  n/a 

 levels been recorded.

1. Is a Significant Life Events form being used? Yes  No  n/a 

Comments for Section D *(continue on additional page if required)*

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## Section E: Documentation of Consent

1. Was appropriate consent obtained and recorded

 (i.e., written, verbal or implied)? (And before all

stages in episode of care? i.e., assessment,

examination, intervention, treatment) Yes  No 

1. If the service user has been referred onwards or

discharged, has consent been recorded? Yes  No  n/a 

1. If applicable, has the child/young person’s competence

been assessed and recorded in line with Gillick and

Fraser Guidelines? Yes  No  n/a 

1. Where applicable, is consent to share information

recorded? Yes  No  n/a 

1. Where applicable, is a signed photography/filming

consent form included in the medical records? Yes  No  n/a 

1. Does the file document if consent is withdrawn? Yes  No  n/a 

1. Is the need for a Mental Capacity Act Assessment

recorded? (*Note: not applicable to under 16s)*  Yes  No  n/a 

Comments for Section E *(continue on additional page if required)*

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## Section F: Recording of Clinical Assessment and Procedure

1. Subjective report quoting main presenting concerns

of patient and/or carers, guardians Yes  No 

1. Where appropriate, is the voice of the child recorded? Yes  No  n/a 
2. Understanding of the service user’s perception of their

needs and expectations of treatment. Yes  No 

1. Clinical assessments carried out Yes  No 
2. Technological assessment including imaging, pressure

 reports, instrumented gait analyses Yes  No 

1. Identification of Contraindications, Precautions, Allergies

Yellow Flags, Red Flags Yes  No 

1. Analysis of findings Yes  No 
2. Treatment options explained to service user Yes  No 
3. The agreed care planned with goals Yes  No 

(Including timeframes)

1. Information regarding all required clinical procedures Yes  No  n/a 

 (Includes shape capture methods and fitting notes)

1. Prescription specifications are clear Yes  No  n/a 

(Including updates/changes/additions to the prescription

with clinical justification)

1. Information/leaflets shared with patient and/or parent/carer? Yes  No  n/a 
2. Evidence of Healthy Conversations/Making Every Contact

Count? Yes  No 

1. Evidence of Social Prescribing Yes  No  n/a 

Comments for Section F *(continue on additional page if required)*

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## Section G: Use of Outcome Measures

1. Have appropriate outcome measures been selected? Yes  No  n/a 
2. Is there an up-to-date outcome measurement form?

Yes  No  n/a 

1. Is there an outcome report completed and returned to

referring clinician at end of episode of care? Yes  No  n/a 

Comments for Section G *(continue on additional page if required)*

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## Section H: Logging of Prescriptions

1. Prescription specifications are clear Yes  No  n/a 

(Including updates/changes/additions to the prescription

with clinical justification)

1. Are all copies of orders and fitting notes included in the Yes  No 

patient record in the correct order?

Comments for Section H *(continue on additional page if required)*

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## Section I: Working Within Episodes of Care

1. Is the original copy of the referral present in the file? Yes  No 
2. Are the details of the referrer (name and designation) clear? Yes  No 
3. Are any subsequent referrals present in the file in reverse Yes  No  n/a 

chronological order?

1. Is all incoming and outgoing correspondence filed in date

 order, most recent on top? Yes  No 

1. Details recorded of information shared and with whom? Yes  No  n/a 
2. Are the reasons for sharing information recorded? Yes  No  n/a 
3. Is there formal documentation of onward referral and/or

discharge? Yes  No  n/a 

1. Do the records note all persons in attendance at appointments?

Yes  No 

Comments for Section I *(continue on additional page if required)*

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## Section J: Identification and Management of Risk

1. Have risk assessments been conducted and documented? Yes  No  n/a 
2. Do the notes identify problems which have arisen? Yes  No 
3. And is the action taken to rectify them recorded? Yes  No 

1. If applicable are there copies of case conference minutes Yes  No  n/a 

in the records?

1. If applicable, are there Core Group meeting minutes in the Yes  No  n/a 

records?

1. If applicable is relevant child protection supervision recorded Yes  No  n/a 

in the notes?

1. Are copies of referrals to Social Care or other departments Yes  No  n/a  included?
2. If safeguarding concerns have arisen, is appropriate action

documented. Yes  No  n/a 

Comments for Section J *(continue on additional page if required)*

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## Section K: Service user non-attendance

1. Does the patient record include documentation of

occurrences where the patient did not attend or

was unable to attend? Yes  No  n/a 

1. Do the notes include follow-up activity planned following

non-attendance (e.g., telephone call/non-attendance letter

sent)? Yes  No  n/a 

1. Do the notes include the outcome of the planned activity

following non-attendance? Yes  No  n/a 

Comments for Section K *(continue on additional page if required)*

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## Section L: Questions to the Auditor

1. Are you satisfied with the overall quality of this record? Yes  No 
2. Would you be proud if these records had your name against them’? Yes  No 
3. If you have answered ‘No’ to either of the above questions, please state your reasoning in the space below *(continue on additional page if required)*:

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