

**BAPO Guidance for Record Keeping**

**Draft revised February 2023**

Produced for prosthetists and orthotists, this guidance is an essential reference point in their clinical environment ensuring clinical records are maintained which are fit for purpose and processed according to legislation.

This document is complemented by the BAPO Guidance for Clinical Governance.

The guidelines in this document apply to NHS records, including records of NHS patients treated on behalf of the NHS in the private healthcare sector and public health records, regardless of the media on which they are held.

“Record keeping is an integral part of orthotic and prosthetic practice and writing clinical records is mandatory for all patient contacts. Adherence to the Standards of Proﬁciency published by the Health and Care Professions Council (HCPC) is mandatory for all registered practitioners. Failure to comply with this requirement is considered as professional misconduct and may lead to disciplinary action. Record keeping is a professional tool which is integral and essential to service user care. Members involved in recording, accessing and storing health records must also

be aware of the legal context in which they work and comply with national, professional body and local employer guidance on record keeping and data protection”.

(BAPO – Standards for Best Practice)

**Contents:**

|  |  |
| --- | --- |
| **Title** | **Page** |
|  | |
| **Clinical Governance** | **6** |
| **Introduction to Clinical Records**   * Keeping records as part of your duty of care * What constitutes a clinical record? * The purpose of clinical records | **6-8**  7  7  7-8 |
| **Legislation, standards and policy related to keeping clinical records**   * The Information Governance Review, 2013 (Caldicott) * Confidentiality, information sharing and consent * Data Protection Act, 1998 and 2018   - Amendments to health records  - Service user access to clinical records   * Human Rights Act, 1998 * Freedom of Information Act, 2000/Freedom of Information (Scotland) Act 2002 * Environmental Information Regulations, 2004 * Privacy and Communication Regulations, 2003 * Access to Medical Reports Act, 1988 * Access to Health Records Act, 1990 * The Health and Social (Safety and Quality) Act, 2015 * Mental health and mental capacity legislation * Health and Care Professions Council requirements * Your professional requirements   - BAPO recommended essential information for clinical records | **9-13**  9-10  10-11  12-15  14  14-15  15  15  16  16  16-17  17  18  18  18-19  19-20  20 |
| **Competence and delegation** | **21** |
| **The Format and Structure of Clinical Records** | **22** |
| **Records That Are Fit For Purpose** | **22** |
| **Requirements for best practice**   * Service user identifiers * Consent * Recording capacity and consent to intervention * Making decision when a service user lacks capacity * Deprivation of liberty safeguards * Comprehensive records * The Prosthetic and Orthotic best practice guidelines * Professional/clinical reasoning * Goal attainment setting * Outcome measures * Making every contact count * Social prescribing * Evidence-based care * Official or unofficial discussions concerning a service user * Frequent and repetitious activities or standard practice * Service user non-attendance * Information provided to the service user | **23-**  23  23  23-25  25  26  26  26-27  27  27  27  28  28  28  28  28  29  29 |

**Contents (Continued):**

|  |  |
| --- | --- |
| * The source of information about a service user or their circumstances * Recording the individuals present * Prosthetic and Orthotic prescriptions * Legibility * The use of acronyms and abbreviations * Signing and counter signing record entries * Timing and dating record entries * Amending a record * Recording when asked not to * Recording risk * The use of hazard or violent warning markers * Recording medication * Discharge/case closure * Timely record-keeping * Making your record-keeping a priority * Clinical records content | 29  29  29  30  30  30-31  31  31-32  32  32  32  33  33  33-34  34  34-35 |
| Failure to Complete and Maintain Clinical Records | **35** |
| **The Handling and Management of Clinical Records** | **36** |
| **Secure Storage of Clinical Records and Personal Data**   * The use, transfer and security of digital images and films * Retention of records * Retention of diaries | **36-38**  37  37-38  38 |
| **References and Further Reading** | **39-45** |
| **Appendices**   * One: Infographic of Key Elements Identifying the Necessary Elements of Quality Required of Clinical Notes. * Two: Approved List of Abbreviations, Symbols, Units and Glossary * Three: Checklist for Prosthetic and Orthotic Clinical Records * Four: Health Records Maintenance Guide Infographic | **46-59**  46-47  48-55  56-57  58-59 |

## Clinical Governance

Clinical Governance is about the quality and safety of patient care. It is everything we do as individual autonomous clinicians and as an organisation to achieve high standards of clinical care. This includes the management of resources, clinical and self-governance.

The Department of Health defines clinical governance as:

"A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."

(Department of Health 1998).

Below are the seven areas of activity, often referred to as ‘the seven pillars of clinical governance,’ which are used to make sure we deliver the highest quality health care to service users.

* Clinical audit
* Risk management
* Education, training, continuing personal & professional development
* Clinical effectiveness
* Information management
* Client/service user and experience and involvement
* Staffing and staff management

As can be seen, maintaining accurate clinical records falls into the remit of all of the pillars of clinical governance.

**Introduction to Clinical Records**

Keeping accurate clinical records is an integral part of the practice of all practitioners in health, social and community care, education and research. It is an absolute requirement as part of your duty of care, and must be completed in line with relevant legislation, the standards of your registration and professional bodies, and local policy.

Clinical records primarily support and enable the provision of care to the service user, as well as demonstrate that you have carried out your responsibilities in line with legal, professional and local requirements. Clinical records are legal documents and may be used as evidence in an enquiry or court of law.

For the purposes of this guidance, the records kept by orthotic practitioners will be referred to as ‘clinical records’ and encompass those kept in all settings. People who receive orthotic intervention/ therapy services are called ‘service users’, or ‘patients’. This term encompasses all ages, groups, and communities of people, and is applicable in all settings.

This guidance provides a standard which is based upon a number of key principles to underpin good records and record keeping. A fundamental principle is that all clinical records and results should always be accessible to the practitioner and all others involved in service user provision in line with sharing of information guidance set by NHS England.

## Keeping records as part of your **duty** of care

*“A duty of care arises where there is a sufficiently close relationship between two parties … and where it is reasonably foreseeable that the actions of one party could, if carelessly performed, cause harm or loss to the other party. Discharging your duty of care requires you to perform your occupational duties to the standard of a reasonably skilled and careful practitioner.”*

(COT 2015a, section 3.1)

Accurate clinical records act as evidence that an individual practitioner has met their duty of care within their practice. It is reasonably foreseeable, therefore, that record-keeping, if carelessly done, could cause harm or loss to those for whom a service is provided. You may be considered in breach of your duty of care if your records fail to show that you have performed your professional responsibilities, including record-keeping itself, to the standard expected of a reasonably skilled practitioner. This guide defines certain key requirements for keeping records and explains some of the rationale which underlies them.

## What constitutes a clinical record?

Clinical records include any material that holds information regarding an individual, collected as part of their care provision. Such material can be handwritten, digital, auditory, or visual, and would include data held on a computer, a tablet or mobile phone. It would include images, auditory or visual recordings, forms, letters, notes, diary entries, emails, text messages and duplicate copies.

## The purpose of clinical records

Clinical records serve many purposes. They are primarily a history of the assessment, decision-making, planning, and care provided for a service user, along with the outcomes of that care. The records may highlight problems and changes in a service user’s condition as well as serving as a record of the service user’s objectives, preferences, and choices, along with their consent to any intervention on their behalf. They protect the welfare of the service user by supporting high-quality, evidence- and rationale-based care, continuity of care and good communication between all those involved. Clinical records support high standards of service user care, enable continuity of care over time, and enable better communication and dissemination of information.

On a wider scale, the data recorded may be used for auditing practice and outcomes, service planning and business decision-making. They may also provide documentary evidence in an investigation or court of law.

Clinical records are also your evidence of good, safe, and effective practice, especially should your work ever be questioned. They define and explain the work that you do as a prosthetic or orthotic practitioner in your particular role.

The purpose and writing of clinical records are detailed on the next page:

1. Clear documentation ensures effective continuous service user care
2. Service user contact records are legal documents and a statutory requirement
3. Note recording:
   1. Encourages logical thinking
   2. Provides a basis for critical analysis in decision making
   3. Standardises quality information for team members
   4. Forms the basis for future clinical and medical decisions
   5. Supports clinical audit and quality assurance
   6. Supports clinical effectiveness studies
   7. Informs retrospective and prospective research
   8. Provides statistical evidence for service development
4. Clinical records may be written using the Subjective, Objective, Assessment/

Analysis, Plan (SOAP) format

* 1. Subjective: information from the service user
  2. Objective: clinician’s findings from assessment and observations
  3. Assessment/Analysis: differential diagnosis/document rationale of decision making/prescription
  4. Plan: state treatment plan/provide treatment/ service user education and instruction/ review/discharge/future intervention/onward referral etc.…

1. Clinical records may be written using the Problem Oriented Medical Records (POMR) if appropriate
2. Written clinical records must:
   * + - 1. Be factual, consistent and accurate
         2. Be contemporaneous, written within 24 hours of the intervention
         3. Provide current information on the care and condition of the service user
         4. Be written legibly in black ink and in such a manner that they cannot be erased or if computer recorded, be non-editable
         5. Be written so that any alterations or additions are dated, timed and signed
         6. Only be altered in such a way that that the original entry can still be read clearly. Any alterations should be scored out with a single line.
         7. Be accurately dated, timed and signed, with the signature and status of writer being made clear
         8. Written without gaps between entries
         9. Not include abbreviations, jargon, meaningless phrases or offensive subjective statements
         10. Be legible
         11. Be written in terms that the service user also can understand
         12. Be headed with concise patient details such as those on hospital adhesive labels
3. Records include all relevant letters, prescriptions and order paperwork
4. Records should clearly document where an entry is made following telephone contact
5. Digital records must meet the same auditing standards as would be expected of handwritten notes.

**Remember: If you have not documented it accurately, you cannot prove it happened.**

## Legislation, standards, and policy related to keeping clinical records

This guidance does not discuss region and local clinical record keeping requirements. It will only identify and discuss some of the more universal pieces of legislation that apply to keeping records across the UK. The British Association of Prosthetists and Orthotists (BAPO) encourage all members to seek out specific guidance for their locality via their service management.

You are expected to be familiar and comply with any UK or national legislation, policies, and best practice standards, along with employers’ policies and procedures that are relevant to your own field of practice, setting and country of practice. This includes compliance to local policy and legislation around cultural identity and language needs.

If you are an independent practitioner, you are advised to put in place your own policies which are compatible with legislation, your professional standards and standard practice.

If you are concerned that your local policy, or any local action that you witness, is causing you to fall short of your legal and professional duties in keeping records, or that it puts the welfare of service users, yourself, or your colleagues at risk, you must raise this with your line manager initially, then to your employer if it is not resolved. You must keep a documented record of your concerns. You are advised to contact your local union representative, BAPO and the Health and Care Professions Council (HCPC) for advice in such situations, as each may be able to advise you.

Guides, standards, and codes of practice set down by professional and regulatory bodies, and at a local level, aim to provide a structure and a universal standard for safe and good working practice. They are not in themselves legally binding, but a failure to follow this recommended practice, it could be argued, may constitute negligence or a breach of your duty of care (Lynch 2009, p10).

For the purpose of this document, ‘public authorities’ includes the NHS, universities and other bodies which do public work.

## The Information Governance Review, 2020 (Caldicott)

In 2013, Dame Fiona Caldicott reviewed the state of information governance across health and social care in England. Information governance is seen as ‘how organisations and individuals manage the way information is handled’ (Caldicott 2013, p9). Following her earlier review in 1997, Caldicott devised six general principles of information governance. In 2002 the Caldicott principles were extended into social care, providing a shared basis for joint working between health and social services. These principles were reviewed in 2020, with the inclusion of an additional principle identifying the importance of sharing information when in the best interest of service users.

Where a novel and/or difficult judgment or decision is required, it is advisable to involve a Caldicott Guardian.

### Principle 1: Justify the purpose(s) for using confidential information

Every proposed use or transfer of confidential information should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed by an appropriate guardian.

### Principle 2: Use confidential information only when it is necessary

Confidential information should not be included unless it is necessary for the specified purpose(s) for which the information is used or accessed. The need to identify individuals should be considered at each stage of satisfying the purpose(s) and alternatives used where possible.

### Principle 3: Use the minimum necessary confidential information

Where use of confidential information is considered to be necessary, each item of information must be justified so that only the minimum amount of confidential information is included as necessary for a given function.

### Principle 4: Access to confidential information should be on a strict need-to-know basis

Only those who need access to confidential information should have access to it, and then only to the items that they need to see. This may mean introducing access controls or splitting information flows where one flow is used for several purposes.

### Principle 5: Everyone with access to confidential information should be aware of their responsibilities

Action should be taken to ensure that all those handling confidential information understand their responsibilities and obligations to respect the confidentiality of patient and service users.

### Principle 6: Comply with the law

Every use of confidential information must be lawful. All those handling confidential information are responsible for ensuring that their use of and access to that information complies with legal requirements set out in statute and under the common law.

### Principle 7: The duty to share information for individual care is as important as the duty to protect patient confidentiality

Health and social care professionals should have the confidence to share confidential information in the best interests of patients and service users within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

### Principle 8: Inform patients and service users about how their confidential information is used

A range of steps should be taken to ensure no surprises for patients and service users, so they can have clear expectations about how and why their confidential information is used, and what choices they have about this. These steps will vary depending on the use: as a minimum, this should include providing accessible, relevant and appropriate information - in some cases, greater engagement will be required.

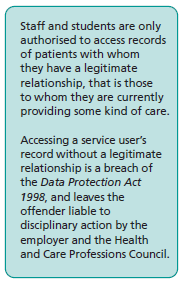
Source: <https://www.gov.uk/government/publications/the-caldicott-principles>

## Confidentiality, information sharing and consent

The Data Protection Act (2018) and the Human Rights Act (1998) (Great Britain. Parliament 1998b) place statutory restrictions on the management and use of personal information. A duty of confidentiality arises when a service user shares personal information with you. Confidentiality is a legal obligation, and a requirement established within professional codes of conduct and employment contracts.

The Health and Care Professions Council have a document entitled Confidentiality Guidance for Registrants (updated in 2017) which gives some guidance on disclosure in the public interest.

Service users have the right to know when information about them is recorded, how it will be recorded and how it will be used. They should be made aware that the information they give may be shared in order to provide them with care and may be used to support local clinical audit and other work to monitor the quality of care provided. Where an individual does not consent to allow information to be disclosed, this may limit the care that the individual receives. Service users must be informed of the potential outcomes of refusing to allow the sharing of such information.



The 2013 and 2020 Caldicott review highlighted the need for information sharing as part of the care of individuals. You have a duty to share information appropriately and when in the service user’s best interest, for their safe and effective care. This should be limited to the information that is necessary and shared only with those who need to know. This does not remove the duty of confidentiality, so the principle of gaining consent to share information should always be maintained.

It is generally accepted that information is shared between members of a team involved in the direct care of an individual. Specific consent should be sought to share information more widely. A person has a choice whether to allow their personal information to be shared and this must be respected, unless there is an over-riding legal reason for disclosure, for example safeguarding concerns.

If a person lacks capacity to decide, a judgement may be made based on their best interests (Health and Social Care Information Centre 2013, p14). If there is a friend or family member who has lasting power of attorney, they can be involved. For children without the ability to understand and consent for themselves, consent may be gained from a person with ‘parental responsibility’.

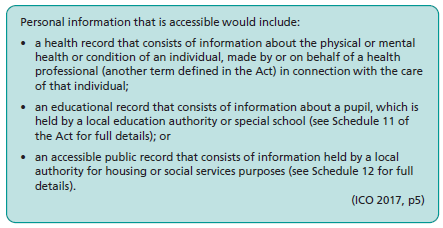
Information needs to be shared between all those involved in a child’s care. It will also need to be transferred, with parental consent, if a child moves across services, or into a different area. The Children Act 2004 (Great Britain. Parliament 2004), which applies throughout the United Kingdom, provides a legal framework to enable practitioners to share early information. It aims to ensure that children and families are getting benefit from services such as education and health care, and to enable them to get the support they need at the right time.

Clinicians who work across public and independent sectors, and may see the same individual in both contexts, should not transfer or share information from one context to another without the service user’s consent. There is a range of information online about data sharing. Some of this is listed in the resources section of this publication.

## Data Protection Act

The Data Protection Act 1998 and its subsequent update in 2018 (Great Britain. Parliament 1998a / 2018) applies throughout the United Kingdom and is concerned with the right of a living person to privacy in respect of personal information. The Act applies to personal data being processed either manually or digitally. It includes film, photography and material recorded in other media. It applies to data held, or planned to be held, on computers or in a ‘relevant filing system’. Defining a ‘relevant filing system’ can be difficult, but if your information is structured in such a way that specific information relating to a particular individual is readily accessible, it would be considered as a relevant filing system. The Act imposes a responsibility on anyone who generates, uses or stores personal information to abide by eight Data Protection Principles. The Principles set down a framework for the lawful processing of such personal data.

The Information Commissioner’s Office (ICO) has an online Guide to data protection (ICO 2017). This provides definitions for all terms in the Act and explains in detail the requirements of the Act. It is available to download from the Information Commissioner’s Office website.



The Act regulates the processing of information. Processing, in relation to information or data, means obtaining, recording, or holding the information or data or carrying out any operation or set of operations on the information or data. (ICO 2017, p8).

In the private sector or industry, records continue to be viewed as personal data and come under the requirements of the Data Protection Act 1998 (Great Britain. Parliament 1998). Independent practitioners, or the bodies for which they work, are responsible for the records that they develop and hold; they should have systems in place which meet the requirements of the Act.

The 2018 review of the Data Protection Act makes data protection laws fit for the digital age when an ever-increasing amount of data is being processed. It also empowers people to take control of their data and introduces the General Data Protection Regulation (GDPR).

Personal data is becoming increasingly valuable, and the collectors and users of data have responsibilities under the Act, such as asking a data subject's permission to use the data. The primary aim of the GDPR is to provide individuals control over

their personal data and simplify the regulatory environment for international

business by unifying the regulation within the EU. The regulation contains provisions and requirements related to the processing of and individual’s personal data who are located in the European Economic Area, and applies to any enterprise, regardless of its location and an individual’s citizenship status or residence. The 2018 Act states that personal data is only to be processed ‘for purposes for which it is required by an enactment to be processed, and by means by which it is required by an enactment to be processed’.

The eight principles of good information handling state that data must be:

* Fairly and lawfully processed
* Processed for limited purposes which are specified and legitimate
* Adequate, relevant, and not excessive
* Accurate and kept up to date
* Not kept for longer than is necessary
* Processed in a secure manner and line with a person’s rights
* Secure
* Not transferred to other countries without adequate protection

The following two safeguards are stipulated in the Act:

* Archiving

This section applies in relation to the processing of personal data for a law enforcement purpose where the processing is necessary

* For archiving purposes in the public interest
* For scientific or historical research purposes, or
* For statistical purposes

The processing is not permitted if:

* + It is carried out for the purposes of, or in connection with, measures or decisions with respect to a particular data subject, or
  + It is likely to cause substantial damage or substantial distress to a data subject
* Sensitive processing

You must be able to demonstrate that the processing is strictly necessary and satisfy one of the conditions in Schedule 8 of the Data Protection Act (listed below) or is based on consent. ‘Strictly necessary’ in this context means that the processing has to relate to a pressing social need, and you cannot reasonably achieve it through less intrusive means.

The conditions for sensitive processing in Schedule 8 of the Act are:

* Necessary for judicial and statutory purposes – for reasons of substantial public interest
* Necessary for the administration of justice
* Necessary to protect the vital interests of the data subject or another individual
* Necessary for the safeguarding of children and of individuals at risk
* Personal data already in the public domain (manifestly made public)
* Necessary for legal claims
* Necessary for when a court acts in its judicial capacity
* Necessary for the purpose of preventing fraud; and
* Necessary for archiving, research, or statistical purposes

**Amendments to health records**

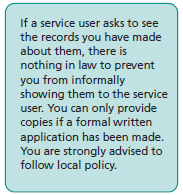
Credible records are an important aid in providing safe healthcare to service users. As previously stipulated, clinical records should reflect the observations, judgements and factual information collected by the contributing health care professional. The Data Protection Act’s fourth principle requires that information should be accurate and kept up-to-date. This provides the legal basis for enforcing correction of factual inaccuracies.

An opinion or judgement recorded by a health professional, whether accurate or not, should not be deleted. Retaining relevant information is essential for understanding the clinical decisions that were made and to audit the quality of care.

If a service user feels that information recorded on their health record is incorrect, they should first make an informal approach to the health professional concerned to discuss the situation in an attempt to have the records amended.

* Where both parties agree that information is factually inaccurate it should be amended to clearly display the correction whilst ensuring that the original information is still legible. An explanation for the correction should also be added.
* Where the health care professional and patient disagree about the accuracy of the entry, the Department of Health recommends the data controller should allow the service user to include a statement within their record to the effect that they disagree with the content. If the patient is unhappy with this outcome, they retain the option of taking this formally.

## Service user access to clinical records

The Data Protection Act 1998/2018 gives an individual the statutory right to have access to their own health and social care records, upon written request, whether they be held on computer or manually (with some conditions). This is known as a subject access request.

The organisation holding the data has 40 days in which to respond. The individual is entitled to know the purpose of the record and who may have access to the information. They may challenge the accuracy of the record and may have records amended, deleted, or destroyed if shown to be inaccurate. An individual may also request in writing that all or part of data processing, relating to their own records, is stopped on the basis that they or a third party

may be significantly damaged or distressed by it. The organisation holding the data has 21 days in which to respond.

Under equality law an organisation has a duty to make sure that its services are accessible to all service users. An individual can request a response in a particular format that is accessible to them, such as Braille, large print, email, or audio format.

If the files contain information about a third party, consent should be gained before sharing this information.

Under the Data Protection Act there are two reasons why access may be denied:

* Providing access to the records may cause the individual distress or harm.
* A person’s access to data may risk disclosing information concerning a third party, unless that third party gives permission.

Access to the clinical records of the deceased is governed by the Access to Health Records Act 1990 (Great Britain. Parliament 1990) and the Freedom of Information Act 2000 (Great Britain. Parliament 2000). Under the terms of the Acts, you will only be able to access the deceased’s health records if you are either:

* a personal representative (the executor or administrator of the deceased person’s estate); or
* someone who has a claim resulting from the death (this could be a relative or another person).

If you are an independent practitioner, you must follow legislation and are advised to develop your own policy. Further information is available on the Information Commissioner’s Office website as well as the HCPC website.

## Human Rights Act 1998

The *Human Rights Act 1998* (Great Britain. Parliament 1998b) implements the provisions of the European Convention on Human Rights (ECHR) (Council of Europe 1950). Article 8 of the ECHR ensures respect for a person’s private and family life. Disclosure of personal information would be a breach of that right unless it was ‘in accordance with the law’, necessary ‘in a democratic society for a legitimate aim (in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others), and proportionate’ (House of Lords and House of Commons, Joint Committee on Human Rights 2008).

## Freedom of Information Act, 2000/Freedom of Information (Scotland) Act 2002

The Freedom of Information Act gives people access to information held by public authorities, including: the right to know how services are run, how much they cost, targets, results and how to make a complaint should they need to. All Hospital Trusts are committed to complying with 'Right of Access' requests made under the Data Protection Act 2018 and the Freedom of Information Act 2000. Anyone can request information recorded and, by law, Hospital Trusts must respond to these requests within a certain time period (usually within 21 days). There are some exemptions, which are managed according to the Freedom of Information Act Code of Practice and guidance from the Information Commissioner's Office.

The Freedom of Information Act does not give people access to their own personal data (information about themselves), such as their health records as individuals have a right of access to information held about them under the UK GDPR and Data Protection Act 2018.

## Environmental Information Regulations, 2004

The Environmental Information Regulations 2004 provide the general public access to environmental information held by public authorities. The Regulations allow for this to occur in two ways:

* Public authorities must proactively make environmental information available
* The public are entitled to request environmental information

The Regulations cover any recorded information held by public authorities in England, Wales, and Northern Ireland. Environmental information held by Scottish public authorities is covered by the Environmental Information (Scotland) Regulations 2004.

## Privacy and Communication Regulations, 2003

The Privacy and Electronic Communications Regulations (PECR) sit alongside the Data Protection Act and UK GDPR, providing people specific privacy rights in relation to electronic communications.

There are specific rules on the following:

* marketing calls, emails, texts, and faxes
* cookies (and similar technologies)
* keeping communications services secure
* privacy as regards traffic and location data, itemised billing, line identification, and directory listings.

Organisations must comply with PECR and promote good practice by offering advice and guidance.

The e-privacy Directive complements the GDPR and sets out more specific privacy rights on electronic communications, recognising that widespread public access to digital mobile networks and the internet opens up new risks to privacy and security.

## Access to Medical Reports Act, 1988

The Access to Medical Reports Act (1988) establishes the rights of access of an individual to medical reports relating to themselves for employment, insurance purposes or other related matters. It states that patients should be offered a copy of their medical report and the opportunity to review it prior to submission to an organisation which has requested it, e.g., their employer or insurance company.

Under the Act, if a service user expresses a wish to see a report before it is submitted, they must arrange to do this within a 21-day period. Any report should be kept for at least six months, with patients having the right to see it during this period.

The General Medical Council recommends that patients should be offered, or given a copy of, any report written about them for employment or insurance purposes before it is sent, with the following caveats:

* The service user has already declined this option
* Disclosure would be likely to cause serious harm to the service user or anyone else
* Disclosure would reveal information about another person who does not consent.

It is the right of an individual to have access, in accordance with the provisions of this Act, to any medical report relating to the individual, which is to be, or has been, supplied by a medical practitioner for employment purposes or insurance purposes.

On occasion, clinicians may receive a request from a service user’s employer for a medical report to be delivered directly to the HR department, without the patient seeing it. However, before any medical report can be provided, you must be satisfied that the service user has given valid consent to the release of the information. It is the duty of the person or organisation requesting the report to obtain consent from the patient, and this consent should be in writing. At the same time, if the report is covered by the Access to Medical Reports Act (1988), they should also let the service user know about their rights. You should be satisfied that the patient has sufficient information about the scope, purpose and likely consequences of the disclosure, and the fact that relevant information cannot be concealed or withheld. If you are concerned that disclosing certain information may cause problems for the service user, it is a good idea to discuss this with them first.

Only factual information which can be substantiated should be disclosed, presented in an unbiased manner and relevant to the request. You should not usually disclose the whole record. Exceptions to this include benefit claims and litigation.

An individual has the right to signal any disagreement with the content of the report. For reports covered by the Access to Medical Reports Act, this should be done in writing. Patients can append their disagreement to the report or withdraw their consent for the release of the information.

If you agree that the information is wrong, you can amend the report. If the patient refuses consent, information can still be disclosed if required by law, or if it is in the interest of the public.

## Access to Health Records Act, 1990

The Access to Health Records Act, 1990, provides certain individuals a right of access to the health records of a deceased individual. These individuals are defined as ‘the patient’s personal representative and any person who may have a claim arising out of the patient’s death’. A personal representative is the executor or administrator of the deceased person’s estate and is the only person with an unqualified right of access to a deceased service user’s record and does not need to give a reason for applying for access to a record, however, would need to provide evidence of identity.

Individuals other than the personal representative have a legal right of access under the Act only where they can establish a claim arising from a patient’s death. There is less clarity regarding which individuals may have a claim arising out of the patient’s death. Whilst this is accepted to encompass those with a financial claim, determining who these individuals are and whether there are any other types of claims is not straightforward. The decision as to whether a claim exists lies with the record holder. In cases where it is not clear whether a claim arises the record holder should seek legal advice.

Record holders must satisfy themselves as to the identity of applicants who should provide as much information to identify themselves as possible. Where an application is being made based on a claim arising from the deceased’s death, applicants must provide evidence to support their claim.

## The Health and Social (Safety and Quality) Act 2015

## This Act came into effect on 1st October 2015 and sets a duty for information to be shared where it facilitates care for an individual and it is legal to do so. This sharing requires the service user to be informed and provide them with an opportunity to object. This is irrespective of the organisation or profession the member of an individual’s integrated multidisciplinary team is from.

## Mental health and mental capacity legislation

All prosthetic and orthotic practitioners will, at times, work with people who have mental health conditions, so should be aware of their duties regarding mental health legislation (Great Britain. Parliament 1983, 2005, 2007). This is perhaps most pertinent with respect to capacity and consent, along with deprivation of liberty and safeguarding. Practitioners working with service users specifically subject to mental health legislation must ensure that they have a good working knowledge of the relevant law. Further information on recording consent and capacity can be found in this guidance.

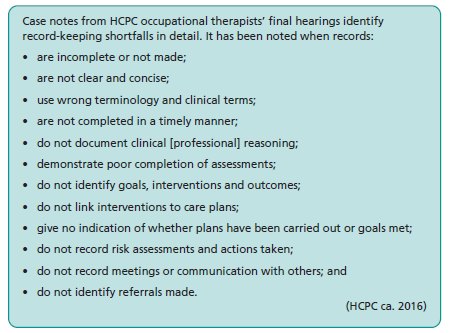
## The Health and Care Professions Council requirements

The Health and Care Professions Council (HCPC) requires you to ‘keep full, clear, and accurate records for everyone you care for, treat, or provide other services to’, and that ‘you must complete all records promptly and as soon as possible after providing care, treatment, or other services’. It is stipulated that records are kept ‘secure by protecting them from loss, damage, or inappropriate access’ (HCPC 2016, section 10).

You must ‘be able to keep accurate, comprehensive, and comprehensible records in accordance with applicable legislation, protocols and guidelines’ and ‘recognise the need to manage records and all other information in accordance with applicable legislation, protocols and guidelines’ (HCPC 2013, section 10.1). All records must be completed ‘promptly and as soon as possible after providing care, treatment, or other services’ (HCPC 2013, section 10.2).

HCPC clearly states that your records must demonstrate your clinical reasoning, in that you must ‘be able to make reasoned decisions to initiate, continue, modify or cease treatment or the use of techniques or procedures, and record the decisions and reasoning appropriately’ (HCPC 2013, section 4.2).

The HCPC sees failures in keeping records as misconduct and/or a lack of competence. When activity on behalf of a service user is not recorded, it cannot be shown to have happened, therefore the practitioner may be considered as unfit or unsafe to practise. Poor record-keeping may be considered to be an indicator of a practitioner who is struggling in terms of their knowledge and skills, attitude, confidence, or perhaps their personal wellbeing.



* **Your professional requirements**

As with the HCPC standards, the BAPO Standards for Best Practice (2018) provide statements which capture the over-riding requirements for record-keeping. You will need to look at each statement and consider what it would take, in terms of your practice and your workplace, to meet each of these. Within the Clinical Record-Keeping guidance of the BAPO Standards for Best Practice, the following is stated:

**“It is recommended that the following essential information be documented. This information is in accordance with International Standards and Department of Health Directives. The practitioner must obtain and document the informed consent of the service user to examination and treatment in accordance with local governance requirements.”**

**BAPO recommended essential information for clinical records**

A clinical record must be raised and maintained for each service user

Referrals are normally accepted from a:

* 1. Medical Physician or Consultant
  2. General Practitioner Doctor
  3. Nurse or Allied Health Professional
  4. Service user
  5. Carer or parent on behalf of the service user

It is recommended that the following essential information be documented. This information is in accordance with International Standards and Department of Health Directives, including Information Governance Alliance: Records Management code of Practice 2016. The practitioner must obtain and document the informed consent of the service user to examination and treatment in accordance with local governance requirements

* 1. Service user administrative details including:
* Name, address, and telephone number
* Date of birth and gender
* Hospital or unique identifier number
* General Practitioner name and practice
* Referrer name and designation
  1. Personal Information:
* Height and weight
* Vocational activity
* Recreational activity
* Transfer method
  1. General medical condition:
* Primary diagnosis
* Significant medical history, including infection precautions
  1. Clinical condition and pathology:
* 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 (for guidance see ISO 8548-1, 2, 3;
* method of describing amputation stumps and limb deficiencies)
* Impairment stable/changing
  1. Notes:
* The problem
* Subjective notes
* Objective notes
* Assessment/Analysis
* Plan of treatment
  1. Objectives of treatment and/or care plan
  2. Biomechanical requirement of orthosis/prosthesis
  3. Category of orthosis/prosthesis as defined in ISO 8549:1989 Prosthetics and Orthotics-Vocabulary Parts 2 and 3
  4. Device specification number and date supplied along with any individual device identification information provided by the manufacture Compliance with 93/42/EEC
  5. Date and time of review appointment
  6. Signature, name (in block capitals), date and time
  7. Designation: e.g., prosthetist/orthotist, orthotist, prosthetist

## Competence and Delegation

All prosthetists and orthotists should be aware of and abide by the current legislation, guidance and standards that are relevant to your practice, remaining up to date with relevant training where necessary.

This means that you must ensure that all clinical records that you create, or use meet legal, national and/or local requirements. You should have access to appropriate training, professional guidance, and support where and when necessary.

Within the BAPO Standards for Best Practice, parts 1.7 and 1.8 focus on ‘Management and supervision’ and ‘Participation in training and education’. If you delegate interventions or other procedures, you should be satisfied that the person to whom you are delegating is competent to carry them out. In these circumstances, you, as the delegating practitioner, retain responsibility for the orthotic care provided to the service user.

If you supervise staff (including assistant practitioners/limited orthotic practitioners (LOPs)) and delegate tasks and/or responsibilities to them, it is your responsibility to ensure that they are competent to carry out those tasks. This includes the keeping of records. Where they need additional help or guidance in record-keeping, it is your responsibility to provide this or arrange for it to be provided.

If you have a student, or new/inexperienced member of staff, you may take on some responsibility for teaching them good record-keeping practices. This requires you to directly oversee their record entries and countersign them until such a time as they are deemed competent to carry them out unsupervised.

If you are a student on placement and you are unsure of your record-keeping skills, you need to seek out guidance and support. This does not necessarily need to come from a prosthetist or an orthotist if one is not present. It is recommended that all students use this guidance alongside the support provided by other professionals in your location and educators at your place of study.

BAPO have endorsed the document ‘Preceptorship in Prosthetics & Orthotics’ which may be of use to both the individual (preceptee) and supervisor (preceptor) in question.

<http://www.ewin.nhs.uk/sites/default/files/Prosthetists%20and%20Orthotists%20Preceptorship%20Guide.pdf>

## The Format and Structure of Clinical Records

Many clinical records are kept in a variety of ways: paper or electronic, from specific orthotic files to shared rehabilitation notes, or fully integrated into medical or social care records. The format of records can be varied, provided that the principles and standards for keeping records are maintained and that current government or local policy is being followed. The use of integrated digital systems will bring greater consistency in terms of format, structure, and content across many prosthetic and orthotic services.

‘SOAP notes’ are an example of a highly structured format for documenting the progress of a service user during treatment and is one of the most favoured formats used by practicing prosthetists and orthotists. These are entered in the client’s medical record to effectively communicate information to other providers of care, to provide evidence of patient contact and to inform the clinical reasoning process.

**SOAP is an acronym for:**

* **S**ubjective - What the service user says about the problem / intervention.
* **O**bjective - The therapists’ objective observations and treatment interventions (e.g. ROM, outcome measures)
* **A**ssessment - The clinician’s analysis of the various components of the assessment.
* **P**lan - How the treatment will be developed to the reach the goals or objectives.

## Records That Are Fit For Purpose

Prosthetists and orthotists need to be able to show all that they have done for, with or in relation to a service user, including the clinical reasoning behind the occupation-focused care planning and provision. They also need to be able to demonstrate the outcomes of the care that they have provided, not only for the benefit of the service user and others in the care team with access to the records, but also as a testament to the value of therapy and intervention.

When you consider the requirements of the HCPC and BAPO standards, there are key words that identify the necessary elements of quality which are required. Every service user with whom you have contact must have records that are:

* full/comprehensive.
* clear/comprehensible.
* accurate.
* promptly completed.
* demonstrating your clinical reasoning and evidence.
* compliant with legislation, guidance, and policy on completion,
* confidential, sharing and service user access; and
* securely stored and suitably disposed of.

An infographic of this is available in Appendix One, which can be displayed in clinical areas.**Requirements For Best Practice**

To ensure that you meet legal, professional and registration body requirements, you are advised to take account of the following points.

## Service user identifiers

The use of a consistent and unique identifier assists in the delivery of safe integrated care, data sharing and integrated digital clinical record systems.

A unique service user identifier should be used in all clinical records in all settings and in all UK countries. All information included in the clinical record should be identified by the service user’s name, date of birth and unique identifier.

* **Consent**

Consent is at the heart of the relationship of trust between the service user and practitioner. Before embarking on any examination or treatment, you must be satisfied that your client, or somebody with authority to do so on their behalf, has provided their valid consent to the assessment and procedure you are about to undertake. The key points of the law governing consent are as follows:

* Prosthetists and orthotists are legally, professionally, and ethically obliged to obtain informed consent prior to examining service users or undertaking investigations, assessments or treatment
* Consent will only be valid if it is informed and freely given by an individual who has capacity to consent
* Service users should receive the information they require to support their decision making in a format which is clear and easily understood
* Service users must be given sufficient time to consider their decision before treatment is provided. The amount of time required will be proportionate to the significance of the decision to be made
* Service users are free to withdraw their consent at any time
* Adults (aged 18 and over) are assumed to have capacity to consent unless they are unable to make a decision at a specific time because their mind is affected by illness or disability
* Young adults (aged 16 or 17) can provide consent to treatment. Their entitlement to refuse treatment which is in their best interests is more complex
* Persons aged 15 and younger can provide consent to treatment in their best interests if they are considered to be ‘Gillick competent’
* When the service user lacks capacity or is not competent to provide consent, treatment can be provided in the patient’s best interests
  + **Recording capacity and consent to intervention**

With regard informed consent, the Royal College of Occupational Therapists’ Code of ethics and professional conduct states that:

**“Informed consent is a continuing requirement. Unless restricted by mental health and/or mental capacity legislation, it is the overriding right of any individual to decide for himself (herself) whether or not to accept intervention.**

**A service user can only give informed consent if he or she has the mental capacity to do so … You must assess service users’ mental capacity to make decisions in relation to occupational therapy provision, in accordance with current legislation.”**

(COT 2015a, section 3.3)

Informed consent is when a person gives consent and agrees to a course of action, based on a clear understanding of the information given, and the implications and consequences of the proposed action.

When seeking consent, it is presumed that a person has capacity and does not have to prove otherwise. Capacity would only need to be assessed when a person is unable to make a decision at a specific time, because their mind is affected by illness or disability. It is understood that capacity is a fluctuating state and may need to be re-assessed.

The Mental Capacity Act 2005 (Great Britain. Parliament 2005) enables those in health and social care to carry out capacity assessments. If you are unsure of your ability to do this, seek guidance and suitable training from your employer. This guidance is not about how to assess capacity, but the importance of recording your assessment and its outcomes. If you think that an individual lacks capacity, you need to be able to demonstrate it. Your records should show that it is more likely than not that the person lacks the capacity to make a specific decision at the time that they need to. You should document how the service user’s capacity was assessed and whether any lack of capacity is considered permanent or temporary.

If a service user’s capacity is affected, clinicians are advised to adhere to guidance recommended by the General Medical Council, taking particular care to give the service user the time and support they need to maximise their ability to make decisions for themselves. For example, careful consideration will be required about the extra support needed by people with dementia or learning disabilities.

The consent process must be supported by clear, contemporaneous, and accurate records which should include details of the information provided with respect to diagnosis, prognosis, treatment options (including no treatment), risks and benefits of the proposed treatment and the reasonable alternatives, concerns or questions raised by the patient and their reasons for choosing their preferred option. It should be remembered that even when informed consent has been obtained, a failure to maintain adequate details of the decision-making process will leave clinicians vulnerable if the validity of consent is challenged. A signed consent form is not proof of informed consent. It is one aspect of the recording of a service user’s consent

You must be able to record the rationale for any actions or recommendations taken following your assessment. Your records are your evidence of this and how any further action taken is in the individual’s best interests. You should follow your local policies and procedures. An example of this is shown in Appendix Three.

Your records need to demonstrate that you have provided enough information about your proposed intervention or action, including all options and possible risks. You need to ensure that this has been understood by the service user in order to make an informed and valid decision, whether to give or refuse consent.

You should also record the form in which consent is given, whether verbal, non-verbal or signed. If the gaining of consent is not recorded, you cannot state that consent was given.

The nature and degree of any risks must be documented: it is not enough to write, ‘advised of risks’. It should be immediately clear to any other person reading the records what information has, or has not, been given to the service user, along with any specific requests or concerns raised by the service user.

Where valid consent is refused or withdrawn you must respect this and record it in the records, while informing the service user of any possible risks or consequences of their decision.

Signed consent is only necessary where there is a greater risk to the service user, or your proposed intervention may have significant consequences for the service user’s employment, personal or social life (General Medical Council 2017). Where consent forms are used, be aware that they must enable you to enter all the necessary information.

A failure to obtain informed consent exposes practitioners to a real risk of criminal or civil liability and to a risk of action against their registration by the Health and Care Professions Council (HCPC) your regulatory body.

## Making decisions when a service user lacks capacity

In making decisions about the treatment and care for service users who lack capacity, you must ensure the following:

* make the care of your patient your first concern
* treat patients as individuals and respect their dignity
* support and encourage patients to be involved, as far as they want to and are able, in decisions about their treatment and care
* treat patients with respect and not discriminate against them
* document in the notes that treatment was conducted in the individual’s best interests, with agreement from other health care professionals (who should be named in the clinical notes, with their professional title included), or the name and relation of any family members/guardian/power of attorney who may be present

You must also consider the following:

* whether the patient’s lack of capacity is temporary or permanent
* what you and the rest of the healthcare team know about the patient’s wishes, feelings, beliefs, and values
* any evidence of the patient’s previously expressed preferences, such as an advance statement or decision
* the views of anyone the service user asks you to consult, or who has legal authority to make a decision on their behalf, or has been appointed to represent them
* the views of people close to the service user on the patient’s preferences, feelings, beliefs, and values, and whether they consider the proposed treatment to be in the patient’s best interests
* which options for treatment would provide overall clinical benefit for the service user
* which option, including the option not to treat, would be least restrictive of the patient’s future choices

## Deprivation of liberty safeguards

The deprivation of liberty safeguards (DoLS) in England and Wales set out a framework whereby a person who lacks capacity to consent can be provided with care in a way that amounts to a deprivation of liberty. This can only happen if it is absolutely necessary and can only be done following a defined process. Your local authority will have guidance on the DoLS and your local processes to follow.

As a practitioner, you need to be aware when your practice may be affected by the DoLS and what you may need to do to be compliant. Seek training if you are unsure of your responsibilities. Your records must demonstrate your reasoning and the evidence upon which you make your judgements. If you are stating that a certain course of action, perhaps using particular equipment which will restrict liberty, is in the best interests of the service user, you must be able to justify this.

The Social Care Institute for Excellence (SCIE) website provides comprehensive guidance on deprivation of liberty safeguards for England and Wales.

<https://www.communitycare.co.uk/2019/05/16/dols-replacement-bill-becomes-law-ahead-expected-implementation-2020/>

## Comprehensive records

A court of law will adopt the approach that ‘if it is not recorded, it has not been done, has not been considered, or was not said’ (Lynch 2009, p 45). A record of all prosthetic and orthotic activity should be kept, including everything that is planned, done or occurs with, or on behalf of, your service users. You should also record your professional or clinical reasoning.

All communication and information relevant to the individual’s care, given and received, must be recorded.

You need to record the outcome of your practice, which means you need to identify the status of the service user and how it changes. This might include problems and any actions taken to resolve them.

Your records should not contain material that is of no value to the care of the individual, such as speculation, subjective statements or personal opinions.

## The Prosthetic and Orthotic best practice guidelines

Should another person be required to read your records, they should be able to identify the process that you have gone through and why. Keeping this process in mind will help you to demonstrate that you have performed your professional responsibilities to the standard expected of a reasonably skilled prosthetic and orthotic practitioner.

Your records are the evidence that you:

* understand and can properly use, record and interpret assessments.
* have agreed the service user’s objectives.
* have planned intervention based on the assessments, the service user’s objectives, available evidence, and sound professional judgement; and
* the outcomes of your intervention have been evaluated.

If you are in a diverse setting where keeping records is not common practice, you must still keep a record of your activity and the rationale for your actions, even if you do not have direct contact with service users. All interventions relating to an individual needs to be accurately documented even if the service user has not been seen in clinic (e.g., drop in repairs or adaptions).

## Professional/Clinical reasoning

You are required to record why you have chosen to carry out, or perhaps not carry out, a particular task or activity with, or on behalf of, a service user. You will probably be carrying out professional reasoning in your mind continually, for example, selecting suitable activities or equipment based on your assessments. You must record this process in your records so that your choice of actions is justified should it ever be questioned.

* **Goal attainment scaling**

Goal attainment scaling (GAS) is a method of scoring the extent to which a service user’s individual goals are achieved in the course of intervention. In effect, each client has their own outcome measure, but this is scored in a standardised way as to allow statistical analysis. Traditional standardised measures include a standard set of tasks (items) each rated on a standard level. In GAS, tasks are individually identified to suit the service user, and the levels are individually set around their current and expected levels of performance.

* **Outcome measures**

Outcome measures (OMs) is a term which describes various tools used to assess diverse aspects of health including physical ability, quality of life and pain. They commonly include clinical assessment procedures such as timed walking tests, and questionnaires. OMs, such as timed walking tests, are typically termed performance measures or Clinician Reported Outcome Measures (CROMs). Questionnaires completed by the service user are commonly termed Patient Reported Outcome Measures (PROMs). Obtaining outcome measures allow for a ratified method through which treatment/intervention efficacy can be measured.

It is essential that the effects of medical interventions, including prosthetic and orthotic care, are accurately assessed, and recorded. OMs are useful in assessment, clinical decision making and evidencing the outcomes of treatment to either the service user or third parties as well as facilitate clinical audit and research, providing an evidence base toward prosthetic and orthotic practice.

OMs should be clearly evidenced within notes taken so that the effect of intervention provided can be accurately identified and monitored.

You may wish to share outcomes of treatment with the initial refer or the service user’s GP, with their consent. Outcome report forms should be copied and held in correspondence sections of clinical records.

Further details regarding OMs in prosthetics and orthotics can be found on: <https://www.bapo.com/wp-content/uploads/2019/02/Measuring-Change-BAPO-website.pdf>

## Making Every Contact Count

Making Every Contact Count (MECC) is an approach to behaviour change that utilises the millions of day-to-day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations as well as leading on to social prescribing.

Your note keeping should document all MECC conversations help with services users in your care.

* **Social prescribing**

Social prescribing, sometimes referred to as ‘community referral’, is a means of enabling people to be referred to a range of local, non-clinical services.

Recognising that people’s health is determined by economic and environmental factors, social prescribing seeks to address people’s needs in a holistic way. It also aims to support people to take greater control of their own health.

All social prescribing discussions should be documented in the clinical notes, along with copies of any referrals made.

## Evidence-based care

Clinical records should show that the care provided is appropriate, in accordance with current best practice of the time and based on evidence, where evidence is available. There is a benefit to following national, professional, or local guidelines, procedures, or care pathways, etc. because the evidence base is integral to them and will be demonstrated in the record, but any variance must be explained.

## Official or unofficial discussions concerning a service user

Whenever a service user is discussed, in a team meeting, in the course of a phone call or even in an unplanned situation, the occurrence, the content and any outcomes of the discussion should be recorded in the clinical records. Decisions made in a team meeting, or as part of supervision, concerning the care provided to an individual are part of the care process. Such decisions need to be recorded.

## Frequent and repetitious activities or standard practice

Where activities are frequent and repetitious, it is tempting to think that minimal or no records are required. However, legally, if an activity is not recorded, it cannot be proven to have occurred. All activity should be recorded fully, including the activity, the rationale for it, the service user’s response, and any other outcomes. You must always record what you do for every service user, even if it is standard or routine practice. If you do not, you have no evidence that the action was done.

## Service user non-attendance

If a service user is unable to attend an appointment, or if a planned intervention does not occur, this should be recorded in the clinical records, with an explanation. Including this in the record demonstrates that the therapist’s planning and care was disrupted for unavoidable reasons, rather than being withheld, or not provided, because of disorganisation or incompetence.

Remember that some service users such as children, or those dependent upon carers may be reliant on others to attend appointments. In these scenarios non-attendance in clinic should be documented as ‘was not brought to clinic’. NB. These situations may trigger your need to consider safeguarding approaches and you should consult local safeguard leads for further guidance.

## Information provided to the service user

Any verbal or printed information or advice given to the service user, or their carer(s) should be appropriately recorded. It is not enough to write ‘Advice given’; the nature and level of information given should be documented.

## The source of information about a service user or their circumstances

It is important to record the source of any information gathered about the service user, especially if the accuracy of the information is uncertain, or circumstances around the individual’s care change. The information about the service user may have come from medical notes, another professional’s notes, from a carer or member of the family, or from the service user him or herself. If you are given information by a third party, you must record the source, worded as ‘reported by xxxxxx’, giving their full name and job title/role, with their contact details if possible. Choose your wording carefully. You do not know it to be fact, but you need to make others aware, especially if there may be risk involved. Remember it could be challenged by the service user.

## Recording the individuals present

There may be times when a prosthetist/orthotist sees the service user when others are present (for example, students, colleagues, family members).

The service user’s consent should be sought for this. Having others present may influence the nature of the care given; the conversation held if confidentiality is a concern; or it may have an impact on the effectiveness of care.

## Prosthetic and Orthotic prescriptions

Service users’ prescriptions should be maintained separately with the clinical notes. The clarity and legibility of these prescriptions need to be maintained to the same level as the clinical notes. These orders, along with any accompanying fitting notes, should be maintained in a chronological order, with any update of technical specification clearly documented in the clinical notes as well as being able to be clearly identified in the orders/prescriptions.

## Legibility

Written clinical records need to be legible in order to be safe and of any use. If care is delayed, miscommunication occurs, or a service user is ultimately harmed because your handwriting is illegible, you could be accused of professional negligence and be held liable as a result.

All hand-written notes should be written in permanent (non-erasable) black ink and readable when photocopied. Should any errors be made, small alterations can be scored out with a single line and must signed with the clinician’s initials. Any significant alterations must be readable, dated, timed, and signed by the clinician affecting these changes. At no time should correction fluid be used to make alterations.

## The use of acronyms and abbreviations

There is published evidence that a significant proportion of the acronyms used are either ambiguous or poorly understood, with many misinterpretations of the abbreviations across professions, posing imminent risk (Parvaiz et al 2008, Rees 2013).

The Nursing and Midwifery Council (NMC ca. 2015, section 10.4) and the Record Keeping Guidelines (NHS Professionals 2010, section 1.10) state that abbreviations should not be used in clinical records. That said, it is common practice to use these. Some key organisations, for example NHS Digital, have produced online glossaries for acronyms to attempt a common use and understanding (NHS Digital ca. 2016).

It is vital that all members of a care team can read and correctly understand the clinical records. Service users are entitled to access their records upon request and should be able to read and understand what is written in them. It should also be recognised that terms and acronyms may change over time and that these differ across service providers.

If you continue to use acronyms, the meaning must be unambiguous. Practitioners within services or teams should use a limited number of acronyms or abbreviations and should ensure that these are defined in full within each set of clinical records. This should be monitored and enforced. BAPO have created a list of approved and recognised acronyms, symbols, and units – See Appendix Three.

## Signing and countersigning record entries

When you sign a clinical record, or an entry is made into a digital record system under your access code/password, you are confirming that it is an accurate account of any communication, planning, intervention, or outcomes related to the care of an individual service user. Unless otherwise indicated, you are identifying yourself as the individual responsible for the action(s) defined in the record and for the entry itself. Thus, the person who carries out the intervention should be the person who writes/enters the record and signs the entry.

Your signature should be legible. It is essential that you are clearly and easily identifiable. Anyone making an entry to the records should be identifiable to another person reading the records at a later date. You should sign and print your name and give your designation when completing written entries, additions, and amendments to records.

If using digital records, each practitioner should have their own access code/password on the system. This should never be used by another practitioner. Local procedures should be in place for students and temporary staff.

All prosthetists and orthotists should know and follow their local policy on countersigning records. Unless local policy differs, you are required to countersign records created by orthotic students or therapy assistants and are responsible for ensuring the competence of any practitioner before you delegate any task to them, which includes keeping records.

## Timing and dating record entries

As with any aspect of care provided to an individual, the day and time that it occurred is important. Recording the date and time of an event demonstrates that your care was appropriate and as planned. It also enables monitoring of the frequency of care and the timeframe for the progress, or deterioration, of the service user. Should the care provided be examined at a later date, the time and date of an event may be a vital piece of evidence.

The date should be given in full, including the day, month, and year. The time should define morning or afternoon. The time and date given should reflect when the service user was seen, or an event occurred. If records are written retrospectively, the time must be given when the service user was seen, and a time and date given when the record was entered.

## Amending a record

A record can only be amended if there is an error. Inaccurate records can be amended but must not be deleted or destroyed.

If you disagree with another professional’s recording, it is suggested that you discuss this with the person, raising your concerns and giving your rationale. You must not change or delete another person’s records for any reason, unless you know and can justify that they are factually inaccurate.

Where the information given is inaccurate in written records, the material that is incorrect should be scored out with a single line, then signed, timed, and dated by the person who made the amendment. The original entry must remain and be clear to read. Similarly, a digital system should allow you to add to, or be re-directed from, any section which is shown to be inaccurate. Information should never be completely erased from a digital record, or over-written, but the system should automatically keep an audit trail of any changes: what was changed, when and by whom. The reason for the amendment should be given, for example, if the service user’s date of birth was entered incorrectly.

Under the Mental Health Act 1983 (Great Britain. Parliament 1983), there are limitations on what may be amended in mental health records, and errors may only be changed in specific circumstances. Clinicians working with people with mental health diagnoses should familiarise themselves with the relevant legislation.

The former National Information Governance Board (NIGB) for Health and Social Care provided guidance on requesting amendments to health and social care records (NIGB 2010) for when service users want information amended or removed from their records.

## Recording when asked not to

If a service user discloses information that may have an impact upon their, or another person’s care or safety, and then asks that this information is not recorded. The service user should be informed that the practitioner has a professional obligation to record the information. If, when warned that any disclosed information will be recorded, the service user chooses not to then share, this occurrence should also be recorded, in case it has future significance. You should consider sharing this information with your supervisor or another appropriate person.

If another member of staff asks you not to record information, the same principles apply.

Your professional responsibility to record should not be negatively influenced by another person. If you are concerned, you are advised to contact BAPO or the HCPC for further advice.

## Recording risk

Moving and handling assessments and equipment provision are a key part of some practitioners’ work. You are required to carry out a risk assessment in all moving and handling situations where there is potential risk of harm. You must record the outcomes of any risk assessments you carry out (identifying the hazard, the potential for harm and the action taken to control the risk), or any risk factors that you identify in the course of your work in the clinical records.

Information on generic and individual risk assessments in relation to moving and handling is available on the Health and Safety Executive (HSE) website (HSE n.d.).

Risk assessments applicable to modification or non-standard use of medical devices can be found on the BAPO website, entitled ‘MHRA Guidance’ (2019): <https://www.bapo.com/2019/07/12/mhra/>

## The use of hazard or violent warning markers

Where it is known that there is a potential hazard in relation to a particular service user or their environment, it is your responsibility to ensure that this information is shared and highlighted in records. Your employer will have a system for this, whether paper or digital systems of recording are used.

In 2006 the Information Commissioner’s Office produced a Data Protection Good Practice Note on the use of violent warning markers (ICO 2006). It emphasises that the use of markers must comply with the Data Protection Act. It provides guidance when trying to balance employee safety with fairness to service users. It is available to download from the Social Care Institute for Excellence website ([www.scie.org.uk](http://www.scie.org.uk)).

Training should be sought for new employees and students on the local use and understanding of hazard or violent warning markers.

## Recording medication

Named clinicians and therapists may, under Patient Group Directions, supply and administer limited medications. Registered and non-registered practitioners may give non-injectable prescribed medicines, provided they are suitably trained. The medicine must be given to the person that they were intended for, when this is strictly in accordance with the directions that the prescriber has given.

It is vital for you, if in this situation, to maintain clear, accurate and immediate records of all medicines administered, following local policy, and ensuring that you are clearly identified. Any decision not to supply prescribed medication, or any refusal to take supplied medication, should also be recorded and accompanied by a full explanation.

Where the task of collecting, transporting, or administering medicines has been delegated to you, the records must include the identity of the person delegating, the full details of any medication, the action taken and any outcomes.

The clinician must record full medication details at a service user’s initial appointment, with any changes recorded during subsequent contacts, regardless of whether you work within a service where medicines are administered. It might also be worth stating that access to the main hospital PAS system where all other records are held is essential.

## Discharge/case closure

You must record the point at which you discharge the service user, or close the case, and the reason why. This may be because the service user has met their objectives, has been transferred to another professional or service, refuses further input, or perhaps moves away. Any action which occurs after you discharge the individual must still be recorded (for example, a phone call from a service user with an enquiry).

## Timely record-keeping

It is vital that records are complete and accurate. The longer the time that has elapsed between an event occurring and it being recorded, the greater is the likelihood of inaccuracies or omissions in the records. Records should be written contemporaneously as soon as possible after the clinical activity/event or intervention has occurred (within 24 hours).

Some instances (e.g., is a service use in a palliative care setting informs they intend to follow a path of voluntary euthanasia or there are clinical signs of suicidal ideation) require the need to be recorded immediately, with relevant people in the care team involved. A delay in recording this type of information would not be acceptable in an enquiry or court of law.

During assessments and interviews, information may be shared by the service user that is important to the current and future care of the individual, including particular wishes or requests. It is important that such information is recorded promptly, to ensure that the information is shared as necessary and/or ongoing care is appropriate.

There are situations when events occur, or a record needs to be made when practitioners do not have access to the main clinical records. Practitioners should have access to appropriate means of recording information in various

settings.

This might be portable digital equipment for use in the community, or telephone message recording notebooks in an office. Any notes made, whether digital or on paper, become part of the clinical record and need to be treated as such in terms of confidentiality and security, for the time that they exist. The contents of the note should be transferred into the clinical records as soon as possible and with complete accuracy and consistency. Depending on its nature and format, the original note needs to be destroyed or kept securely if required.

As stated above, if records are written retrospectively, the time must be given when the service user was actually seen, or the event occurred. The date and time of recording should also be entered. If the delay is significant, an explanation should be given in the records.

## Making your record-keeping a priority

A concern is often raised that practitioners have insufficient time to complete their records in a timely way. This cannot be used as an excuse for failing to complete clinical records and would not be acceptable in an enquiry or court of law.

The keeping of records is an integral and equally important part of the delivery of care as any contact or activity time.

It is recognised that maintaining records which meet all the requirements takes time. Support should be given within a service to enable clinicians to complete their records in a timely manner. It may be possible to introduce systems and practices which facilitate more time-efficient working, but still maintain the standards, or it may be necessary to introduce protected time for the purpose of keeping records. Where an individual practitioner requires additional time or facilities to complete their records, perhaps due to dyslexia or other needs, this should be identified and accommodated.

## Clinical records content

All pages within a physical clinical record should be numbered. Physical notes must contain the following:

* Front sheet/Patient information section
* Patient addressograph stickers (comprising: Hospital number, surname, forename, and date of birth)
* Clinical notes section:
  + Medical history/Clinical assessment (maintained chronologically)
  + Progress notes (maintained chronologically)
  + Correspondence, Reports and Forms (maintained in chronological order)
  + Referrals
* Order history

When a new Front Sheet is added to the service user’s clinical records, all previous front sheets remain in the file and are scored out. These are maintained in reverse-chronological order (newest/most recent at the front of the record).

Pages need to be labelled and identified in such a manner in order to ensure that all notes are present in a clinical record and maintained in the correct order.

In order for clinical records to be maintained as up to date as practicable, all information relating to a service user’s records needs to be filed in a timely fashion. Any delay in submitting and securing pertinent service user information can lead to confusion and delays in therapy.

**Failure to complete and maintain clinical records**

Failure to complete records may be an indicator of a practitioner who is struggling in terms of their knowledge and skills, their attitude and confidence, or perhaps their personal wellbeing. Considering the clinical and legal responsibility that goes alongside any delegated task, the relevant supervisor should raise this as a concern in supervision, providing support when required.

A checklist for Prosthetic and Orthotic Clinical Records is available in Appendix Three.

**NB: Please be aware that failure to complete and maintain clinical records may invalidate indemnity insurances held by yourself, whether arranged personally, provided by your employer or BAPO.**

**The Handling and Management of Clinical Records**

Under the law, and in respect of your duty of care for your service users, all information must be held with due respect for your service users’ confidentiality, consent, right to access and overall best interest.

In some instances, there may be the requirement to duplication notes in order to ensure that inpatient notes are documented and maintained correctly and appropriately along with any departmental notes, if the two are held as separate entities. References should not be made for people to see an entry in another medical record – all information regarding clinical activity and interventions must therefore be maintained within one accessible document to allow the information to be accessed as required. It is the responsibility of the prosthetist/orthotist to ensure no treatment takes place before the patients note file is found in order to enable the status of the individual to be reviewed and confirmed and allow any intervention to be appropriately documented.

## Secure Storage of Clinical Records and Personal Data

All records, whether paper or digital, should be secure from opportunistic viewing, inappropriate access, theft, loss, or damage. Practitioners need to be aware that they have a responsibility for any records they create or use and have joint responsibility for shared records. Records may be kept within the department, room, or service responsible for the related work, but must always be kept securely. Storage equipment or facilities and data protection measures should be secure, but records should be accessible to those who need the information for their work.

In order to ensure all paper health records are complete, up-to-date, and filed/scanned in accordance with national and local protocols, loose sheets must not be included in clinical health records. Loose sheets must be kept securely until they can be either filed securely in the paper records or scanned on to an electronic health record as soon as possible by the department who created them.

The movement and location of all records should be controlled to ensure that a record can be retrieved at any time. When paper records are taken from the central storage there should be an auditable tracking system in place to ensure that they are not lost. If digital data is held on portable devices, including mobile phones, tablets, DVDs, or memory cards, they must also be trackable, or recorded and secure at all times. Personal data should always be secure and encrypted.

The tracking system should identify who is in possession of the records and where they are being taken. When transporting records, the principles of data protection remain. The information within the records must be kept safe, therefore practitioners should ensure they are not accessible to others outside of the direct care team, and that records in any format are not left unattended anywhere which is potentially insecure, for example, in a car. You should not hold information about your service users on your personal digital devices, including mobile phones or memory sticks. If you require such devices for your work, you should be supplied with them by your employer and you should follow local associated procedures. If you are self-employed, you will need to purchase devices specifically for your work.

If you are an independent practitioner with computer-held records or files, you

must ensure that no other person has access to the material you hold. You must

protect the information with suitable security and data protection. The Information Commissioner’s Office website has information on data protection for small or medium-sized businesses. It also has information on storing and transferring personal digital data.

## The use, transfer and security of digital images and films

Informed consent must be gained before any digital images or film are taken of a service user, whether by the practitioner or any other person present. The service user needs to understand why the image is being taken and what it will be used for. A record of any digital images or films made should be held. Check your local policy as written consent is usually required.

Digital images or film should be stored on a secure central system and not remain on any portable devices. They must be fully deleted on these. If you use social media or back-up sites, you must be sure that images do not automatically upload to them. Information on how to do this is widely available on the internet. You may only transfer an image or film to another professional or service with the service user’s informed consent. Any transfer must be done in a fully secure way. All personal data should be secure and encrypted when it becomes mobile.

There is nothing in law to say that a service user, or a parent of a child, cannot make a digital image or film, or a sound recording, of meetings or the care they receive. A practitioner should not be saying anything or providing any care that they do not wish to be recorded, unless the privacy and dignity of the service user is put at risk. A friend, carer or family member cannot make a digital image, film, or sound recording of a service user without their informed consent. In this situation, you are advised to discuss any implications of taking digital images or sound recordings. Ask what the image/film/recording is going to be used for. Work co-operatively, discussing how it might be a helpful way to remember any information or instructions given. If you are at all concerned that there may be any elements of risk, for example for vulnerable adults or children, or the confidentiality of the information may be in question, you are advised to stop the intervention/meeting and seek help/advice from your employer or seek legal advice.

If you are an independent practitioner, you may wish to consider what you would do in a situation like this before it arises. You may find it helpful to have a policy and consent form which you can use as standard practice, if required. There is some information for small business on data protection and digital security on the Information Commissioner’s Office website (ICO n.d.).

## Retention of records

The Data Protection Act 2018 states that records should not be held for longer than is necessary to fulfil the purpose of the record. The length of time a record is held depends upon the nature of the record, the person concerned and the nature of their condition or circumstances.

The Information Governance Alliance for England has produced the Records management code of practice for health and social care 2016, which includes a general retention schedule. It is now common practice for local authorities and health providers to define and produce their own schedules, which are available online.

Practitioners can gain advice from their local data or information manager on the retention or destruction of clinical records. The Information Commissioner’s Office website gives general information. If you are an independent practitioner, you are advised to seek legal advice, especially if there has been any adverse incident which may increase the risk of action being taken against you.

## Retention of diaries

Paper and digital diaries of health visitors, district nurses and allied health professionals should be retained for two years after the end of the year to which the diary relates, if the relevant service user-specific information is transferred to the service user’s clinical record. If the information is not transferred the diary must be kept for eight years (Information Governance Alliance 2016, p60).

Data from a digital diary must be transferred to a secure central system, where it can be stored for the relevant length of time. A diary should be kept for as long as necessary if it contains particular details concerning an ongoing enquiry or concern, for example, a service user complaint or incident. Advice should be sought from those leading the enquiry or looking into the concern.

**Always remember the 5 Ss of Information Governance:**

**Save it, Secure it, Share it appropriately, Meet the Standards and Use the Support**

An infographic regarding health records maintenance is available in Appendix Four.

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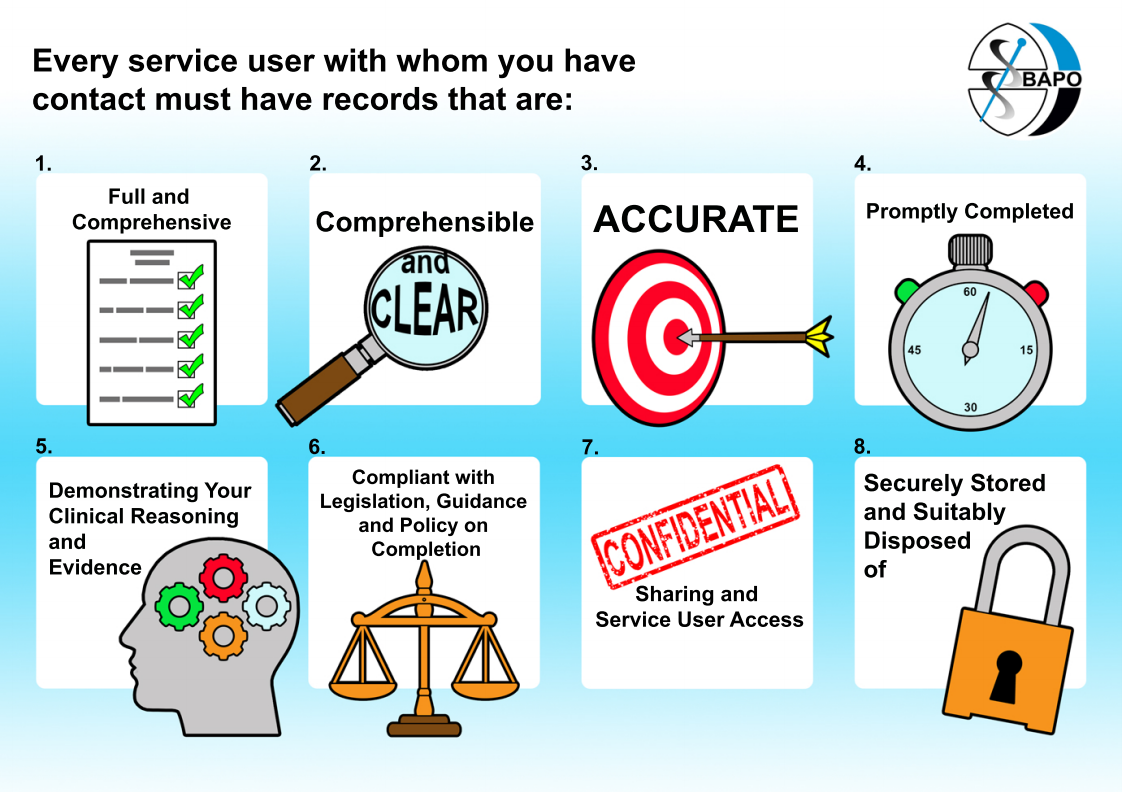
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**Appendix One**

**Infographic of Key Elements Identifying the Necessary Elements of Quality Required of Clinical Notes**

The following guide displays the key words that identify the necessary elements of quality which every service user with whom you have contact must have with regard their clinical records.



**Appendix Two**

# List of Abbreviations, Symbols, Units and Glossary

The following list of abbreviations, symbols, units and glossary have been compiled. In order to use these, you must comply with the standards and requirements set out by the sources referenced.

**List of Abbreviations**

**3Ns** Nystagmus, nausea and other neurological symptoms

**3PP** Three point pressure

**5Ds** Dizziness, diplopia, drop attacks, dysphagia and dysarthria

**10MWT** 10 metre walk test

**// bars** Parallel bars

**A&E** Accident and Emergency

**AAA** Abdominal aortic aneurysm

**AAAFO** Ankle of the ankle in the AFO

**AAC** Alternative and Augmentive Communication Service

**AAU** Acute Assessment Unit

**ABC** Activities-specific Balance Confidence Scale

**Abd(n)** Abduction

**ABPI** Ankle-brachial pressure index

**Accom** Accommodate/Accommodative

**Accomn** Accommodation

**ACCORD** Action to control cardiovascular risk in diabetes

**ACJ** Acromioclavicular joint

**ACL** Anterior cruciate ligament

**ACS** Acute coronary syndrome

**ACS** Assistive Communications Service

**Add(n)** Adduction

**ADHD** Attention deficit hyperactivity disorder

**ADL** Activities of daily living

**Admin** Administration

**AEA** Above elbow amputation

**AED** Antiepileptic drugs

**AF** Atrial fibrillation

**AFO** Ankle Foot Orthosis

**A/g** Against

**AHP** Allied Healthcare Professional

**AIDS** Acquired immunodeficiency syndrome

**AIIS** Anterior inferior iliac spine

**AKA** Above Knee Amputation

**ALAC/ALAS** Artificial limb appliance centre/service

**ALD** Adrenoleukodystrophy

**ALS** Advanced life support

**ALS** Amyotrophic lateral sclerosis

**AM** Morning

**AMHP** Approved mental health professional

**ANA** Adult neuromuscular assessment

**ANR** Acute Neuro Rehabilitation

**AO1/AO2** Assistance of 1 / 2

**A/P** Anterior-posterior

**AP** Assistant practitioner

**Approx** Approximately

**Appt** Appointment

**AQP** Any qualified provider

**AROM** Active range of movement

**ART** Anti-retroviral therapy

**ARU** Amputee Rehablitation Unit

**AS** Ankylosing spoldylitis

**ASAP** As soon as possible

**ASD** Autistic Spectrum Disorder

**ASIS** Anterior superior iliac spine

**Assoc** Associated

**ATFL** Anterior talofibular ligament

**AUP** Acceptable usage policy

**AV** Atrioventricular

**AVN** Avascular necrosis

**Ax** Assessment

**BAL** Beach activity limb

**BAPO** British Association of Prosthetists and Orthotists

**BBIU** Blackheath Brain Injuries Unit

**BC / B.Cl** Bowley Close

**Bg** Background

**BKA** Below knee amputation

**B/L / Bilat** Bilateral

**BLESMA** British Limbless Ex-Servicemans’ Association

**BLS** Basic life support

**BMD** Bone mass density

**BMI** Body mass index

**BNF** British national formulary

**Botox** Botulinum toxin-A

**BP** Blood pressure

**B/P** Body powered

**BPA** Bio-psychosocial assessment

**BRAFO** Bed resting ankle foot orthosis

**BSL** British Sign Language

**BVC** Bi-valved cast

**C&C / C+C** Call and collect

**C&W** Chelsea and Westminster

**C (followed by number)** Cervical vertebra

**Ca** cancer

**CABG** Coronary artery bypass graft

**CAD** Coronary artery disease

**CAD-CAM** Computer aided design-Computer aided manufacture

**CAF** Common assessment framework

**CAG** Clinical academic group

**CAMHS** Child and adolescent mental health services

**CARE (Feet)** Check, assess, record, early referral

**CAU** Comprehensive/Clinical Assessment Unit

**CBT** Cognitive behavioural therapy

**CCF** Congestive cardiac failure

**CCG** Clinical Commissioning Group

**CCH** Care closer to home

**CCL** Compression class

**CCU** Coronary Care Unit

**CCT** Community care team

**CDH** Congenital dislocation of the hip

**CDU** Clinical Decisions Unit

**Cf** Compared to

**CF** Carbon fibre

**CFS** Chronic fatigue syndrome

**CHD** Coronary heart disease

**CHF** Congestive heart failure

**ChPR** Child protection register

**CIN** Child in need

**CIDP** Chronic inflammatory demyelinating polyneuropathy/polyradiculoneuropathy

**CKD** Chronic kidney disease

**C-Lateral** Contralateral

**CLI** Critical limb ischaemia

**CMCJ** Carpometacarpal joint

**CMHN** Community mental health nurse

**CMHTs** Community mental health teams

**CMT** Charcot Marie Tooth

**CN** Community nurse

**CNS** Central nervous system

**C/o** Complains of / Care of

**CO** Cervical orthosis/Collar

**COA** Charcot Osteoarthropathy

**Cons** Consultant

**Cont(d)** Continue(d)

**COPD** Chronic Obstructive Pulmonary Disease

**COW** Computer on wheels

**CP** Cerebral Palsy

**CPD** Continuing professional development

**CPN** Community Psychiatric Nurse

**CPP** Child protection plan

**CPR** Cardiopulmonary resuscitation

**CPR (feet*)*** Check Protect Refer

**CQC** Care Quality Commission

**CQUIN** Commissioning for Quality and Innovation

**CRE** Carbapenem-resistant Enterobacteriaceae infection

**CRO** Carbapenem resistant organisms

**CROM** Clinician reported outcome measure

**CROW** Charcot restraint orthotic walker

**CRP** C-reactive protein

**CRPS** Chronis regional pain syndrome

**CS** Check socket

**C-Spine** Cervical spine

**C-Stockings** Compression stockings

**CT 1-3** Core trainee

**CTEV** Congenital talipes equinovarus

**CTLSO** Cervical thoracic lumbar sacral orthosis

**CTO** Cervical thoracic orthosis

**CTS** Carpal tunnel syndrome

**CT Scan** Computerised axial tomography scan

**CVA** Cerebrovascular accident

**CVD** Cardiovascular disease

**CXR** Chest X-ray

**D&V** Diarrhoea and vomiting

**DaD** Dementia and delirium

**DAFO** Dynamic ankle foot orthosis

**DBB** Dennis Brown boots

**DBT** Dialectical behavior therapy

**D/C** Discussed

**D/Ch** Discharged

**DDA** Dynamic dorsiflexion assist

**DECS** Diabetic eye complication screening service

**Del** Delivered

**Dept** Department

**D/F / D/Flex** Dorsiflex

**DFC** Diabetic Foot Clinic

**D/Flexn** Dorsiflexion

**DFU** Diabetic foot ulcer

**DGH** Districtgeneral hospital

**DHoH** Deaf and hard of hearing

**DHSC** Department of Health and Social Care

**DHx / D/H** Drug history

**DHS** Dynamic hip screw

**DID** Dissociative identity disorder

**DIPJ** Distal interphalangeal joint

**DKD** Diabetes kidney disease

**DLE** Discoid lupus erythematosus

**DM** Diabetes mellitus

**DMD** Duchenne muscular dystrophy

**DN** District Nurse

**DNA** Did not attend

**DNR** Do not resuscitate

**DO** Digital orthosis

**DOB** Date of birth

**DPA** Data Protection Act

**DPN** Diabetes peripheral neuropathy

**Dr** Doctor

**DRS** Diabetic retinopathy screening

**DRUJ** Distal radioulnar joint

**DSHR** Double stance heel raise

**DSPB** Double swivel pelvic band

**DSU** Day Surgery Unit

**DToC** Delayed transfer of care

**DV** Domiciliary visit

**DVT** Deep vein thrombosis

**DUK** Diabetes UK

**D/W** Discussed with

**Dx** Diagnosis

**EB** Epidermolysis bullosa

**EB** End bearing

**EBH** Evidence-based healthcare

**EBM** Evidence-based medicine

**EC** Elbow crutch

**ECG** Electrocardiogram

**ED** Emergency Department

**EEG** Electro-encephalogram

**(e)GFR** (Estimated) glomerular filtration rate

**EMS** Emergency Medical Services

**EMS** Early morning stiffness

**ENT** Ear, nose and throat

**EoLC** End of life care

**EoR** End of range

**EPR** Electronic patient records

**ERP** End range pain

**ESD** Early supported discharge

**ESK** Endolite stabilised knee

**ESR** Energy storage and release

**ESRF** End stage renal failure

**Etc...** Et ceteraEv(n)Eversion

**EWHO** Elbow, wrist, hand orthosis

**EVA** [Ethylene-vinyl acetate](https://en.wikipedia.org/wiki/Ethylene-vinyl_acetate)

**Ex-Prem** Extremely premature

**Ext** External

**Extn** Extension

**Ext-Rot** External rotation

**F/A** Foot ankle

**FAB** Foot abduction brace

**FAS** Foetal alcohol syndrome

**FBC** Full blood count

**FCRU** Frank Cooksey Rehabilitation Unit

**FDL** Flexor digitorum longus

**FGM** Female genital mutilation

**F/Hx** **/ FH** Family history

**Fib** Fibula

**FIB** Foot impression box

**Flexn** Flexion

**FMS** Fine motor skills

**FoI** Freedom of Information

**FF** Forefoot

**FM** Fibromyalgia

**FMS** Fine motor skills

**Fn** Function

**F/Pad** Floating pad

**FPI** Foot posture index

**FPS/FPT** Foot protection service/team

**FROM** Full range of movement

**FSMD** Facioscapulohumeral mucular dystrophy

**FSTF** Free standing toilet frame

**FSU** Friends Stroke Unit

**FT** Foundation Trust

**FTA** Failure to attend

**F/U** Follow up

**F/W or F/Wear** Footwear

**FY 1/2** Foundation Year Doctor

**GA** General anaesthetic

**GAD-7** General anxiety disorder assessment

**GAS** Goal attainment scaling

**GALS** Gait, arms, legs and spine

**GBS** Guillain–Barré syndrome

**GCS** Glasgow coma scale

**GP** General Practitioner

**GPSI** GP with a special interest

**GHJ** Glenohumeral joint

**GI(T)** Gastrointestinal (tract)

**GMFCS** Gross motor function classification system

**GMFM** Gross motor function measure

**GMS** Gross motor skills

**GORD** Gastro-oesophageal reflux disease

**GOSH** Great Ormond Street Hospital

**GStT** Guy’s and St. Thomas’

**GUM** Genito-uninary medicine

**GVD** Generalied vascular disease

**H@H** Hospital at home service

**HA** Health authority

**HASU** Hyper acute stroke unit

**HAV** Hallux Abducto Valgus

**Hb** Haemoglobin

**HbA1C** Glycated haemoglobin

**HBV** Hepatitis B virus

**HCV** Hepatitis C virus

**HPB** High blood pressure

**HPV** Human Papillomavirus

**HCA** Healthcare Assistant

**HCAI** Healthcare-associated infection

**HCP** Healthcare professional

**HCPC** Health and Care Professions Council

**HCSW** Healthcare support worker

**HDA** Hip disarticulation amputation

**HDPz** High density plastazote

**HDU** High Dependency Unit

**H/e** However

**HEE** Health Education England

**HEP** Home exercise programme

**H.F.** Heart failure

**HF** Hindfoot

**HI** Head injury

**HIA** Health impact assessment

**HIN** Health Innovations Network

**HIS** Healthcare Information System

**HIV** Human immunodeficiency virus

**HLD** Hypersensitivity lung disease

**HMSN** Hereditary motor sensory neuropathy

**H/O** History of

**HO** House Officer

**HOKL** Hand operated knee lock

**HPV** Human papilloma virus

**Hr** Hour

**HRT** Hormone replacement therapy

**HS** Heel strike

**HSCIC** Health and Social Care Information Centre

**HSD** Heel-sole differential

**HSP** Hereditary spastic paraplegia

**HSW** healthcare support worker

**Ht** Height

**HTLV1** Human T-Cell lymphotropic virus-1 / Human T-cell leukemia virus type 1

**HTn** Hypertention

**HV** Health visitor / Home visit

**H/W** Herewith

**HWB** Health and wellbeing

**HWE** Healthwatch England

**Hx** History

**IAPT** Improving access to psychological therapies

**IBD** Irritable bowel disease

**IC** Initial contact

**ICP** Integrated care pathway

**ICT** information and communication technology

**ICT** Integrated care team

**ICU** Intensive Care Unit

**IDDM** Insulin dependent diabetes mellitus

**IDT** Interdisciplinary team

**IG** Information governance

**IGT** Impaired glucose tolerance

**IGTN** In growing toenail

**IHD** Ischaemic heart disease

**I-Lateral** Ipsilateral

**IMPaRTS** Integrating mental & physical healthcare: research, training & services

**I/M** Intramuscular

**Inv(n)** Inversion

**Inf** Inferior

**Int** Internal

**Int-Rot** Internal rotation

**IP or I/P** Inpatient

**IPC** Infection prevention and control

**IPJ** Interphalangeal joint

**I/Pt or In-Pt** Inpatient

**IR** Interventional Radiology

**IRQ** Inner range of quadriceps

**I/S** Inside

**ISKD** Intermedullary skeletal kinetic distraction

**ISPO** International Society of Prosthetics and Orthotics

**ISQ** In status quo (no change)

**ITB** Iliotibial band

**ITB Pump** Intrathecal Baclofen pump

**ITU** Intensive Treatment/Therapy Unit

**IUGR** intrauterine growth retardation/restriction

**IV** Intravenous

**IVI** Intravenous infusion

**IWGDF** International Working Group on the Diabetic Foot

**JIA** Juvenile idiopathic arthritis

**Jt** Joint

**JtC** Joint circumference

**JtW** Joint width

**KAFO** Knee ankle foot orthosis

**KC** Knee centre

**KCH** King’s College Hospital

**KDA** Knee disarticulation amputation

**KE** Knee extension

**KF** Knee flexion

**KHP** King’s Health Partners

**KO** Knee orthosis

**KPI** Key performance indicator(s)

**L or Lt** Left

**L (followed by number)** Lumbar vertebra

**L/Lg** Large

**LA** Local anaesthetic

**LA** Local authority

**LAC** Looked after child

**Lat** Lateral

**LBP** Low back pain

**LCL** Lateral collateral ligament

**LDs** Learning disabilities

**LDPz** Low density plastazote

**LGA** Local Government Association

**LITU** Liver Intensive Care Unit

**LFT** Liver function test

**LL or L.Limb** Lower limb

**LLD** Leg length discrepancy

**LOC** Loss of consciousness

**LoS** Length of stay

**LR** Loading response

**LTR** Long term review

**LSC** Lumbar sacral corset

**LSCB** Local safeguarding children board

**LSO** Lumbar sacral orthosis

**LSP** Local service provider

**L-Spine** Lumbar spine

**LSS** Lumbar sacral support

**LTC** Long term condition(s)

**M2M / MTM** Made to measure / Bespoke

**MECC** Make every contact count

**MH** Mental health

**M/L** Medio-lateral

**M/Med** Medium

**MAC** Movement Assessment Clinic

**MAU** Medical Assessment/Admission Unit

**Max** Maximum

**MC** Metacarpal

**MCA** Malignant middle cerebral artery

**MCA** Mental capacity act

**MCL** Medial collateral ligament

**MCM** Major congenital malformation

**MCPJ** Metacarpophalangeal joint

**MD** Muscular dystrophy

**MDC** Multidisciplinary clinic

**MDEVA** Medium density EVA

**MDM** Multidisciplinary meeting

**MDT** Multidisciplinary Team

**ME** Myalgic infarction (chronic fatigue syndrome)

**Med** Medial

**Met/MT** Metatarsal

**Mets** Metastases

**MG** Myasthenia gravis

**MHRA** Medicines and Healthcare Products Regulatory Agency

**MHx** Medical history

**MF** Midfoot

**M/F** Multiflex

**MI** Myocardial infarction

**Min** Minimum

**Mins** Minutes

**MIU** Minor Injuries Unit

**MJTHREADS Ca** Myocardiac infarction, jaundice, tuberculosis, hypertension, rheumatic fever, epilepsy, asthma, diabetes, stroke, cancer (treatment if so)

**MKL** Manual Knee Lock

**MLA** Medial longitudinal arch

**MND** Motor Neurone Disease

**MND** Motor Nerve Disease

**Mob** Mobility/Mobilisation

**MPT** Mid-patellar tendon

**MRI** Magnetic resonance imaging

**MRSA** Methicillin-resistant Staphylococcus aureus

**M.S.** Mid stance

**MS** Multiple Sclerosis

**MSC** Mary Sheridan Centre

**MSE** Mental state examination

**MSK** Musculoskeletal

**MTA** Metatarsus Adductus

**MTC** Major Trauma Centre

**MTH** Metatarsal head(s)

**MTJ** Midtarsal joint

**MUS** Medically unexplained symptoms

**Mvt** Movement

**MYO** Myoelectric

**N/A** Not applicable

**NAD** No abnormalities detected

**NaDIA** National Diabetes Inpatient Audit

**NAI** Non-accidental injury

**NB** Note well (from Latin: nota bene)

**NBI** No bony injury

**NBM** Nil by mouth

**NDA** National Diabetes Audit

**NDFA** National Diabetes Foot Care Audit

**NETT** Neuro-enhanced transitions team

**Neuro** Neurological

**NHS** National Health Service

**NHS-E** National Health Service England

**NICE** National Institute for Health and Care Excellence

**NIDDM** Non-insulin dependent diabetes mellitus

**NHS** National health service

**NMD** Neuro muscular disease

**NoF** Neck of femur

**Non-W/B** **/ NWB** Non weightbearing

**NP** New patient

**NPWT** Negative pressure wound therapy

**NRAS** National Rheumatoid Arthritis Society

**N/S** NeuroSurgical

**NSAID** Non-steroidal anti-inflammatory drug

**NSTEMI** Non-ST-elevation myocardial infarction  
**NWB** Non-weight-bearing

**N&V** nausea and vomiting

**O/A** On assessment

**OA** Osteoarthritis

**Obs** Observations

**Occ Health** Occupational health

**OCD** Obsessive compulsive disorder

**O/E** On examination

**OGD** Oesophago-gastro-duodenoscopy

**OI** Osteogenesis imperfecta

**OI** Osseous integration/Osseointegration

**OM** Osteoyelitis

**O/M** Outcome measures

**OOH** Out of hours

**OOM** Osteomalacia

**OP** Osteoporosis

**OP or O/P or O/Pt** Outpatient

**OPAS** Orthotic patient administration system

**OPAT** Outpatient parenteral antibiotic therapy

**OPD** Outpatient Department

**Opp** Opposition

**OPUS** Orthotic & Prosthetic User’s Survey

**O/Q** on questioning

**ORIF** Open reduction internal fixation

**Ortho** Orthopaedic

**O/S** Outside

**OT** Occupational Therapist

**OTC** Over the counter

**OTS** Off the shelf / Stock

**OWP** Open wounds policy

**P&N** Pins and needles

**PAD** Peripheral arterial disease

**PADL** Perconal activities of daily living

**PALS** Patient Advice and Liaison Service

**P.Bars** Parallel bars

**PBC** Practice-based commissioning

**PCL** Posterior cruciate ligament

**PCT** Primary Care Trust

**PD** Parkinson’s Disease

**PE** Pulmonary embolism

**PECD** Procedure explained consent denied

**PECG** Procedure explained consent gained

**PEG** Percutaneous endoscopic gastrostomy

**PFFD** Peripheral proximal focal deficiency

**PFJ** Patellofemoral joint

**PHE** Public Health England

**PHQ-2/PHQ-9** Patient health questionnaire

**PHR** Partial hip replacement

**Physio** Physiotherapist

**pGALS** paediatric gait, arms, legs and spine

**PICC Line** Peripherally inserted central catheter line

**PICU** Paediatric Intensive Care Unit

**PID** Prolapsed intervertebral disc

**PIdD** Person Identifiable Data

**PIIS** Posterior inferior iliac spine

**PIL** Patient information leaflet

**PiMs** Patient information management system

**PIPJ** Proximal interphalangeal joint

**PKR** Partial knee replacement

**Pl/Fasciitis** Plantar fasciitis

**Pl/Flex** Plantarflex

**PlFlexn** **/ PF** Plantarflexion

**Pl/Grade / PG** Plantigrade

**PLS** Posterior Leaf Spring AFO

**PN** Practice Nurse

**PN** Peripheral neuropathy or Painful neuropathy  
**PNS** Peripheral nervous system

**PNS** Patient not seen

**POHO** Post-operative hip orthosis

**POMR** Problem oriented medical records

**PoP** Plaster of Paris

**PPAM Aid** Pneumatic post-amputation mobility aid

**PPG** Patient Participation Group

**PPn** Prescription

**PPS** Post-polio syndrome

**Pr** Pair

**PRAFO** Pressure relieving ankle foot orthosis

**Prem** Premature

**pREMS** Paediatric regional examination of the musculoskeletal system

**Pron(n)** Pronation

**PROM** Passive range of movement

**PROMs** Patient-reported outcome measures

**Pros** Prosthetist

**Prox** Proximal

**PRUH** Princess Royal University Hospital

**PsA** Psoriatic arthritis

**PSIS** Posterior superior iliac spine

**Pt** Patient

**PTA** Physiotherapy assistant

**PTB** Patellar tendon bearing

**PTO** Please turn over

**PTSD** Post traumatic stress disorder

**PTTD** Posterior tibial tendon dysfunction

**PTTI** Physiotherapy Technical Instuctor

**PU** Pressure ulcer

**PVD** Peripheral vascular disease

**PWB** Partial weightbearing

**QEH** Queen Elizabeth Hospital

**QMH** Queen Mary’s Hospital

**QOF** Quality and Outcomes Framework

**QoL** Quality of life

**QoM** Quality of motion

**R or Rt** Right

**RA** Rheumatoid arthritis

**RCA** Route cause analysis

**RCL** Radial collateral ligament

**RD** Radial deviation

**ReAx** Reassess

**Ref** Referral / Refer

**Rehab** Rehabilitation

**Reps** Repetitions

**REMS** Regional examination of the musculoskeletal system

**Req** Require(d) / Request(ed)

**Rev** Review

**R/F** Rollator frame

**Rheum** Rheumatology

**RN** Registered Nurse

**ROM** Range of movement

**Rotn** Rotation

**RCSP** Resting calcaneal stance position

**RPB** Rigid pelvic band

**RRR** Recovery, rehabilitation and reablement

**RSI** Repetitive strain injury

**RSS** Roehampton Silesian suspension

**RTA** road traffic accident

**RTT** Referral to treatment

**R/U** Radioulnar

**R/V** Review

**Rx** Prescription

**S/Sm** Small

**SAB** Shank angle to bench

**SACH** Solid ankle cushion heel

**SAD** Seasonal affective disorder, or Subacromial decompression

**SAFO** Solid/Silicone ankle foot orthosis

**SAKL** Semi-automatic knee lock

**SALT** Speech and Language Therapy

**SAN** Sensory ataxia neuropathy

**SARS** Severe acute respiratory syndrome

**SAU** Surgical Assessment Unit

**SB** Spina bifida

**SC** Supracondylar

**S/C** Subcutaneous

**SCB** Scotchcast boot

**SCF** Semi compressed felt

**SCI** Spinal cord injury

**SCJ** Sternoclavicular joint

**SCR** Secondary care record

**SCS** Socket comfort score

**SDO** Sensory dynamic orthosis

**SEN** Special education needs

**SFA** Superficial femoral artery

**SFS** Supplied from stock

**SH** Short heel

**S/H / S.House** Sunshine House

**SHO** Senior house officer

**SHx** Social history

**SiAFO** Silicone ankle foot orthosis

**SIJ** Sacroiliac joint

**Skt** Socket

**SLA** Service level agreement

**SLaM** South London and Maudsley Trust

**SLE** Systemic lupus erythematosus

**SLR** Straight leg raise

**SLS** Single leg stance

**Snr** Senior

**SO** Shoulder orthosis

**SOAP** Subjective, objective, analysis/action, plan

**SOB** Shortness of breath

**SOBOE** Shortness of breath on exertion

**SoC** Standard of care

**SOCRATES** Site, onset, character, radiation, alleviating factors, timing, exacerbating factors, severity

**SOEOB** Sitting on edge of bed

**SOL** Space occupying lesion

**S/Pad** Soft pad

**SLAM** South London and Maudsley NHS Trust

**SLE** Systemic lupus erythematosus

**SMA** Spinal muscular atrophy

**SMAFO** Supra malleolar ankle foot orthosis

**SN / StN** Sternal notch

**SSHR** Single stance heel raise

**S/Skt** Suction socket

**ST** Sustentaculum tali

**S/T** Short term

**ST 4-6** Speciality trainee

**Std** Standard

**STI** Sexually transmitted infection

**S.Ti** Soft tissue

**STIA** Stroke or transient ischemic attack

**STJ** Subtalar joint

**STN** Subtalar neutral

**STP** Sustainability and Transformation Partnership

**StR** Speciality Doctor

**STS** Sit to stand

**Sup** Superior

**Supn(n)** Supination

**Supv** Supervision

**SVA** Shank to vertical angle

**S.W.** Social worker

**T (followed by number)** Thoracic vertebra

**T1DM** Type 1 diabetes mellitus

**T2DM** Type 2 diabetes mellitus

**TA** Tendo Achilles

**TB** Tuberculosis

**T/C** Telephone call

**TCC** Total contact cast

**TCI** Total contact insole

**TCJ** Talocrural joint

**Tech** Technician

**Tel** Telephone

**Temp(s)** Temperature(s)

**TENS** Transcutaneous electrical nerve stimulation

**TES** Total elastic suspension

**T/F** Transfer

**TFL** Tensor fasciae latae

**TFA** Transfemoral amputation

**TFL** Tensor fascia lata

**THA** Transhumeral amputation

**THA** Through hip amputation

**THR** Total hip replacement

**THREADS** Thyroid, hypertension, rheumatoid arthritis, epilepsy, asthma, diabetes, and stroke

**TIA** Transient ischaemic attack

**Tib** Tibia

**Tib post** Tibialis posterior

**TKA** Through knee amputation

**TKR** Total knee replacement

**TLOC** Temporary loss of consciousness

**TMJ** Temporomandibular joint

**TLSO** Thoracic lumbar sacral orthosis

**TO** Toe off

**ToP** Tender on palpation

**TRA** Trans-radial amputation

**T-Spine** Thoracic spine

**TS** Terminal stance

**TSF** Taylor special frame

**TShR** Total shoulder replacement

**TTA** Trans tibial amputation

**TTA** To take away (medication)

**TUAG** Timed up and go test

**TWB** Touch weightbearing

**Tx** Transfer

**UC** Ulcerative colitis

**UCL** Ulnar collateral ligament

**UD** Ulnar deviation

**UK** United Kingdom

**UL or U.Limb** Upper limb

**USA** United States of America

**USGI** Ultrasound-guided injection

**USS** Ultra sound scan

**UTA** Unable to attend

**UTI** Urinary tract infection

**V.** Very

**VAS** Visual analogue scale (units x/10)

**Vasc** Vascular

**VCG** Verbal consent given

**VI** Visual impairment

**VL** Vastus lateralis

**VMO** Vastus medialis oblique

**VRE** Vancomycin-resistant enterococci

**VTE** Venous thromboembolism

**VV(s)** Varicose veins

**W/B** Weightbearing

**WC** Water closet/toilet

**W/Ch** Wheelchair

**WHC** Wrist hand complex

**WHO** Wrist hand orthosis

**WHO** World Health Organisation

**WHTO** Wrist hand thumb orthosis

**WIS** Walking Impact Scale

**WNL** Within normal limits

**W/O** Without

**W/Shop** Workshop

**WT** Weight

**X** Number of repetitions

**XP** Xiphoid process

**XS** Extra small

**XL** Extra large

**Yr** Year

**Z/F** Zimmer frame

**Approved Symbols**

**>** Greater than

**<** Less than

**≥** Greater than or equal to

**≤** Less than or equal to

**=** Equals / Equivalent to

**&** And

**@** At

**→** Leading to

↑Increase

↓Decrease

**#** Fracture / Number

**≈** Approximately

**1/365 or 1/7** 1 day

**1/52** 1 week  
**1/12** 1 month

**x/40** Weeks of pregnancy

**¼** Quarter

Third

**½** Half

° Degree

**1°** Primary

**2°**Secondary

**1st** First

**2nd** Second

**?** Query

,, or  Bilateral

 or  Right

 or  Left

**+/-** With or without  
**ć** With

♀Female

♂Male

**+ve** Positive

**-ve** Negative

**+** Plus

**-** Minus

∵ Due to / Because of

Therefore

**dd/mm/yyyy** Date format

**Approved Units**

**x/5** Oxford scale

**cm** Centimetres

**g** Gram

**In / ”** Inches

**kg** Kilogram

**km** Kilometre

**m** Metres

**mm** Millimetres

**mmHg** Millimetres of mercury

**+** Present/noted

**++** Present significantly

**+++** Present in excess

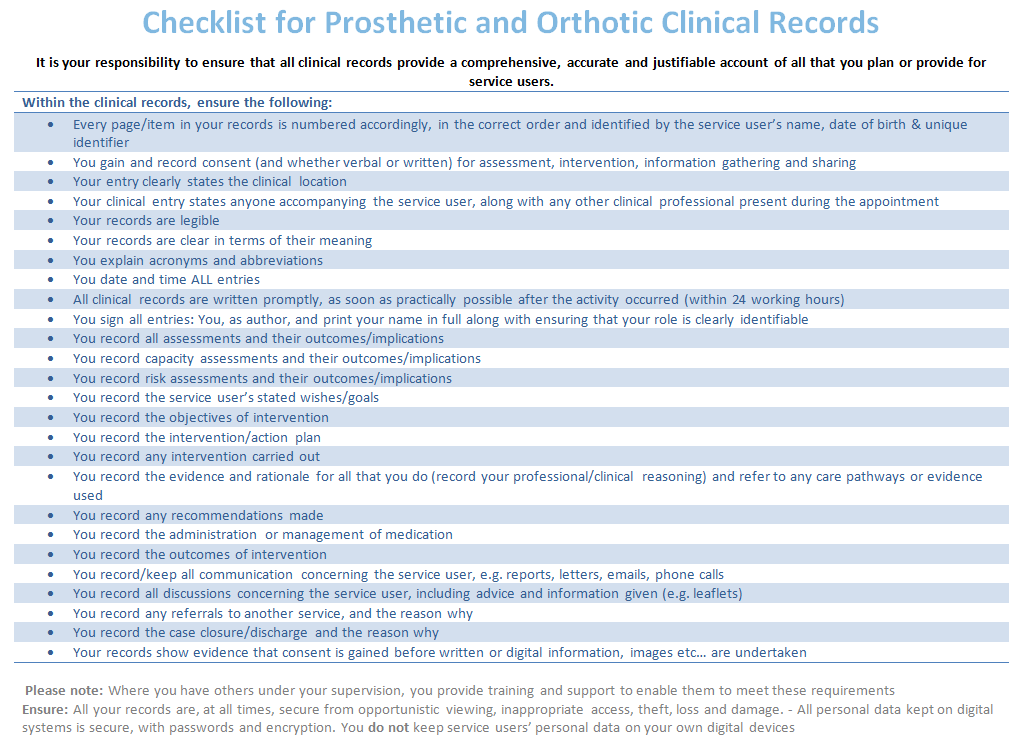
**Glossary**

|  |  |
| --- | --- |
| **Acute Care** | A branch of secondary health care where a patient receives active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. In medical terms, care for acute health conditions is the opposite from chronic care, or longer-term care. |
| **Antenatal Care (Maternity)** | The care patient receives from healthcare professionals during pregnancy. The purpose of antenatal care is to monitor the patient health, the baby’s health and support the patients to make plans which are right for them. |
| **Ambulatory Care** | Health services provided on an outpatient basis to those who visit a hospital or other healthcare facility and depart after treatment on the same day. PHR Partial hip replacement |
| **Contemporaneous Notes** | Notes which are made at the time or shortly after an event occurs in order to represent the best recollection of what was witnessed.  (The legal definition of ‘contemporaneous’ is Events which occur at the same time or very proximate to each other.) |
| **Commissioning** | A continual process of analysing the needs of the community, designing pathways of care then specifying and buying services that will deliver and improved agreed health and social outcomes within the resources available. |
| **Day Surgery** | Minor surgery that does not require the patient to stay in hospital overnight. |
| **Dermatology** | The branch of medicine concerned with the diagnosis and treatment of skin disorders. |
| **District Nurses** | Are senior nurses in the United Kingdom's National Health Service who manage care within the community, leading teams of community nurses and support workers, as well as visiting house-bound patients to provide advice and care such as palliative care, wound management. |
| **Diagnostic Tests** | Blood or urine tests, X-rays, ultrasound, and other imaging techniques that help clinicians see what is happening inside the body to help them diagnose a patient condition. |
| **Emergency Care** | An immediate response to time critical health care need. |
| **End of Life Care** | An important part of palliative care for people who are nearing the end of their life. End of life care is for people who are considered to be in the last year of life, but this timeframe can be difficult to predict. |
| **Equality Act** | Passed in 1995, this law makes it illegal to offer a public service which is inaccessible to someone because of their physical or learning disabilities. |
| **Follow-up** | A second or subsequent appointment to check on the outcome of a treatment plan. |
| **In-patients Care** | Provided in a hospital where patient will stay overnight at least one night. |
| **Integrated Care Pathway** | A multidisciplinary outline of anticipated care, placed in an appropriate timeframe, to help a patient with a specific condition |
| **Minor Injuries Unit** | A hospital department in the UK largely staffed by emergency nurse practitioners (ENPs) working autonomously looking after minor injuries such as lacerations and fractures and have access to X-ray facilities. |
| **Musculoskeletal (MSK) Service** | Care of conditions related to body muscles, bones, and joint mobility. |
| **NHS Clinical Commissioners** | This is the membership organisation of clinical commissioning groups. Their job is to help get the best healthcare and health outcomes for their local communities and patients. |
| **‘One Stop’ Care Model** | One stop shop is the Outpatient model to which EKHUFT aspire. They are designed to allow us to reduce appointments and create opportunities for getting consultations, diagnostic tests, and treatment plan all in one appointment. For surgical patients it will also include pre assessment and agreement of operation date. |
| **Ophthalmology** | The branch of medicine that deals with the anatomy, physiology, and diseases of the eye. |
| **Option Appraisal** | Comparing key points about several alternatives to guide a choice that ensures agreed objectives are met as close as possible. |
| **Orthosis** | An externally applied device which is used to modify the structural or functional characteristics of the neuromuscular skeletal system |
| **Orthotist** | Autonomous registered practitioners who provide gait analysis and engineering solutions to patients with problems of the neuro, muscular and skeletal systems. They are extensively trained at undergraduate level in mechanics, biomechanics, and material science along with anatomy, physiology, and pathophysiology. Their qualifications make them competent to design and provide orthoses that modify the structural or functional characteristics of the patients' neuro-muscular and skeletal systems enabling patients to mobilise, eliminate gait deviations, reduce falls, reduce pain, prevent, and facilitate healing of ulcers. They are also qualified to modify CE marked Orthoses or componentry taking responsibility for the impact of any changes. They treat patients with a wide range of conditions including Diabetes, Arthritis, Cerebral Palsy, Stroke, Spina Bifida, Scoliosis, MSK, sports injuries and trauma. Whilst they often work as autonomous practitioners, they increasingly often form part of multidisciplinary teams such as within the diabetic foot team or neuro-rehabilitation team. |
| **Outpatients Care** | Provided in a hospital or at a freestanding surgery centre. Afterward patients are released to recuperate at home. |
| **Paramedics** | The senior healthcare professional at an accident or a medical emergency. Working on their own, or with an emergency care assistant or ambulance technician, they assess the patient’s condition and give essential treatment. |
| **Palliative Care** | Care for people living with a terminal illness where a cure is no longer possible. It’s also for people who have a complex illness and need their symptoms controlled. |
| **Patient Discharge** | To inform patient officially that he/she can or must leave the hospital. |
| **Pre-assessment Tests** | Checks made by a nurse before patient has an operation or other healthcare procedure. |
| **Primary Care** | The day-to-day health care given by a health care provider. Typically, this provider acts as the first contact and principal point of continuing care for patients within a health care system, and coordinates other specialist care that the patient may need |
| **Prosthetists** | Autonomous registered practitioners who provide gait analysis and engineering solutions to patients with limb loss. They are extensively trained at undergraduate level in mechanics, biomechanics, and material science along with anatomy, physiology, and pathophysiology. Their qualifications make them competent to design and provide prostheses that replicate the structural or functional characteristics of the patients absent limb. They are also qualified to modify CE marked prostheses or componentry taking responsibility for the impact of any changes. They treat patients with congenital loss as well as loss due to diabetes, reduced vascularity, infection, and trauma. Military personnel are forming an increasing part of their caseload. Whilst they are autonomous practitioners they usually work closely with physiotherapists and occupational therapists as part of multidisciplinary amputee rehabilitation teams. |
| **Pharmacy Outlet** | A chemist’s shop which dispenses prescription |
| **Rheumatoid Arthritis** | Rheumatoid arthritis (RA) is where the joints of the body become inflamed and cause pain and tenderness. |
| **Self-care and Preventative Activities** | Includes any intentional actions patient takes to care for their physical, mental, and emotional health. |
| **Social Prescribing** | Social prescribing, also sometimes referred to as community referral, is a means of enabling people to be referred to a range of local, non-clinical services.  Recognising that people’s health is determined by economic and environmental factors, social prescribing seeks to address people’s needs in a holistic way. It also aims to support people to take greater control of their own health.  Social prescribing can meet a wide range of needs, with many schemes aiming to improve mental health and physical wellbeing. It can be used to support adults, young people and children as well as people with learning disabilities or mental health problems. It can be used in primary and secondary care. Social prescribing can also help to address social issues such as debt, unemployment, gambling, and loneliness.  Examples of schemes include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports.  (Source: <https://www.rsph.org.uk/our-work/resources/ahp-social-prescribing-frameworks.html>) |
| **Specialist Care** | Care for people with severe health conditions in a specialist hospital. Very small number of patients needs this type of emergency or complex care. |
| **Stroke** | A "brain attack". It can happen to anyone at any time. It occurs when blood flow to an area of brain is cut off. When this happens, brain cells are deprived of oxygen and begin to die. When brain cells die during a stroke, abilities controlled by that area of the brain such as memory and muscle control are lost. |
| **Surgery** | The specialty of medicine that treats diseases and disorders by cutting, removing, or changing the body with an operative procedure. Surgery could either be minor or major. |
| **Telemedicine** | Use of new technology to help clinicians to discuss a patient access to relevant medical images and information |
| **Tiers of Care** | Tiered model of care seeks to match intensity and acuity of the problem to the intensity and acuity of the treatment; primary care plays a key role in these models |
| **Therapy** | Treatment that helps patient regains their ability to carry out tasks of daily leaving. |
| **Unscheduled Care** | Involve services that are available for the public to access without prior arrangement where there is an urgent actual or perceived need for intervention by a health or social care professional |
| **Urgent Care** | The response before the next in–hours or routine (primary care) service is available |
| **Vascular Disease** | Includes any condition that affects the circulatory system, such as peripheral artery disease. This ranges from diseases of the arteries, veins and lymph vessels to blood disorders that affect circulation |
| **Walk-in Centres** | Are staffed by teams of nurse practitioners who provide treatment and advice for patients on a range of minor illnesses and injuries, without an appointment. |
| **Women’s Health** | Health issues specific to female anatomy. |

**Appendix Three**

# Checklist for Prosthetic and Orthotic Clinical Records

The following checklist can be used as a reference to ensure clinical records are maintained appropriately, with comprehensive, accurate and justifiable documentation included.



**Appendix Four**

**Health Records Maintenance Guide Infographic**

The following guide displays the key elements required for maintaining clinical records.

This document was adapted from Health Records Maintenance Guide produced by Guy’s & St. Thomas’ NHS Foundation Trust, with kind permission.

