A comprehensive guide to clinical record keeping, data protection, confidentiality, and consent

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"Record keeping is an integral part of orthotic and prosthetic practice and writing clinical records is mandatory for all service user 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)

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.

Executive summary

This comprehensive guide, produced by the British Association of Prosthetics and Orthotics (BAPO), provides detailed standards and guidance for clinical record keeping, data protection, confidentiality, and consent within the prosthetic and orthotic profession. It is designed to support clinicians in meeting professional, legal, and ethical requirements in their daily practice.

The guide underscores the importance of accurate, timely, and comprehensive clinical records as a fundamental aspect of safe, effective, and lawful healthcare delivery. It aligns closely with Health and Care Professions Council (HCPC) requirements and national legislation such as the Data Protection Act (2018), GDPR, the Mental Capacity Act (2005), and the Human Rights Act (1998).

Key topics include:

Clinical governance and record-keeping responsibilities as part of professional duty of care.

Legal and policy frameworks, including confidentiality laws, data access rights, and the Caldicott Principles for information sharing.

Best practices in documentation, covering essential components such as informed consent, clinical reasoning, assessment findings, treatment plans, and outcomes.

Consent and capacity, with practical guidance on gaining and recording valid consent, especially for children, vulnerable adults, and those lacking capacity.

Standards for secure storage, retention, and access to health records, with specific recommendations for digital and paper-based systems.

Delegation and supervision responsibilities, particularly in training environments, to ensure appropriate oversight of learners and junior staff.

The document also includes checklists and appendices to support compliance and promote consistency across clinical settings. It reinforces the principle that "if it is not recorded, it has not been done," emphasising the role of documentation in legal defence, clinical audit, and quality improvement.

Ultimately, this guide sets a clear benchmark for record keeping that ensures accountability, enhances service user safety, and protects both the service user and practitioner.

Clinical governance

Clinical governance is about the quality and safety of service user 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 healthcare to service users.

1. Clinical audit
2. Risk management
3. Education, training, continuing personal, and professional development
4. Clinical effectiveness
5. Information management
6. Client/service user experience and involvement
7. Staffing and staff management

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 clinicians in health, social, and community care, education, and research. It is a requirement as part of your duty of care, and must be completed according to Professional, statutory and regulatory body (PSRB) requirements.

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 prosthetists/orthotists will be referred to as 'clinical records' and encompass those kept in all settings. People who receive prosthetic and/or orthotic intervention are called 'service users'. 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 several key principles to underpin good clinical records and good record keeping. A fundamental principle is that all clinical records and results must always be accessible to the prosthetist/orthotist and all other health professionals involved in service user provision.

For further information please refer to **Intra NHS Scotland Information Sharing Accord**, **Meeting the Requirements Information Sharing NHS Wales**, and **Northern Ireland Code of Practice on Protecting the Confidentiality of Service User Information**.

> ***"All prosthetists and orthotists involved in the care of service users must have timely access to their clinical records. Employment status should not hinder access to these records. Specifically, prosthetists and orthotists contracted to provide prosthetic and orthotic services to NHS service users must be granted the same level of access to clinical notes as those employed directly by the NHS."***

Keeping records as part of your duty of care

Accurate clinical records act as evidence that an individual healthcare professional 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 clinician. 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 contains information regarding an individual, collected as part of their care provision. Such material can be handwritten, digital, auditory, or visual, and includes data held on a computer, a tablet, or mobile phone. It includes 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, intervention 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 and outcomes, service planning, and business decision-making. In these situations, care should be taken to anonymise data to reduce the risks of inappropriate disclosure and to maintain confidentiality.

Clinical records may also provide documentary evidence in an investigation or court of law.

Clinical records are also a record of your interaction with the service user that can be used as evidence should your work ever be questioned. They define and explain the work that you do as a prosthetist/orthotist in your particular role.

Legislation, standards, and policy related to keeping clinical records

This guidance does not discuss local clinical record keeping requirements. It only identifies and discusses some of the more universal pieces of legislation that apply to clinical record keeping across the UK. BAPO encourage all members to seek out specific guidance for their locality via their Trust / Health board or private employer.

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 prosthetist/orthotist, you are advised to put in place your own policies which are compatible with legislation, your professional body 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.

Guides, standards, and codes of practice produced 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, higher education institutes, 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 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-information-governance-review

Confidentiality, information sharing, and consent to share information

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 HCPC have a document entitled **Consent and Confidentiality** (updated in 2024) 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 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.

Staff and learners are only authorised to access records of service users with whom they have a legitimate relationship, that is those to whom they are currently providing some kind of care.

Accessing a service user's record without a legitimate relationship is a breach of the *Data Protection Act 1998*, and leaves the offender liable to disciplinary action by the employer and the Health and Care Professions Council.

Service users need to be made aware that they have the right to object to the sharing of information with other members of the healthcare team.

Whenever disclosing information, for example when writing to a colleague, you should let the service user know what is happening and what information that you intend to share. When seeking express consent for disclosure, you must make sure that the individual is given enough information on which to base their informed decision. They will need to know the reasons for the disclosure, the likely consequences of disclosure, and potential consequences of withholding the information. It should be explained how much information will be disclosed and to whom it will be given. This transparency is important to allow the service user the opportunity to raise any objections. This helps to ensure the individual's rights are respected. This discussion and outcome should be documented in the clinical notes.

If a person lacks capacity to decide and provide consent, 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 (known as power of attorney in Scotland), 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'. In these cases, only as much information as is needed to support their care should be disclosed, considering any previously documented expressed wishes, and be informed by the views of relatives or carers as to the likely wishes of the individual.

Each individual situation needs to be judged on its merits in awareness of the obligations of the Mental Capacity Act, with care taken to avoid breaching confidentiality or creating difficulties for the service user. Decisions and justifications of disclosure should be recorded in the clinical notes.

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 healthcare professionals to share early information. It aims to ensure that children and families are getting benefit from services such as education and healthcare, 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 which is listed in the resources section of this publication.

Should a service user raise an objection to information being disclosed with other health professionals involved in their care, they must be informed how disclosure could reduce risk and benefit the continuity and quality of their care. If their decision has implications for the proposed treatment and management, it will be necessary to inform the service user of this.

Ultimately, if the individual refuses to information being shared, their decision should be respected, even if it means that for reasons of safety, treatment options are limited. This decision, along with details of discussions held explaining the risks and potential limitations to their treatment and management options, should be documented within their clinical notes.

In exceptional circumstances, it may be necessary to disclose confidential information without consent when it is deemed to be in the public interest—for example, in cases involving a serious crime. Such breaches of confidentiality must be carefully considered and justified, weighing the potential harm to the service user if the information were not disclosed. Generally, incidents such as theft, fraud, or property damage do not justify breaching confidentiality. It is strongly recommended to consult with a manager and/or the Caldicott Guardian before disclosing any confidential information.

For professional purposes, it may be appropriate to discuss cases with colleagues to seek advice, share knowledge or experiences, or during clinical supervision. In such instances, it is essential to ensure that discussions take place in settings where they cannot be overheard. Additionally, it is generally unnecessary to disclose the names of individual service users during these conversations.

Disclosure in connection with litigation

Information must not be disclosed to a solicitor or officer of a court without the service user's express consent or an appropriate court order. When this occurs, a written request from the solicitor must be sought, which should be accompanied by an authorisation signed by the service user/representative/guardian (or, in the case of a deceased individual, the executor). If a request received from a solicitor is not accompanied with signed authorisation from the service user, this can be accepted provided the Data Controller is satisfied the request is made by a solicitor acting under the instructions from the service user.

To obtain legal advice, information may be shared with your own solicitor. You should consult with your employer before disclosing any service user information.

The police do not have automatic right of access to health or clinical records. An obligation to disclose records to the police will arise when the police have obtained a court order for disclosure. If you receive an order for disclosure from the police, you should alert your employer. Data Controllers should seek legal advice before disclosing any information in response to a court order to ensure that the order is valid. In the absence of such an order, the Data Controller may have a discretion to disclose the records voluntarily in the public interest, however before making a voluntary disclosure the Data Controller should give the matter careful consideration and seek appropriate advice. The police will need to provide you with sufficient information about the nature of the matter under investigation to allow you to make a reasoned decision on whether to disclose the information without the service user's permission.

In the absence of a specific requirement there must be either explicit service user consent or a robust public interest justification for disclosure. Ultimately, the courts decide what is or isn't in the public interest, however, if a clinician, member of staff, or the public has been threatened or attacked in some way by a service user and it is felt this needs to be reported to the police, the name and address of the individual can be disclosed where necessary to seek legal advice or report the matter to the police, but their medical details should not be disclosed.

The Inland Revenue do not have automatic rights to access service user records. If financial information has been recorded in the service user records, however, it renders them a financial document which they do have the right to access. The service user's confidentiality also should not be overridden. Financial and clinical records should therefore be kept separate.

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.

Personal information that is accessible would inlude:

- **a health record that consists of information about the physical or mental health condition of an individual, made by or on behalf of a healthcare professional (another term defined in the Act) in connection with the care of that individual;**
- **an educational record that consists of information about a pupil, which is held by a local education authority or special school (see Schedule 11 of the Act for full details); or**
- **an accessible public record that consists of information held by a local authority for housing or social services purposes (see Schedule 12 for full details).**

(ICO 2017, p5)

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, records continue to be viewed as personal data and come under the requirements of the Data Protection Act 1998 (Great Britain. Parliament 1998). Independent prosthetists and orthotists, 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'.

To comply with the UK GDPR, all practices are required to provide information to service users about the way in which personal data will be processed. This should be provided in the form of a **Privacy Notice**.

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

1. **Fairly and lawfully processed**
2. **Processed for limited purposes which are specified and legitimate**
3. **Adequate, relevant, and not excessive**
4. **Accurate and kept up to date**
5. **Not kept for longer than is necessary**
6. **Processed in a secure manner and line with a person's rights**
7. **Secure**
8. **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
- 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
- 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 must 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
- 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 healthcare 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 healthcare 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 healthcare professional concerned to discuss the situation and to request to have the 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 healthcare professional and service user 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 service user is unhappy with this outcome, they retain the option of taking formal action.

UK GDPR provides 'Data Subjects' with a right to erasure/deletion of clinical records, but that is a qualified right and is only available in certain circumstances. It is difficult to envisage circumstances in which it would require the erasure of a service user's clinical records before the end of the retention period.

Service user access to clinical records

The Data Protection Act 1998/2018 and GDPR 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 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. The procedure must consider any special provisions related to health records, as set out in the Data Protection Act 2018, including the 'Serious Harm Test'.

If a service user asks to see the records you have made about them, there is nothing in law to prevent you from informally showing them to the service user. You can only provide copies if a formal written application has been made. You are strongly advised to follow local policy.

For the Serious Harm Test, the Data Controller should consider whether the data has already been seen by, or is within the knowledge of, the data subject. Where they are not satisfied that is the case, they must consider whether the disclosure to the data subject would be likely to cause serious harm to the physical or mental health of the data subject or another individual.

If the Data Controller is not a registered healthcare professional (e.g. within an NHS Trust/Health Board) they must obtain the opinion of someone who is an appropriate healthcare professional to ensure that the Serious Harm Test is not met before any disclosure is made. To satisfy the requirements of the Data Protection Act 2018 the clinician whose opinion is obtained will usually be the principle treating clinician.

In cases where the Serious Harm Test is met in respect of any aspect of the data, it cannot be disclosed in response to a subject access request.

Disclosure does not automatically follow from a decision that the Serious Harm Test is not met. The Data Controller must still take account of the other qualifications on the right to access such as the rights of third parties.

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 and the rights of those individuals must be considered before a decision is made regarding disclosure of some/all of the health records.

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

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, a person will only be able to access the deceased's health records if the person is 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).

Access to a Child's health record

A person with parental responsibility can make a subject access request on behalf of their child/children who are too young to make their own request. A young person aged 12 years and above is generally considered mature enough to understand what a subject access request is and can make their own request for which they would need to provide their consent to allow their parent/guardian to make the request for them. The Data Controller must use their judgement to decide whether a particular young person (aged 12 years or over) is mature enough to make their own request as they do not always have the maturity or capacity to do so.

If you are an independent prosthetist/orthotist, 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 NHS Trusts/Health Boards are committed to complying with 'Right of Access' requests made under the Data Protection Act 2018 and the Freedom of Information Act 2000/2002. Anyone can request information recorded and, by law, NHS Trusts / Health Boards 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 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 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 service users 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 service users having the right to see it during this period. The General Medical Council recommends that service users 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 healthcare professional 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 service user 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 service user, 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 service user 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 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. Service users 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 service user 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 service user's personal representative and any person who may have a claim arising out of the service user'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, they 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 service user's death. There is less clarity regarding which individuals may have a claim arising out of the service user'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 ensure they verify the identity of individuals requesting access, who should provide sufficient information to confirm their identity. In cases where the application is made in connection with a claim related to a deceased individual, the applicant must submit appropriate evidence to substantiate 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 prosthetists/orthotists 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. Healthcare professionals 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 on pages 27-31 of this guide.

The Health and Care Professions Council requirements

The 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' (HCPC 2024, section 10.2). It is stipulated that records are kept 'secure by protecting them from loss, damage, or inappropriate access' (HCPC 2024, 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 2024, section 10.1).

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 2024, 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 healthcare professional may be considered as unfit or unsafe to practice. Poor record-keeping may be considered to be an indicator of a prosthetist/orthotist who is struggling in terms of their knowledge and skills, attitude, confidence, or perhaps their personal wellbeing.

Case notes from HCPC fitness to practice final hearings identify record-keeping shortfalls in detail. It has been noted when records:

- **are incomplete or not made**
- **are not clear and concise**
- **use wrong terminology and clinical terms**
- **are not completed in a timely manner**
- **do not document clinical [professiona] reasoning**
- **demonstrate poor completion of assessments**
- **do not identify goals, interventions and outcomes**
- **do not link interventions to care plans**
- **give no indication of whether plans have been carried out or goals met**
- **do not record risk assessments and actions taken**
- **do not record meetings or communication with others and**
- **do not identify referrals made**

(HCPC ca. 2016)

Your professional requirements

As with the HCPC standards of conduct, performance, and ethics, standards of proficiency for prosthetists and orthotists, the BAPO Standards for Best Practice (2025) 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 healthcare professional 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

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

2 **Referrals are normally accepted from a:**

- Medical Physician or Consultant
- General Practitioner Doctor
- Nurse or Allied Health Professional
- Service user
- Carer or parent/guardian on behalf of the service user

3 **It is recommended that the following essential information be documented. This information is in accordance with International Standards and Department of Health Directives, including Records Management Code of Practice 2016 and 2021. The practitioner must obtain and document the informed consent of the service user to examination and treatment in accordance with local governance requirements.**

a) 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

b) Personal Information:

- Height and weight
- Vocational activity
- Recreational activity
- Transfer method

c) General medical condition:

- Primary diagnosis
- Significant medical history, including infection precautions

d) 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

e) Notes:

- The problem
- Subjective notes
- Objective notes
- Assessment/Analysis
- Plan of treatment

f) Objectives of treatment and/or care plan

g) Biomechanical requirement of orthosis/prosthesis

h) Category of orthosis/prosthesis as defined in ISO 8549:2020 Prosthetics and Orthotics-Vocabulary Parts 2 and 3

i) Device specification number and date supplied along with any individual device identification information provided by the manufacture compliance with 93/42/EEC

j) Date and time of review appointment

k) A signature for hand written notes, name (in block capitals for hand written notes), date, and time.

l) Designation: e.g., Prosthetist/Orthotist, Orthotist, Prosthetist

Competence, delegation, and supervision

All Prosthetists and Orthotists should be aware of and abide by the current legislation, guidance, and **BAPO and HCPC standards** that are relevant to their 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 prosthetist/orthotist, retain responsibility for the prosthetic and/or orthotic care provided to the service user.

If you supervise staff (including technicians and support workers) 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 learner, 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. All record entries made by learners must be counter-signed by a registered professional.

If you are a learner on placement and you are unsure of your record-keeping skills, you must 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 learners use this guidance alongside the support provided by other professionals at the placement centre and educators at your place of study.

For further support and information see BAPO's **a guide to preceptorships in prosthetics and orthotics** and a **guide to supervision**.

The format and structure of clinical records

Many clinical records are kept in a variety of ways: paper or electronic, from specific prosthetic/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 governance or local policy is being followed. The NHS Ten Year Plan outlines a plan to introduce a fully digitilised single patient record making information visible across different care settings. The use of integrated digital systems will bring greater consistency in terms of format, structure, and content across many prosthetic and orthotic services.

Key elements of well-structured clinical records include:

1 **Clear documentation ensures effective continuous service user care**

2 **Note recording:**

- Encourages logical thinking
- Provides a basis for critical analysis in decision making
- Standardises quality information for team members
- Forms the basis for future clinical and medical decisions
- Supports clinical audit and quality assurance
- Supports clinical effectiveness studies
- Informs retrospective and prospective research
- Provides statistical evidence for service development

Clinical records may be written using the Subjective, Objective, Assessment/Analysis, Plan (SOAP) format:

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

Clinical records may be written using the Problem Oriented Medical Records (POMR) if appropriate.

Written clinical records must:

- Be factual, consistent, and accurate
- Be contemporaneous, written within 24 hours of the intervention
- Provide current information on the care and condition of the service user
- Hand written notes must be legible in black ink and in such a manner that they cannot be erased or if computer recorded, and have a clear audit trail of any amendments
- All alterations to clinical records must have a date and time the alteration was added. Handwritten notes must be signed.
- Hand written notes must be altered in such a way that the original entry can still be read clearly. Any alterations should be scored out with a single line.
- Be accurately dated, timed, and signed, with the signature and status of writer being made clear
- Written without gaps between entries
- Not include abbreviations, jargon, meaningless phrases, or offensive subjective statements
- Be legible
- Be written in terms that the service user also can understand
- Be headed with concise patient details such as those on hospital adhesive labels
- Include all relevant letters, prescriptions, and order paperwork
- Should clearly document where an entry is made following telephone contact

Records that are fit for purpose

Prosthetists and orthotists must maintain comprehensive documentation that clearly reflects all actions taken for, with, or in relation to a service user. This includes the clinical reasoning underpinning care planning and delivery. It is also essential to demonstrate the outcomes of the provided care, not only for the benefit of the service user and the wider care team with access to these records, but also to highlight the value and impact of the intervention.

In alignment with the standards set by the HCPC and BAPO, high-quality records must meet the following criteria for every service user interaction:

- Be comprehensive and complete
- Be clear and easily understood
- Be factually accurate
- Be completed in a timely manner
- Demonstrate clinical reasoning and evidence-based practice
- Comply with all relevant legislation, guidance, and policy
- Maintain confidentiality
- Be securely stored and appropriately disposed of

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

It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical investigation, or providing personal care, for a person. This principle reflects the right of service user to determine what happens to their own bodies and is a fundamental part of good practice. A healthcare professional (or other healthcare staff) who does not respect this principle may be liable both to legal action by the service user and to action by the HCPC. Employing bodies may also be liable for the actions of their staff.

Before embarking on any examination or treatment, you must be satisfied that the service user, 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.

Valid consent

For consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question (this will be the service user or someone with parental responsibility for a service user under the age of 18 years, someone authorised to do so under a Lasting Power of Attorney (LPA) or someone who has the authority to make treatment decisions as a court appointed deputy. Acquiescence where the person does not know what the intervention entails is not 'consent'.

Assessing mental capacity

The Mental Capacity Act 2005 defines a person who lacks capacity as a person who is unable to make a decision for themselves because of an impairment or disturbance in the functioning of their mind or brain. It does not matter if the impairment or disturbance is permanent or temporary.

A person lacks capacity if:

- They have an impairment or disturbance (for example a disability, condition, or trauma or the effect of drugs or alcohol) that affects the way their mind or brain works, and
- That impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made.

An assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general. A person is unable to make a decision if they cannot do one or more of the following things:

- Understand the information given to them that is relevant to the decision
- Retain that information long enough to be able to make the decision
- Use or weigh up the information as part of the decision-making process
- Communicate their decision – this could be by talking or using sign language and includes simple muscle movements such as blinking an eye or squeezing a hand.

People may have capacity to consent to some interventions but not to others or may have capacity at some times but not others.

Under the Mental Capacity Act, a person must be assumed to have capacity unless it is established that they lack capacity.

If there is any doubt, then the healthcare professional should assess the capacity of the service user to take the decision in question. This assessment and the conclusions drawn from it should be recorded in the service user's notes. 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. Guidance on assessing capacity is given in chapter four of the Mental Capacity Act (2005) Code of Practice.

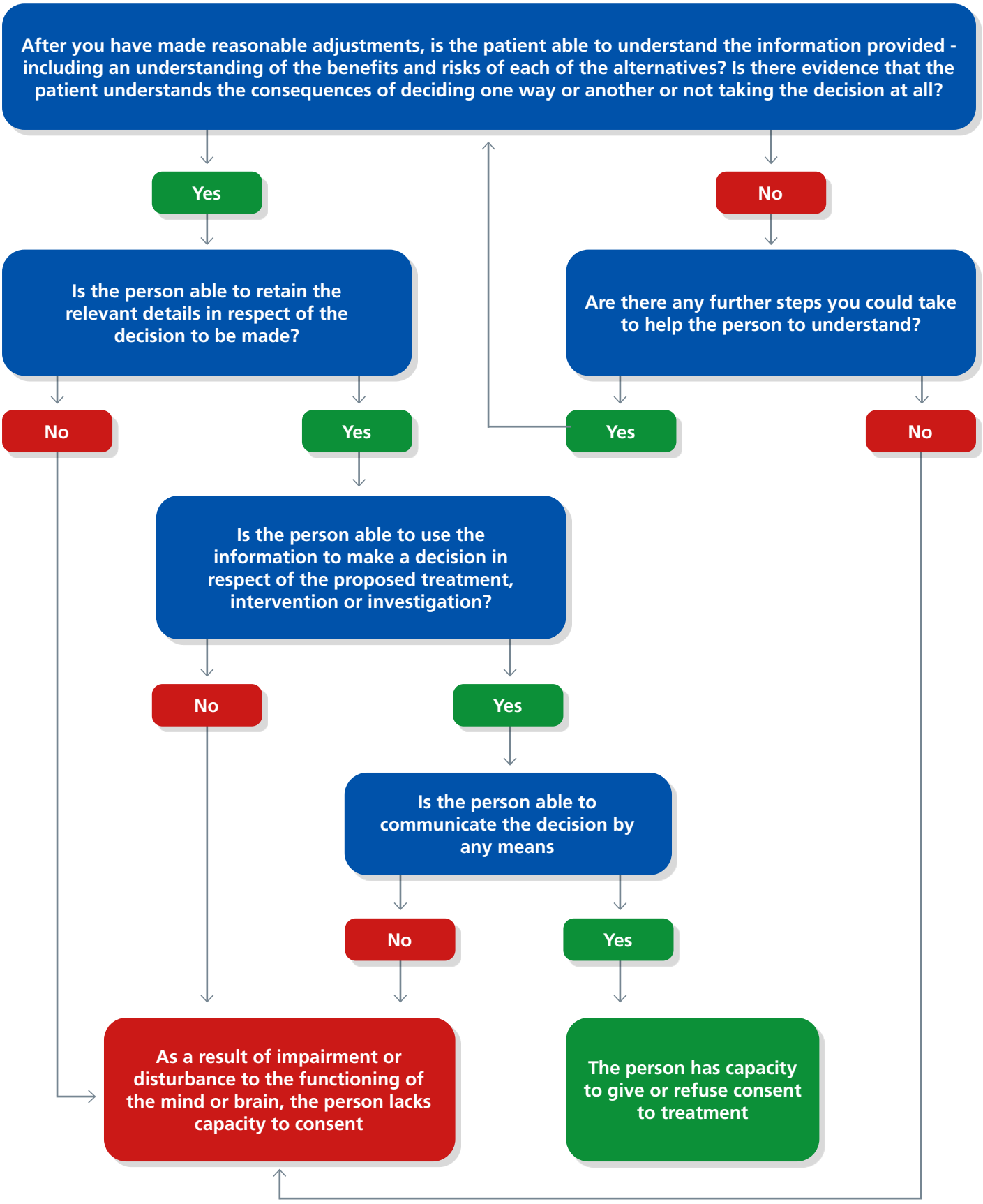
The key points of the law governing consent are as follows:

- 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 years 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 years) can provide consent to treatment. Their entitlement to refuse treatment which is in their best interests is more complex
- Persons aged 15 years 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 their best interests

Guidance to support the implementation of the Mental Capacity Act for adults with a learning disability

There are a range of resources available to support staff to fulfill their legal requirements around the Mental Capacity Act specifically when supporting service users with a learning disability.

Mental Capacity Assessment flowchart



Adapted from NHS England

Barriers to the effective implementation of the Mental Capacity Act

The Mental Capacity Act 2005 (MCA) is a critical piece of legislation that protects and empowers individuals who may lack the capacity to make certain decisions for themselves. Despite its importance, the effective implementation of the MCA continues to face numerous challenges. These barriers, both systemic and cultural, can compromise the quality of care and the legal protections afforded to vulnerable individuals.

Key obstacles include: (adapted from NHS England's guidance to support implementation of the Mental Capacity Act in acute trusts for adults with a learning disability)

1. **High-Pressure Clinical Environments**
   Acute care settings are often fast-paced and demand rapid decision-making. The urgency to act swiftly in clinical scenarios can lead to omissions or shortcuts in the proper assessment of mental capacity, undermining the core principles of the MCA.

2. **Insufficient and Inconsistent Training**
   A significant barrier is the lack of regular, role-specific training for healthcare professionals on the MCA and associated frameworks, such as the Deprivation of Liberty Safeguards (DoLS). Without sufficient training, staff may view the Act as overly complex or burdensome, which may lead to non-compliance or misapplication, particularly in nuanced areas like diagnostic overshadowing.

3. **Misconceptions About Capacity**
   There is a persistent misconception among some professionals that a diagnosis of a particular condition—such as dementia, learning disability, or mental illness—automatically equates to a lack of capacity. This flawed assumption undermines the statutory principle that capacity must be presumed unless proven otherwise, and that it is decision-specific and time-specific.

4. **Tension Between Autonomy and Protection**
   Healthcare professionals often face ethical dilemmas in balancing the promotion of individual autonomy with their perceived duty to protect. This tension can result in paternalistic decision-making, where best interest judgments are made without proper capacity assessments or meaningful involvement of the service user.

5. **Fear of Legal Repercussions**
   The potential for litigation or professional censure can lead to overly cautious practices. Clinicians may make risk-averse decisions—sometimes unnecessarily overriding a person's choices—to shield themselves from liability, rather than supporting informed risk-taking in line with the Act.

6. **Communication Barriers**
   Effective capacity assessment and decision-making can be hindered by communication challenges, including language differences, sensory impairments, or cognitive difficulties. Inadequate provision of reasonable adjustments, such as interpreters or alternative communication methods, can render assessments non-compliant and inequitable.

7. **Limited Involvement of Families and Carers**
   Family members and carers are often key to understanding an individual's preferences and best interests. However, they may be excluded from the decision-making process due to time constraints, misunderstandings about confidentiality, or a lack of clarity around their role.

8 **Conflicting Views and Disputes**

Disagreements between healthcare providers, service users, and families are not uncommon, particularly in high-stakes or emotionally charged situations. These conflicts can delay decisions, create friction within care teams, and place additional stress on all parties involved.

9 **Poor Documentation Practices**

Accurate and consistent documentation of capacity assessments and best interests decisions are vital for transparency, accountability, and legal protection. However, documentation is often incomplete or absent due to time pressures, perceived complexity, or the lack of user-friendly tools or templates.

10 **Limited Access to Specialist Support**

Staff may not have timely access to legal advice, mental capacity experts, or safeguarding leads when dealing with complex or contentious cases. This can lead to uncertainty and inconsistent application of the MCA in practice.

11 **Inadequate Organisational Policies and Guidelines**

A lack of robust, accessible organisational policies and clear procedural guidance on the MCA and DoLS contributes to inconsistent practices. Where such guidance exists, it may be outdated or poorly disseminated.

12 **Weak Leadership and Cultural Prioritisation**

The successful implementation of the MCA relies on leadership at all levels that visibly supports and prioritises lawful and ethical decision-making. When leadership fails to emphasise the importance of the MCA, it can foster a culture where compliance is viewed as optional rather than essential.

Recording capacity and consent to intervention

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.

If you think that an individual lacks capacity, you need to be able to demonstrate it. Your records must 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.

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 service user 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.

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 to make an informed and valid decision, whether to give or refuse consent.

You must 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 healthcare professionals to a real risk of criminal or civil liability and to a risk of action against their registration by the HCPC.

Including the Voice of the Child

When working with children or young people, it is essential to gain a clear picture of their wishes, thoughts, and feelings. Children and young people must have their words accurately represented in notes, summarising their conversations with healthcare professionals. The voice of children must therefore be recorded and taken into account, no matter what their age or ability to communicate directly. This not only refers to what children say directly, but to many other aspects of their presentation and requires the clinician to see their experiences from their point of view.

This can be done by:

- Direct engagement
- Observation

In addition, a discussion with the child or young person's parent/guardian, family members, carers, or other relevant agency might be useful. Alongside, analysis of information held to consider what the impact might be on the child.

A good start is to explain your own role, to listen openly and to seek the voice of the child without advising or judging, remembering to consider explaining to parent/guardian and carers in advance and seek consent where necessary.

When children and young people share their experiences of abuse or neglect, they need to be confident that their voices are heard, and their words are captured accurately by the healthcare professional. The conversations they have need to be appropriate to their age, developmental stage, and cognitive and language abilities. Summaries of these conversations should be written up immediately and reflect only the facts as the children and young people presented them. Where possible, the children and young people should also have an opportunity to reflect on what they said and review the record of the conversation.

It can also be helpful to give some written material to take away and consider (such as guides and leaflets) to parent/guardian and young people to assist with explanations and participation and then offer another opportunity to talk again later.

Gillick competency and Fraser guidelines

Gillick competence is concerned with determining a child's capacity to consent. Fraser guidelines, on the other hand, are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.

Legally, a person's 18th birthday draws the distinction between childhood and adulthood (Children Act 1989 s105). In healthcare matters, an 18-year-old enjoys the same autonomy as any other adult. To a more limited extent, 16- and 17-year-olds can also take medical decisions independently of their parents or guardians. The right of younger children to provide independent consent is proportionate to their competence - a child's age alone is clearly an unreliable predictor of his or her competence to make decisions.

In 1983 the criteria for establishing whether a child under has the capacity to provide consent to treatment; the 'Gillick test' was delineated. It was determined that children under 16 years can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success, and the availability of other options.

If a child passes the Gillick test, he or she is considered 'Gillick competent' to consent to that medical treatment or intervention. However, as with adults, this consent is only valid if given voluntarily and not under undue influence or pressure by anyone else. Additionally, a child may have the capacity to consent to some treatments but not others. The understanding required for different interventions will vary, and capacity can also fluctuate such as in certain mental health conditions. Therefore, each individual decision requires assessment of Gillick competence.

If a child does not pass the Gillick test, then the consent of a person with parental responsibility (or sometimes the courts) is needed to proceed with treatment.

The 'Fraser guidelines' specifically relate only to contraception and sexual health.

Healthcare professionals should still encourage the young person to inform his or her parent/guardian or get permission to do so on their behalf, but if this permission is not given, they can still give the child advice and treatment. If the conditions are not all met, however, or there is reason to believe that the child is under pressure to give consent or is being exploited, there would be grounds to break confidentiality.

There is no lower age limit for Gillick competence or Fraser guidelines to be applied. That said, it would rarely be appropriate or safe for a child less than 13 years of age to consent to treatment without a parent/guardian involvement.

Young people aged 16 or 17 years old are presumed in law, like adults, to have the capacity to consent to medical treatment. However, unlike adults, their refusal of treatment can in some circumstances be overridden by a parent, someone with parental responsibility, or a court. This is because we have an overriding duty to act in the best interests of a child. This would include circumstances where refusal would likely lead to death, severe permanent injury, or irreversible mental or physical harm.

It should be noted that if a young person under the age of 16 years presents to a healthcare professional, then discloses a history raising safeguarding concerns:

- If they are **not** deemed to be Gillick competent, the healthcare professional is obliged to raise the issue as a safeguarding concern and escalate their concerns through the safeguarding process
- If they **are** deemed to be Gillick competent and disclosure is considered essential to protect them from harm or to be in the public interest, the healthcare professional must escalate concerns through the safeguarding processes
- In **both** cases, the healthcare professional should inform the young person of this action, unless doing so could pose significant additional risk for their safe care.

In some circumstances the local authority or police may decide whether it is appropriate to inform the parent/guardian of the concerns raised. In some circumstances this may not be in the best interest of the young person.

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 the service user your first concern
- treat service users as individuals and respect their dignity
- support and encourage service users to be involved, as far as they want to and are able, in decisions about their treatment and care
- treat service users 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 healthcare 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 service user's lack of capacity is temporary or permanent
- what you and the rest of the healthcare team know about the service user's wishes, feelings, beliefs, and values
- any evidence of the service user'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 decide on their behalf, or has been appointed to represent them
- the views of people close to the service user on the service user's preferences, feelings, beliefs and values, and whether they consider the proposed treatment to be in the service user'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 service user'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 prosthetist/orthotist, 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.

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 prosthetist/orthotist.

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 interventions based on the assessments, the service user's objectives, available evidence, and sound professional judgement
- the outcomes of your interventions have been evaluated

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 devices 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 service user has their own outcome measure, but this is scored in a standardised way as to allow 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 facilitating 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 referrer or the service user's GP, with their consent. Outcome measures must be recorded in the service user's clinical record.

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 with service users in your care.

Social prescribing

With an ageing society and rising rates of loneliness, we need to address the social factors that influence people's health. Some people can find support for issues like loneliness or financial problems by themselves. But many face barriers that stop them getting the help they need. These could include health problems, disabilities, caring responsibilities, financial problems, anxiety about trying something new, or simply not knowing what's out there and where to start.

In some cases, there may be barriers to good health or access to healthcare because of ethnicity, where someone lives, or many other factors. Social prescribing can look at the circumstances that make people unhealthy and their symptoms. It can help people to find the support they need, based on their unique situation.

Many things that affect our health can't be treated by clinical interventions alone. Like loneliness, debt, or stress due to financial pressures or poor housing. Social prescribing is an approach that connects people to activities, groups, and services in their community to meet the practical, social, and emotional needs that affect their health and wellbeing

This could involve a Social Prescribing Link Worker or an equivalent role:

- Helping someone who is isolated join a befriending group, an art class, or a community gardening project, based on what works for them.
- Connecting someone struggling with financial stress to a service that helps with managing debt or claiming benefits.
- Supporting someone with dementia to join a dementia choir, enabling them to maintain a sense of social connection.
- Working with someone with high blood pressure to take up a form of exercise that they're comfortable with.

Social prescribing can help change the circumstances that can make people unwell. It can empower people to manage existing health problems, to get the right benefits or get back into employment. It can help people to connect and to grow in confidence.

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 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.

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 clinician 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'. 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 themselves. 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, learners, 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

It is essential to recognise that prosthetic and orthotic devices represent clinical prescriptions, not merely product orders, and must be thoroughly documented in the service user's clinical records. Each order or prescription should be explicitly linked to the corresponding clinical note that provides the rationale for its issuance.

Prescriptions must maintain the same standards of clarity and legibility as clinical notes. All orders and associated documentation should be organised chronologically. Any updates to technical specifications must be clearly recorded in the clinical notes and easily identifiable within the corresponding prescriptions.

> *"Each order or prescription should be explicitly linked to the corresponding clinical note that provides the rationale for its issuance"*

Legibility

Written clinical records need to be legible in order to be safe and effective. If care is delayed, miscommunication occurs, or a service user is ultimately harmed because 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.

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.

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 hand written entries, additions, and amendments to records.

If using digital records, each prosthetist/orthotist should have their own unique access code/password on the system. This should never be used by another individual. Local procedures should be in place for learners 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 prosthetic/orthotic learners, support workers, and technicians. The registered professional is responsible for ensuring the competence of any support staff they delegate a task to, 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 later, 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 information 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 prosthetist/orthotist 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.

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, prosthetists/orthotists have a 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.

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

Recording medication

Prosthetists and orthotists, under Patient Group Directions, may supply and administer limited medications. 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.

Access to the main hospital Patient Administration System (PAS), where all service user records are maintained, is essential for all prosthetists and orthotists involved in delivering care. This requirement applies equally to those employed directly by the NHS, contracted professionals, and locum practitioners.

BAPO has produced a guide to the supply and administration of medicines by prosthetists and orthotists.

Discharge/case closure

You must record the point at which you discharge the service user and the reason why. This may be because the service user has met their objectives, has been transferred to another professional or service, declines further input, or moves out of area. 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 essential that clinical records are both complete and accurate. The longer the delay between an event and its documentation, the higher the risk of inaccuracies or omissions. Records should be completed contemporaneously—ideally within 24 hours of the clinical activity, event, or intervention.

Certain situations demand immediate documentation. For example, if a service user in a palliative care setting expresses an intention to pursue voluntary euthanasia, or if there are clinical indicators of suicidal ideation, these must be recorded without delay and shared with relevant members of the care team. Failure to promptly document such information may not be defensible in formal inquiries or legal proceedings.

During assessments and consultations, service users may share information that is critical to their current or future care, including personal wishes or specific requests. Such details must be recorded promptly to ensure appropriate information sharing and continuity of care.

Notes made using portable digital devices or handwritten telephone message logs in office settings are considered part of the clinical record. These notes must be handled with the same level of confidentiality and security as formal clinical documentation. The information should be accurately and consistently transferred to the clinical record as soon as possible. Depending on the format and nature of the original note, it should either be securely destroyed or stored appropriately, if retention is required.

If records are completed retrospectively, both the time of the original event and the time of recording must be documented. In cases of significant delay, an explanation should be included in the record.

Making your record-keeping a priority

Concerns are often raised regarding the limited time available to clinicians for timely completion of clinical records. However, insufficient time cannot be used as a justification for incomplete documentation and would not be acceptable during formal investigations or legal proceedings.

Record-keeping is a fundamental component of clinical care and holds equal importance to direct patient contact and intervention. While it is acknowledged that high-quality documentation requires time, services must provide appropriate support to enable clinicians to meet this responsibility effectively.

This support may include the implementation of efficient systems and practices that uphold documentation standards while improving time management, or the allocation of protected time specifically for record-keeping. Additionally, reasonable adjustments—such as the need for additional time or alternative facilities due to conditions like dyslexia—must be recognised and appropriately accommodated.

BAPO's standards outline the recommended duration of appointments necessary to ensure the delivery of safe and effective prosthetic and orthotic care.

Organisation of clinical records

All pages within a physical clinical record must be clearly numbered to ensure traceability and maintain the integrity of the service user's healthcare documentation. The structure of the physical notes should include the following essential components:

- Front Sheet / Service User Information Section
- Service User Identification Labels (Including hospital number, surname, forename, and date of birth)
- Clinical Notes Section, maintained in chronological order:
- Medical History / Clinical Assessment
- Progress Notes
- Correspondence, Reports, and Forms
- Referrals
- Order / Prescription History

When a new front sheet is required, all previous front sheets should remain in the file but be clearly scored out. These should be retained in reverse-chronological order, with the most recent at the front of the record.

All pages must be properly labelled and ordered to ensure completeness and facilitate quick reference. Maintaining an accurate and logical sequence supports both the continuity of care and the audit process.

To uphold the integrity and currency of clinical records, all service user documentation must be filed promptly. Any delay in submitting or organising essential information can result in confusion or disruption to the service user's care.

It is also critical to recognise that prosthetic and orthotic orders form part of a service user prescription. As such, they must be stored within the clinical notes and explicitly linked to the clinical entry from which they were generated. In the event of a medical device recall, such as a product identified as unsafe by the Medicines and Healthcare products Regulatory Agency (MHRA), services must have systems in place to trace relevant prescriptions and notify affected service users without delay. This is a vital measure to ensure service user safety and regulatory compliance.

Failure to complete and maintain clinical records

Failure to complete records may be an indicator of a prosthetist/orthotist 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.

Please note that failure to complete and maintain accurate clinical records may render any indemnity insurance – whether arranged personally, provided by your employer, or through BAPO – invalid.

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 duplicate 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. It is the responsibility of the prosthetist/orthotist to ensure no treatment takes place before the service user's clinical record is available in order to enable the status of the individual to be reviewed and allow any intervention to be appropriately documented.

"All information regarding clinical activity and interventions must be maintained within one accessible document to allow the information to be accessed as required"

Secure storage of clinical records and personal data

All clinical records, whether in paper or digital format, must be safeguarded against unauthorised access, opportunistic viewing, theft, loss, or damage. Prosthetists and orthotists are individually responsible for any records they create or use and share joint responsibility for records maintained collaboratively. Records should be stored securely within the appropriate department, with storage systems and data protection measures ensuring both security and accessibility for those with legitimate need.

To maintain completeness and compliance with national and local protocols, loose paper sheets must not be left unfiled within clinical records. Such documents should be securely stored until they can be properly filed or scanned into the electronic health record by the originating department at the earliest opportunity. Paper notes should not be removed from the building they are stored without appropriate authorisation.

The location and movement of all records must be controlled through an auditable tracking system to ensure records can be retrieved at any time. When paper records are removed from central storage, the tracking system must identify who is in possession of the records and their destination.

Digital data stored on portable devices—including mobile phones, tablets, or memory cards—must be securely recorded and encrypted. Data protection principles apply at all times during the transport or handling of records. Prosthetists and orthotists must ensure records remain inaccessible to individuals outside the direct care team and are never left unattended in unsecured environments (e.g., vehicles).

Personal digital devices, such as mobile phones or memory sticks, must not be used to store service user information. Where digital devices are required for clinical work, they should be issued by the employer and used in accordance with local procedures. Self-employed practitioners must procure dedicated devices for professional use and ensure that these comply with data protection regulations.

Independent practitioners maintaining computer-based records must ensure that access is restricted to authorised individuals only. Robust data protection and security measures must be implemented. The Information Commissioner's Office (ICO) provides guidance on data protection for small and medium-sized businesses, including the secure storage and transfer of personal digital data.

Further information regarding records storage for operational use is available in section four of NHS England's **Records Management Code of Practice**.

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

Informed consent must be obtained prior to capturing any digital images, video, or audio recordings of a service user, whether by healthcare professionals or others present. The service user must be made fully aware of the purpose of the image or recording and how it will be used. A documented record of all images or recordings taken must be maintained. Local policies should be consulted, as written consent is often required.

All digital images and videos must be stored on a secure, centralised system and must not remain on portable devices. Care must be taken to prevent automatic uploads to social media or cloud backup platforms. Guidance on disabling such features is widely available online. Transferring images or recordings to another professional or service must be done only with the service user's informed consent, and via secure, encrypted methods.

While there is no legal restriction preventing service users or their legal guardians from recording care interactions, prosthetists and orthotists should conduct themselves professionally at all times, as if their actions or words may be recorded. Any third-party recording—such as by a friend, carer, or family member—requires the service user's informed consent.

If recordings are proposed by others, professionals should engage in open discussion regarding their purpose and how they may support the service user's understanding or recall of information. If there are concerns—such as risks to vulnerable individuals or potential breaches of confidentiality—the professional should pause the session and seek guidance from a manager or legal advisor.

Independent practitioners are encouraged to proactively develop policies and consent forms to manage such situations consistently. Additional guidance is available on the Information Commissioner's Office (ICO) website, particularly for small businesses.

Always remember the five Ss of Information Governance:
Save it, Secure it, Share it appropriately, meet the Standards and use the Support

References and further reading

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Appendix 1

Checklist for preparing to assess the mental capacity of someone with a learning disability

Think about the person being assessed

1 ❑ Do they have health issues that may affect their concentration (for example, flu)?

2 ❑ Is this the best time of day to assess their capacity? Some people concentrate better at certain times of the day and religious observances may have an impact.

3 ❑ Are they taking medication that could affect their concentration during the assessment?

4 ❑ Have you set aside enough time to do the assessment at the pace that works for the person and to answer their questions? You can have a second conversation with someone to make sure that they have understood what you are talking to them about.

5 ❑ Has a significant event occurred recently in their life (for example, bereavement/changing accommodation) or a more subtle event (for example, being upset by a friend)?

Communications needs

6 ❑ How does the person usually communicate? (for example, Makaton, their first language, assistive technology)

7 ❑ Does the person usually access assistance from others? If so, could that person be present during the assessment? If not, who can assist you in this situation?

8 ❑ Does the person need someone to sign or interpret for them? If so, arrange for an interpreter or signer to be present.

9 ❑ Does the person use hearing aids or glasses? If so, check they are wearing them before the assessment.

10 ❑ Have you prepared how you will give information in simple language when carrying out the assessment, avoiding jargon or acronyms? You may want to prepare communication aids such as Easy Read information or pictures to help you explain a procedure.

11 ❑ Has the person or their family/carer asked for more information or information in a different format, and have they been given it?

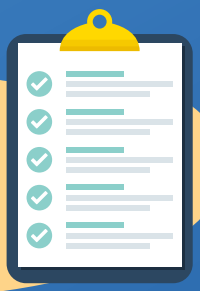
Environment

12 ❑ Is the environment where you will carry out the assessment free from noise and distractions?

Mental Capacity Act assessments

Consent for treatment must be **valid, voluntary, informed, and made by someone with capacity.**

Assess Capacity
if there is any doubt

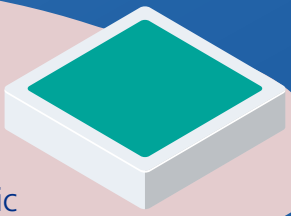


Listen and involve
people who know the person well. Family can't automatically consent for individuals aged 16 or over

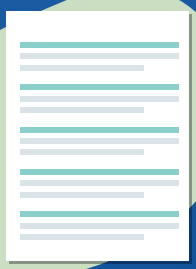
Do not Assume
people who are non-verbal or have a learning disability do not have capacity

Make Reasonable Adjustments
to support decision-making

Decision-Specific
Capacity is decision-specific



Record Assessments
on the correct forms



Follow Trust Policy when assessing capacity and seeking consent

Your Mental Capacity Act (MCA) lead is:

Appendix 2

Glossary

Acute care	A branch of secondary healthcare where a service user 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 a service user receives from healthcare professionals during pregnancy. The purpose of antenatal care is to monitor the service user's health, the baby's health and support the service user 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 service user 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 service users 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 service user's condition.
Emergency Care	An immediate response to time critical healthcare 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 a service user will stay overnight at least one night.
Integrated Care Pathway	A multidisciplinary outline of anticipated care, placed in an appropriate timeframe, to help a service user with a specific condition
Minor Injuries Unit	A hospital department in the UK largely staffed by emergency healthcare professionals 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 service users.
'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 service users 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 service users 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 service users ' neuro-muscular and skeletal systems enabling individuals 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 people 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 service users 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 service user'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.
Service user Discharge	To inform a service user officially that they can or must leave the hospital.
Pre-assessment Tests	Checks made by a health professional before service user has an operation or other healthcare procedure.
Primary Care	The day-to-day healthcare given by a healthcare provider. Typically, this provider acts as the first contact and principal point of continuing care for service users within a healthcare system, and coordinates other specialist care that the service user may need.

Prosthetists	Autonomous registered practitioners who provide gait analysis and engineering solutions to service users 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 individual's absent limb. They are also qualified to modify CE marked prostheses or componentry taking responsibility for the impact of any changes. They treat people 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 a service user 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: **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 service users' 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.
Telehealth	The provision of healthcare remotely by means of telecommunications technology.
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 service users regain 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 healthcare professionals who provide treatment and advice for service users on a range of minor illnesses and injuries, without an appointment.
Women's Health	Health issues specific to female anatomy.

Appendix 3

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.

It is your responsibility to ensure that all clinical records provide a comprehensive, accurate and justifiable account of all that you plan or provide for service users.

Within the clinical records, ensure the following:

- Every page/item in your records is numbered accordingly, in the correct order and identified by the service user's name, date of birth & unique identifier
- You gain and record consent (and whether verbal or written) for assessment, intervention, information gathering and sharing
- Your entry clearly states the clinical location
- Your clinical entry states anyone accompanying the service user, along with any other clinical professional present during the appointment
- Your records are legible
- Your records are clear in terms of their meaning
- You explain acronyms and abbreviations
- You date and time ALL entries
- All clinical records are written promptly, as soon as practically possible after the activity occured (within 24 working hours)
- You sign all entries: You, as author, and print your name in full along with ensuring that your role is clearly identifiable
- You record all assessments and their outcomes/implications
- You record capacity assessments and their outcomes/implications
- You record risk assessments and their outcomes/implications
- You record the service user's stated wishes/goals
- You record the objectives of intervention
- You record the inervention/action plan
- You record any intervention carried out
- You record the evidence and rationale for all that you do (record your professional/clinical reasoning) and refer to any care pathways or evidence used
- You record any recommendations made
- You record the administration or management of medication
- You record the outcomes of intervention
- You record/keep all communication concerning the service user, e.g. reports, letters, emails, phone calls
- You record all discussions concerning the service user, including advice and information given (e.g. leaflets)
- You record any referrals to another service, and the reason why
- You record the case closure/discharge and the reason why
- Your records show evidence that consent is gained before written or digital information, images etc... are undertaken

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Please note: Where you have others under your supervision, you provide training and support to enable them to meet these requirements
Ensure: All your records are, at all times, secure from opportunistic viewing, inappropriate access, theft, loss, and damge. All personal data kept on digital systems is secure, with passwords and encryption. You do not keep service users' personal data on your own digital devices.

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