



Standards for Best Practice



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1 Role and scope of practice of the Prosthetist/Orthotist

1.1 Introduction

This Standard explains the role and scope of practice of the Prosthetist/Orthotist as he/she/they delivers treatment. As well as the practicing clinician it should also be of particular interest to the service user, prosthetic/orthotic student, technicians and support workers, other healthcare professionals and service commissioners.

1.2 Statement

The Prosthetist/Orthotist is a regulated, autonomous healthcare professional with a definitive and unique role: the assessment, design and provision of prosthetic and orthotic treatments

1.3 Professional Role

The Role of the Prosthetist/Orthotist is to take the lead in the assessment and provision of prosthetic/orthotic interventions, to effectively supervise technicians and support workers and provide consulting expertise to medics, other health care workers and service users

In doing so the practitioner will:

- 1.3.1 Abide by the standards of conduct and proficiency for Prosthetists/Orthotists as determined by the Health and Care Professions Council (HCPC)
- 1.3.2 Work within the scope of practice as described in this document
- 1.3.3 Actively contribute to the promotion of progress within the profession for the benefit of the service user
- 1.3.4 Gain informed consent to treatment from the service user or their representative and exercise a professional duty of care
- 1.3.5 Be committed to continuing professional development (CPD) and reflective practice
- 1.3.6 Be able to provide upon request a written CPD profile
- 1.3.7 Integrate the best available evidence into their practice
- 1.3.8 Be aware of current pertinent research evidence
- 1.3.9 Contribute to audit, research and development relevant to the service user
- 1.3.10 Maintain service user confidentiality
- 1.3.11 Ensure current competence and awareness of local clinical risk management, basic life support, manual handling, infection control and child protection

1.4 Assessment, Diagnosis and Treatment Planning

In formulating a treatment plan and deriving a prescription the practitioner will:

- 1.4.1 Participate as a full and equal member of the clinic team; conduct the examination, refer for additional tests/images, formulate differential diagnosis and determine the prescription; design the prosthetic/orthotic intervention, including the socket or body/device interface, suspension and selection of proper components required for treatment
- 1.4.2 Make best use of available resources to realise the best outcome for the service user without compromising service user safety or the clinical effectiveness of the intervention
- 1.4.3 Assist and advise on all relevant aspects of pre-surgical, post-surgical, medical and therapeutic management of the prosthetic/orthotic intervention required for treatment
- 1.4.4 Record and report any pertinent information regarding the service user and their family or carers, including a determination of expectations and needs
- 1.4.5 Communicate appropriate information to the service user and their family or carers
- 1.4.6 Whenever possible, guarantee the full inclusion of the service user and their family or carers in treatment planning and decision making

1.5 Fabrication, Provision and Treatment

During the process of device fabrication and provision the practitioner will:

- 1.5.1 Identify physical and other relevant characteristics that may affect the treatment of the service user
- 1.5.2 Formulate prosthetic or orthotic designs, including selection of materials and components which may include mechanical or electronic assistive mobility devices, postural management systems and wheelchairs
- 1.5.3 Capture anthropometric data including casts, scans, measurements, kinetic and kinematic data and imaging, required for appropriate design, fabrication and fitting
- 1.5.4 Specify and direct modification of physical or virtual, positive or negative models to obtain the optimal design, functions, fit, cosmesis and comfort of devices
- 1.5.5 Communicate design specifications effectively to ensure correct provision by the device supplier and/or manufacturing technician(s)
- 1.5.6 Conduct the fitting, static and dynamic alignment and initial check-out of devices, and where appropriate, the preliminary training of the service user
- 1.5.7 Perform and/or direct the fabrication of the prosthesis or orthosis as appropriate
- 1.5.8 Supervise the activities of Clinical and Technical as outlined in section 2 of this standard

1.6 Evaluation and Review

During the evaluation and review of prosthesis/orthosis provision the practitioner will:

- 1.6.1 Advise the team and participate directly in the final check-out and evaluation of fit, function, cosmesis and comfort
- 1.6.2 Instruct the service user or carer in the use and care of the device and provide written information as appropriate
- 1.6.3 Lead follow up/review/maintenance and replacement procedures
- 1.6.4 Assess, record and communicate achieved outcomes in relation to treatment goals

1.7 Management and Supervision

Within a defined career position and level of practice, the practitioner will:

- 1.7.1 Delegate tasks to others and supervise the activity of support staff as appropriate
- 1.7.2 Manage clinical and laboratory/workshop activities assigned to him/her including:
 - (a) Use and maintenance of tools and equipment
 - (b) Maintenance of safe working environment and procedures
 - (c) Inventory and stock control
 - (d) Personnel matters
 - (e) Financial matters
 - (f) Appropriate record keeping
 - (g) Total quality management
- 1.7.3 Identify and introduce operational efficiency as necessary
- 1.7.4 Interact with professional groups and appropriate external stakeholders, influencers or agencies

1.8 Participation in Training and Education

The practitioner will:

- 1.8.1 Be prepared to share skills and knowledge to ensure the education, training and mentoring of prosthetic/orthotic students, technicians and support workers within clinical protocols. When appropriate, the practitioner should be prepared to take the role of practice educator
- 1.8.2 Lecture and demonstrate to colleagues in his/her/their profession and other professionals concerned with prosthetics/orthotics and also to other interested groups
- 1.8.3 Take part in and contribute to the process of continuing professional development
- 1.8.4 Critically evaluate new developments in prosthetics/orthotics for inclusion in a teaching syllabus
- 1.8.5 Be familiar with new techniques, materials, components and products
- 1.8.6 Make a professional contribution to and take part in community programmes related to prosthetics/orthotics

1.9 Participation in Research and Development

The practitioner will:

- 1.9.1 Conduct continuing evaluation of his/her/their activities
- 1.9.2 Develop and actively participate in formal evaluation and research programmes.
- 1.9.3 Participate in scientific/professional meetings and contribute papers to scientific/professional journals
- 1.9.4 Use and/or develop outcome measures to review treatment procedures to determine best practice as outlined in BAPO 'Measuring Change' publication

1.10 Participation in the Multidisciplinary Team

When working in a multidisciplinary team the practitioner will:

- 1.10.1 Give professional guidance to the team regarding appropriate prosthetic and orthotic intervention, referral, assessment, prescription, specification, design and sourcing and how this may impact on overall treatment or management
- 1.10.2 Participate in the evaluation of the service users' needs and goals with a view to developing an effective and appropriate treatment including considerations of device/treatment function and design
- 1.10.3 Document pertinent information in the service users' clinical records
- 1.10.4 Assist in pre- and post-operative management of the service user
- 1.10.5 Make cross boundary referrals to other healthcare professionals or departments as appropriate
- 1.10.6 Participate in multidisciplinary training, research and audit

1.11 Medical, Legal and Ethical Requirements

The practitioner will:

- 1.11.1 Provide service user care which complies with medical, legal and ethical requirements including those that are specific to data protection and access to health records requests
- 1.11.2 Maintain insurance cover commensurate with minimum requirements. This should include:
 - (a) Professional indemnity
 - (b) Public liability
 - (c) Medical malpractice
 - (d) Product liability
- 1.11.3 Comply with Disclosure & Barring Service (DBS) or similar national certification as appropriate
- 1.11.4 Comply with BAPO Ethical Code and the registrant body Standards of Conduct, Performance and Ethics
- 1.11.5 Comply with relevant Health and Safety legislation
- 1.11.6 Comply with relevant national laws

1.12 Levels of Practice

BAPO recognises that the career development journey of a Prosthetist/Orthotist starts from qualification, as they progressively gain further education, training and experience which develops their knowledge, skills and practice, including that required to practise at higher levels of professional practice.

The level of complexity, uncertainty and risk managed by prosthetists and orthotists in their practice increases at each level of professional practice. These levels of practice include enhanced, advanced and consultant level practice. Practitioners will meet and build upon the standards in this document appropriate to their level of practice and role.

To provide additional clarity about these levels of practice, the table below provides an indication of the job titles typically used at each level of practice.

Level of practice	Indicative job titles
Enhanced practice	Specialist prosthetist Specialist orthotist Senior prosthetist Senior orthotist
Advanced practice	Advanced practitioner Advanced clinical practitioner Advanced prosthetist Advanced orthotist
Consultant practice	Consultant prosthetist Consultant orthotist

More information about enhanced, advanced and consultant level practice can be found in the BAPO document – Advanced practice in prosthetics and orthotics (2024).

1.13 Definition of Practice

- 1.13.1** In cases where the Prosthetist/Orthotist is returning to practice they will follow the standards stated in the HCPC document - Returning to Practice
- 1.13.2** For professionals working in education, management or research, the HCPC assures registrants that these activities are considered to be part of practice
- 1.13.3** For professionals who work on a voluntary basis, or do occasional part-time work, or who have moved into a role that is related to their profession, but not directly part of it, the HCPC have defined 'practising your profession' as drawing on your professional skills and/or knowledge in the course of your work. The HCPC states that individuals will need to make a personal decision about whether they are doing this
- 1.13.4** For dual-qualified Prosthetists/Orthotists who change to practice in the alternate discipline, an individual must be able to demonstrate that they meet all the HCPC standards of proficiency relevant to the areas in which they work. So, if they specialise in a particular area, they only need to meet the standards relevant to that area of work. The individual should have the skills, knowledge and experience in order to practise safely and effectively in their new area of practice. This means that the practitioner should exercise their personal judgement and decide whether they need additional training or experience to move into a new area.

Changing the area of practice is therefore an issue of professional judgement, with support from the employer or service provider where appropriate. HCPC requirements for CPD will support a Prosthetist developing into the areas of practice associated with Orthotists and vice versa.

2 Role of prosthetic/orthotic technicians and support workers

2.1 Introduction

This Standard explains the role and scope of practice of Technicians and Support Workers in prosthetics and orthotics as he/she/they assists the registered clinician in the delivery of treatment. As well as Technicians and Support Workers it should also be of particular interest to the service user, Prosthetist/Orthotist, prosthetic/orthotic student, other healthcare professionals and service commissioners.

2.2 Statement

- 2.2.1 This Standard applies to anyone whose role requires them to work under the direction of a registered Prosthetist or Orthotist to offer assistance during clinical or therapeutic interventions
- 2.2.2 This Standard covers Technicians' and Support Workers' roles in supporting the practitioner within the context of therapeutic interventions and clinical or technical procedures
- 2.2.3 The focus of the Standard is on being effective in an assisting role rather than the clinical/therapeutic skills involved in the intervention, which are covered by other guidelines

2.3 The Role of Technicians and Support Workers in Prosthetics and Orthotics

Technicians and Support Workers will need to know and understand:

- 2.3.1 That they are working in line with normal clinical governance protocols under the supervision of a registered Allied Health Professional who remains accountable for appropriate treatment of the service user
- 2.3.2 That treatment is being provided by the Technician or Support Worker on behalf of the registered professional and within the professional's legal registration
- 2.3.3 The implications for patient safety and comfort in the application of rehabilitation devices to the body
- 2.3.4 Why it is necessary to confirm the identity of the individual and obtain valid consent prior to working with an individual and the methods used to achieve this where the individual is not able to give their consent
- 2.3.5 Appropriate methods and procedures for communicating information to others and factors that facilitate an effective and collaborative working relationship
- 2.3.6 The type and range of information that might be needed by the practitioner prior to or during the course of a clinical/therapeutic intervention
- 2.3.7 Their own level of competence, authority and knowledge in relation to their role as a Technician or Support Worker
- 2.3.8 How to explain their role and procedures to individuals and relevant carers in terms that they will understand
- 2.3.9 How to manage the privacy and dignity of individuals throughout required procedures
- 2.3.10 Protocols and procedures relating to the clinical/therapeutic intervention to be undertaken

- 2.3.11 The importance of following standard precautions relevant to the clinical/therapeutic intervention and the potential consequences of poor practice
- 2.3.12 Policies and guidance relating to the moving and positioning of individuals and the impact they have upon work methods
- 2.3.13 Types of information it is appropriate to give others about an individual's treatment programme
- 2.3.14 The correct procedures to be followed where other colleagues' actions give cause for concern
- 2.3.15 Record keeping practices and procedures in relation to clinical/therapeutic interventions
- 2.3.16 Current European and national legislation, national guidelines and local policies and protocols which affect working practice in relation to providing assistance to practitioners during clinical/therapeutic interventions. In particular, Technicians and Support Workers specifically involved in the provision of prostheses and orthoses should be aware of the Health and Care Professions Council 'Standards of proficiency for Prosthetists and Orthotists'
- 2.3.17 Their responsibilities under current European and national legislation, national guidelines and local policies and protocols within the working environment
- 2.3.18 Policies and guidance which clarify Technician or Support Worker scope of practice and the relationship between the Technician or Support Worker and the practitioner in terms of delegation and supervision

2.4 Supervision of Technicians and Support Workers

- 2.4.1 The nominated overseeing Prosthetist/Orthotist takes responsibility for all treatments provided under his/her/their legal registration. Therefore, decisions on the level and type of supervision should be determined by the Prosthetist/Orthotist
- 2.4.2 For the safety of the service user, protocols and competencies should be regularly reviewed and supported
- 2.4.3 Prosthetic and Orthotic Technicians and Support Workers must not work in isolation, beyond authorised protocols, or beyond agreed competencies, but only within protocols written in accordance with applicable NHS policies on risk management. Technicians and Support Workers working outside of clear protocols or beyond their scope of practice do so at their own legal and clinical risk
- 2.4.4 Decisions on the level and type of supervision are the responsibility of the Prosthetist/Orthotist and should be based upon the following criteria:
 - The needs of the patient/client
 - The nature of the task
 - The experience and training of the Technician or Support Worker
 - The Technician's or Support Worker's familiarity with the task as well as the patient/client
 - The complexity of the task

2.5 Technician and Support Worker Performance

2.5.1 Technicians and Support Workers should be able to do the following:

- Work within their level of competence, responsibility and accountability and respond in a timely manner to meet individual's needs
- Ensure the safety and comfort of the service user in the application and removal of prosthesis/orthosis
- Ensure effective infection control at all times
- Respond promptly to requests and directions from the practitioner leading the prosthetic/orthotic intervention
- Check the service user's identity and that valid consent has been obtained
- Carry out delegated activities following the protocols and procedures related to the prosthetic/orthotic intervention in accordance with the individual's care/treatment plan and their own scope of practice in accordance with clinical governance
- Collaborate effectively and proactively during actions that require close team working
- Communicate required information to others clearly, accurately and in a timely fashion
- Ensure maintenance of the confidentiality of information in accordance with information governance
- Keep accurate, complete and legible records as directed by the Prosthetist/Orthotist, in accordance with local policies and procedure and information governance
- Take appropriate and prompt action in line with relevant protocols and guidelines where other colleagues' actions give cause for concern
- Recognise situations and problems that lie outside their competency and refer to the Prosthetist/Orthotist

2.6 The Training and Education of Technicians and Support Workers

2.6.1 BAPO recognises that employers and individuals may choose from a variety of educational packages to attain qualifications for Technician and Support Worker roles. BAPO supports validated courses as an option but recommends the Foundation Degree for Health and Social Care as a standard of excellence

2.6.2 To supplement education, work-based training of Technicians and Support Workers in orthotic and prosthetic provision within protocols should be led or guided by Prosthetists/Orthotists

3 Clinical record keeping

3.1 Introduction

The aim of this document is to provide practitioners with a useful tool in their clinical environment. The standard is based upon a number of key principles to underpin good records and record keeping. A fundamental principle is that all clinical records and imaging results should always be accessible to the practitioner and all others involved in service user provision.

3.2 Statement

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

3.3 The Purpose and Writing of Clinical Records

- 3.3.1 Clear documentation ensures effective continuous service user care
- 3.3.2 Service user contact records are legal documents and a statutory requirement
- 3.3.3 Note recording:
 - (a) Encourages logical thinking
 - (b) Provides a basis for critical analysis in decision making
 - (c) Standardises quality information for team members
 - (d) Forms the basis for future clinical and medical decisions
 - (e) Supports clinical audit and quality assurance
 - (f) Supports clinical effectiveness studies
 - (g) Informs retrospective and prospective research
 - (h) Provides statistical evidence for service development
- 3.3.4 Clinical records may be written using the Subjective, Objective, Assessment/ Analysis, Plan (SOAP) format;
 - (a) Subjective: information from the service user
 - (b) Objective: clinician's findings from assessment and observations
 - (c) Assessment/Analysis: differential diagnosis/document rationale of decision making/prescription
 - (d) Plan: state treatment plan/provide treatment/ service user education and instruction/ review/discharge/ future intervention/onward referral etc.
- 3.3.5 Clinical records may be written using the Problem Oriented Medical Records (POMR) if appropriate
- 3.3.6 Written clinical records must:
 - (a) Be factual, consistent and accurate
 - (b) Be contemporaneous, written within 24 hours of the intervention
 - (c) Provide current information on the care and condition of the patient
 - (d) Be written legibly in black ink and in such a manner that they cannot be erased or if computer recorded, be non-editable
 - (e) Be written so that any alterations or additions are dated, timed and signed
 - (f) Only be altered in such a way that that the original entry can still be read clearly. Any alterations should be scored out with a single line.

- (g) Be accurately dated, timed and signed, with the signature and status of writer being made clear
- (h) Written without gaps between entries
- (i) Not include abbreviations, jargon, meaningless phrases or offensive subjective statements
- (j) Be legible
- (k) Be written in terms that the service user also can understand
- (l) Be headed with concise patient details such as those on hospital adhesive labels

3.3.7 Records include all relevant letters, prescriptions and order paperwork

3.3.8 Records should clearly document where an entry is made following telephone contact

3.3.9 Digital records must meet the same auditing standards as would be expected of hand written notes.

3.4 Recommended Essential Information for Clinical Records

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

3.4.2 Referrals are normally accepted from a:

- (a) Medical Physician or Consultant
- (b) General Practitioner Doctor
- (c) Nurse or Allied Health Professional
- (d) Service user
- (e) Carer or parent on behalf of the service user

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

(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 8549:1989 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) Signature, name (in block capitals), date and time

(l) Designation: i.e. Pros/Orth, Orth, Pros

3.5 Audit

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

See **Appendix 1: Sample clinical records audit checklist**

3.6 Legal Implications

Service User Clinical Records can be called in evidence before a court of law either by the Health Service Commissioner or in order to investigate a complaint at a local level. HCPC registered Orthotists, Prosthetists or Prosthetist/Orthotists have both a professional and a legal duty of care. Record keeping should therefore be able to demonstrate:

- 3.6.1 A full account of assessment, treatment planned and treatment provided
- 3.6.2 Relevant information about the condition of the user
- 3.6.3 The measures taken in response to the user's needs
- 3.6.4 Evidence of understanding and conducting a duty of care and that any actions or omissions have not compromised the users' safety in any way
- 3.6.5 A record of any arrangements made for the continuing care of the service user

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

If record keeping is delegated to pre-registration students, the practitioner must ensure that they are competent, are supervised and that entries are countersigned. Practitioners are strongly advised never to use initials only as a signature

Practitioners must ensure compliance at all times with manufacturers' instructions regarding the fitting and/or adjustment of components or devices. Prosthetist/Orthotists are qualified to modify CE marked prostheses and orthoses but must ensure suitable risk assessment is undertaken when doing so and this must be documented. Practitioners must ensure that verbal and/or written instructions intended for patient use are given and that this is documented in the notes

3.7 Ownership and Access

Practitioners should assume that service user records will be scrutinised at some point. Service users not only have a legal right to see their records but are increasingly participating in writing and holding them

3.7.1 Access Legal Implications

The Access to Health Records Act 1990 gives Service users the right of access to manual health records about themselves which were made after 1 November 1991. The Data Protection Act 1984 gives patients access to their computer held records. It also regulates the storage and protection requirements of computerised patient information. Service user rights of access are defined in:

- Access Modification (Health) Order 1987
- Access to Medical Reports Act 1988
- Access to Health Records Act 1990
- Access to Health Records (Northern Ireland) Order 1993
- Data Protection Act 1998
- Human Rights Act 1998

The Information Commissioners Office sets out in detail the information rights of the public (www.ico.gov.uk)

3.7.2 Inter-Disciplinary Access to Records

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

3.7.3 Retention

The period for which clinical records must be kept depends upon the relevant legislation or NHS policy statements issued by the Department of Health.

Current applicable retention schedules are detailed in Appendix 3 of the Information Governance Alliance: Record Management Code of Practice for Health and Social Care 2016. Those working privately should retain records for the same duration as would be expected when working for the NHS

3.7.4 Ownership

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

3.7.5 Service user/Patient-held Records

Service users, parents or carers may hold the healthcare records. This is determined at a local level and may be appropriate following team consultation

3.7.6 Research and Education

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

3.8 Computer Held Records

Computer held records tend to be easier to read, require less clerical input, reduce the need for duplication and can improve inter-professional communications. Detailed guidance is available in Information Governance Alliance: Record Management Code of Practice for Health and Social Care 2016

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

4 Prosthetic and orthotic episodes of care

4.1 Introduction

This Standard is for use by service providers, service managers and professionals concerned with the delivery of safe and effective healthcare. It underpins clinical best practice

The aim of this document is to provide Prosthetists/Orthotists with a useful tool in the clinical environment. It will also serve as guidance for service managers and commissioners

4.2 Statement

The British Association of Prosthetists and Orthotists (BAPO) believes that all service users referred to a Prosthetist or Orthotist should follow a specified pathway of care involving initial assessment, review appointments and onward referral as necessary.

An episode of care is an inpatient episode, a day case episode, a day patient episode, an outpatient episode or an AHP episode. Each episode is initiated by a referral (including re-referral) or admission and is ended by a discharge

Each patient type, with a few minor exceptions, is associated with a type of episode of care

Examples are:

- an inpatient in an inpatient episode within a specialty
- an outpatient in an outpatient episode within a specialty
- an orthotic patient in an orthotic episode

These episodes comprise a series of service contacts as, for example, in an outpatient episode or a period of continuous contact as in an inpatient episode

All episodes of care should follow recognised processes with appropriate resources allocated to support the practitioner. Resources will include administrative and documentation support and suitable time allocations per service user to maximise clinical care and effectiveness

The care process must include a functional status assessment, goal setting, treatment planning and monitoring, and outcome measurement.

4.3 Assessment Standards

4.3.1 It is the duty of Prosthetist/Orthotist to determine the appropriateness of the referral and to respond to the referrer accordingly

4.3.2 Prosthetists/Orthotists are advised to ensure that they use suitable and effective referral documentation to enable all healthcare professionals to refer appropriately

4.3.3 The lead Prosthetist/Orthotist should be involved in setting up triage guidelines indicating priority and need for any further information or needs prior to a first appointment. In the absence of guidelines, it is essential that the Prosthetist/Orthotist triages the referral personally

4.3.4 The Prosthetist/Orthotist should decline to accept a referral or initiate treatment if, subject to any legal requirement to provide a minimum service, the basic standards of treatment or intervention cannot be met at any time, for whatever reason

4.3.5 When establishing resource priorities, the needs and requirements of the service users and carers should be taken into account wherever possible

- 4.3.6** Clinical Record Keeping Systems and Documentation:
- Practitioners must, without exception, make and keep clinical records of all care episodes
 - Practitioners are advised to consult the service user's clinical record prior to the commencement of treatment

For detailed guidance see:

- Health and Care Professions Council (HCPC) Standards
- Information Governance Alliance: Record Management Code of Practice for Health and Social Care 2016
- BAPO Standards of Practice 3: Clinical Record Keeping
- BAPO Ethical Code

- 4.3.7** Inappropriate referrals should always be referred back to the referrer

- 4.3.8** The practitioner should make the service user aware of the treatment options available for their condition and how treatment fits within the overall goals of the care pathway

- 4.3.9** The practitioner should clearly explain their clinical findings to enable the user to make an informed decision on available treatment options

- 4.3.10** Appropriate Assessment Documentation: Practitioners are advised to use documentation which is suited to local needs and requirements. Simple but comprehensive assessment forms can assist in rapid and effective note-taking

- 4.3.11** A practitioner or service user may request a second opinion from a different practitioner or clinical centre with specific regard to an orthotic or prosthetic prescription. Onward referrals should be made as appropriate

- 4.3.12** Practitioners should ensure that suitable arrangements are made for the routine review of prosthetic/orthotic treatment, preferably with specific time intervals determined by the level of complexity, nature of pathology or type of prosthesis/orthosis

- 4.3.13** Practitioners are advised that a procedure for the formal discharge of patients from the prosthetic/orthotic service should be available in the workplace

- 4.3.14** The practitioner, provided with a medical diagnosis, is competent to provide a differential clinical diagnosis and a prosthetic/orthotic prescription

- 4.3.15** The practitioner, when appropriate, should be able to ask for a chaperone to accompany the service user

- 4.3.16** The practitioner must preserve the dignity and comfort of service users at all times

- 4.3.17** The practitioner is advised to follow a documented procedure when treatment involves visits to a service user's home. In cases where known risks exist, they should take appropriate precautions including requesting an accompanying colleague

4.4 Treatment Times: Orthotics

- 4.4.1** Appointment lengths are recommended to be in blocks of 30 minutes, with multiple blocks allocated if one or more of the following applies:

- a) A complex pathology
- b) A cast, scan, or complex measurement
- c) A multidisciplinary assessment
- d) Difficulties in communication or behaviour
- e) More than one type of orthosis is likely to be required

This is not an exhaustive list and there may be other factors which would require a lengthier appointment as dictated by the Orthotist in line with local protocols.

- 4.4.2** Appointments include not only time spent with patient, but also time to complete other essential parts of that patient's care. Appointment lengths should include time for the following without exception:

- a) Clinical record-keeping
- b) The raising of any orders
- c) Completion of fitting instructions to technicians or manufacturers
- d) Cleansing of the clinical environment and equipment
- e) Completion of any onward referral
- f) Public health, or 'making every contact count' conversations

4.4.3 Appointments do not include the time required for the Orthotist to conduct essential user-related tasks which support clinical activity, including but not limited to

- a) Triage referrals
- b) Corresponding with clinical colleagues
- c) Responding to queries.

Where the Orthotist is also expected to complete these tasks, one or more blocks of 30 minutes may be left free per clinic to accommodate this as required.

4.4.4 Telephone appointments for triaging, screening, advice, and simple reviews may be appropriately scheduled less clinical time where an assessment is not conducted. Telephone appointments should be allocated a minimum of 10 minutes.

4.4.5 Virtual appointments including a video link should be allocated a minimum of 30 minutes. If, following a virtual assessment, it is decided that a face-to-face appointment is required; the in-person appointment time may be abridged to account for part of the assessment being completed previously by virtual means.

4.4.6 These recommended times are for competent practitioners only. For Orthotists with less than one year's experience or occupational health needs, times should be increased to reflect this.

4.4.7 If more time is required than is allocated at the appointment, this should be explained to the patient and a further appointment made with the required time. Appointments should not be rushed as this can lead to mistakes in care. It is the responsibility of the Orthotist to ensure adequate time is allocated for their patients and to manage their caseload safely, whilst optimising time spent and productivity.

4.4.8 Responsibility for screening and triaging written referrals lies with the Orthotist who may delegate this locally to a designated individual working within a defined protocol. This enables clinical prioritisation and allocation of appropriate treatment times.

4.5 Treatment Times: Prosthetics

4.5.1 Care episodes are recommended in 30-minute blocks. All treatment times, without exception, include time for a record to be made. This recommended time does not include the time required for the Prosthetist to conduct essential user-related tasks which support clinical activity

4.5.2 The date of a review appointment should be specified or ascertained on all occasions

4.5.3 The recommended times are for fully-competent practitioners only. For Prosthetists with less than one year's experience, or for more complex cases, it is advisable to increase these times to reflect the level of experience or complexity

See Appendix 2: Prosthetic appointment times

5 Standards for the work environment

5.1 Statement

The British Association of Prosthetists and Orthotists supports the view that a physical environment suitable and appropriate to the needs of the service user and the Prosthetist/Orthotist is an integral part of effective treatment

5.2 Introduction

The following information is intended to be useful to any organisation wishing to establish a new orthotic or prosthetic service, up-grade an existing service or audit their existing buildings and facilities. The standards should be regarded as minimum requirements

The safety, ease of access, privacy and dignity of the service user will be the main criteria in the maintenance of a suitable environment for prosthetic/orthotic practice

The prosthetic/orthotic clinic should have adequate space, facilities and equipment to support and encourage best clinical practice

The following information provides specific additions for the specialist prosthetic/orthotic environment

5.3 The Working Environment

The chief function of a prosthetic/orthotic clinic is to provide a safe environment for the service user and practitioner to provide specialist consultation, examination and treatment

Service users with high levels of disability and severe mobility problems are seen routinely in the work environment, therefore all user and practitioner facilities must take this into account

5.3.1 All service user areas must be suitable for purpose: reception, waiting, consultation, examination and treatment

5.3.2 Plaster casting and/or shape capture and measurement facilities must be available for the practitioner

5.3.3 A suitable service user walkway must be available for the practitioner. Gait assessment, whether observational or instrumental, is critical to the process of prosthetic/orthotic practice from assessment to the final dynamic check out of devices

5.3.4 A suitably-equipped; positive plaster cast rectification area must be available for practitioner use. Those using digital scans for shape capture must have access to relevant hardware and software to allow for modification of such scans.

5.3.5 Device adjustment facilities must be available and on-site fabrication facilities are preferable

5.3.6 Adequate storage, infection control and decontamination facilities are particularly important for safe practice

5.3.7 Where prosthetic and orthotic outreach services are conducted, efforts should be made to provide all of the above facilities

6 References

- British Association of Prosthetists and Orthotists (2024). Advanced practice in prosthetics and orthotics
- Health and Care Professions Council (2023). Standards of proficiency for prosthetists and orthotists.

7 Glossary of terms

Orthosis/orthotic device	Externally applied device used to modify the structural or functional characteristics of the neuro-muscular and skeletal systems
Orthotics	Science and art involved in treating patients by the use of orthoses
Orthotist	Person who, having completed an approved course of education and training, is authorised by an appropriate national authority to design, measure and fit orthoses
Prosthetics	Science and art involved in treating patients by the use of prostheses
Prosthesis/prosthetic device	Externally applied device used to replace, wholly or in part, an absent or deficient limb segment. (Note: It includes any such device having a part within the human body for structural or functional purposes)
Prosthetist	Person who, having completed an approved course of education and training is authorised by an appropriate national authority to design, measure and fit prostheses
Prosthetist/Orthotist	Person who, having completed an approved course of education and training, is authorised by an appropriate national authority to design, measure and fit orthoses and prostheses

Source: *International Standard ISO 8549-1: 2011*

8 Further information

Further information is available from the BAPO Secretariat. This standard is regularly reviewed and we welcome your comments.

Review Date: November 2024 Next Review date: May 2026



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HCPC Guidelines can be found at www.HCPC-uk.org

9 Appendices

APPENDIX 1:

Sample clinical records audit checklist (orthotics and prosthetics)

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

Use of the document

For each question 100% compliance is required for the total number of notes audited

If 100% compliance is achieved, write YES (Y) in the finding box. If 100% non-compliance is found, write NO (N) in the finding box

If a mixture of compliance and non-compliance is found, write PARTIAL (P) in the finding box. Following this then document the % of non-compliance found in relation to the total number of notes audited. Write this in the “% of non-compliance if P” box. When auditing electronic notes some fields will be non-appliance and this should be noted.

LEGIBILITY

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

IDENTIFIABLE

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

ATTRIBUTABLE TO THE AUTHOR

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

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

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

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

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

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

CORRECTIONS OR ALTERATIONS TO ORIGINAL ENTRY (where applicable)

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

CONTENTS

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

STRUCTURE OF NOTES

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

APPENDIX 2: Prosthetic appointment times

The recommended contact time for all diagnostic fittings, primary deliveries, adjustments and reviews is 60 minutes with both upper and lower limb amputees. A detailed breakdown of other recommended contact times is shown in the following tables.

These contact times are for guidance and it is expected that in some instances longer time slots will be required. The clinician must consider the service user holistically when scheduling appointments as comorbidities or social circumstances may warrant extension of planned contact times.

The treatment times tabled below refer to the amount of time required to deal with a single disabling condition requiring one prosthesis. Multiple limb absence would require more time slots to be booked.

These treatment times are expected to be sufficient for experienced clinicians. Those who are beginning a post-graduation preceptorship pathway or who expanding their clinical skills into wider fields must ensure that treatment times are increased until routine experience and skills are developed. The extent of additional time required will likely vary on a local level depending on many factors such as supervision, complexity of caseload, familiarity of administration duties, need to document reflections, etc.

Scheduling of sessions must avoid excessive physical demands on the clinician, which are associated with some casting methods and other clinical procedures. It has been reported that the prosthetic and orthotic professions are subject to risk factors for work-related musculoskeletal disorders (Anderson et al, 2015). Where appropriate risk assessment should be undertaken to generate a plan to safely perform tasks that may pose an increased risk.

TABLE 2: Recommended Treatment Times for Lower Limb Prostheses

	Transtibial/Partial Foot	Transfemoral/ Knee Disarticulation	Hip Disarticulation/ Transpelvectomy
Primary Assessment cast/measure	60	90	90
Primary fitting	60	90	150
Primary fit/delivery	120	150	-
Cast and measures	60	60	90
Trial Evaluation	60	90	120
Delivery	30	60	60
Fit/delivery	90	120	-
Emergency repairs	30	30	60

TABLE 3: Recommended Treatment Times for Upper Limb Prostheses

	Transtibial/Partial Hand	Transhumeral Disarticulation	Shoulder Disartic/ Forequarter
Primary Assessment cast/measure	60	90	90
Primary fitting	60	90	150
Primary fit/delivery	120	150	-
Cast and measures	60	60	90
Trial Evaluation	60	90	120
Delivery	30	60	60
Fit/delivery	90	120	-
Emergency repairs	30	30	60

BAPO note that in some circumstances a Prosthetist may undertake more than one stage of the treatment cycle within a single clinical contact. In such a scenario BAPO advise treatment times should be lengthened to ensure that all stages can be completed fully within the given contact time. The Prosthetist must extend contact time appropriately to suit the specific tasks, in accordance to their level of practice. BAPO recommend that all stages of the treatment cycle are undertaken for each episode of patient care. Aspects of this may be undertaken by Technicians and Support Workers who are supervised by the clinician as outlined in the Section 2 of these standards (Role of Prosthetic/Orthotic Technicians and Support Workers).



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