Clinical audit tools
Clinical audit tools
Contents

Introduction

Core standards patient record audit
Patient record audit methodology
Patient record audit data collection form

Core standards continuing professional development/lifelong learning (CPD/LLL) audit
CPD/LLL audit methodology
CPD/LLL audit data collection form

Core standards peer review
Peer review methodology
Peer review form

Patient feedback audit
Patient feedback methodology
Patient feedback questionnaire

Service standards audit
Service standards audit methodology
Service standards audit data collection form
'Clinical audit is the systematic and critical analysis of the quality of clinical care including diagnostic and treatment procedures, associated use of resources and outcomes and quality of life for the patient’ (Department of Health, 1989*)

Clinical audit is a cyclical process, involving the identification of a topic, setting standards, comparing practice with the standards, implementing changes and monitoring the effect of those changes. Its purpose is to improve the quality of clinical care.


Figure 1
The Clinical Audit Cycle
The first stage in the audit cycle has been prepared for you – the setting of core and service standards, which can be found in the other documents contained in this pack. This audit tools document will allow you to complete the second stage – comparing practice with the standards. Locally, it will then be possible to identify any underlying reasons for not achieving the standards, and to implement any changes required.

This revision of the CSP Standards of Physiotherapy Practice pack is the first to include a set of clinical audit tools. The different tools are designed to measure performance in different ways, depending on the source of information that will indicate whether the standards and criteria have been met. Together, the five audit tools will allow you to carry out a comprehensive audit of both the core and the service standards. Of course you don’t need to use all the audit tools at the same time, the audit can be done in stages.

- **Core standards patient record audit**

  The patient record audit tool measures standards and criteria for which the patient record provides ‘evidence’ of compliance, for example that the patient’s treatment plan is documented (core standard 8.4). A patient record audit data collection form has been devised for this purpose. Much of physiotherapy practice is recorded in the patient record and needs to be of a high quality to ensure continuity of care and fulfil legal requirements.

- **Core standards continuing professional development / life long learning (CPD/LLL) audit**

  A CPD/LLL audit data collection form has been devised to audit the core standards which relate to CPD/LLL (core standards 19 to 22). Evidence of compliance with these standards is likely to be found in the documentation within an individual’s CPD/LLL portfolio.
• **Core standards peer review**
  Peer review provides an opportunity to determine the appropriateness of the clinical decisions made at each stage of the patient episode. Some of the core standards cannot be measured through documentation or patient feedback, and it is recommended that these be subject to peer review. Peer review relates mainly to areas requiring a clinical reasoning process, for example how the clinical diagnosis was derived or why particular interventions were chosen. Guidance is provided for carrying out a suggested model of peer review and a peer review form has been devised.

• **Patient feedback audit**
  The patient feedback audit measures those standards and criteria where the patient is best placed to judge conformance, for example core standard 2.3 ‘The patient is given the opportunity to ask questions’. Similarly, standards and criteria that have been designed to measure elements of practice such as effective communication, being courteous and respecting patients’ dignity, cannot be easily measured using documentary evidence. To assess these standards, a patient feedback questionnaire has been devised.

• **Service standards audit**
  In addition to the previous tools, which concentrate on areas of practice relating to individual physiotherapists, the service standards audit tool will assess the conformance of the organisation against the service standards and criteria.
One of the key aspects of clinical audit is confidentiality. The reporting of audit results always respects the confidentiality of patients and usually of health professionals, in order to keep the process non-threatening.

However, some physiotherapists may wish to compare their practice with others. Some will want to identify their individual performance, for example as part of their assessment of learning needs (core standard 19.1) or to provide evidence that learning objectives have been met (core standard 22.1), and to include this in their CPD/LLL portfolio. In these circumstances it is usual to code the audit results so each physiotherapist is aware of their own identity, but not that of others.

Clinical audit is a professional development activity, not a procedure to identify negligent practice or gain evidence for disciplinary purposes. When clinical audit is implemented in a positive way, the benefits and acceptance from physiotherapists is likely to be far greater. These audit tools will help physiotherapists provide the highest standards of care, rightly demanded by the general public.
Patient record audit methodology

The steps laid out in this section for carrying out a patient record audit are intended to serve as guide. Some NHS organisations may have clinical audit staff that can help with the audit process, providing support and expertise in this task.

Select a sample
A random selection of patients’ records should be used. Randomisation can be undertaken in many different ways. The most important aspect is that sources of potential bias are excluded. If you require a sample of 20 per cent of one month’s records, an easy option is to take all that month’s records and randomly start at any place in the collection, then select every fifth set of records. An alternative is to use a computer, calculator or random number table to select numbers, which would correspond to each set of records. When consecutive patient’s records are used, it is important to ensure that the records for all the consecutive patients are used. Using a systematic method ensures that the sample represents the ‘normal’ patient record accurately. Sample size depends a great deal on the service/practice configuration so definitive advice is inappropriate. Examples for deciding the sample size are:

- 20 per cent of the patients seen in the last month (for large services this could result in a very large sample).
- 10 patient records from each physiotherapist (for small practices this could result in a very small sample).
- 100 records from the last patients discharged (not appropriate for services that discharge small numbers of patients).
- If there are a number of specialties in the department, it may be appropriate to select a proportion of records from each specialty.

It is important that the sample is large enough to represent the range of practice included in the audit, but still remain manageable. The Research and Clinical Effectiveness Unit at the CSP can provide more detailed advice if necessary.
2 Obtain patient records
Depending on local systems, obtaining the records may be a task undertaken by the medical records department, secretary or administrative assistant.

3 Complete the data collection form
The form that accompanies this section is designed to assess conformance with specific standards and criteria. The forms may be freely photocopied and further locally defined audit questions added as necessary (a blank page is included at the end of the form). There is a number next to each check box, which cross references to the numbering of the criteria in the core standards. This will assist with interpretation. ‘Not applicable’ (n/a) boxes are provided for situations where the criteria do not apply to a particular patient. For example, core standard 9.3 is n/a if the patient is not in receipt of any loaned equipment.

4 Analyse the data
To protect patient confidentiality, data that is entered on to a computer should not include patient identifiers. If it is necessary to use an identifier to cross reference patients, a code or index number (not the patient’s hospital number) should be used.

Results are most usefully expressed in terms of the proportion of records that conform to the criteria, quoted as a percentage. Care should be taken when processing the data items that include ‘not applicable’ responses. In these cases the percentages should be calculated on the responses excluding the ‘not applicables’. For example:

- 100 patient records analysed
- 20 were ‘not applicable’
- 60 records conform to the criteria

Only the 80 applicable records should be included in the analysis, therefore the percentage is

\[
\frac{60}{80} \times 100 = 75 \text{ per cent}
\]
Results are normally analysed in an aggregated form so that the conformance to the standards for all the physiotherapists is assessed. It is sometimes useful for physiotherapists to audit their individual patient's records which may be of benefit to small services, or for the purposes of demonstrating CPD. If it is considered necessary to identify individual physiotherapist's results in a larger sample, it is good practice to use codes to identify the physiotherapists. Each physiotherapist is given their own code, but not that of their colleagues. This coding should be revealed only with the consent of all participants.

**Interpret the results**

Interpretation is very dependent upon local circumstances. It is essential that the reasons for not achieving the standards are understood and plans agreed by those involved in the audit before any changes are implemented. The management of the change is most effective when the process is ‘owned’ by the participants, rather than being imposed.

**Re-audit**

This is a much neglected part of the audit process, nonetheless a very important one. It is only through the regular, systematic approach to audit and re-audit that improvements can be measured. It is recommended that the audit is repeated at least annually.
Patient record audit data collection form

One form should be completed for each patient record. Please photocopy as many forms as necessary. Please place a cross [✓] in the box to indicate a positive response.

Informed consent

2.8 The patient’s consent is documented [✓] [ ]

Assessment

5.1 There is written evidence of a compilation of data consisting of:
   a the patient’s perceptions of their needs [✓] [ ]
   b the patient’s expectations [✓] [ ]
   c demographic details [✓] [ ]
   d presenting condition/problems [✓] [ ]
   e past medical history [✓] [ ]
   f current medication/treatment [✓] [ ]
   g contraindications/precautions/allergies [✓] [ ]
   h social and family history/lifestyle [✓] [ ]
   i relevant investigations [✓] [ ]

Examination

5.2 There is written evidence of a physical examination that includes:
   a observation [✓] [ ]
   b use of specific assessment tools/techniques [✓] [ ]
   c palpation/handling [✓] [ ]

6.6 The result of the outcome measurement is recorded [✓] [ ]

6.7 The result of the outcome measurement is recorded at the end of the episode of care [✓] [ ]

Analysis

There is written evidence of:

7.2 Identified needs/problems [✓] [ ]
7.3 Subjective markers being identified [✓] [ ]
7.4 Objective markers being identified [✓] [ ]
7.5 A clinical diagnosis [✓] [ ]

Guidance: This is the physiotherapist’s assessment of the problem (not the medical diagnosis)
THE CHARTERED SOCIETY OF PHYSIOTHERAPY

Treatment planning

8.4 The plan documents:
   a time scales for implementation/review
   b goals
   c outcome measures
   d the identification of those who will deliver the plan

Implementation

9.1 Interventions are implemented according to the treatment plan
9.2 All advice/information given to the patient is recorded
9.3 There is a record of equipment loaned and issued to the patient

Evaluation

10.1 There is written evidence that:
   a the treatment plan is reviewed at each session
   b subjective markers are reviewed at each session
   c objective markers are reviewed at each session
10.2 All changes, subjective and objective, are documented
10.3 Any changes to the treatment plan are documented
10.4 Outcome is measured at the end of the treatment programme

Transfer of care/discharge

11.2 Arrangements for transfer of care/discharge are recorded in the patient’s record
11.3 When transferred, information is relayed to those involved in their on-going care
11.4 Discharge summary is sent in keeping with agreed local policy

Documentation

14.1 Patient records are started at the time of the initial contact
14.2 Patient records are written immediately after the contact with the physiotherapist or before the end of the day of the contact
14.3 Patient records are contemporaneous

Guidance: Records are not added to after the time of writing
14.4 Patient records conform to the following requirements:

a. concise
b. legible
c. logical sequence
d. dated
e. signed after each entry/attendance
f. name is printed after each entry/attendance
   Guidance: Where patients are treated by the same physiotherapist throughout, it is sufficient for a printed name to appear once on each side of each page
g. no correction fluid is used
h. written in permanent photocopyable ink
i. errors crossed with a single line
j. errors initialled
k. each side of each page is numbered
l. patient’s name and either date of birth, hospital number or NHS number are recorded on each page
m. abbreviations are contained within a locally agreed glossary

15.1 There is evidence that patient records are retained securely:

- written records
- computer records
- audio tapes
- emails
- faxes
- video tapes
- photographs

Patient and physiotherapist safety

16.1 There is written evidence of a risk assessment

16.2 There is written evidence that action has been taken as a result of the risk assessment
Locally defined audit questions

This page has been provided to allow for optional locally defined audit questions to be added if necessary.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
CPD/LLL audit methodology

This audit tool evaluates the process of CPD/LLL, and refers to core standards 19 to 22. For most physiotherapists this process is recorded in a portfolio. The term ‘portfolio’ is used throughout the CPD/LLL standards and audit tools. Other terms such as journal, learning log or personal development plan are used interchangeably and are equally applicable; all provide tangible means by which improvements in practice can be demonstrated to others, as a result of learning.

The portfolio is a private and personal document, and should be used and organised in a way that best suits the individual. From the portfolio, evidence can be drawn out for a particular purpose, for example:

- assessment of learning needs
- job application and interview process
- applying for accreditation of prior learning from an academic institute
- individual performance review
- potential re-registration requirements

The audit tool should be used at least every six months to monitor the progress of the CPD/LLL process.

For further information, paper no. CPD 6, Keeping a portfolio – getting started, is available from the Education department, CSP.
CPD/LLL audit data collection form

One audit data collection form should be completed for each physiotherapist. Please photocopy as many forms as necessary. Please place a cross [x] in the box to indicate a positive response.

Assessing learning needs

19.1 There is written evidence of an assessment of learning needs

This assessment takes account of:

a development needs related to the enhancement of an individual's current scope of practice
b feedback from performance data
c mandatory requirements
d new innovations in practice
e the needs of the organisation
f career aspirations

Planning CPD/LLL

20.1 There is a written plan based on the assessment of learning needs

20.2 The plan includes learning objectives

20.3 The plan identifies activities to achieve the learning objectives

Implementing the plan

21.1 There is written evidence that the plan has been implemented

21.2 The plan is reviewed at least six monthly

Evaluating the plan

22.1 There is evidence that the learning objectives have been met

22.2 New learning objectives are developed to continue the cycle
Peer review methodology

Peer review provides an opportunity to evaluate the clinical reasoning behind the content of the documentation about the patient episode, in order to consider the appropriateness of the clinical decisions made at each stage of the patient episode. The process relates most closely to core standards 4 to 11, the section on the Assessment and Treatment Cycle.

This method enables the clinical reasoning skills of the physiotherapist to be evaluated by a peer. This must not be confused with other forms of professional assessment; it is not a means of judging an individual’s competence to do their job, neither is it a method of clinical supervision or appraisal. (For further information PA 45, Clinical supervision* is available from the Professional Affairs department.)

There are a number of different methods of peer review which could be used. One model, which included observation of practice, was considered too difficult to implement. This view was shared equally by both private and public sector physiotherapists in the standards of physiotherapy practice pilot sites. Individuals felt their behaviour would not be entirely natural if they were being observed and it would only give a ‘snapshot’ of their practice skills, rather than their evaluative and reasoning skills, throughout the whole patient episode. It was agreed to follow the model outlined in this guide.

---

Introduction
Core standards patient record audit
Core standards CPD/LLL audit
Core standards peer review
Patient feedback audit
Service standards audit
Peer review should be approached with commitment, integrity and trust. It can then be an excellent learning opportunity for both parties involved, enhancing clinical reasoning, professional judgement and reflective skills. Whilst this will be the case for the vast majority of physiotherapists, conflict may arise when an individual’s poor clinical reasoning results in the safety of the patient being put at risk. In these exceptional circumstances, peers are directed to the advice set out in Rule V of the CSP Rules of Professional Conduct, (CSP, 1996)* when a more formal procedure may be required, in the best interests of patient care. On a more positive note, for the majority of physiotherapists, evidence of participation in a peer review process (as peer or physiotherapist) should be used as a part of an individual’s demonstration of their continuing professional development and recorded in their CPD portfolio.

* Chartered Society of Physiotherapy (2000), PA 45 Clinical Supervision, CSP, London

The paragraphs listed on the following pages provide guidance on the process of carrying out peer review:
1 **Select a peer**

For the individual to gain maximum benefit from peer review, it is important that they are able to select their own peer. This is one factor which distinguishes peer review from clinical supervision and appraisal. The following criteria serve as a guide to identify a suitable peer:

- The peer should be similar in terms of grade, or experience or qualification or knowledge or skill or any combination of these. (For some physiotherapists there may be a preference for a peer who is of a higher grade, but that is their individual choice.)
- The selected peer should carry a similar complexity of caseload or casemix. This may not necessarily be from the same speciality.
- The peer should work in a similar type of practice or situation.
- There is mutual respect and a comfortable professional relationship.
- The peer is happy to participate.

2 **Arrange a suitable date and time**

The review process should take approximately two hours.

3 **Select patient notes**

The reviewer randomly selects a set of patient notes. This should be from a batch of the last twenty patients the physiotherapist has managed. This process of selection is dependent on local circumstances, and it is therefore the responsibility of the physiotherapist and the peer to make appropriate arrangements.

4 **Review the notes**

The notes are reviewed by the peer, to familiarise themselves with the patient episode. At this stage the physiotherapist being reviewed may wish to re-familiarise themselves with the detailed content of the notes.
Discussion of the episode of care

This should focus on the evaluation of the individual's clinical reasoning skills throughout the patient episode. The following seven questions, which relate directly to the standards, have been formulated to structure the discussion. This should take approximately one hour:

- What sources of information did you consider to assist you with the assessment process? (core standard 4)
- How did you reach a clinical diagnosis, or identify the patient's main problems? (core standard 7)
- How did you decide which outcome measure to use? (core standard 6)
- How did you select the treatment techniques to meet the specific needs of the patient? (core standard 8)
- To what extent did you meet the expectations of the patient? (core standard 10)
- How was each stage of the episode of care evaluated? (core standard 10)
- Was it necessary to communicate with other professionals? If so, did this raise any particular issues? (core standard 13)

Issues arising from the discussion

Any issues raised during discussion, which both peer and physiotherapist feel are important, should be documented on the peer review form. The peer has a responsibility for reflecting only what has been agreed between the two individuals, in the review session. The peer review form should be kept in the physiotherapist's portfolio, as evidence of learning.

Identify areas for education and development

The peer has a responsibility for identifying potential areas for further education and development, in agreement with the physiotherapist. Both parties can then formulate a timed action plan.

Re-review date

A date for re-review is set. It is important that the process is regular and undertaken at least annually.
Peer review form

A peer review was carried out on (date)

Name of physiotherapist
Place of work  Telephone

Name of peer reviewer
Place of work  Telephone

Summary of issues raised during discussion

Agreed suggestions for further education and development

Action plan

Re-review date

Signature of physiotherapist
Signature of reviewer
Patient feedback methodology

‘Patients are the most important people in the health service. The NHS has to be shaped around the convenience and concerns of patients. To bring this about, patients must have more say in their own treatment and more influence over the way the NHS works.’

Alan Milburn, Secretary of State for Health, The NHS Plan, July 2000

The involvement of patients in sharing decision-making about their care with health professionals, and monitoring the quality of that care is growing. This is supported by recent government initiatives and patient groups. In developing the patient feedback component of these audit tools it is recognised that only patients can be the final arbiters of what constitutes quality care. Physiotherapy cannot be considered high quality unless it is effective, efficient and acceptable to patients. The patient feedback questionnaire provides the means to measure the standards and criteria that the other audit tools in this document cannot and/or those where patients are best placed to judge conformance.

There are practical problems with identifying the characteristics of a ‘typical patient’. Some lay people will be apprehensive about getting involved with this type of exercise and can feel intimidated by the idea. In spite of possible difficulties, patient feedback is a vital component of auditing the Society’s standards. The following paragraphs provide guidance on the process of obtaining patient feedback.

1 Identify a sample

A sample that generates 80-100 questionnaire returns from patients should provide robust information. Response rates vary from about 30 per cent to 90 per cent depending on the characteristics of the patient group and the way in which the questionnaire is administered, so be prepared to increase the sample size appropriately.

2 Collect the data

Some suggestions of good practice are outlined below:

• Inform the clinical governance/consumer affairs leads (where they exist) that this exercise is being carried out. They will be pleased you are doing this work and may provide support, encouragement and assistance with the process.
• In some areas approval from the local Research Ethics Committee is required
to send out questionnaires of this type. Whilst this is rare, local arrangements
should be followed.

• Where there are no other options than for the physiotherapist to give out
the questionnaires, first ensure the patient is happy to participate. A careful
explanation given personally ensures a greater response rate. If an individual
is not willing to participate, they always have the right to decline without fear
of this affecting any subsequent care.

• If the questionnaire is sent out by post unannounced, take great care to ensure
the patient is still at the same address and able to complete the questionnaire.
(sending a questionnaire to a deceased patient is very distressing for relatives
and carers). Always provide a contact name and number in case of any queries.

• A personalised covering letter and a postage paid envelope should be used
to increase the response rate.

• To encourage honest feedback patients should be assured the comments
they give remain confidential.

• If a questionnaire reply is not forthcoming, a polite reminder may be helpful.
However, patients should not be coerced into participating.

• An independent person/agency should receive the returned questionnaires
so the patient does not feel uncomfortable about physiotherapists reading
anything they may write. Advice and practical help may be available from
your local department responsible for consumer affairs.

3 Analyse the data
See previous section in the patient record audit.

4 Interpret the results
See previous section in the patient record audit.

5 Re-audit
See previous section in the patient record audit.

If you need help to provide patient feedback questionnaires
in alternative languages or formats, contact:
The Research and Clinical Effectiveness Unit
14 Bedford Row
London WC1R 4 ED
Patient feedback questionnaire

This questionnaire has been developed by the Chartered Society of Physiotherapy, the professional organisation for chartered physiotherapists, in order to improve physiotherapy services. You have been selected to take part in this important survey about the physiotherapy care you have received. If you are happy to participate we would be grateful for a few minutes of your time to complete this questionnaire.

If you would like to talk to someone about the questionnaire or answer any questions, please contact:

There are no right or wrong answers. It is for you to decide on the quality of your experience. This will help the service to improve the care it provides. The information will be confidential, and you will not be identified to any of the physiotherapy staff. Please tick the appropriate box(es) and write in the spaces provided.

1. If a person other than the patient completes this questionnaire, please indicate your relationship:
   - husband/wife/son/daughter
   - parent/guardian
   - other family
   - carer

2. Were you treated by:
   - a student
   - a physiotherapist
   - a physiotherapy assistant
   - other
   - don’t know
Before your first visit

2.1 How long did you have to wait for your first appointment?
- under 24 hours
- 1-7 days
- between 1 and 4 weeks
- between 1 and 2 months
- more than 2 months

2.2 I was offered a choice of appointment times

Your treatment sessions

3.1 I was addressed by the name of my choice
3.2 The staff were courteous and considerate
3.3 I was not given a chance to say what was on my mind
3.4 I felt involved in deciding about my treatment plan
3.5 The physiotherapists listened to what I said
3.6 The physiotherapist told me what I could achieve
3.7 The physiotherapist had a manner which made me feel uneasy

4.1 We aim to be sensitive to your particular expectations. Did we succeed?

If no, please explain:
4. 2  **We aim to be sensitive to your fears and anxieties.**  

Did we succeed?  

[ ] [ ]  

If no, please explain:  


5. 1  Were you informed of the name of the therapist responsible for your care?  

[ ] [ ] [ ]  

5. 2  Were you given a choice of options for your treatment?  

[ ] [ ] [ ]  

5. 3  Were you encouraged to say what you wanted?  

[ ] [ ] [ ]  

5. 4  By the end of your first visit, were the results of the assessment explained?  

[ ] [ ] [ ]  

6. 1  I was asked to do things I didn't agree to  

[ ] [ ] [ ] [ ] [ ]  

6. 2  I was given all the privacy I needed  

[ ] [ ] [ ] [ ] [ ]  

6. 3  The physiotherapist used words I didn’t understand  

[ ] [ ] [ ] [ ] [ ]  

6. 4  The physiotherapist was quite rough when giving me my treatment  

[ ] [ ] [ ] [ ] [ ]
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 . 1 The physiotherapist explained the benefits and risks to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 . 2 I was given the chance to ask questions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 . 3 I was told of my right to decline treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 . 4 If you were offered treatment by a student, were you also given the option of being treated by a qualified physiotherapist?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 . 5 I was told how well I was doing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 . 6 They asked for my permission before talking to my friends/family</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 . 7 If other health professionals were involved in your care, did the physiotherapist discuss with you allowing them access to information about your physiotherapy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 . 8 If you had to do exercises at home, were you given a clear explanation of what to do?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 . 9 If you had photographs or video taken, did you sign a consent form?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 . 10 If you were left alone during your treatment session, were you told how to call for help?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Your discharge** (if this is not applicable, please go on to question 9)

Once you have completed your treatment plan, discharge arrangements should be made so things go smoothly.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 . 1 I felt involved in the plans for my discharge</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 . 2 I was given enough advance warning of my discharge</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 . 3 I understood the physiotherapist easily</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 . 4 All the plans for my discharge went smoothly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9 If you were given equipment to use at home, were you given instructions? |     |    |            |
General impressions

Please indicate your overall impression of the physiotherapy care you have received.

10.1 Overall, I was very satisfied with my care
10.2 I didn’t recover as well as I had hoped
10.3 The physiotherapy was a complete waste of time
10.4 I enjoyed coming for physiotherapy

11 Please add any further comments that will help us improve the care we provide:

Thank you for your help in completing this questionnaire.
Please return the completed questionnaire to:
Service standards audit methodology

The use of the service standards audit data collection form is intended to serve as a checklist for services. It follows the same concept as the previous audit tools and as such they will serve either to demonstrate that the service complies with the standards, or that improvements should be made. Many physiotherapy managers will be able to read through the standards with their current knowledge, assessing whether their service complies with the standards. Whilst this is a useful familiarisation exercise, the use of the accompanying audit tool will make the process more formal. Completing the form requires the production of evidence (possibly not always written evidence) that certain structures and procedures are in place. The standards cannot be exhaustive and, for example, if the standard requires a clinical governance strategy, the audit tool will provide the means to assess whether there is or there is not a clinical governance strategy present, but cannot assess its quality or relevance. This is beyond the scope of these standards. The number next to each check box cross references to the numbering of the criteria in the service standards.

These standards aim to reflect the diversity of physiotherapy services in the UK. However there are instances in many services where the standards are genuinely not applicable, or the responsibility lies elsewhere. In these circumstances simply proceed to the next applicable standard.
**Service standards audit data collection form**

Please place a cross [x] in the box to indicate a positive response.

**Clinical governance**

There is evidence of:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Clinical governance strategy</td>
<td>[ ]</td>
</tr>
<tr>
<td>1.2</td>
<td>Locally agreed standards of practice for common conditions</td>
<td>[ ]</td>
</tr>
<tr>
<td>1.3</td>
<td>Routine collection and analysis of information about the service:</td>
<td></td>
</tr>
<tr>
<td>a</td>
<td>clinical outcomes</td>
<td>[ ]</td>
</tr>
<tr>
<td>b</td>
<td>complaints</td>
<td>[ ]</td>
</tr>
<tr>
<td>c</td>
<td>adverse events</td>
<td>[ ]</td>
</tr>
<tr>
<td>d</td>
<td>accident reports</td>
<td>[ ]</td>
</tr>
<tr>
<td>e</td>
<td>waiting times for appointment</td>
<td>[ ]</td>
</tr>
<tr>
<td>f</td>
<td>waiting times within the department</td>
<td>[ ]</td>
</tr>
<tr>
<td>g</td>
<td>DNAs</td>
<td>[ ]</td>
</tr>
<tr>
<td>h</td>
<td>reports to referrers</td>
<td>[ ]</td>
</tr>
<tr>
<td>i</td>
<td>clinical education provision</td>
<td>[ ]</td>
</tr>
<tr>
<td>1.4</td>
<td>Action taken in response to criterion 1.3</td>
<td>[ ]</td>
</tr>
<tr>
<td>1.5</td>
<td>An annual physiotherapy clinical governance report</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
### Risk management

There is evidence of:

1. Clearly documented procedures for the management of risk
2. Training to undertake risk assessments
3. The findings from risk assessments are analysed and work practices reviewed and changed
4. Managers have checked the state registration certificate of all physiotherapists annually
5. A system to ensure all physiotherapists have skills and experience in the areas in which they are required to work
6. A procedure to recognise and correct poor clinical performance
7. Action on any new guidance about equipment safety

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.7</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Clinical audit

There is evidence that:

1. The clinical audit programme takes account of:
   a. national priorities
   b. the priorities of the service
   c. patient priorities
2. All physiotherapists participate in a regular and systematic programme of clinical audit
3. The documented results and recommendations from clinical audit are made available through the clinical governance process
4. Physiotherapists participate in multiprofessional clinical audit, where it is undertaken
5. Changes in practice implemented as a result of the clinical audit programme

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Evidence based practice

There is evidence that there are links with:

4.1 a CSP and CSP Clinical Interest and Occupational Groups [ ] [ ] ____________
b patient/user organisations [ ] [ ] ____________
c professional bodies [ ] [ ] ____________
d Institutes of Higher Education [ ] [ ] ____________
e national sources of critically appraised reviews [ ] [ ] ____________

4.2 Physiotherapists have access to:

a library and library search facilities [ ] [ ] ____________
b internet facilities [ ] [ ] ____________

4.3 There are systems for disseminating information about effective practice [ ] [ ] ____________

Complaints

There is evidence that:

5.1 Users of the physiotherapy service have access to information about the complaints procedure [ ] [ ] ____________

5.2 All physiotherapists understand their role within the complaints procedure [ ] [ ] ____________

5.3 Complaints are dealt with within a locally defined time-scale [ ] [ ] ____________

5.4 Complaints are monitored [ ] [ ] ____________
**Human Resources**

**Continuing professional development/Lifelong learning**

There is evidence that:

6.1 The service supports the implementation of the physiotherapists CPD/LLL plan

6.2 Records of CPD/LLL plans are maintained

6.3 The development and learning needs of the service are evaluated on an annual basis

There is evidence that:

7.1 The provision of student clinical education is addressed in workforce planning

7.2 There is documentation detailing the agreed arrangements for clinical education placements

7.3 The provision of clinical education placements is monitored

7.4 The service responds to the evaluation of the student’s learning experience

7.5 There is regular liaison with the clinical co-ordinators of Higher Education Institutes

7.6 Clinical educators are supported

7.7 Induction material is made available to the students prior to the start of the placement

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>6.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.7</td>
</tr>
</tbody>
</table>
**Induction**

There is evidence that:

8. 1 A named person is responsible for the planning, implementation and evaluation of the induction programme

8. 2 A written copy of the induction programme is given to each new physiotherapist

8. 3 The induction programme is completed within locally agreed time-scales

---

**Staffing**

There is evidence that:

9. 1 Staffing is commensurate with delivering a safe and effective service in terms of:

   a grade
   b skill mix
   c experience
   d numbers

9. 2 There are locally agreed procedures to deal with situations where staffing levels fall below locally agreed minimum levels

9. 3 Staffing levels are reviewed regularly

---

**Agency staff**

There is evidence that:

10. 1 The suitability of new agency staff is assessed by reviewing their current CV and references before they begin work

10. 2 The CV and references are retained in the relevant personal file

10. 3 Agency staff are state registered

10. 4 A signature is recorded in the signature book before the agency staff embarks on physiotherapy duties
THE CHARTERED SOCIETY OF PHYSIOTHERAPY

Appraisal

There is evidence of:

11.1 A procedure for appraising physiotherapists

11.2 A system to familiarise all physiotherapists with the appraisal process

11.3 Appraisal is undertaken at least annually

11.4 All appraisals are agreed, documented, and retained in accordance with local procedures

Yes No Comments

[Blank Box] Yes [Blank Box] No Comments

[Blank Box] Yes [Blank Box] No Comments

[Blank Box] Yes [Blank Box] No Comments

[Blank Box] Yes [Blank Box] No Comments
## Service provision

### User involvement

There is evidence that:

1. When changes to physiotherapy services are proposed, there is a system to involve service users

2. There is evidence of action taken as a result of user feedback

3. There is a system for obtaining feedback from service users

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Patient information

There is evidence that:

1. Patients are provided with details about the range of services available

2. Patients are provided with information about arrangements for their first contact

3. Patients have access to information about:
   a. access to services
   b. how to make a complaint
   c. consent to treatment
   d. access to medical records
   e. hazards related to clinical care
   f. discharge planning
   g. transport options
   h. DNA policies

4. Information is available to patients that helps them make informed choices based on the best available evidence

5. There is information for carers and users on condition-specific support groups and networks

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
13.6 There is evidence that:
   a. information is clear and easy to understand  □ □ □
   b. information is available in appropriate languages for users  □ □ □
   c. information is produced in a range of media and formats  □ □ □

13.7 All information provided identifies:
   a. author  □ □ □
   b. production date  □ □ □
   c. review date  □ □ □

**Access to physiotherapy services**

There is evidence that:

14.1 Physiotherapy managers collaborate with service commissioners to plan service provision  □ □ □

14.2 There is a policy in place for the prioritisation of patients waiting to be seen  □ □ □

14.3 There are criteria for urgent and routine referrals  □ □ □

14.4 A choice of appointment times is available  □ □ □

14.5 Routine referrals are re-evaluated if not seen within a locally agreed time-scale  □ □ □

14.6 There is a policy in place describing discharge arrangements  □ □ □

14.7 Physiotherapy managers collaborate with service commissioners to review service provision  □ □ □

**Communication**

There is evidence that:

15.1 All staff are aware of lines of communication within the departmental structure  □ □ □

15.2 An organisational/departmental chart is available  □ □ □

15.3 Regular staff meetings/briefings are held  □ □ □

15.4 Physiotherapists are represented at organisation-wide meetings  □ □ □

15.5 The physiotherapy manager is involved in senior management policy making and business planning processes  □ □ □
Health and safety

16.1 The health and safety local policy includes procedures to manage:

- fire
- waste disposal
- cardiopulmonary resuscitation (CPR)
- first aid
- control of infection
- disposal of ‘sharps’
- working alone/out of hours working
- control of substances hazardous to health
- safe moving and handling of loads
- report of industrial diseases and dangerous occurrences
- planned maintenance of equipment

16.2 All physiotherapy staff attend health and safety training in the following:

- fire procedures
- CPR
- moving and handling
- dealing with violence and aggression
- infection control
16.3 All physiotherapy staff attend a health & safety induction programme when joining the service or transferring to a different location

16.4 A regular health and safety audit is carried out, in accordance with locally defined time-scales

16.5 The following variables are maintained in accordance with local policy:
   a. temperature
   b. humidity
   c. lighting
   d. ventilation

16.6 Notices of hazards to patients are prominently displayed in areas of known risk

16.7 There is a system for summoning help in an emergency

16.8 The service acts on guidance about health and safety

16.9 Clinical trials have approval from the relevant Research Ethics Committee
Management of the hydrotherapy pool

There is evidence that:

17.1 The pool water temperature is maintained within a range 32 to 36 degrees Celsius, with the optimum being 34 to 35.5 degrees Celsius □ □ _______________

17.2 The ambient temperature in the pool hall is maintained within the range 25 to 28 degrees Celsius □ □ _______________

17.3 The ambient temperature in the change and rest areas is maintained within the range 22 to 26 degrees Celsius □ □ _______________

17.4 The atmospheric humidity level is maintained within the range 50 to 65 per cent with a preferred maximum of 60 per cent □ □ _______________

17.6 Disinfectant levels are maintained within the following parameters:

- If disinfected using chlorine only:
  - free chlorine is within the range 1.0 to 4.0 ppm □ □ _______________
  - total chlorine is within the range 1.5 to 5.0 ppm □ □ _______________
  - residual chlorine is never more than 1.0 ppm □ □ _______________

- If disinfected using chlorine and ozone:
  - free chlorine is maintained at approximately 0.5 ppm □ □ _______________
  - in slipstream ozone systems free chlorine is maintained at approximately 1 to 4 ppm □ □ _______________
  - ozone levels are less than 1 mg/litre □ □ _______________

- If disinfecting with chlorine and ultraviolet:
  - free chlorine is maintained within the range 0.5 to 1.0 ppm □ □ _______________
**17.7** The pH of the pool water is maintained within the range 7.2 to 7.8

**17.8** The total alkalinity is maintained within the range 100 to 250 ppm

**17.9** The calcium hardness is maintained within the range 100 to 300 ppm

**17.10** Water balance is maintained within the parameters of the Langelier saturation index of 12.1 ± 0.5

**17.11** Pool water is tested at the following frequency:
- chlorine – free and total: twice daily for automated systems three times a day for manual systems
- pH – as for chlorine
- total alkalinity – once a week
- calcium hardness – once a week
- water balance – once a week

There is evidence that:

**17.12** Samples of pool water are tested for bacteriological counts at least once per month

**17.13** Tests shall be conducted for the following: plate counts, coliforms, escherichia coli, pseudomonas species, pseudomonas aeruginosa and staphylococcus aureus

There is evidence that:

**18.1** For individual treatment, adults have four square metres of pool space

**18.2** For group treatment, adults have two square metres of pool space

**18.3** For all forms of treatment, there is a minimum of one pool side staff member either present within the pool room or within earshot

**18.4** Physiotherapists should not work in the pool for more than three hours within any normal working day
Documentation

There is evidence that:

19.1 Facilities are available for the secure storage of patient records

19.2 Patient records are stored so that they can be easily retrieved

19.3 Local Information Technology (IT) security policies are followed

19.4 There is a local policy which allows patients to access their records

19.5 A notice is clearly displayed to ensure that the patient is aware of their right to access their records

19.6 All records are disposed of in accordance with statutory requirements:
   a. records are retained for a minimum of 8 years after the conclusion of treatment
   b. obstetric records are retained for 25 years
   c. records relating to children or young people are retained until the patient’s 25th birthday or 8 years after the last entry, whichever is the longer

19.7 A signature book is maintained

19.8 An abbreviations glossary is maintained
**Information technology (IT) security**

There is evidence that:

- **20.1** There is a policy for IT security
- **20.2** IT systems containing patient information are registered with the Data Protection Registrar
- **20.3** Physiotherapists are made aware of their responsibilities under the Data Protection Act
- **20.4** Systems are configured to maintain security and include:
  - a password protection
  - b daily backup procedures
  - c protection in the event of interruption in power supply
  - d protection against computer viruses
  - e audit trails that can identify any person who edits/changes patient records
**Locally defined audit questions**

This page has been provided to allow for optional locally defined audit questions to be added if necessary.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Chartered Society of Physiotherapy is the professional, educational and trade union body for the United Kingdom’s 35,000 chartered physiotherapists, physiotherapy students and assistants.

October 2000