EUROPEAN REGION OF THE
WORLD CONFEDERATION
FOR PHYSICAL THERAPY

AUDIT TOOL

for use with

European Core Standards of Physiotherapy Practice

ADOPTED FINAL VERSION at the
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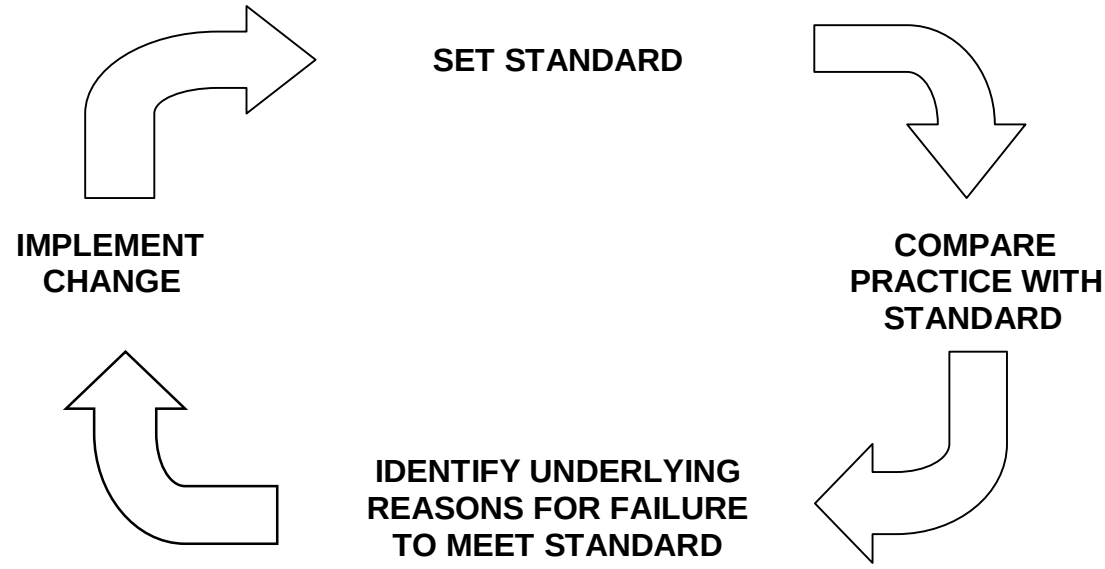
04 June 2003, Barcelona, Spain

Introduction

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, UK, 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.



The first stage in the audit cycle has been prepared for you – the setting of core standards of physiotherapy practice. This audit tools document will allow you to complete the second stage – comparing practice with the core standards. It will then be possible to identify any underlying reasons for not achieving the standards, and to implement any changes required.

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 the core practice standards. Of course you don't need to use all the audit tools at the same time, the audit can be done in stages.

<u>The four audit tools are:</u>

1. **Core standards patient record audit**
2. **Core standards continuing professional development / life long learning (CPD/LLL) audit**
3. **Core standards peer review**
4. **Patient feedback audit**

1. 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 formulated (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.

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

A **CPD/LLL audit data collection form** has been devised to audit the coreStandards, 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.

3. 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.

4. 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.

1.1 Patient record audit methodology

Core standards patient record audit

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

1.1.1 Select a sample and obtain patient records

A random selection of patients' records should be used. Randomisation can be undertaken in many different ways (see Appendix 1).

1.1. 2. Complete the data collection form

The form that accompanies this section is designed to assess whether practice standards have been met. 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 refers 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 does 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.

1.1. 3 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 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 applicable'.

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 extent to which the standards are met can be 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.

1.1.4. 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.

1.1.5. 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 be repeated at least annually.

1.2 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.

	Yes	No	N/A
1.2.1 Informed consent	☐	☐	☐
Core standard 2.8 The patient's consent is documented			
1.2.2 Assessment	☐	☐	☐
Core standard 5.1 There is written evidence of a gathering together of data consisting of:			
a. the patient's perceptions of their needs	☐	☐	
b. the patient's expectations of physiotherapy intervention	☐	☐	
c. the patient's 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	☐	☐	
1.2.3 Examination	☐	☐	☐
Core standard 5.2 There is written evidence of a physical examination that includes:			
a. observation	☐	☐	
b. use of specific assessment tools/techniques	☐	☐	
c. palpation/handling	☐	☐	
1.2.4 Outcome measure	☐	☐	☐
Core standard 6.6 The result of the outcome measurement is recorded immediately	☐	☐	
Core standard 6.7 The result of the outcome measurement is recorded at the end of the episode of care	☐	☐	

1.2.5 Analysis Yes No N/A

Core standard 7 There is written evidence of:

7.2 Identified needs/problems ☐ ☐

7.3 Subjective measures being identified ☐ ☐

7.4 Objective measures being identified ☐ ☐

7.5 A physiotherapy diagnosis ☐ ☐

Guidance: *This is the physiotherapist's assessment of the problem (not the medical diagnosis)*

1.2.6 Treatment planning ☐ ☐ ☐

Core standard 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 ☐ ☐

1.2.7 Implementation ☐ ☐ ☐

Core standard 9

9.1 All 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 ☐ ☐

1.2.8 Evaluation ☐ ☐ ☐

Core standard 10.1 There is written evidence that at each treatment session there is a review of:

a. the treatment plan ☐ ☐

b. subjective measures ☐ ☐

c. objective measures ☐ ☐

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 ☐ ☐

1.2.9 Transfer of care/discharge

	Yes	No	N/A
	☐	☐	☐
Core standard 11			
11.2 Arrangements for the transfer of care/discharge are recorded in the patient's record	☐	☐	
11.3 When the care of a patient transferred, information is relayed to those involved in their on-going care	☐	☐	
11.4 A discharge summary is sent to referrer upon completion of the episode of care, in keeping with agreed local policy	☐	☐	

1.2.10 Documentation

Core standard 14			
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 comptemporaneous	☐	☐	

***Guidance**: Records are not altered after the time of writing. Any genuine omissions should be recorded at the time the omission is identified.*

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 of the record*

g. no correction fluid is used	☐	☐	
h. written in permanent photocopyable ink	☐	☐	
i. errors crossed with a single line and initialed	☐	☐	
j. each side of each page is numbered	☐	☐	
k. patient`s name and either date of birth, record/archive number or personal id number are recorded on each page of the record	☐	☐	

l. abbreviations are used only within the context any locally agreed glossary ☐ ☐

Core standard 15 **Yes No N/A**

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 ☐ ☐ ☐

Core standard 16

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.

	Yes	No	N/A
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

2. Core standards CPD/LLL audit

2.1 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.

2.2 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 ☒ in the box to indicate a positive response.

2.2.1 Assessing learning needs Core standard 19	**Yes**	**No**
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	☐	☐

2.2.2 Planning CPD/LLL Core standard 20		
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	☐	☐

2.2.3 Implementing the plan Core standard 21		
21.1 There is written evidence that the plan has been implemented	☐	☐
21.2 The plan is reviewed at least six monthly	☐	☐

2.2.4 Evaluating the plan Core standard 22		
22.1 There is evidence that the learning objectives have been met	☐	☐
22.2 New learning objectives are developed to continue the cycle	☐	☐

3. Core standards peer review

3.1 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.

There are a number of different methods of peer review that could be used. One model, which included observation of practice, was considered too difficult to implement. It was agreed to follow the model outlined in this guide.

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, physiotherapists should seek advice from their professional association. 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.

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

3.1.1 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 physiotherapist 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 specialty.
- 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.

3.1.2 Arrange a suitable date and time

The review process should take approximately two hours.

3.1.3 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.

3.1.4 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.

3.1.5 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**)

3.1.6 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.

3.1.7 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.

3.1.8 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 _____

4. Patient feedback audit

4.1 Patient feedback methodology

The involvement of patients in sharing decision-making about their care with health professionals, and monitoring the quality of that care is growing. In developing the patient feedback component of these audit tools it is recognised that only patients can judge what is 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 make this assessment.

.4.1.1 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.

4.1.2 Collect the data

Some suggestions of good practice are outlined below:

- Inform the appropriate personnel that his 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.
- When a physiotherapist decides to give out the questionnaires, the physiotherapist must 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, if possible 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.

4.1.3 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 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 extent to which the standards are met can be assessed. It is sometimes useful for physiotherapists to audit their individual patient's records that 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.

4.1.4 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.

4.1.5 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.

4.2 Patient feedback questionnaire

This questionnaire has been developed 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.

4.2.1 If a person other than the patient completes this questionnaire, please indicate your relationship:

husband/wife/son/daughter ☐

parent/guardian ☐

other family ☐

carer ☐

4.2.2 Were you treated by:

a student ☐

a physiotherapist ☐

a physiotherapy assistant ☐

other ☐

don't know ☐

<u>Before your first visit</u>

4.2.2.1 How long did you have to wait to see a physiotherapist?

under 24 hours ☐

1-7 days ☐

between 1 and 4 weeks ☐

between 1 and 2 months ☐

more than 2 months ☐

4.2.2.2 I was offered a choice of appointment times

Yes	No	N/A
☐	☐	☐

4.2.3 Your treatment sessions

Which statement most accurately reflects your views?

	Strongly disagree		uncertain		agree strongly
					agree
4.2.3.1 I was addressed by the name of my choice	☐	☐	☐	☐	☐
4.2.3.2 The staff were courteous and considerate	☐	☐	☐	☐	☐
4.2.3.3 I was not given a chance to say what was on my mind	☐	☐	☐	☐	☐
4.2.3.4 I felt involved in deciding about my treatment plan	☐	☐	☐	☐	☐
4.2.3.5 The physiotherapists listened to what I said	☐	☐	☐	☐	☐
4.2.3.6 The physiotherapist told me what I could achieve	☐	☐	☐	☐	☐
4.2.3.7 The physiotherapist had a manner which made me feel uneasy	☐	☐	☐	☐	☐

4.2.4.1 We aim to be sensitive to your particular expectations

Did we succeed?

Yes	No
☐	☐

If no, please explain:

4.2.4.2 We aim to be sensitive to your fears and anxieties.
Did we succeed?

Yes	No
☐	☐

If no, please explain:

	Yes	No	don't know
4.2.5.1 Were you informed of the name of the physiotherapist responsible for your care?	☐	☐	☐
4.2.5.2 Were you given a choice of options for your treatment?	☐	☐	☐
4.2.5.3 Were you encouraged to say what you wanted?	☐	☐	☐
4.2.5.4 By the end of your first visit, were the results of the assessment explained?	☐	☐	☐

	Strongly disagree		uncertain		agree strongly agree
4.2.6.1 I was asked to do things I didn't agree to	☐	☐	☐	☐	☐
4.2.6.2 I was given all the privacy I needed	☐	☐	☐	☐	☐
4.2.6.3 The physiotherapist used words I didn't understand	☐	☐	☐	☐	☐
4.2.6.4 The physiotherapist was quite rough when giving my treatment	☐	☐	☐	☐	☐

	Yes	No	don't know	N/A
4.2.7.1 The physiotherapist explained the benefits and risks to me	☐	☐	☐	
4.2.7.2 I was given the chance to ask questions	☐	☐	☐	
4.2.7.3 I was told of my right to decline treatment	☐	☐	☐	
4.2.7.4 If you were offered treatment by a student, were you also given the option of being treated by a qualified physiotherapist?	☐	☐	☐	
4.2.7.5 I was told how well I was doing	☐	☐	☐	
4.2.7.6 They asked for my permission before talking to my friends/family	☐	☐	☐	☐
4.2.7.7 If other health professionals were involved in your care, did the physiotherapist discuss with you allowing them access to information about your physiotherapy?	☐	☐	☐	☐
4.2.7.8 If you had to do exercises at home, were you given a clear explanation of what to do?	☐	☐	☐	☐
4.2.7.9 If you had photographs or video taken, did you sign a consent form?	☐	☐	☐	☐
4.2.7.10 If you were left alone during your treatment session were you told how to call for help?	☐	☐	☐	☐

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.

	Strongly disagree		uncertain	agree	strongly agree
4.2.8.1 I felt involved in the plans for my discharge	☐	☐	☐	☐	☐
4.2.8.2 I was given enough advance warning of my discharge	☐	☐	☐	☐	☐
4.2.8.3 I understood the physiotherapist easily	☐	☐	☐	☐	☐
4.2.8.4 All the plans for my discharge went smoothly	☐	☐	☐	☐	☐

	Yes	No	N/A
4.2.9 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.

	Strongly disagree		uncertain		agree strongly
	disagree				agree
4.2.10.1 Overall, I was very satisfied with my care	☐	☐	☐	☐	☐
4.2.10.2 I didn't recover as well as I had hoped	☐	☐	☐	☐	☐
4.2.10.3 The physiotherapy was a complete waste of time	☐	☐	☐	☐	☐
4.2.10.4 I enjoyed coming for physiotherapy	☐	☐	☐	☐	☐

4.2.11 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:

Locally defined audit questions	**yes**	**no**	**comments**
This page has been provided to allow for optional locally defined audit questions to be added if necessary.			
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____
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Appendix 1

Randomising the sample.

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
- 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.