# Documentation: Occupational Therapy

## Site Applicability

All VCH sites: including acute, ambulatory, rehabilitation, long term care, community

## Practice Level

- Occupational Therapist (OT): basic skill
- Rehabilitation Assistant (RA): basic skill

## Requirements

Occupational therapists and rehabilitation assistants will follow regulatory body requirements, organizational policies and program guidelines when documenting in the client's health record.

## Need to Know

This guideline provides more detail specific to occupational therapy practice and process than is provided in organization wide or local program interdisciplinary guidelines.

Occupational therapy documentation in the health record:

- Is a record of information used to plan and implement the care plan,
- States the occupational therapist's clinical reasoning and the basis for decisions made (COTBC, 2014),
- Informs health team members of the care provided, the treatment and care planned, and the outcome of that care (WHO-SEARO, 2007), and
- Facilitates continuity and coordination of care by the OT and the care team and enables appropriate care decisions.

## Equipment and Supplies

Occupational therapists will document on approved occupational therapy or interdisciplinary forms in the electronic and/or paper health record.

## Guideline

The occupational therapist using approved OT forms and/or program specific interdisciplinary tools, will document:

### Referral Process

The referral process includes source of and reason for referral as well as "information necessary and pertinent to the purpose of the OT assessment and intervention" (COTBC, 2014).

### Consent Process

Consent for each visit and task (e.g. assessment and/or intervention) will be obtained and documented.

The consent process includes:

- confirmation that criteria for valid consent were met,
- from whom, when and how consent was obtained,
- concerns raised during the consent process, and actions taken to address concerns (e.g., if the client was determined to be incapable of providing consent and an authorized substitute decision maker was identified), and
- reasons for refusal or withdrawal from occupational therapy services (COTBC, 2019a).

See Appendix A for a sample template for documenting consent.

### Assessment

An OT assessment will be documented on the appropriate assessment form and/or in the progress/case note section and will include as appropriate:

- Identified client and family goals (Accreditation Canada, 2018).
- Strengths and resources as well as, limitations and barriers (Townsend, 2002).
- Assessment procedures, results obtained, and clinical reasoning (COTBC, 2014) including functional implications of results.
- Initial or functional assessments which provide a picture of the client's baseline and current function including the physical, cognitive and affective components that affect function and the environmental context.
- Occupational Performance Issues (OPIs) as well as, occupational performance components and environmental conditions contributing to the OPIs will be identified. See Appendix B for examples.
- OPIs will have corresponding measurable, behavioural goals and plans. See Appendix B for examples.
- If an assessment cannot be completed within appropriate timelines, then a screening note and the reason for not completing the assessment will be documented in the progress/case notes.

### Intervention Plan

Documentation of an OT intervention plan will be done on the appropriate form (e.g. assessment form), progress or case notes, and/or in the interdisciplinary care plan.

The intervention plan:

- identifies client and family goals and collaborative goals (between client and OT) for this admission or referral. Goal statements will include time frames and be measureable and achievable (e.g. SMART goals). See Appendix B for examples.
- is based upon the clinician assessment of occupational performance as well as the identified client and family goals,
- outlines what will be done, by whom, how and when, as well as expected outcomes
- is updated as information changes

### Progress or Case Notes

- Occupational therapists will document clinical interactions in a SOAP (Subjective, Objective, Assessment or Plan) format.
- Progress or Case notes:
    - provide a clinical narrative over the course of intervention
    - explicitly state clinical reasoning
    - indicate the outcome of an intervention
    - indicate changes in the client's condition
    - identify new OPIs and/or intervention plans and goals (COTBC, 2014).

### Discharge or Transition Summary

The discharge or transition summary is a communication tool for the healthcare team as well as client and family at transitions in care.

It will include:

- safety concerns,
- client goals, and
- reason for discharge or transition (Accreditation Canada, 2018).

It may include:

- the client's status at discharge,
- summary of outcomes attained,
- recommendations,
- referrals, and/or
- an explanation of when interventions initiated were not completed (COTBC, 2014).

A copy of discharge or transition summaries and referrals to other OT services may be kept in the health record.

## Documentation Requirements

### Language

Should be:

- Client centered i.e., chosen with the understanding that the client may read it
- Objective, observational, and non-judgmental
- Concise and not repeat information captured in other areas
- Explicit i.e., answer the question 'what does that look like'. For example: 'the client grimaced repeatedly while putting socks on while seated at edge of bed' rather than 'the client appeared to be in pain while dressing'.

### Abbreviations

- Use of abbreviations and acronyms is discouraged (PHC, PHSA and VCH, 2018a).
- Abbreviations, acronyms and diagrams used in in the client record must have a supporting reference available for those who access the record (COTBC, 2014).

### Timeliness

- Documentation is completed in a timely manner appropriate to the client, clinical situation (COTBC, 2014) and program expectations.
- Documentation occurs
    - at each event of care, transition in care, or whenever there is a change in client status or intervention plan.
    - as close as possible to the time of the event of care
- The appropriate frequency and detail of documentation is determined by considering:
    - client complexity (e.g. medical stability, number of factors impacting function, capacity to consent, ability to understand or provide accurate information, funding sources),
    - environmental factors (e.g. program policies and procedures, pressures from organization, or team need for information),
    - the occupational therapist's professional judgment,
    - degree of risk (consider probability and consequences).
- If the documentation is not completed at the time of care or at the latest on the same day, the note will be identified as a late entry and the time and date of assessment/intervention will be indicated.

### Draft Documents and Raw Data

- If materials need to be kept, they must be placed in the health record. There should be no ghost or unofficial charts. If documents are not placed in the health record, they must be shredded. (PHC, PHSA and VCH, 2018b and PHC, PHSA VCH, 2018c). See Health Record Policy - Records Retention and Disposal for more details. Information that informs the clinical decision making process should be recorded in the official health record. A summary of assessment results may be adequate to make clear your clinical reasoning rather than including the paper form. In that case, the whole assessment form is not required to be placed in the health record. If a paper document must be kept, a note should be made in the electronic record stating that the paper document has been placed in the official paper chart.
- If draft documents exist, they are part of the health record and must be released upon request (COTBC, 2014).

### Document from Personal Observation or Knowledge

- Document from personal observation or knowledge only. Entries on paper forms or in the electronic system are made by the health professional providing the care. (VCH, 2009).

### Multiple Health Professionals Completing an Assessment

- When multiple health professionals contribute to the same record, who provided the service and who documented each entry will be clearly indicated (COTBC, 2014).

### Rehabilitation Assistant Documentation

- Rehabilitation Assistants (RAs) will obtain and document consent for each interaction.
- Rehabilitation Assistants record their observations and care provided in the health record as directed by the occupational therapist, using Subjective, Objective, and Plan (SOP) format. See Appendix B for examples. RAs will document any deviation from the treatment plan. The occupational therapist will record the consent process, description of activities assigned, supervision plan and that RA notes were reviewed.

### Referring to Persons Involved in Care

- To refer to or mention another person involved in the client's care, state the person's first name, last initial and designation/role.

### Student Documentation

- The occupational therapist will obtain and record client consent for student participation. Students will follow OT documentation guidelines under the supervision of the preceptor.
- If the preceptor has been present for the client interaction and agrees with the note, the preceptor may co-sign the note.
- If the preceptor has not been present for the client interaction, the preceptor reviews the documentation and documents a brief note (e.g. 'read and agree') to indicate that they have read and agree with the plan or the preceptor adds an addendum.

### Text, Email and Video Communication

- Text, email and multimedia messages of significance as well as client care provided via telephone or video conference must be documented in the client's health record in accordance with usual documentation requirements. Once this documentation has been made, the text, email and multimedia messaging history and any personal and confidential information must be deleted from the mobile device. Refer to VCH guidelines related to documenting text, email and video communication with clients and families.
    - Texting Policy
    - Emailing Policy
    - FaceTime Use - Clinical
    - Zoom Application Use Guideline

### Evaluation

The VCH Occupational Therapy Chart Audit Form will be used by occupational therapy Practice Coordinators to evaluate occupational therapy documentation and provide feedback. It may also be used as a self-assessment tool.

## Related Documents

**VCH**

- VCH Interdisciplinary Documentation Policy (LGH) (D-00-05-30194)
- VCH Paper/Electronic Documentation Standards (Vancouver Acute/Richmond) (D-00-05-30023)
- CST Documentation Policy (PHC, PHSA, VCH)
- Vancouver Community AOA Progress Notes Practice Guidelines
- Vancouver Community AOA Progress Notes Policy Statement
- Community Mental Health and Substance Use Documentation Standard D-00-15-30005
- Profile Electronic Medical Record (EMR) User Help
- PARIS Website/Guidelines
- PARIS User Help

## References


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## Appendices

- Appendix A: Sample Template for Documenting Consent
- Appendix B: Sample Goals, Occupational Performance Issues (OPI), Plans and SOAP Notes

## Appendix A: Sample Template for Documenting Consent

Consent template from COTBC 2019 Annual Continuing Competence Review

**Sample template**
On [insert date], [insert client's name] provided consent [insert how] for [insert nature of heath care/ services]. No concerns were raised during the consent process and all elements of consent were met.

If there were concerns re: capability to provide consent, documentation could include:
• [Name of substitute decision maker] was appointed as the substitute decision maker due to the client's [describe reasons for the client not being capable of providing consent]

If the client refused or withdrew from services, documentation could include:
• The client asked that I/we [stop, delay, etc.] because [insert reasons]

## Appendix B: Sample Goals, Occupational Performance Issues (OPI), Plans and SOAP Notes

| Setting | Client and Family Goal | Occupational Performance Issue | Components | Collaborative Goal for this Admission/ Episode of Care | Intervention Plan | SOAP note (example from a point along the continuum of care)<br>O and P always required |
|---|---|---|---|---|---|---|
| Inpatient rehab | "my arm to work better" | Unable to dress and groom self independently due to | Poor postural control<br>left inattention<br>increased tone in left arm<br>no active movement left upper extremity | Client will dress upper extremity and groom self independently by 3 weeks | Daily dressing practice with Rehab Assistant (RA)<br>Training for scanning to left side for client to do with family<br>Education for family about inattention and training strategies<br>Physical treatment to increase postural control | Dressing and Grooming<br>**S:** "I'm happy to work with the Rehab Assistant on dressing"<br>**O:** RA transfer of function form completed, see form for details of dressing program. Requested client to ask family to bring in clothes.<br>**A:** Client is motivated and has carryover for participation in program. Will need to be positioned in supportive chair and cued to left side during practice sessions.<br>**P:** Daily dressing practice with RA. |
| | | | | | **RA Note** | Date 1<br>Dressing<br>**S:** "My daughter is bringing in my clothes this afternoon"<br>**O:** Used hospital pyjamas for dressing practice while seated in bedside chair with armrests. Client required cueing |

| Setting | Client and Family Goal | Occupational Performance Issue | Components | Collaborative Goal for this Admission/ Episode of Care | Intervention Plan | SOAP note (example from a point along the continuum of care)<br>O and P always required |
|---|---|---|---|---|---|---|
| | | | | | | to orient pyjama top and put left arm in first.<br>**P:** See client tomorrow as per OT request.<br>Date 2<br>Dressing<br>**S:** "I'm too tired this morning, there was a lot of noise last night and I didn't sleep."<br>**O:** Dressing practice not done today.<br>**P:** Inform OT that client trying to get some sleep. See client tomorrow. |
| Acute care | To go home independently | Unable to toilet self independently | Impulsive and decreased safety awareness<br>Decreased short term memory<br>Decreased balance<br>Generalised weakness | Client will be able to toilet self safely and independently using mobility and toilet equipment prior to discharge | Create toileting schedule with nurses – ensure gets up to toilet rather than using bedside commode<br>Review need for toilet safety equipment at home | Toileting<br>Date 1<br>**S/O:** Reviewed toileting schedule with client, he is agreeable. Reviewed need to have nurse or care aid present when gets up. Client states will try to remember to ring bell when needs to use toilet. Spoke with nurse and agreed upon toileting every 2 hours in bathroom. Bed alarm on. Bedside commode removed and two wheeled walker (2ww) placed beside bed. |

| Setting | Client and Family Goal | Occupational Performance Issue | Components | Collaborative Goal for this Admission/ Episode of Care | Intervention Plan | SOAP note (example from a point along the continuum of care)<br>O and P always required |
|---|---|---|---|---|---|---|
| | | | | | Referral to Home Health OT to assess bathroom equipment and falls risks | Schedule posted at bedside and in plan of care. Care team and client aware of plan and posted schedule.<br>**A:** Client may need cueing and encouragement to follow schedule, and wait for assist to get up and use 2ww.<br>**P:** Will monitor by checking with care team daily for one week to assess if client remembers to ask for help.<br>Date 2<br>**O**: Spoke to client and daughter about toilet equipment for home. Showed pictures of options. MEPP referral for over toilet commode faxed to Vancouver Red Cross. Daughter to pick up. Home health referral made to assess for placement of permanent grab bars beside toilet.<br>**A:** No further equipment needs at this time.<br>**P:** Check that commode picked up before discharge. |

| Setting | Client and Family Goal | Occupational Performance Issue | Components | Collaborative Goal for this Admission/ Episode of Care | Intervention Plan | SOAP note (example from a point along the continuum of care)<br>O and P always required |
|---|---|---|---|---|---|---|
| Acute/rehab/ long term care | "I don't want him to get a wound" | Potential for skin breakdown while lying in bed | Difficulty shifting position<br>Prefers to sleep on back<br>Stays in bed from 1pm to 9 am daily<br>Need for surfaces to distribute pressure<br>Need to offload heels | Skin will remain intact | Recommend Repositioning q2h<br>Provide education to client and family re: pressure injury and need to change position<br>Recommend use of 'X' mattress<br>Provide Heelzup to offload heels<br>Liaise with RN and PT to adjust daily schedule to be out of bed for lunch and dinner | **S/O**: spoke to nurse and reviewed risks for skin injury. Nurse updated care plan to include repositioning every two hours. Schedule created to have out of bed to wheelchair daily for lunch and dinner. Mattress 'X' delivered. Provided education to patient and daughter Liz re: pressure injury prevention.<br>**A**: Client may need cueing and physical assistance from care team to adhere to positioning schedule.<br>**P:** OT to request RA to provide Heelzup. OT to monitor skin on heels and identified pressure areas with visual check daily and request care team does same. Monitor mattress comfort and effectiveness by asking client a minimum of once per week. |
| | | | | | **RA Note** | Heelzup<br>**O:** Heelzup provided and positioned as per OT instructions. Heels not touching mattress.<br>**P:** Inform OT. |

| Setting | Client and Family Goal | Occupational Performance Issue | Components | Collaborative Goal for this Admission/ Episode of Care | Intervention Plan | SOAP note (example from a point along the continuum of care)<br>O and P always required |
|---|---|---|---|---|---|---|
| Inpatient rehab | "I don't want to wait for someone to come get me" | Unable to get to therapy sessions without cueing | Impaired attention, time awareness, memory, executive functioning | Client will be able to get to therapy appointments independently and on time within 2 weeks | Create daily schedule<br>Review unit layout with rehab assistant<br>Facilitate use of internal and external strategies for remembering schedule, therapists, routes<br>cognitive rehabilitation to address identified components<br>client and family education | **S:** "The schedule posted at the nursing station is too confusing"<br>**O:** Client was unable to tell me his schedule even with cueing when looking at unit schedule<br>**A:** would benefit from personal schedule<br>**P**: OT to create weekly rehab schedule for client and post in his room. |
| Outpatient | To be able do daily activities | Difficulty grasping and holding things | Pain in thumbs<br>Decreased range of thumb CMC and finger IP joints | Client will be able to grasp and hold commonly used objects e.g. milk carton, keys, cups, pen within one month | Splint thumb CMC joints<br>Education about protecting joints, non-pharmacological | Grasping<br>**S:** "It's too hard to use the splint when I'm chopping. I take it off and then it hurts."<br>**O:** Observed wearing splint and using it when cutting. Reviewed cutting technique while using splint and goals |

| Setting | Client and Family Goal | Occupational Performance Issue | Components | Collaborative Goal for this Admission/ Episode of Care | Intervention Plan | SOAP note (example from a point along the continuum of care)<br>O and P always required |
|---|---|---|---|---|---|---|
| | | | Decreased grip strength in hand | | pain management strategies<br>Education about range of motion exercises<br>Education re: applicable adaptive equipment | of wearing splint. Discussed other splint options and strategies for protecting thumb joints. Splint adjusted to accommodate grasping knife. Knife handle options discussed.<br>**A:** Client requires the support of a rigid splint rather than try soft splint due to client's reported pain.<br>**P:** Trial adjusted splint and pacing strategy. Client to investigate other knives. |
| Community | To get a stair glide | Unable to access bedroom and bathroom upstairs | Increasing fatigue<br>Weakness in legs<br>Increasing lack of bladder control<br>Fear of falling<br>X stairs to upstairs | Client will be able to independently and safely access upper bedroom and bathroom within X timeframe using X equipment | Identify appropriate stair glide and possible vendors<br>Identify funding source and apply<br>Train in stair glide use | Stair Glide<br>**S/ O:** Stair glide X installed by X vendor on Monday X Date. Provided training to client and husband on use of equipment and safety features. Both report they are comfortable using the stair glide and have no concerns.<br>**A**: Stair glide in place and functional. Client able to use the stair glide safely. No further training required. Client able to access upper bedroom and bathroom functionally and safely.<br>**P**: No further OT needs identified. |

| Setting | Client and Family Goal | Occupational Performance Issue | Components | Collaborative Goal for this Admission/ Episode of Care | Intervention Plan | SOAP note (example from a point along the continuum of care)<br>O and P always required |
|---|---|---|---|---|---|---|
| Mental Health and Substance Use | To return to school | Unable to meet course expectations | -difficulty with memory and concentration<br>-decreased confidence in academic abilities<br>-lack of established support network | To enrol in one course in the next three months. | -Cognitive assessment<br>-Develop compensatory strategies and study skills<br>-Identify and connect with community educational supports/services<br>-Identify potential environmental adaptations | **S:** Client stated, "I thought the assessment went well".<br>**O:** Client completed 1 hour Cognitive Functional Assessment X related to educational goals. Verbal consent obtained. Client presented at baseline with no observed signs of changes to mental status. Client scored X/X on Cognitive Assessment. Full details available in Assessment module labelled "Cognitive Assessment X" on [date].<br>**A:** Client evidences cognitive impairment that has functional consequences. Client may benefit from trialing compensatory support including smartphone lists and apps, calendar on fridge/wall, and family involvement. Client could also benefit from extended time for tests.<br>**P:** Client to meet with writer on [date] to start trialing compensatory strategies. Writer to contact school to explore environmental accommodations. |

| Setting | Client and Family Goal | Occupational Performance Issue | Components | Collaborative Goal for this Admission/ Episode of Care | Intervention Plan | SOAP note (example from a point along the continuum of care)<br>O and P always required |
|---|---|---|---|---|---|---|
| | | | | | **RA Note** | *OT has met with client to trial compensatory strategies and has assigned strategy practice (in this case, weekly scheduling) to RA*<br><br>**S/O:** RA met with client to set up his schedule for the week. Client recorded his volunteer schedule which he knew from memory. RA prompted client to also include his appointments, gym schedule, and household-related tasks. Client could not remember if he had a doctor's appointment, so RA suggested client make a call to confirm (appointment is in two weeks). During session, client said he would like to be busier on the weekend doing something outside. RA supported client to search for free outdoor activities happening in Vancouver this weekend. Client chose to attend "music in the park" and added it to his schedule. RA reminded client to post his schedule somewhere visible. Client said he would put same on his fridge.<br><br>**P:** Continue to support client with weekly scheduling as assigned by OT. |

| Setting | Client and Family Goal | Occupational Performance Issue | Components | Collaborative Goal for this Admission/ Episode of Care | Intervention Plan | SOAP note (example from a point along the continuum of care)<br>O and P always required |
|---|---|---|---|---|---|---|
| Mental Health and Substance Use | To make more friends | Difficulty engaging in social interactions | -symptoms of anxiety<br>-decreased confidence in social skills | To be able to start a conversation with someone new in the next month. | -social skills training<br>-anxiety management strategies<br>-connect with activity based social groups in the community | **S:** Client reported, "I wanted to talk to someone in my support group yesterday but I couldn't even make eye contact".<br>**O:** Discussed different ways anxiety affects the body. Practiced breathing techniques and making eye contact.<br>**A:** Client's ability to tolerate eye contact increasing gradually when paired with grounding exercise.<br>**P:** Weekly social skills and grounding practice to be assigned to rehab assistant (RA). Client to continue with weekly support group. |
| | | | | | **RA Note** | **S/O:** RA guided client through "5 to 1" grounding technique and "Box Breathing" technique. Client stated "I think these techniques help to calm me down." RA then led client through role-play of making conversation about summer plans. Client made eye contact three times for approximately 10 seconds each time during 5 minute conversation. Client asked RA once for |

| Setting | Client and Family Goal | Occupational Performance Issue | Components | Collaborative Goal for this Admission/ Episode of Care | Intervention Plan | SOAP note (example from a point along the continuum of care)<br>O and P always required |
|---|---|---|---|---|---|---|
| | | | | | | a suggestion re: how she could keep the conversation going.<br>**P:** RA to continue practicing grounding activities and role play activities with client at weekly sessions as assigned by OT. |

| | |
|---|---|
| **First Released Date:** | 18-SEP-2020 |
| **Posted Date:** | 18-SEP-2020 |
| **Last Revised:** | 18-SEP-2020 |
| **Last Reviewed:** | 18-SEP-2020 |
| **Approved By:**<br>*(committee or position)* | VCH |
| | **Endorsed By:**<br>VCH Regional SharePoint 2nd Reading<br>Health Authority Profession Specific Advisory Council Chairs (HAPSAC)<br>Health Authority and Area Specific Interprofessional Advisory Council Chairs (HAIAC)<br>VCH Operations Directors<br>VCH Professional Practice Directors<br>**Final Sign Off:**<br>Vice President, Professional Practice & Chief Clinical Information Officer, VCH |
| **Owners:**<br>*(optional)* | VCH |
| | **Developer Lead(s):**<br>Regional Practice Leader – Occupational Therapy, VCH<br>**Development Team members:**<br>• Practice Coordinator – Occupational Therapy, Mental Health and Substance Use, Vancouver<br>• Practice Coordinator – Occupational Therapy, Mental Health and Substance Use, Vancouver<br>• Practice Coordinator – Occupational Therapy, Mary Pack Arthritis Program and OASIS<br>• Practice Coordinator – Occupational Therapy, Coastal |