Lessons from notifications webinar 20 June 2022 - Q&A

Consent:

Is verbal consent to treatment adequate?

Yes, but it is important that you document in the patient's clinical record that informed consent has been obtained. This should include a summary of the information you gave the client before consent was given.

If a client advises they wish to proceed with services but declines to sign service agreement, how should this be documented to ensure that we have this recorded in the event of a notification occurring?

A signed service agreement is a convenient way to formalise and document initial consent to provide services. However, informed consent is a process, rather than an event, that requires your ongoing attention.

Informed consent requires clear and effective communication on an ongoing basis.

During the course of treatment and as the therapeutic relationship progresses the treatment plan and proposed treatment may change, or a client may change their mind and wish to withdraw consent.

You must continue to ensure the client is informed about and consents to any treatment and/or services.

Clear clinical records stating that you obtained informed consent (including financial consent if relevant) are essential.

It is advised to provide an (unsigned) copy of your service agreement to the client so they are aware of your service terms and document the fact that you have done so.

What should I do if I am unsure whether a client has capacity to provide informed consent?

Whether or not a client has capacity to consent to a proposed treatment will depend on the facts of each case.

Generally, an adult is presumed to have decision-making capacity unless there is evidence to the contrary.

If you have concerns, you may wish to check whether the client has a substitute decision-maker appointed or, for non-urgent treatment, it may be appropriate to suggest the patient return with a support person who could assist them.

Am I breaching a patient's privacy if I provide their clinical records to a compensation body to allow auditing of my work?

You may be breaching the patient's privacy if you disclose their personal information without their consent to do so.

Generally, you must respect the confidentiality and privacy of patients by seeking informed consent before disclosing their private information.

In some cases, it may be wise to seek (and document) the patient's consent to share their clinical records for specific purposes (e.g. audit) before you commence treatment.

If you are required by statute to provide information for a specific purpose, this may override privacy rights. You should seek further advice if you are unsure how to respond to a statutory compulsion.

Please refer to *principle 3.3 confidentiality and privacy* of the Code of Conduct for further information.

- For guidance on working with patients, including obtaining informed consent and persons with additional needs, please refer to the Code of Conduct. The Board published an article on informed consent in its May 2022 newsletter.

Clinical record keeping:

I am contracted by a provider that provides home care packages. I would assume that the service agreement is through this provider. How do I document this?

You should not assume. You should obtain a copy of the service agreement to be clear about the services you are contracted to provide to the client.

If you are working in a large workplace such as a hospital or large company, where a broad consent is signed it is recommended that you seek verbal consent to proceed with your specific services and document any consent provided.

In addition to any service agreement, you are responsible for documenting the services that you provide, with sufficient detail to facilitate continuity of care.

Please refer to *principle 8.3 health records* of the Code of Conduct for further information.

In relation to service agreements, does the frequency of services need to be stated? As this is completed before an initial appointment therefore frequency is usually unclear.

No. A services agreement is the beginning, not the end, of your obligation to secure consent to treatment and to document the services you provide. It should be amended and consent to the amendments attained if the terms of the agreed services change.

How long do records need to be kept and stored?

For practitioners working in public sector hospitals and facilities, there are specific authorities, policies and guidelines to manage medical records. You should follow the instructions of your workplace.

For practitioners in private practice, requirements vary from state to state (or territory). You should seek advice specific to your circumstances.

Who is responsible if clinical notes are not completed; the practitioner or the practice?

It is the practitioner's responsibility to maintain clear and accurate patient health records.

In regard to sharing the client's information and the client requesting that - who is responsible for funding therapist time to send notes to client?

It is the practitioner's responsibility to promptly facilitate the transfer of health information in accordance with legislation on privacy and health records when requested by patients.

I would like to know Ahpra's position on documentation when it comes to making recommendations, specifically email versus PDF recommendations, as unfortunately many referrers do not want to actually pay for formal reports and recommendations, stating "email recommendations are sufficient".

Ahpra and the Board do not have a formal position on the correct format for sharing clinical information.

As long as you clearly state your clinical reasoning then the form of the documentation should not matter.

All correspondence should be documented in the client's clinical record. If you have an electronic record management system, a copy of the email can be stored electronically. Otherwise it may be printed or otherwise documented in a written record.

- For guidance on appropriate standards of professional behaviour, including maintaining clear and accurate health records, please refer to the Code of Conduct. The Board published an article on clinical record keeping in its May 2022 newsletter

Supervision and mentoring:

What is the difference between mentoring and supervision?

There are three different types of relationships that should be considered when thinking about supervision and mentoring:

(1) **Supervised practice as a condition of registration.** This is a formal agreement whereby a more senior practitioner explicitly agrees to monitor and evaluate the practitioners' practice to ensure it is safe and is not putting the public at risk. For further information the Board has published information about supervised practice.

(2) **Supervision.** Standard supervision (as opposed to Supervised Practice as a condition of registrations) is a formal relationship often setup within workplaces to support practitioners to practice effectively. Supervision generally includes opportunities for education, reflection, debriefing and clinical review and monitoring. The Board strongly encourage all practitioners to actively engage in supervision.

(3) **Mentoring.** Mentoring is a relationship where the mentor supports the mentee to reflect on their practice and career aspirations. While mentoring can sometimes include many elements similar to supervision, it tends to be more focused on reflection and the mentees self-identified needs.

Do we need to document when guidance / supervision is accessed for client care?

If you are participating in a formal supervision arrangement, you should document this clearly in your supervised practice report.

Otherwise, it is prudent to document the fact that you discussed a client's care with a colleague, and the outcome of those discussions.

Be aware of issues of privacy and potential conflicts of interest when seeking guidance from a colleague.

Is the Board able address issues with employers repeatedly not supporting new grads?

Not unless the employer is a registered practitioner, and their performance or conduct is placing patients at risk.

The Board strongly encourages all occupational therapists to develop and maintain their own mentoring relationships/networks.

Notifications:

If a business is advertising that they have occupational therapists, but in fact are using unqualified individuals pretending to be occupational therapists, do we report this to Ahpra?

Yes. Information about practitioner's title, qualifications, speciality, training and areas of experience must be factual. Further, an unregistered individual using a protected title may be committing the offence of 'holding out'.

Do you have any information on how often notifications are made in regard to overseas qualified OTs following their supervised practice period?

No. We have not completed this analysis.

How do you manage vexatious complaints?

The Code of Conduct specifically states that practitioners must not raise notifications (complaints/concerns) that are vexatious or not in good faith about other health practitioners.

Vexatious and bad-faith notifications may be viewed as unprofessional conduct or professional misconduct and the Board may take regulatory action.

Please refer to *principle 8.2 Vexatious notifications* of the Code of Conduct for further information.

In relation to vexatious and bad-faith complaints from non-practitioners, Ahpra has published resources about vexatious notifications.

How many notifications are investigated where the therapist has then been found to have done nothing wrong? Is it acknowledged when the Board finds the patient or notifier was found to be unreasonable?

The Board does not make findings that 'the practitioner has done nothing wrong' or that the notifier was 'unreasonable'.

The Board may decide to take no further action against a practitioner:

- if there is no ongoing risk to the public that it needs to manage, or
- because of the action already taken by the individual and/or their workplace there is no future risk to the patient

Of the 70 notifications about occupational therapists that were closed in the 2020/21 year, 85.7% were closed with no further action.

Is the data of notifications skewed to less experienced clinicians?

In an analysis of risk factors for notifications across all registered health practitioners, Spittal et al[1] found that there was no significant difference in complaint risks for practitioners 26–35 years and those aged less than 25 years. However, practitioners in older age groups had 1·5 to 2·1 times higher risk of receiving a complaint and risk generally increased with age.

For most types of registered health practitioner, the best predictor for receiving a notification is the number of notifications received in the past.

Are clinicians notified of all complaints made?

Ahpra usually writes to practitioners to advise that a notification has been received about them and to either advise that the matter was closed or to seek a response or further information.

Very rarely, Ahpra will not contact the practitioner at this stage if it is considered doing so would:

- prejudice an investigation
- place a person's safety at risk, or
- place a person at risk of intimidation.

For more information about the notifications process from a practitioner's perspective, please refer to the Ahpra website.

- For further information about making a notification about a practitioners' health, performance, or conduct, please refer to the Board's website For information about advertising, please refer to Ahpra's advertising hub.

[1] Spittal, Matthew., Bismark, Marie., and Studdert, David. (2019) *Identification of practitioners at high risk of complaints to health profession regulators* 19(1) BMC Health Services Research.