Transcript: Learnings from notifications – 20 June 2022

Vathani Shivanandan: Hi everyone. My name is Vathani, and I am the Executive Officer for the Occupational Therapy Board of Australia. Before we begin, we would like to acknowledge the traditional custodians of the land we are meeting on for their continuing connection to land, sea, community and culture. For us here in Melbourne, we would like to acknowledge the Wurundjeri people and the Boonwurrung people of the Kulin Nation for their continuing connection to this land. We pay our respects to their Elders past, present and emerging, and to any Aboriginal and Torres Strait Islander people who may be present with us online today.

Before I hand over to the members of the Board, I would like to run through some tips for the webinar. You should be able to see this box on the top right of your screen. Clicking on the arrow in the red box should either expand or contract this view. You'll see that your microphones are muted, so we won't hear your voices. If you have a question, please type it in the Q&A box. Please note that this is a public webinar, so you won't be able to see each other's questions. Please also note that we received lots of questions as part of your registration to the webinar, so we will be trying to answer as many of those questions, as well as live questions through each of the question breaks today. You can adjust your audio by clicking on the sound check button. Please also note that we're recording the webinar today so that it can be published on the Board's website at a later date. We also note that in the event of technical issues we are recording this webinar, so a whole recording will be available on the Board's website and published at a later date, and we'll also try to answer as many of the questions that we have received in an FAQ document that will also be published.

I'd now like to introduce our speakers for today. Julie Brayshaw is the Chair of the Occupational Therapy Board of Australia. Julie is an academic staff member at the Curtin University in Western Australia. Julie has been a member of the Board since July 2011.

Roxane Marcelle-Shaw is a community member of the Board and chairs the Board's Registration and Notification Committee. Roxane currently works at the Professional Standards Authority as its Chief Executive Officer. Roxane has been a member of the Board since 2014.

Rebecca Singh is a practitioner member on the Board and is based in South Australia. Rebecca works in community practice and is an experienced practitioner working in adult physical and cognitive rehabilitation, acute services and driving.

I'll now hand over to Julie, who will start today's webinar.

Julie Brayshaw: Thanks Vathani. Here are the topics that we hope to cover today. The role of Ahpra and the Board, complaints, code of conduct, informed consent, record keeping, communication, and resources. Within the sections relating to informed consent, record keeping and communication, we'll be presenting some case studies which are taken from a compilation of notifications data that the Board has considered over the years. These case studies will help to highlight the Board's expectations in relation to these notification scenarios. We'll also be taking regular question breaks to answer some of the questions that we received prior to the webinar. And if we have time, we will try and address questions that are also raised during the course of this session.

The Occupational Therapy Board regulates the occupational therapy profession and its powers and functions include registering occupational therapists and students, developing and reviewing standards, codes and guidelines for the profession, it considers and makes decisions on complaints about occupational therapists, approves accreditation standards and approves accredited programs of study.

The fundamental principle underpinning registration is protection of the public. This is done by regulating practice, ensuring practitioners are suitably trained, defining standards to ensure competence, and responding to complaints about practitioners' conduct and competence.

This slide shows who we are. As you can see, the Board is made up of a mix of members who are occupational therapists and community members, and we're located across Australia.

Ahpra works in partnership with 15 National Boards to ensure that the community has access to a safe health workforce across all professions registered under the National Registration and Accreditation Scheme, which we refer to as the National Scheme. Ahpra supports the work of the Boards and Ahpra is your first point of contact when you apply for registration.

I'll now hand over to Roxane, who will take us through our next session.

Roxane Marcelle-Shaw: Thanks, Julie. In the National Scheme, we call a complaint about a registered health practitioner a notification. They are called notifications in the law because we are notified about a practitioner where there are concerns or complaints, which Ahpra and the National Boards then manage. Notifications can be made about a practitioner's conduct, performance, health, advertising, and use of the protected title – occupational therapist.

Notifications can be made by a client, their family or friends, a member of the public or other practitioners. We call the people who make a notification a notifier. The figure in this slide shows who made notifications to the Board during 2020-2021. As you can see, the largest proportion of the notifications received by the Board are made by patients or clients, relatives or members of the public.

By law, registered health practitioners, employers and education providers must make a mandatory notification in some limited circumstances. Mandatory notifications help to protect the public by ensuring that Ahpra and the National Boards are alert to any potential risks to the public. Notifiable conduct in relation to mandatory notifications is defined under the National Law as being intoxicated by alcohol or drugs, being engaged in sexual misconduct in connection with professional practice, impairment that would place the public at substantial risk of harm, or a significant departure from the accepted professional standards.

Anyone can make a complaint about an occupational therapist aside from these mandatory notifications. These are called voluntary notifications. Voluntary notifications can be about a practitioner's conduct if it is placing the public at risk, that is their conduct is below the standards reasonably expected, or a practitioner is practising their profession in an unsafe way, or a practitioner's health is having a detrimental effect on their capacity to practise safely. The critical element in relation to notifications about health is that not all impairments will reach the threshold to trigger a voluntary notification.

We will consider the information Ahpra gathers from the complainant or the notifier and usually ask the practitioner concerned to provide a response to the notification. We need to understand how you have responded to the event that triggered the complaint or notification. This includes actions you have taken after reflection to reduce the likelihood of future risk, and you can assist the process by responding promptly in the best interests of the client, actively reflecting and sharing how you will respond effectively in similar circumstances in the future. We will then make a decision on whether to take regulatory action, such as a caution or condition, whether further investigation is required or whether no further action is required.

I will now hand over to Rebecca, who will speak about your advertising obligations.

Rebecca Singh: Thanks, Roxane. Advertising is an important way for practitioners and providers of regulated health services to promote their services to the public. The National Law establishes the requirements for advertising for a regulated health service. These requirements are important for public protection and help to ensure the public receives accurate and honest information about healthcare services. If you're advertising a regulated health service, your advertising must not be false, misleading or deceptive, or likely to be misleading or deceptive, offer a gift, discount or other inducement unless the terms and conditions of the offer are also stated, use testimonials or purported testimonials about the service or business, create an unreasonable expectation of beneficial treatment, or directly or indirectly encourage the indiscriminate or unnecessary use of regulated health services.

Advertising might be false, misleading or deceptive when it misleads either directly or by implication through the use of emphasis, comparison, contrast or omission, provides partial information and/or omits important details, makes statements about the effectiveness of treatment that are not supported by acceptable evidence, makes unqualified claims about the effectiveness of treatment by listing health conditions that a treatment or service can assist with or treat, suggests a practitioner is a registered health practitioner or holds specialist registration, qualifications or an endorsement when they do not by using a title and/or a

means, or minimises, underplays or underrepresents the risk or potential risk associated with the treatment or procedure.

The National Law regulates the use of certain titles, which are protected titles. Misuse of a protected title is an offence under the National Law. Advertisers should be aware of the protected titles for the profession that they are advertising. Penalties can apply for a breach of National Law title protection provisions. In the case of an individual, there may be a financial penalty, imprisonment or both. The National Law requires you to be registered if you use the title of occupational therapist, if you claim to be qualified to practise as an occupational therapist, or you claim to be registered as an occupational therapist. Practising as an occupational therapist is not limited to providing direct clinical services to clients. Typically, the Board will require you to be registered if you hold qualifications as an occupational therapist and if you are using your skills and knowledge as an occupational therapist, regardless or not whether you are actually treating people.

Given the protected titles under the National Law, it is unlawful to claim to be registered as an occupational therapist when you are not. This is often referred to as unlawfully holding out to be a registered health practitioner. Holding out occurs when a person is led to believe that another person is registered in one of the health professions or specialties regulated under the National Law. Holding out to be a registered health practitioner or holding out another person to be a registered health practitioner is a criminal offence that can be reported to Ahpra.

Roxane Marcelle-Shaw: Thanks, Rebecca. Now that we've outlined some of the circumstances in which voluntary and mandatory notifications can be made under the National Law, we thought it would be interesting to look at some of the Annual Report data to break down the numbers. During 2020-2021 there were a total of 124 notifications received nationally about occupational therapists. As you can see, the proportion of notifications received about occupational therapists is relatively small when compared with other professions, at around 1%. The highest number of notifications are received about medical practitioners, nurses and pharmacists.

This next figure from the 2020-21 Annual Report highlights the common types of complaints we receive nationally. They are documentation, clinical care, and communication issues most commonly being considered by the Board. The data highlights that there is potential for reducing the possibility of a notification by following good practices in advertising, providing information about assessments, obtaining informed consent, and communicating clearly and courteously.

In addition to the high level Annual Report data, in 2019 the Board commissioned research to undertake a more detailed analysis of notifications data received by Ahpra and its coregulatory bodies in New South Wales and Queensland. This was for the period between 1 July 2012 and 30 June 2019. The project was undertaken to identify the main drivers of notifications. The project was also designed to highlight educational practice and professional development that may help to reduce future risk. Between 1 July 2012 and 30 June 2019 there were 382 notifications or complaints about 320 occupational therapists finalised by the Board across Australia.

Findings from the Board's notifications analysis between 2012 and 2019 found that notifications in the performance stream typically related to the following broad themes: Inadequate or inappropriate treatment, inadequate or inappropriate history, examination, testing or investigation. The analysis found that there was a high rate of notifications in the conduct stream that was driven by misunderstandings by the general public and other health practitioner groups about the scope of practice for occupational therapists. Many of the notifications in the performance stream were the result of client dissatisfaction with an occupational therapy assessment.

Areas of practice that attracted a higher number of notifications were disability, paediatrics, assessment of driving, assessment for home modification, or the need for domestic assistance. Practitioners at risk of a notification are more likely to be male, have completed their first qualification more than 30 years ago, practise in an outer, regional, remote or very remote area, work in a community practice setting, and practise from a single site practice.

We will now take a small break to answer some questions and in our next section we will explore in detail the key learnings from notifications data so far and we will be drawing on the Board's code of conduct for guidance on what good practice includes.

Vathani Shivanandan: Thanks, Roxane, Rebecca and Julie. Our first question today is in relation to the process for how Ahpra and the Board manages notifications. Roxane, would you like to take that one?

Roxane Marcelle-Shaw: Thanks, Vathani. The Board has appointed a Registration and Notifications Committee to review and consider all notifications and assess the potential risk to the public. When a concern has been raised, all information provided by the notifier will be considered and Ahpra may speak to the notifier. All information held about the practitioner, including registration history, will be considered, and a risk assessment will be conducted. Ahpra will speak to the practitioner to gather information about their practice setting and context, and seek to understand any steps that the practitioner has put in place in their workplace to manage risk to the public. Where appropriate, Ahpra will also speak to a practitioner's employer to validate any of this information. Ahpra may also seek advice from our appointed occupational therapy clinical advisors as to the appropriate standards of practice across different settings and contexts. This information will then be presented to the Board's Registration and Notification Committee, who will determine whether regulatory action should be taken.

Vathani Shivanandan: Thanks, Roxane. Julie, we have a question here about what workplaces can do when they have been alerted to a complaint about one of their employees.

Julie Brayshaw: That's an interesting question, and one we see quite often when the Registration and Notification Committee consider notification matters. Employers play a critical role in managing risks at the front end of care delivery and are instrumental in investigating and responding to risk in the workplace. Workplaces that do this well have strong clinical governance policies and procedures in place, investigate and review all incidents, provide training and education to improve performance, supervise practitioners, and respond to all adverse events and actively support quality and safety.

Vathani Shivanandan: Thanks, Julie. Our next question goes to the topic of the code of conduct, but more broadly is a question about what resources should practitioners be looking to, to ensure that they are practising ethically and professionally. Rebecca, what are your thoughts on this one?

Rebecca Singh: Thanks, Vathani. The required standard of practice is detailed in a range of important documents that collectively set out the Board's expectations about what good practice looks like. These documents include the range of Commonwealth, state and territory legislation that establishes the requirements to become a registered occupational therapist, establishes workplace obligations and privacy requirements, to name a few. The Code of Conduct, which we'll be discussing in greater detail in the next section, outlines expectations about professional behaviour and the competency standards set out professional behaviours all occupational therapists should demonstrate to practise safely and ethically. The Board's website has a range of resources, particularly in the codes and guidelines section, where practitioners can find information about the code of conduct and competency standards.

Vathani Shivanandan: Thanks, Rebecca. Our next question raises a topic about clinical care, which appears to be in a high area in which notifications are received. What types of issues does the Board see in relation to this area? Roxane, what are your thoughts on this one?

Roxane Marcelle-Shaw: It's an interesting one, Vathani. Within that clinical care area, the most common issues that we see as a Board would be in relation to inadequate or inappropriate treatment. For example, this might relate to a particular type of treatment plan or the outcome of an assessment report not being in line with the client's expectations, or in the case of driving assessments, an adverse finding on the assessment.

Vathani Shivanandan: Thanks, Roxane. Julie, we have a question here that's related, and it's about what types of issues are presented in relation to notifications about documentation?

Julie Brayshaw: As you would have seen from the previous slide, the most common area in which we see notifications is about documentation issues. Examples of these notifications include notes made by a practitioner that do not reflect what the client considers to be the true facts or details, or notes made by the practitioner that are not sufficiently comprehensive to provide a rationale for treatment.

Vathani Shivanandan: Thanks, Julie. Rebecca, our next question is about whether the Board routinely shares lessons learned from notifications with practitioners.

Rebecca Singh: We absolutely do, Vathani. Through the Board's bi-annual newsletter we have been trying to share items in relation to good practice. These are drawn from the code of conduct, but also from

the notifications data. The newsletters are sent to all registered OTs and are available online. If you haven't read it already, the last newsletter discussed informed consent and recordkeeping.

Vathani Shivanandan: Thanks, Rebecca. Our last question goes to Roxane, and it is about whether the Board has any resources available that could be useful for non-healthcare workers to inform them about best practice.

Rebecca Singh: It's a great question, and I'm glad that that's come through because it's an area that the Board has a particular interest in, in being able to inform the broader community. The revised code of conduct which comes into effect at the end of the month, is a really valuable resource for both practitioners and the public in understanding what the standards of practice are that can be expected for all practitioners. As part of the development of the new code, work is already under way to develop resources that we will be specifically target towards consumers to assist their understanding. When these resources are finalised, they will be published on the Board's website. The Board also has developed a range of resources to support the Australian occupational therapy competency standards, which I'm sure all participants are very familiar with, including a video, a postcard and poster which provide highlights about what the competency standards mean for the profession as well as the public. These resources are also published on the Board's website.

Vathani Shivanandan: Thanks, Rebecca. That was our last question for the section and leads us well into the next section. Rebecca will now take us through this next section of the webinar, where we will explore in detail the learnings we have from our notifications data. And we will be drawing on the Code of Conduct to highlight what is good practice in three key areas.

Rebecca Singh: Thanks, Vathani. The Board, along with 14 other National Boards has recently published an advanced copy of the revised Shared Code of Conduct on its website. Following an extensive review and a consultation process, the shared code was revised to more clearly define the standards of professional conduct that the Board and the public can expect of practitioners. The Board uses the code as a regulatory tool to evaluate practitioners' conduct. If professional conduct varies significantly from the code, practitioners should be prepared to explain and justify their decisions and actions. Serious or repeated failure to meet the code may lead to patient harm and have consequences for registration.

The revised code comes into effect on 29 June 2022, so just in a week. There are 11 principles set out in the shared code and they address safe and collaborative practice, Aboriginal and Torres Strait Islander health and cultural safety, respectful and culturally safe practice for all, working with patients, working with other practitioners, working within the healthcare system, minimising risk to patients, professional behaviour, maintaining practitioner health and wellbeing, teaching, supervising and assessing, and ethical research. We strongly encourage all practitioners to review the revised code, which is available on the Board's website, to become familiar with the new information and supporting resources that have come into effect.

We'll be drawing on the revised code in the next section of the webinar to highlight what is considered good practice in the context of informed consent, record keeping and communication. We have developed some case studies which are a compilation of notification matters that we have considered over the years, which we hope will help illustrate what good practice looks like.

Before we look at a case involving informed consent, let's first get a reminder about what that means in an OT setting. Informed consent is when a client has the required knowledge and understanding of the benefits and risks about healthcare when making a decision about what services they agree to proceed with and how. As a practitioner, informed consent requires you to provide information to clients in a way that they can understand before asking for their consent. If you are providing services to a person with impaired decision-making capacity, you should consider whether supportive decision-making is required or if they have an appointed decision-maker. Informed consent must include information on material risks and expected outcomes and take into account other information such as the services that you provide.

The Board often receives complaints about clients being unaware of the financial implications associated with the services that they have received. In relation to financial consent, it is your responsibility to discuss fees and address costs required for all services. You should attempt to get a general agreement about the level of treatment to be provided preferably before the service commences. Lastly, it's very important that you document consent appropriately. You should consider the need to obtain written consent for services which are of high risk.

Roxane and Julie will now take us to our first case study to highlight the importance of gaining and documenting informed consent. We have developed these case studies from a composite of notifications received.

Roxane Marcelle-Shaw: Thanks, Rebecca. This first case study is about Kelly, who has undertaken an initial assessment of a client with a physical disability. I've seen a couple of questions come through in the Q&A around the NDIS, so hopefully these case studies will give you some insights into the types of matters that we are seeing come up. The client in this case is self-managing their NDIS funding and has engaged Kelly to provide a home modification assessment. Kelly commenced treatment, which included soft tissue and musculoskeletal treatments without completing a formal report on her initial assessment. It was alleged that the practitioner did not obtain informed consent for the treatment to be provided.

Julie Brayshaw: An examination of Kelly's clinical notes indicated a lack of documentation was provided to the client regarding consent and financial costs associated with the recommended treatments. Given the vulnerable client group, it would be reasonable to expect greater transparency in relation to invoicing and the risks and benefits associated with the recommended treatment. An analysis of the information provided by the client and Kelly also indicates that treatment was started before the initial report was finalised. Good practice requires that an initial assessment, with reports documenting clinical reasoning for interventions, be provided to the client before treatment is commenced. Given the particular vulnerabilities of the client group, it would be reasonable to expect a practitioner to take extra precautions in making sure the client is appropriately informed of the risks and benefits associated with the treatments, that written information is provided to the client about the recommended treatment options, and that signed consent is obtained to confirm the client's understanding.

An added complexity which the Board is seeing more frequently is how practitioners navigate funding arrangements provided through the NDIS. In this case, Kelly did not clarify how funding would proceed before commencing with treatment. While the client was self-managing his NDIS funding and could commence treatment on his approval, typically any services undertaken with NDIS funding should be outlined in the service agreement and the NDIS have a template for this purpose.

The final issue was in relation to the occupational therapy treatments undertaken. It's important that occupational therapy interventions are informed by best available research, knowledge of the client and knowledge of the practice context.

Roxane Marcelle-Shaw: The outcome in this case was that Kelly was cautioned following the Board's consideration of the matter. In all aspects of her practice, the Board would now expect that Kelly establish a formal process for obtaining signed consent, ensure that her clinical records include information about the risks and benefits associated with the recommended treatment, and that this is documented alongside consent, and that there is a document for a service agreement and, where relevant, templates have been used that are available, such as those through the NDIS if treatment involves NDIS funding.

I'll hand over to Vathani to take us through some questions.

Vathani Shivanandan: Thanks, Roxane. Our first question is about how can practitioners ensure that they have provided information in a way that can be understood by a client? Rebecca, what are your thoughts on this one?

Rebecca Singh: Thanks, Vathani. A really challenging area in practice and one that practitioners have to manage often given the range of clients that we work with in our practices. What is important to remember is that positive professional relationships are built on effective, courteous and respectful communication. When seeking consent, we must remember to communicate in a way that takes into consideration age, maturity and intellectual capacity of our clients. For example, adjusting your communication if you're working with a young person or a person who may have additional communication needs. It's your responsibility to ensure that you provide information in a way that can be understood. You must be aware of any barriers in your client's health literacy and take steps to ensure that information is communicated in simple and clear language.

In addition to effective communication, we would encourage you to endeavour to confirm with your clients whether they have understood the information that you have communicated to them, and if there's any doubt, relay the information again and always document these steps in your health records. We will be talking more in the next section about what is good practice in relation to recordkeeping, so I won't go into detail about that topic just yet.

Vathani Shivanandan: Thanks, Rebecca. Roxane, we've got a question here about how do we gain informed consent in relation to minors or people with impaired decision-making?

Roxane Marcelle-Shaw: Thanks, Vathani. That's another great question. We all know that some clients, including those with impaired decision-making capacity or young people have additional communication needs. When working with these clients, it is important that you act in accordance with the client's capacity for decision-making and consent, including when caring for children and young people, based on their maturity and capacity to understand and the nature of the proposed care. It is important that you recognise the role of parents and carers or guardians when working with young clients or those with impaired decision-making. You should consider the need for the consent of a parent or carer or guardian or other substitute decision-maker. Where consent from a parent, carer, guardian or other substitute decision-maker is required, you should gain this consent before carrying out the treatment examination or investigation.

Vathani Shivanandan: Thanks, Roxane. We've received quite a few questions as to whether there's a template for how practitioners should be documenting their consent. Rebecca, did you want to take that question?

Rebecca Singh: Yeah, it's a good question, Vathani. The Board doesn't have a specific template for how consent should be recorded. But it would be useful that when documenting consent, you document the material risks and the expected outcome of your services, document the appointment of any nominees or substitute decision-makers, document with whom and what information you have consent to share, document financial consent and the level of treatment to be provided that aligns with the fees that are payable to you, and document consent for all the treatment procedures, including any high-risk procedures that may result in serious injury or death. When consent has been provided by a parent, a carer, a guardian or a substitute decision-maker due to the client's age or capacity, then this should also be documented.

Vathani Shivanandan: Thanks, Rebecca. We've got a related question about how do we document verbal consent, particularly in the context of telehealth consultations? Julie, what are your thoughts on this one.

Julie Brayshaw: Similar to the last question, where you have received consent verbally regarding a treatment or service, it would be important that you record this in your clinical records. The clinical records should document the material risks and expected outcomes, financial consent and the level of treatment to be provided that aligns with the fees payable, the treatment procedures, including any high-risk procedures that may result in serious injury or death.

Vathani Shivanandan: Thanks, Julie. That was our last question for this section. I'll now hand over to Rebecca, who'll take us through our next section.

Rebecca Singh: Thanks, Vathani. Before we go through our example, which involves record keeping, we're going to talk through what good record keeping practice looks like. Concise contemporaneous clinical records are fundamental in continuing good care of clients. Notes should include sufficient rationale for your assessment choices, intervention decisions and plans. Clinical records should also document relevant clinical history, findings, investigations and information given to clients, and other clinical risks identified. Where the risks are high or clients are vulnerable it is especially important to document steps including provision of information, informed consent, any concerns or complaints raised, and the response to these.

When preparing your clinical records, it's important for you to ensure that they are in a form that can be easily understood by other practitioners. It is also important to write your clinical records, assuming that your client will one day read them, as all clients have the right to access their clinical notes. I must say I tell my staff that pretty regularly I reckon. It is your responsibility to ensure that your clinical records are held securely so as to maintain the privacy and integrity of your clinical records. Clinical records must not include demeaning or derogatory remarks.

Clients have a right to access information contained in their health records and it's your responsibility to facilitate access when requested. It is also your responsibility to ensure the correct transfer and management of health information in accordance with privacy and health record legislation. An occupational therapist whose practice is sound and maintains high quality clinical records is well-placed to account for or defend their conduct in an investigation or any legal proceedings, so it really is a protection in place for yourselves.

Julie and Roxane will now take you through a case study highlighting how inadequate recordkeeping can impact on your practice and client care.

Julie Brayshaw: Here we have Scott. Scott's an occupational therapist working in a small community practice setting. He is a recent graduate and has limited mentoring supports available. This is another scenario that the Board has seen quite often, that is new graduates entering roles where they have access to limited mentoring supports.

Scott was engaged to provide home modification assessments and to assess access issues for a client for the purposes of determining recommendations for NDIS funding. On performing the assessment, Scott was informed by the client's father that the client experienced dangerous behaviours of concern associated with their condition. These behaviours had the potential to impact on the safe use of the home environment, particularly the kitchen area.

Scott's report does not indicate that he assessed the impact of these behaviours of concern. In particular, it appears he did not question what exactly were the behaviours and what preceded them. There was also no evidence to indicate that he'd assessed other aspects of the client's safety in the kitchen environment. It was alleged that Scott's report and records included inadequate or misleading information, particularly given that Scott had been informed by the client's parent of other areas of concern that should have reasonably been considered as part of the assessment and included in the health records.

Roxane Marcelle-Shaw: On review of Scott's clinical record, it was found that he had an incomplete record of the client's health history, particularly the impact of the behaviours of concern on the client's safe use of their kitchen environment and how modifications could be made to enable the continued safe use of that environment. This case study highlights the importance of taking accurate, up to date and factual health records. Record keeping in this manner will ensure that you have the appropriate information available when developing treatment plans. Scott's inadequate health records provided insufficient information to allow another practitioner to continue care and the treatment plan that was developed omitted crucial details of the client's clinical history which were discussed in the initial consultation.

Julie Brayshaw: Scott was cautioned following the Board's consideration of this matter. The Board's particular concern was that he had failed to take into account and record a holistic account of the client's history, presentation and living conditions, particularly when he was alerted to relevant facts about the client to ensure the completion of a safe and appropriate assessment. In all aspects of his practice, the Board now expects that Scott conduct appropriate information gathering and assessment when identifying a client's status, functioning, strengths, occupational performance and goals, discuss assessments with more experienced practitioners when advice/mentorship and guidance might be appropriate, and maintain clear and accurate health records to enable continuing good care of clients.

I'll now hand over to Vathani, who's going to take us through our next question break.

Vathani Shivanandan: Thanks, Julie. Roxane, our first question is about whether we need to keep in our records a copy of all emails and text messages that we have for the client.

Roxane Marcelle-Shaw: Thanks, Vathani. I think it continues the theme that we're seeing in the case studies, communicate, record, communicate, record. And we would say that when making your clinical records, it is important that you keep accurate, up to date, factual, objective and legible records that report relevant details of clinical history, clinical findings, investigations, information given to clients, treatment plans, all in a form that can be understood by other health practitioners, and that you ensure that records are sufficient to enable continuity of care.

Where written communication takes place with a client that will impact on their continuity of care, then it would be suggested that this information be included in your clinical records. This is a judgement call, and we would suggest that you err on the side of caution when deciding what information to include in clinical records. Your clinical records can be a useful resource if there is ever a complaint made about you, and can provide useful evidence as to what occurred during or after consultations.

Vathani Shivanandan: Thanks, Roxane. Rebecca, we have a question here about whether records need to be made at the time the service has been provided, or is it sufficient that they are made soon after a service has been provided?

Rebecca Singh: Great question, Vathani, and one that we touched on in our last case study. In accordance with the Code of Conduct, practice includes making records at the time of events or as soon as possible afterwards. And as we saw in the case study for Scott, if there's a gap between the time in which records

are made and in consultations, there is more room for error. Your recollections of a consultation later may not always be complete or accurate.

Vathani Shivanandan: Thanks, Rebecca. Julie, we've got a question about what are the critical elements that we should be including in our treatment notes?

Julie Brayshaw: It's a good question for us to recap on. We touched on this earlier, it's important that your records include relevant details of clinical history, clinical findings, investigations, information given to clients, treatment plans. Many practitioners work closely with a wide range of other practitioners for the benefit of patient care and it's important that the information you include in your records is sufficient and in a form that can be understood by other health professionals. It's also critical that your health records facilitate continuity of care. It's important to recognise that adverse events do take place when providing care. Where such an event occurs, in addition to rectifying and recognising that the event has occurred, you should document in your clinical records the nature of the event and the steps that were taken following the event.

Vathani Shivanandan: Thanks, Julie. We've received quite a few questions about whether we are obliged to give clients access to our clinical records. Roxane, did you want to take this one?

Roxane Marcelle-Shaw: Thanks, Vathani. And this sort of harks back to what Julie and Rebecca said earlier about assuming that a client may read your clinical records in the future. This is because clients have a right to access information contained in their health records. Where a client has sought access to their records, it is your responsibility as a practitioner to help the client access the records and to promptly facilitate the transfer of the health information when requested by the patient. The transfer of this information should be done in accordance with legislation governing privacy and health records within your state or territory. Facilitating access to clinical records is important to ensuring the continued good care of a client.

Vathani Shivanandan: Thanks, Roxane. Julie, our last question for the section is about whether we can use cloud-based software to record our clinical records.

Julie Brayshaw: While we won't go into the specifics about templates and resources that can be used to record your clinical notes, it's important to ensure that any records that you make are held securely and not subject to unauthorised access. That includes protecting the privacy and integrity of the electronic records.

Vathani Shivanandan: Thanks, Julie. That was our last question for the section. And I'll now hand over to Rebecca, who'll take us through our next section.

Rebecca Singh: Thanks, everyone. Before we go on to our next case study in relation to communication issues, let's just recap on what good communication in your practice should look like. Clear and effective communication is fundamental to all areas of practice, particularly in relation to ensuring that clients or carers feel satisfied with the process or the outcomes of the service. The conscious focus on really good communication is one of the things which all practitioners can do to reduce their risks and strengthen the outcomes of their care. It is important that practitioners communicate in a manner that is respectful and courteous, that accommodates language, cultural and specific communication needs, is open, honest and effective, is sensitive and appropriate and targeted towards the health literacy of the client, and be mindful of how they deliver bad news. For example, I work in driving, so recommendations leading to restriction to someone's driver's licence can be quite sensitive and needs quite careful delivery and support around them. Good communication has the potential to not only reduce the risk of harm but also to enhance practice.

Julie and I will take you through a case study, our final case study, about communication issues. We've got the case study about Francesca, who works in private practice working with children and young people predominantly who have autism with varying abilities to articulate their needs. Obviously this group of clients is particularly vulnerable. Francesca, as I said, works in private practice, and we know that when working in sole private practice, practitioners are working with limited to no oversight or supervision of their performance or conduct. There are limited risk controls in place and practitioners have to rely heavily on their own insight and their ethics in practice. Practitioners can also draw on resources such as the code of conduct can be particularly helpful in reviewing their practice.

It was alleged that Francesca's communication to the client and her parents disregarded their concerns and questions, and also dismissed their request to amend the report to remove demeaning and inflammatory commentary.

Julie Brayshaw: On analysis of the accounts of the client, her parents and the practitioner, it was clear that Francesca conducted an inadequate assessment of the child's physical requirements so as to enable appropriate equipment to be ordered. Francesca simply used records from a previous practitioner without assessing whether any of these factors had changed. Francesca's failure to conduct an adequate assessment had implications on the child's capacity to participate in the school. Furthermore, Francesca's failure to modify reports, which were subsequently shared with the school, had implications on how the child was perceived in the school environment, which again had flow-on effects on their ability to participate at school.

Rebecca Singh: Francesca had conditions imposed on her practice. The Board held significant concerns that Francesca had a significant lack of awareness about how her communication could have lasting implications on the client's capacity to participate in a school environment. It's important to note that when a client makes a complaint to an occupational therapist, that effective communication with the client can resolve the issue and ensure that care is not adversely affected. If a client believes they have not been listened to and that their care has been adversely affected, they are more likely to lodge a formal notification with the Board, as was the case for Francesca. Where a concern has been raised, it is important that you communicate in an open and transparent way and seek to address these concerns directly with the client.

I'll now hand over to Vathani to take us through our next question break.

Vathani Shivanandan: Thanks, Rebecca. We've had a question here about what is involved in communicating with clients who have additional communication needs? Roxane, did you want to take this one?

Roxane Marcelle-Shaw: Thanks, Vathani. And let me say, I think that's a really important question, particularly from what I look at from my community member sort of perspective on the Board, and that is that we just can't underestimate the importance of clear and courteous communication, particularly when Rebecca was saying that the working environment is often challenging in terms of understanding and meeting expectations. As occupational therapists are often working with vulnerable clients or those at risk, working with these clients really puts the emphasis on using all of those good practice skills. And these can include paying particular attention to your communication, ensuring that all clients are treated with respect and that their views are listened to, and that they know that their views are being heard. It means recognising the role of parents, carers or guardians, they are an important part of the communication environment for clients, particularly those who are vulnerable or have additional risks, and where appropriate, encourage the client to include them in the decisions about services and the care that they are receiving.

And lastly, where other people are involved in the care of a client, such as significant others or family members, that you take that extra care to always seek to involve them in the arrangements for the client, of course being mindful of doing so where it's appropriate.

Vathani Shivanandan: Thanks, Roxane. We've received quite a few questions about what guidance is available in relation to how practitioners should be communicating with other practitioners? Rebecca, did you want to answer that one?

Rebecca Singh: Sure can. As we often work with other practitioners, so that might be OTs or it might be other health practitioners, when we're working with clients in the community good practice in working with other practitioners is documented in the code of conduct. The code of conduct suggests that we need to communicate clearly, effectively, respectfully and promptly with colleagues and with other practitioners who are also providing services to our clients. And we also need to acknowledge and respect the valuable contribution of all the practitioners involved in the services that are provided with clients and make sure we're working collegiately.

And when working with other practitioners it's also important that we communicate and understand our role and also the role of other team members and attend to the responsibilities associated with that role, and make sure that's clear for our clients as well about who's doing what in terms of the care team. You might choose to appoint a recognised team leader or coordinator, even though the care within the team might be provided by different practitioners from different health professions within different models of care, to provide a central person that the client and their family can go to if they need to direct any queries is helpful.

Vathani Shivanandan: Thanks, Rebecca. Julie, we've had a couple of questions come through about how do we document verbal communications with patients?

Julie Brayshaw: Thanks, Vathani. This is a good question, and touches on some of the content from earlier. When making your clinical records it's really important that you keep accurate, up to date, factual, objective, legible records that report relevant details of clinical history, clinical findings, investigations, information given to clients, treatment plans in a form that could be understood by other health practitioners, and ensure that records are sufficient to enable continuity of care.

Vathani Shivanandan: Thanks, Julie. Our next question is for Roxane and asks at what point do issues relating to poor recordkeeping or poor communication does a notification arise? Roxane, did you want to recap about this one?

Rebecca Marcelle-Shaw: Thanks, Vathani. It's a terrific question to end on because I would have to say that through our Registration and Notifications Committee experience, in almost every notification or complaint that we deal with there is often an element of communication involved somewhere along the line. Communication and recordkeeping, I think, are absolutely key, and it touches on a lot of the content that we have already covered today.

As we discussed, anyone can raise with Ahpra a concern that they have about a practitioner, whether this is due to their communication or recordkeeping. These concerns are called, as we discussed at the beginning, voluntary notifications. We will consider the information Ahpra gathers from the complainant or the notifier, together with information that we gather from the practitioner concerned in terms of their response to the complaint or notification. We need to understand how you as a practitioner may have responded to the event that triggered the complaint or the notification, and this includes actions you have taken after reflection to reduce the likelihood of future risk.

You can really assist this process by responding promptly in the best interests of the patient, actively reflecting and sharing how you will respond effectively in similar circumstances in the future. We will then make a decision on whether to take regulatory action such as a caution or condition, or whether further investigation might be required, or indeed whether no further action is needed at all. Thanks, Vathani.

Vathani Shivanandan: Thanks Roxane. We've had a question come through today about what's involved in a caution, which links to the content that you just covered. Do you want to cover that as well, Roxane?

Roxane Marcelle-Shaw: Thanks, Vathani. A caution is one of our regulatory tools for being able to bring to the practitioner's attention an area of their practice that can be improved for the future because it's not met expectations in a particular set of circumstances. When we deal with a notification or complaint and the standard expected has not been met in all of the circumstances, we may propose to caution the practitioner. This is a set of words that raises the Board's concern with what's occurred and puts it to the practitioner. They then have an opportunity to respond to that proposed caution. We don't take any regulatory action without first hearing from the practitioner because there may be extenuating circumstances that haven't been properly considered in the course of dealing with the matter, and we would want to hear about those before making a final decision.

Once we've received a practitioner's response to a proposed caution, we will then determine whether or not to proceed, or whether some alternative approach would be better in that particular matter. If the decision is taken by the Board through the committee to impose the caution, this is typically issued to the practitioner in writing, and it is typically not something that will appear on the register. It's a really important engagement between the Board and the practitioner to say things did not go well in this particular set of circumstances and you now have the opportunity to take steps to ensure that it never occurs again and to ensure that the standards of practice are met in all future occasions. We see it as a very important opportunity for learning and growth as a practitioner, and to deal with a poor set of circumstances in a really productive way.

Vathani Shivanandan: Thanks, Roxane. We've had another couple of questions come through in relation to whose responsibility is it to ensure that clinical records are complete and not inaccurate. Rebecca, did you want to take that one?

Rebecca Singh: Sure. That's absolutely on the practitioner's head to make sure that their clinical records are complete and accurate. And I guess that some of the challenges, for example in report writing, is that we're often gaining a lot of information in assessments and reports and so it's understandable that we may hear something different or may have a different interpretation of what a client might have said, so it's absolutely okay to go back and clarify information, even if you've documented it in a report and amend that to make sure that it accurately reflects information that the client has provided to you. But this is definitely

on the practitioner to ensure that that records are accurate, and we need to make sure that we review that information with the client to ensure it accurately reflects their situation.

Vathani Shivanandan: Thanks, Rebecca. We've had another question in relation to vexatious complaints. Roxane, did you want to cover briefly about vexatious complaints and how the Board deals with those types of complaints?

Roxane Marcelle-Shaw: Thanks, Vathani. I think there's been a few other questions there also where the client or the patient might not be willing to engage or wants to make an anonymous complaint. And I would say that all of these are possibilities in notifications that come to the Board. Our responsibility is to ensure that we understand the concern that has been raised and our focus is on public safety. That's what underpins our assessment with the assistance of Ahpra in understanding the notification or the complaint when it comes forward.

I think that there can often be vexed circumstances in what brings a complaint or notification forward. Sometimes the relationship between a practitioner and a client may have deteriorated, and this starts colouring the way in which a notification or complaint might be made. Nevertheless, it's important that we understand the concern that is brought forward and that we respond to that concern even where the engagement might not be as we would wish in all of the circumstances. The focus for us is very much on understanding the issue that's brought forward, dealing with that issue and understanding whether it raises a concern about practice, conduct or health in all of the circumstances.

I think it's worth bearing in mind that the vast majority of notifications can be resolved between a practitioner and client or patient through really good communication, in understanding expectations and communicating well about the outcomes in a particular treatment scenario, and that in fact for the majority of notifications and complaints we do not take regulatory action in response towards a practitioner and we will accept that if the practitioner has done all that is reasonably practicable in the circumstances to respond to the concern raised and to resolve it, that may be sufficient for us to close that particular notification or complaint in relation to that practitioner.

Rebecca Singh: Can I add in there as well, Roxane, how important is self-reflection. The Board really appreciates when practitioners are insightful and really deeply reflecting on their practice, and that goes a long way when we're reviewing any complaint that is made, that you really have reflected on your practice and tried to identify any ways that you could improve, that does make a significant difference.

Vathani Shivanandan: Thanks, Roxane, and thanks, Rebecca, as well. We might close the questions there. I know that there are a lot of questions on the Q&A section, which we will respond to after the webinar today. There are some quite detailed and really fantastic questions that came through, so we will respond to those after the webinar tonight. Thank you all for your engagement through the question and answer sections of the webinar.

I will hand over to Julie for some final comments before we close the webinar for tonight.

Julie Brayshaw: Thanks, Vathani. We thought it might be helpful to recap on some of the resources that are being published on the Board and the Ahpra websites that help to set out the expectations about professional practice. As you'll know, there's the Code of Conduct document, there's the Australian occupational therapy competency standards documents, and there re the guidelines for advertising a regulated health service. We've touched on all of those issues today and the associated documentation you will find on the website.

Thank you for everyone for your participation today. We hope that you found the session helpful, and we hope you found it useful that we've highlighted some of the common pitfalls that we see in occupational therapy practice.

I'll now hand over to Vathani, who will close for today.

Vathani Shivanandan: Thanks, Julie. And also thank you to Rebecca and Roxane for taking us through the lessons that have been learned by the Board through its notifications data. I think we'll all agree that there's some really useful content covered, and hopefully this will help to guide practices going into the future. Just a reminder that the webinar has been recorded and will be published on the Board's website. We will also send around an email to all people who've registered for the webinar, so that you know that the webinar has been published and is available to you all afterwards. Also, just another comment that, like I said before, we will be responding to all of those fantastic questions that we received, so please rest assured

that we will deal with those after the webinar today. Thank you again for your engagement through the questions. Before you log out of the Zoom session today, you'll note that there is a short survey that will pop up, and you can give us some feedback on what you thought about the webinar and any other future ideas that you would like the Board to speak to you all about. And thank you again for your engagement today. It's been fantastic to have such a huge turnout for the webinar this evening. Thanks everyone.

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