Updated January 31, 2023

Standards of Practice

College of Occupational Therapists of Ontario
Regulator of occupational therapists in Ontario

Contents

Introduction

The Standards of Practice establish the minimum expectations for all occupational therapists in Ontario. They describe how occupational therapists will provide safe, quality, ethical, accountable, and effective services. The Standards apply to all registrants of the College of Occupational Therapists of Ontario ("the College"), regardless of practice setting, job title, or role. The Standards, together with the Code of Ethics, Competencies, and Practice Guidance, establish the expectations for professional practice and the delivery of occupational therapy services.

Code of Ethics	The Code of Ethics defines the College's expectations for ethical practice. It includes a set of values and principles, and is intended for use in all **contexts** and for all levels of decision-making. It forms the foundation for occupational therapists' ethical obligations. Occupational therapists must know and adhere to these principles.
Competencies	The *Competencies for Occupational Therapists in Canada, 2021,* articulates the broad range of skills and abilities required of all occupational therapists. Occupational therapists are to remain familiar with the Competencies to inform practice and professional development.
Standards	Standards of Practice establish the minimum expectations for occupational therapists—expectations that contribute to public protection. Standards apply to all occupational therapists, regardless of their role, job description, or area of practice.
Practice Guidance	Practice Guidance provides information about specific practice situations or legislation. These are recommended practices.

How the Standards are developed and updated

The Standards are based on core occupational therapy principles outlined in the *Competencies for Occupational Therapists in Canada* (2021). The College monitors and revises Standards regularly through its committees, subcommittees, focus groups, and panels. The College consults with registrants and the public to ensure the Standards include core practice elements before seeking approval by the College's Board of Directors. Registrant input is vital to ensuring the Standards reflect changing practice environments and expectations. Data from College committees and program areas such as Investigations and Resolutions, Quality Assurance, Registration, and the Practice Resource Service helps the College keep the Standards current.

How the Standards are used

Clients and the public

Occupational therapy clients and the public use the Standards to understand what they can expect from occupational therapists. These expectations include knowing that services are being provided in ways that are accessible, culturally sensitive, equitable, and inclusive.

The College

The College uses the Standards in all statutory programs to ensure that applicants and registrants have the competencies and skills to practise effectively, to address questions or concerns about a registrant's practice, and to review and support the provision of quality services.

Failure to comply with the Standards constitutes professional misconduct (*Ontario Regulation 95/07*, s. 1 [1]).

The College's Practice Resource Service is available as an additional resource to help registrants and the public if they have questions about the Standards and occupational therapy practice. The Practice Service is confidential and available at 416-214-1177 or practice@coto.org.

Occupational therapists

Clinical and non-clinical occupational therapists are expected to use these Standards in their daily practice and, when requested by the College, be able to demonstrate how their practice meets the performance indicators. Occupational therapists must be able to provide a reasonable rationale when a Standard was not met, including when contextual factors required a deviation from the expectations.

In applying the Standards, occupational therapists must use professional judgement in the following ways:

- Determine how to best meet client needs in accordance with the Standards.
- Understand that these Standards are the College's interpretation of regulatory and practice expectations. When Standards and legislation conflict, the legislation prevails.
- If workplace policies conflict with the Standards, collaborate with their employers to identify and work toward resolving the differences in clients' best interests.

Employers

Employers of occupational therapists use the Standards to know and follow the College's expectations of occupational therapists working at their organization.

Educators and students

Educators and students use the Standards to inform curriculum and placement expectations.

Use of the terms "client," "patient," and "service"

The College uses the term "client" to align with the *Competencies for Occupational Therapists in Canada*. It states that clients are "people of any age, along with their families, caregivers, and substitute decision makers. Therapists may also work with collectives such as families, groups, communities, and the public at large" (2021, p. 19). **The term "clients" applies to people and organizations that occupational therapists work with in both clinical and non-clinical settings.**

The *Regulated Health Professions Act, 1991* (RHPA) uses the term "patients" to refer to people receiving care from regulated health professionals. This definition is not as broad as the term "client" used in the *Competencies.* In these Standards, the College uses the broader term "client" with one exception: it remains consistent with the RHPA by using the term "patient" when referring to sexual abuse legislation.

The term "service" is used throughout these Standards to encompass all aspects of occupational therapy, including assessment, intervention, and consultation. "Service" also includes non-clinical roles

or activities completed by occupational therapists in their practice setting (for example, leading education sessions, coordinating services, researching, or teaching).

How the Standards are organized

As one document, the Standards are sorted alphabetically by title. Each Standard contains:

- An introduction to the main topic explaining why the Standard is important
- Performance indicators or specific behaviours that show how the Standard is to be met
- A list of further references, including College, legislative, and regulatory documents

General References

Association of Canadian Occupational Therapy Regulatory Organizations, Association of Canadian Occupational Therapy University Programs, and Canadian Association of Occupational Therapists. (2021). *Competencies for occupational therapists in Canada*. https://acotro-acore.org/sites/default/files/uploads/ot_competency_document_en_hires.pdf

College of Occupational Therapists of Ontario. (2020). *Code of Ethics*. https://www.coto.org/resources/code-of-ethics

Occupational Therapy Act, 1991, Statutes of Ontario (1991, c. 33). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/statute/91o33

Ontario Regulation 95/07, Professional Misconduct. (2007). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/regulation/070095

Regulated Health Professions Act, 1991, Statutes of Ontario (1991, c. 18). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/statute/91r18

Standard for Acupuncture

Acupuncture is a controlled act under the Regulated Health Professions Act, 1991 (RHPA). This is because it involves a procedure performed on tissue below the dermis. Controlled acts are procedures that pose a risk to clients if not performed by a qualified practitioner. Occupational therapists who are competent to perform acupuncture are permitted to do so (Ontario Regulation 107/96: Controlled Acts, s. 8 [2] in the RHPA).

Occupational therapists are expected to:

1. Obtain and maintain competence

1.1 Have successfully completed formal acupuncture training with instructional, theoretical, and practical components taught by a qualified acupuncture practitioner or through a recognized acupuncture program. The course of study must include:

- a. Introduction to the theories, philosophy, and principles of acupuncture
- b. Anatomy, acupuncture points, and acupuncture meridians
- c. Applications of acupuncture, including:
  - i. Understanding of the indications, contraindications, benefits, risks, and limitations of acupuncture techniques
  - ii. Selection of clients, planning of treatment, and evaluation of progress and benefit to clients
  - iii. Practical training of point location and safe needle insertion and removal
  - iv. Practical examination
- d. Infection prevention and control and safety procedures in acupuncture
- e. Treatment principles, techniques, and specific clinical conditions

1.2 Provide verifiable documents showing completion of acupuncture training if requested by the College.

1.3 Assess clients as candidates for acupuncture based on current evidence of the treatment's effectiveness. Before proceeding, follow the **Standard for Consent**.

1.4 Perform acupuncture safely and in accordance with all Standards of Practice and relevant legislation.

1.5 Use electroacupuncture only if clinically indicated and with proper training.

1.6 Document details of the acupuncture procedure (for example, needle points used, length of needle, depth and direction, and use of stimulation or manipulation) and the outcome or effectiveness of the procedure.

1.7 Take part in professional development to ensure ongoing competence (for example, recognized acupuncture educational and training programs, workshops, conferences, or learning modules).

1.8 Know and follow appropriate infection prevention and control methods, including:

- a. Maintaining required standards of cleanliness, skin disinfection, and needling technique
- b. Ensuring that needles used for treatment are single use, prepackaged, presterilized, unexpired, manufactured for use in acupuncture, intended for the specific kind of

acupuncture being performed, and properly disposed of.

2. Work within the scope of occupational therapy practice

2.1 Document the clinical rationale for using acupuncture within the occupational therapy intervention plan.

2.2 Use the protected title “acupuncturist” only if registered with the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario and performing acupuncture techniques outside the scope of occupational therapy practice.

2.3 Refer clients to another qualified practitioner if they need acupuncture beyond the scope of occupational therapy practice or the competence of the occupational therapist.

3. Follow the rules for delegation

3.1 Before performing techniques of acupuncture that involve another controlled act, obtain delegation to perform the act. Delegation refers to the transfer of authority to perform a controlled act from one practitioner who has the authority to another practitioner who has the knowledge, skill, and judgement to perform the procedure safely and effectively.

3.2 Never delegate or assign any part of acupuncture to students, occupational therapy assistants, or any other health practitioners.

Related College documents

Controlled Acts and Delegation
Standard for Consent
Standard for Infection Prevention and Control (IPAC)
Standard for Record Keeping
Standard for the Supervision of Students and Occupational Therapy Assistants

References

Ontario Regulation 107/96, Controlled Acts. (1991). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/regulation/960107

Standard for Assessment and Intervention

Occupational therapy includes all aspects of assessment, intervention, and consultation. Assessments are the foundation for occupational therapists' professional opinions and the interventions they recommend. All assessments and interventions are to involve a collaborative approach with clients where their occupational needs and preferences are prioritized when possible.

Occupational therapists are expected to:

1. Screen the request for services

1.1 Gather enough information to decide whether to proceed with services, including considering any conflicts of interest.

1.2 Compile client information only with consent.

1.3 Understand the laws, rules, and organizational policies relevant to the area of practice and method of service delivery.

1.4 Carefully consider the social, **ecological**, and economic implications of care.

1.5 Decide whether it is safe to proceed with the services and what method of delivery is best (for example, in-person or virtual).

1.6 If it is not appropriate to proceed, explain the rationale to the client, the referral source, and any other professionals, partners, and interested parties. Discuss any alternatives available.

1.7 If it is appropriate to proceed:

a. Clearly explain the occupational therapist's role and responsibilities

b. Clearly explain the scope and time frames of the services and the next steps

c. Follow the **Standard for Consent**

d. Make reasonable efforts to ensure that referral information remains accurate, including any details collected from other sources.

2. Assess clients within the scope of the services requested

2.1 **Co-create** an assessment process with clients that is **culturally safer**, is accessible, and will assess their occupational participation and needs.

2.2 Select assessment methods and tools that are most suitable for clients and that consider the scope of services, using current theories, relevant evidence, and best-practice approaches.

2.3 Know the properties of standardized assessments, including reliability, validity, and administration criteria. Have the knowledge, skills, and required training to administer any assessment tools used.

2.4 Manage any risks or limitations to using the selected assessment tools and methods with clients (for example, communication needs, culturally sensitive practices, and physical impairments).

2.5 Apply culture, equity, and justice considerations throughout the assessment process.

2.6 Collaborate and communicate with clients, other professionals, partners, and interested parties to support evidence-informed decision-making.

2.7 Within the identified circle of care, collaborate and communicate with clients and others to obtain relevant information and gather collateral data to identify the occupational participation challenges and goals to be addressed.

3. Analyze assessment findings and recommend the services needed

3.1 In formulating professional opinions and recommendations, identify any gaps in the assessment findings, and decide whether additional information is needed, including assessments by other health professionals.

3.2 Ensure that assessments represent a fair and balanced evaluation of clients. Consider assessment findings with all other relevant information collected. Analyze findings and outline recommendations in the context of each client and their specific situation.

3.3 Analyze clients' strengths, challenges, contexts, and occupations and the impacts these have on occupational participation.

3.4 Develop evidence-informed recommendations based on the analysis of the information gathered.

3.5 Work with clients to develop context-specific occupational therapy goals, including determining whether the services of other professionals are required.

3.6 Should additional information become available following assessment, decide whether re-evaluation is required.

4. Develop and implement the occupational therapy plan

4.1 Work with clients to co-create and develop personalized intervention plans. Each plan must include the client's understanding of their health, well-being, and recovery. Plans must keep clients' occupations at the centre of practice.

4.2 Take into consideration the resources that are available and accessible for proceeding with the services proposed.

4.3 Confirm that clients understand occupational therapy plans. Review and evaluate plans regularly in partnership with clients, and change plans as needed. Plan and discuss the setting or resetting of goals, service transitions, and discontinuation.

4.4 Follow the **Standard for Consent** throughout service delivery.

4.5 Collaborate with other professionals to navigate shared or overlapping roles and responsibilities.

4.6 Be clear about the roles and responsibilities of the occupational therapist if supervising other individuals in delivering services.

5. Communicate assessment and intervention information effectively

5.1 Be clear and timely when communicating assessment and intervention information, such as results, opinions, recommendations, and updates. Use terms that clients and other professionals, partners, and interested parties can understand. Allow time for asking and answering questions.

5.2 Document all services per the **Standard for Record Keeping**.

5.3 Provide business contact information in case questions arise later.

5.4 Comply with current legislation if it is necessary to withhold any assessment or intervention information that poses a risk of harm to clients or others.

5.5 Ensure that clients are aware of the processes to access their record or assessment report.

Related College documents

Standard for Consent
Standard for the Prevention and Management of Conflicts of Interest
Standard for Record Keeping
Standard for the Supervision of Students and Occupational Therapy Assistants

Standard for Consent

Under the law, occupational therapists are required to obtain two types of consent:

- *Informed consent* before starting and throughout the delivery of occupational therapy services (assessment, intervention, and consultation) (*Health Care Consent Act, 1996*)
- *Knowledgeable consent* for the collection, use, and disclosure of clients' personal information and personal health information (*Personal Health Information Protection Act, 2004*)

Importantly, the process of obtaining consent is ongoing. When occupational therapists ask clients for consent, it is expected that they consider the **power imbalance** in client-therapist relationships. Occupational therapists must ask for consent in a way that is culturally sensitive and that allows clients time to ask questions, decline all or part of the services, or withdraw from services at any time.

If another health professional is obtaining consent on behalf of the occupational therapist, they must be a member of another regulated profession that uses the informed consent process outlined in the *Health Care Consent Act, 1996*.

Occupational therapists are expected to:

1. Determine client capacity to provide consent

1.1 Collaborate with clients using relevant communication and information-gathering methods to determine capacity. Use interpreters or augmentative communication tools if needed. Allow time for clients to understand the information and ask questions before finalizing capacity decisions.

1.2 Assume that clients are capable of providing consent unless there is information that indicates otherwise. Do not presume incapacity based on:

a. Age
b. Communication challenges
c. Diagnosis of a psychiatric or neurological condition
d. Disability
e. The fact that a guardian, power of attorney, or substitute decision-maker is in place
f. Language differences
g. Personal bias about social or cultural structures of marginalized groups or communities
h. Refusal of intervention

1.3 Gather relevant information and apply clinical reasoning and judgement to determine the client's capacity to decide on the proposed services.

1.4 If the occupational therapist finds that the client does not have the capacity to provide consent:

a. Explain to or assist the client in exercising their right to have a review of the finding.
b. Use the *Health Care Consent Act, 1996* hierarchy of substitute decision-makers (see Appendix) to determine who is to provide consent.

c. Inform the client that the substitute decision-maker will make decisions regarding occupational therapy services. Involve the client in discussions about services whenever possible.

2. Obtain informed consent

2.1 Follow the *Health Care Consent Act,1996* to ensure that clients have all the information a reasonable person would need to decide about the occupational therapy services. This information includes:

a. Scope and reason for the referral or services
b. Purpose and nature of the services
c. Expected benefits and risks of proceeding, including any cultural, ecological, or economic considerations
d. Likely consequences of not proceeding
e. Expected outcomes
f. Alternative courses of action
g. The right of clients to withdraw consent at any time
h. How services will be paid for
i. Any legal authority given through a legal process for occupational therapy services

2.2 Allow time and opportunity for questions and discussion about the proposed services.

2.3 Respect clients' choice if they decide not to proceed.

2.4 Explain each component of the plan, and obtain ongoing consent when moving from one component of services to another.

2.5 Use interpreters or augmentative communication tools to support the informed consent process.

2.6 Obtain consent from clients to involve others in service delivery, such as students and occupational therapy assistants. Clarify their roles and responsibilities.

2.7 Be clear about any fees involved and ensure that they are agreed upon before services start.

2.8 Apply an informed consent process to third party referrals (for example, independent examinations or expert reports). Explain that the services are at the request of the third party payer. Describe the nature and scope of the occupational therapist's role and reporting responsibilities.

3. Obtain knowledgeable consent

Knowledgeable consent refers to the collection, use, and disclosure of personal information according to the privacy legislation that applies to the occupational therapy practice. In Ontario, one of three privacy laws applies: the *Personal Health Information Protection Act*, *2004*, the *Personal Information Protection and Electronic Documents Act, 2000*, or the *Privacy* Act, 1985.

3.1 Know which privacy law applies to the occupational therapist's practice, and follow the legal requirements for consent and ongoing consent for the collection, use, and disclosure of information.

3.2 Explain to clients why information is being collected, used, and shared and with whom. Make sure that clients understand that they have a right to withdraw consent, but that the withdrawal cannot be applied retroactively to information already shared.

3.3 Provide professional contact details in case questions arise later about how information was collected, used, and shared during occupational therapy service delivery.

3.4 For third party referrals (for example, independent examinations or expert reports):

a. Obtain consent for the disclosure of assessment results, reports, and intervention plans to third party payers, other professionals, partners, and interested parties unless exceptions to this disclosure apply under privacy legislation
b. Obtain consent before reviewing any additional client health information that was provided by the third party after the original assessment services were completed (for example, other medical reports or surveillance material).

4. Handle client information respectfully and responsibly

4.1 Collect only as much client information as is needed to provide the services.

4.2 Access only records that apply to the occupational therapist's role and practice.

4.3 Protect the confidentiality of client information, and ensure that all information is secured against unauthorized access, loss, or theft.

4.4 Understand privacy legislation and organizational policies and procedures.

4.5 In the case of third party referrals, take reasonable measures to ensure that any assessment information shared is accurate and represents the occupational therapist's professional opinion.

5. Document both informed and knowledgeable consent

Documentation can take the form of a note in the client record, signed and dated consent forms, or a consent policy, procedure, or guideline that is referenced in the client record. A signed consent form does not necessarily prove that informed or knowledgeable consent has been obtained. Consent forms should not be a substitute for the communication process that must accompany proper informed consent. Forms, however, can be used to support the process and to standardize methods of obtaining consent.

5.1 Ensure that documentation is timely (determined by practice factors such as workplace policies, client risk, and reporting priorities) and includes notes on these details:

a. Whether or not the client understood and agreed to all, some, or none of the proposed services and plans of care.
b. Risks, limitations, and benefits of the services discussed.
c. Any limits imposed on the collection, use, and disclosure of the client's personal information and personal health information.
d. Type of alternative communication methods used or details of interpretation services.
e. Name of the substitute decision-maker. If applicable, include a copy of authorizing documents such as power of attorney for personal care.

6. Manage withdrawal of consent

6.1 Ensure that clients understand their right to withdraw consent and any implications of doing so.

6.2 If the client withdraws consent, continue the services only if immediate withdrawal poses a serious risk to the health or safety of the client or others. Explain to the client why the withdrawal cannot be immediate.

6.3 Ensure that the record includes all services provided before consent was withdrawn and the reasons the clients withdrew consent (if known).

6.4 If the client withdraws consent for disclosure of health information, explain that withdrawal cannot be applied retroactively to information already shared.

Related College documents

Consent Checklist
Decision Tree for Obtaining Consent
Standard for Record Keeping
Standard for the Supervision of Students and Occupational Therapy Assistants

References

Health Care Consent Act, 1996, Statutes of Ontario (1996, c. 2, Sched. A). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/statute/96h02

Office of the Privacy Commissioner of Canada. (2018). *Summary of privacy laws in Canada*. https://www.priv.gc.ca/en/privacy-topics/privacy-laws-in-canada/02_05_d_15/

Personal Health Information Protection Act, 2004, Statutes of Ontario (2004, c. 3, Sched. A). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/statute/04p03

Personal Information Protection and Electronic Documents Act, Statutes of Canada (2000, c. 5). Retrieved from the Justice Laws website: https://laws-lois.justice.gc.ca/eng/acts/p-8.6/

Privacy Act, Revised Statutes of Canada (1985, c. P-21). Retrieved from the Justice Laws website: https://laws-lois.justice.gc.ca/eng/acts/p-21/fulltext.html

Appendix: Hierarchy of Substitute Decision-Makers

When a healthcare practitioner believes that a client is not capable of making a decision about assessment, intervention, admission to a care facility, or personal assistance, they must obtain consent from the substitute decision-maker unless the circumstances warrant urgent intervention.

In most situations, the substitute decision-maker does not have to be appointed by the courts. They must be at least 16 years old unless they are the parent of the client, and they must be capable of giving consent.

The *Health Care Consent Act, 1996* (s. 20 [1]) lists a hierarchy of persons who can provide substitute consent. Generally, the practitioner must obtain consent from the highest-ranking person who is available and willing to be a substitute decision-maker. An exception is if a lower-ranking substitute is present and believes that the higher-ranking substitute would not object.

Based on the *Health Care Consent Act* (s. 20 [1]), the hierarchy is as follows:

1. The client's court-appointed guardian of the person if the guardian has the authority to give or refuse consent to treatment
2. Attorney for personal care conferred by a written form when the client was capable
3. Representative appointed by the Consent and Capacity Board
4. Spouse or partner
5. Child or parent (custodial parent if the child is a minor)
6. Parent of the incapable person who has only a right of access
7. Sibling
8. Any other relative

Note: If no person described in the hierarchy meets the requirements, the occupational therapist would go back to the top of the hierarchy, where the Public Guardian and Trustee shall make the decision to give or refuse consent.

Standard for Infection Prevention and Control (IPAC)

Occupational therapists protect the public by using best practices to minimize the risks of transmitting infection. Public Health Ontario (PHO) defines IPAC as “evidence-based practices and procedures that, when applied consistently in health care settings, can prevent or reduce the risk of transmission of microorganisms to health care providers, clients, patients, residents and visitors” (PHO, 2021).

In addition to infectious agents, occupational therapists must be aware of other environmental factors that could impact client health and safety, such as insect infestations or food-borne illnesses. Refer to Appendix 1 for IPAC resources.

Occupational therapists are expected to:

1. Know and apply current, evidence-informed best practices

1.1 Identify and access current and best-practice IPAC resources relevant to the practice setting.

1.2 Develop or apply existing IPAC policies and procedures including routine practices such as hand hygiene and the selection and use of personal protective equipment. Ensure that equipment is cleaned and maintained.

1.3 Inform clients and others about IPAC best practices as they relate to service provision.

1.4 Ensure that protocols are in place when risks of transmission are not preventable and address adverse events related to IPAC. Use clinical judgement, collaborate with clients to find alternative options if risks remain high, and document these processes.

1.5 Advocate for adequate resources to support IPAC best practices.

2. Control the environment

2.1 Conduct a point-of-care risk assessment.

2.2 Understand and apply evidence-informed cleaning, disinfection, and sterilization protocols for the practice setting’s physical environment, devices, and equipment. Comply with the equipment manufacturer’s instructions for use and best practices for cleaning. Appendix 2 explains the three types of equipment and devices: non-critical, semi-critical, and critical.

2.3 Follow additional College and public health directives when working with practice modalities requiring IPAC measures.

2.4 Use clinical judgement to determine when commonly used items such as pens and measuring tapes should be reused, cleaned, or discarded.

2.5 As best practices for IPAC evolve, review and update protocols for cleaning, disinfecting, and sterilizing devices and equipment.

Related College documents

Standard for Acupuncture
Standard for Record Keeping

Appendix 1: IPAC Resources

Infection Prevention and Control Canada: Infection Prevention and Control Resources (n.d.)
https://ipac-canada.org/infection-prevention-and-control-resources.php

Public Health Agency of Canada: Infection Control Guideline Series (n.d.)
https://www.canada.ca/en/public-health/services/infectious-diseases/nosocomial-occupational-infections.html

Public Health Ontario: Infection Prevention and Control (2021)
https://www.publichealthontario.ca/en/health-topics/infection-prevention-control

- Provincial Infectious Diseases Advisory Committee Best Practice Documents
  https://www.publichealthontario.ca/en/about/our-organization/external-advisory-committees/pidac-ipc
  - Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices in All Health Care Settings (2013)
  - Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings (2018)
  - Best Practices for Hand Hygiene in All Health Care Settings, 4th Edition (2014)
  - Infection Prevention and Control for Clinical Office Practice (2013)
- Public Health Ontario Online Learning (2020)
  https://www.publichealthontario.ca/en/education-and-events/online-learning

Appendix 2: Classification of Equipment Used in Practice and Best Practices for Reprocessing Equipment

PHO classifies the equipment used by health professionals as non-critical, semi-critical, or critical. PHO uses the term "reprocessing" to refer to the steps for cleaning, disinfecting, and sterilizing medical equipment or devices (PHO, 2013). Occupational therapists must be knowledgeable about the PHO classifications of medical equipment and about best practices for reprocessing.

This chart outlines PHO's classification system and notes best practices for cleaning, disinfecting, and sterilizing.

Classification of Equipment and Devices	Definitions and Examples	Best Practices for Reprocessing
Non-critical	Those that do not touch the client directly or touch only the client's intact skin Examples: splints, goniometers, blood pressure cuffs, and stethoscopes	Cleaning; may also require low-level disinfection or single use
Semi-critical	Those that encounter non-intact skin or mucous membranes but do not penetrate them Examples: respiratory equipment and probes	Meticulous cleaning followed by, at a minimum, high-level disinfection
Critical	Those that enter sterile tissues Examples: indwelling catheters and footcare equipment	Meticulous cleaning followed by sterilization

Standard for the Prevention and Management of Conflicts of Interest

Occupational therapists are required to be proactive in preventing, recognizing, and managing conflicts of interest in their practice. They must not exploit the client-therapist relationship for any form of direct or indirect benefit. They must ensure that clients' interests and well-being are always prioritized. Practising occupational therapy while in a conflict of interest is an act of professional misconduct (paragraphs 1.1 and 1.18 of the *Professional Misconduct* regulation).

Occupational therapists are expected to:

1. Understand what conflicts of interest are

1.1 Understand the types of conflicts of interest, their relevance to the occupational therapist's practice, and the situations that may lead to them. Conflicts of interest can be:

   a. Perceived (for example, referring clients internally for other services)
   b. Potential (for example, a close family member interviewing for a position at an organization to which the occupational therapist refers clients)
   c. Actual (for example, receiving or making payment for referrals)

1.2 Recognize that client consent is not an acceptable reason to practise while in a conflict of interest.

1.3 If uncertain whether a conflict of interest exists, seek advice from knowledgeable individuals such as managers, peers, the College, or legal counsel.

2. Monitor and manage conflicts of interest

2.1 Provide fair and equitable services (for example, avoid preferential scheduling for referral sources that pay more).

2.2 Never take advantage of their position as an occupational therapist, and always maintain relationships of trust and confidence with clients.

2.3 Remain aware of and address any conflicts of interests that arise during the client-therapist relationship.

2.4 Understand when conflicts of interest are based on strongly held values, beliefs, or biases, or on cultural, human rights, or social grounds, and address these sensitively and carefully.

2.5 Avoid dual or multiple relationships with clients, such as additional financial, personal, or professional roles with clients while also providing occupational therapy services.

2.6 Take appropriate steps to resolve conflicts of interest in the client's best interests. This could include ending the therapeutic relationship.

2.7 If avoiding a conflict of interest is not possible, manage it by taking these steps:

   a. Discuss the conflict of interest with the client, other professionals, partners, and interested parties before providing services
   b. Advise the client of their right to decline services at any time and, if possible, suggest alternatives
   c. Document in the client record the steps taken to address the conflict.

3. Avoid giving or receiving gifts or benefits

3.1 Know that the inappropriate exchange of gifts, money, services, or hospitality can exploit client relationships and is considered a boundary violation.

3.2 Exchange gifts with clients only if these have little to no monetary value, the offer is not recurring, and refusal could harm the client-therapist relationship.

3.3 Recommend only products or services that are appropriately indicated, and that do not involve any personal gain, relationship, or financial interest for the occupational therapist or someone close to them. This applies unless the occupational therapist can manage the conflict of

interest by taking these steps:

a. Disclose the nature of the benefit or relationship to clients in advance
b. Discuss other options for products or services, and allow clients to choose
c. Assure clients that services will not be adversely affected should they select an alternative supplier or product
d. Document the discussion in the client record

3.4 Never give or receive any incentive or benefit in return for client referrals.

3.5 Avoid self-referrals or soliciting clients (for example, referring clients from an employer's practice to the occupational therapist's private practice). This applies unless alternative options are not available or are not in clients' best interests (for example, clients are at risk of not receiving the services). In these cases, take these steps:

a. Disclose the self-referral to the occupational therapist's employer, clients, and others involved in the referral or services
b. Give clients the option of seeking alternative services
c. Document the full disclosure in the client record.

4. Manage relationships with interested parties

4.1 Ensure that professional interactions with other professionals, partners, and interested parties (for example, vendors or lawyers) are in clients' best interests. Recognize that the occupational therapist's primary obligation is to their clients. Relationships with other professionals, partners, and interested parties must never affect the integrity of, trust in, and confidence in the client-therapist relationship.

4.2 Provide clients with options when recommending other services, professionals, and equipment.

5. Follow protocols for client participation in research or quality projects

It is important for occupational therapists to help build their profession's body of knowledge and to contribute to research and initiatives that will innovate practice. This may involve formal or informal research studies, client and non-client participants, or quality activities in the workplace. Occupational therapists must recognize any conflicts of interest that may arise from these initiatives and manage them appropriately.

5.1 Before involving clients in research activities, get approval from a Research and Ethics Board (following the Tri-Council Policy) to ensure that the proposed study is ethically defensible, socially responsible, and scientifically valid. This must include disclosing any conflicts of interest if the occupational therapist is acting as a researcher while also providing clients with services.

5.2 Obtain informed consent from clients before and throughout participation.

5.3 Ensure that clients are not pressured, unduly influenced, or coerced to participate, and that there is no adverse impact on them should they decline.

5.4 Disclose to clients any financial or other benefit that they or the occupational therapist will receive for participating.

5.5 Ensure that clients are fully informed about the purpose, methods, and risks, including intended use of any results.

5.6 Communicate the results to clients where possible, or provide them with information about where the results can be found.

Related College documents

Code of Ethics
Standard for Consent
Standard for Professional Boundaries and the Prevention of Sexual Abuse
Standard for Record Keeping

References

Ontario Regulation 95/07, Professional Misconduct. (2007). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/regulation/070095

Panel on Research Ethics. (2020, February 19). *Tri-Council Policy statement: Ethical conduct for research involving humans – TCPS 2 (2018)*. https://ethics.gc.ca/eng/policy-politique_tcps2-eptc2_2018.html

Standard for Professional Boundaries and the Prevention of Sexual Abuse

Occupational therapists are fully responsible for establishing and maintaining professional relationships with clients, colleagues, students, and all others they encounter in their practice setting. Breaching clinical, financial, intimate, or social boundaries with clients demonstrates a lapse in professional judgement and jeopardizes clients' emotional and personal safety.

The most serious boundary violation is when relationships with clients become intimate, romantic, or sexual. This is *sexual abuse*. When referring to sexual abuse, both the *Health Professions Procedural Code* (s. 1 [6]) and the *Regulated Health Professions Act, 1991* (RHPA; *Regulation 260/18*) use the term "patient" to refer to anyone who receives services from an occupational therapist, even if the services are provided at no cost or are not documented. The *Health Professions Procedural Code* says that, in the context of the rules on sexual abuse, a person continues to be a patient for one year after the professional relationship ends. In these Standards, the terms "patient" and "client" are used interchangeably.

The College has a position of zero tolerance toward all forms of sexual abuse that may occur within client-therapist relationships. Consent is never a defence. In situations involving sexual abuse, clients are not able to consent. It is always considered inappropriate to enter into a sexual relationship with a client. The RHPA sets out the penalties for occupational therapists who have been found guilty of sexually abusing patients. These include revoking the occupational therapist's certificate of registration (see Appendix 1).

Occupational therapists are expected to:

1. Form appropriate therapeutic relationships

1.1 Never provide occupational therapy services to spouses or partners.

1.2 Avoid providing services to an individual the occupational therapist knows personally or with whom they have a relationship. Exceptions may apply when alternative services are not available or in emergency situations.

1.3 Never form intimate, personal, or romantic relationships with current clients, their relatives, or their support people. Such relationships would exploit the power imbalance inherent in the client-therapist relationship, and objectivity could not be maintained.

1.4 Never form intimate, personal, or romantic relationships with clients currently receiving treatment from colleagues. In these cases, the occupational therapist may be privy to the client's personal information, and objectivity could not be maintained.

1.5 Never form intimate, personal, or romantic relationships with previous clients who were especially **vulnerable**, no matter how much time has passed since the client-therapist relationship ended.

2. Recognize power dynamics

2.1 Be aware of the power imbalance inherent in the client-therapist relationship.

2.2 Understand how power dynamics are related to **intersectionality**.

2.3 Maintain professionalism by limiting excessive sharing of personal or private information, and consider how communication is being interpreted.

2.4 Avoid creating situations where dependencies develop between clients and the occupational therapist.

2.5 Educate students, occupational therapy assistants, and others being supervised about maintaining professional boundaries.

2.6 Never form intimate, personal, or romantic relationships with current students or anyone under the occupational therapist's supervision. Such relationships would exploit the power imbalance in the professional relationship.

3. Monitor and manage boundaries and boundary violations

3.1 Know that boundaries extend beyond clients and include those who support them. Boundaries also extend to people the occupational therapist supervises. Maintain all boundaries regardless of the actions, consent, or participation of clients, their support people, or those being supervised.

3.2 Respect each client's boundaries, which are unique to their beliefs, capacity, choices, culture, disability, ethnicity, gender, language, life experiences, lifestyle, past trauma, race, religion, socioeconomic status, and values.

3.3 Be sensitive to how the practice setting and service location (for example, in the client's or therapist's home or in a community setting) may affect boundaries.

3.4 Recognize and manage any shifts in clients' expectations of boundaries (in-person or online) within the client-therapist relationship.

3.5 Be aware of and reflect on any feelings that are developing toward clients and could result in boundary violations (for example, the desire to form intimate connections or the internalization of a client's grief).

3.6 Immediately take steps to document, address, and rectify boundary violations if they occur. This can include discontinuing services and facilitating a referral to another provider.

3.7 Address boundary risks or violations committed by those under the occupational therapist's supervision or direction (for example, assistants, students, or support persons).

3.8 Ensure that policies and procedures are in place to identify and manage boundary risks or violations, including those related to conflicts of interest. Policies should include the documentation process for boundary violations, resulting actions, and resolutions.

4. Prevent sexual abuse

Sexual abuse includes remarks or behaviour of a sexual nature, touching of a sexual nature, or sexual relations between occupational therapists and clients. Sexual abuse is unethical and involves a serious breach of trust and a fundamental abuse of power.

4.1 Never engage in sexual abuse of clients, including behaviour, remarks, or touching of a sexual nature, sexual intercourse, or other forms of physical sexual relations. The consequences of sexual abuse are listed in Appendix 1.

4.2 Always obtain informed consent before initiating any clinical services that involve touching unless in an emergency.

4.3 Respect clients' privacy and dignity. For example, use curtains or dividers in assessment and intervention spaces, use draping and garments to minimize exposure, and provide the option of an observer for potentially sensitive situations.

4.4 File a mandatory report if there is reason to believe that another regulated health professional has sexually abused a client. See Appendix 2 for details.

4.5 Never form intimate, personal, or romantic relationships with previous clients or their relatives and support people unless the following four conditions are met:

a. At least one year has passed since therapeutic services were last provided or since the client was discharged from the occupational therapist's care and

b. The occupational therapist can demonstrate that any previous power imbalance no longer exists and

c. The person involved is not dependent on the occupational therapist and

d. **No** future client-therapist relationship is ever resumed

4.6 Know and follow all other mandatory reporting requirements for sexual abuse.

Related College documents

Code of Ethics
Culture, Equity, and Justice in Occupational Therapy Practice
Decision-Making Framework
Standard for Consent
Standard for the Prevention and Management of Conflicts of Interest
Standard for Record Keeping
Standard for the Supervision of Students and Occupational Therapy Assistants

References

Family Law Act, Revised Statutes of Ontario (1990, c. F.3). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/statute/90f03

Ontario Regulation 95/07, Professional Misconduct. (2007). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/regulation/070095

Ontario Regulation 260/18, Patient Criteria Under Subsection 1 (6) of the Health Professions Procedural Code. (2018). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/regulation/r18260

Regulated Health Professions Act, 1991, Statutes of Ontario (1991, c. 18). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/statute/91r18

Schedule 2: Health Professions Procedural Code. (1991). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/statute/91r18#BK41

Appendix 1: Consequences Related to Sexual Abuse of a Patient

The RHPA sets out the penalties for health professionals, including occupational therapists, who have been found guilty of sexually abusing a patient. A discipline hearing is the most serious proceeding that a regulated health professional can face under the Act.

If a panel of the College's Discipline Committee finds that an occupational therapist has sexually abused a patient, Schedule 2 of the *Health Professions Procedural Code*, s. 51 (5), requires the Committee to reprimand the occupational therapist and revoke their certificate of registration if the sexual abuse includes any of the following:

i. Sexual intercourse.
ii. Genital to genital, genital to anal, oral to genital or oral to anal contact.
iii. Masturbation of the [occupational therapist] by, or in the presence of, the patient.
iv. Masturbation of the patient by the [occupational therapist].
v. Encouraging the patient to masturbate in the presence of the [occupational therapist].
vi. Touching of a sexual nature of the patient's genitals, anus, breasts, or buttocks.
vii. Other conduct of a sexual nature prescribed in regulations […].

Even if the act of sexual abuse was not one to which the mandatory revocation provision applies, depending on the seriousness of the conduct, the panel of the Discipline Committee may also take one or more of the following actions (*Health Professions Procedural Code*, s. 51 [2]):

1. Directing the Registrar to revoke the [occupational therapist's] certificate of registration.
2. Directing the Registrar to suspend the [occupational therapist's] certificate of registration for a specified [or indefinite] period of time.
3. Directing the Registrar to impose specified terms, conditions and limitations on the [occupational therapist's] certificate of registration for a specified or indefinite period of time.
4. Requiring the [occupational therapist] to appear before the panel to be reprimanded.
5. Requiring the [occupational therapist] to pay a fine of not more than $35,000 to the Minister of Finance.

5.1 […] requiring the [occupational therapist] to reimburse the College for funding provided for that patient [for therapy and counselling].

5.2 […] requiring the [occupational therapist] to post security acceptable to the College to guarantee the payment of any amounts the [occupational therapist] may be required to reimburse [the College for funding provided to the patient for therapy and counselling].

Appendix 2: Mandatory Reports

The RHPA requires occupational therapists to make a mandatory report when they have reasonable grounds, obtained while practising the profession, to believe that another regulated health professional (of the same or a different College) has sexually abused a patient. A mandatory report must also be made by the operator of the health facility.

The mandatory report must be in writing to the alleged abuser's College. It must be made within 30 days after the obligation to report arises. However, if the occupational therapist has reasonable grounds to believe that the alleged abuser will continue to abuse the patient or will abuse others, the occupational therapist must file the report immediately.

If the occupational therapist becomes aware of the possible sexual abuse through a patient's disclosure, they must inform the patient that the occupational therapist is obliged to make a mandatory report. They must obtain the patient's written consent to disclose the patient's name to the College. If the patient does not consent to disclose their name, the occupational therapist will withhold it from the report.

Furthermore, if the occupational therapist becomes aware of possible sexual abuse of a patient while providing psychotherapy to another regulated health professional, the occupational therapist is required to make a report, and if they are able to form one, provide an opinion concerning whether the abusing practitioner is likely to sexually abuse patients in the future. The occupational therapist must make a report even if they stop providing services to the abusing professional.

If the occupational therapist fails to make a mandatory report, they will be subject to a fine of not more than $50,000.

Health facilities that fail to make a mandatory report are subject to a fine of not more than $50,000 in the case of an individual and $200,000 in the case of a corporation.

In addition, if the College finds that the occupational therapist has failed to make a mandatory report, the College may deem the occupational therapist to have engaged in an act of professional misconduct.

Standard for Psychotherapy

This Standard applies to occupational therapists who perform psychotherapeutic techniques, including psychotherapy as a controlled act under the *Regulated Health Professions Act, 1991* (RHPA). The *Occupational Therapy Act, 1991* includes regulations that apply to occupational therapists when performing the controlled act of psychotherapy (see Appendix 1).

The definition of the controlled act of psychotherapy references a client's "serious disorder" ("of thought, cognition, mood, emotional regulation, perception or memory") that may seriously impair their "judgement, insight, behaviour, communication or social functioning" (*Occupational Therapy Act*, s. 3.1 [1]). Because psychotherapeutic services that occupational therapists provide carry with them a risk of harm even when the client's disorder may not be "serious," to ensure the greatest public protection, these Standards apply to occupational therapists performing all types of psychotherapeutic techniques, including the controlled act of psychotherapy. Refer to the supporting document "When the Standard for Psychotherapy Applies: Occupational Therapy in Mental Health" in Appendix 2 for more information.

The College recognizes that clients' disorders and levels of impairment can fluctuate during the provision of services. In response, occupational therapists providing psychotherapy are to have the competency to adapt to clients' evolving needs.

This Standard does not apply when occupational therapists are using approaches that are not psychotherapeutic, such as health teaching, supportive listening, and coaching. Again, even if the client's current level of impairment may not be considered "serious" or one that may "seriously impair" their judgement or other areas mentioned above, this Standard applies when the occupational therapist is using any psychotherapeutic technique.

Occupational therapists are expected to:

1. Obtain and maintain competence

Performing psychotherapy is not an entry-level practice competency. It is an intentional and defined approach, and it is not recommended to be an occasional practice. Occupational therapists must obtain and maintain competence in each psychotherapy technique they intend to use.

Occupational therapists are to obtain psychotherapy training that has these components: instructional (is instructor led, not self-taught), theoretical (is based on psychotherapeutic theories), and practical (involves supervision). Pairing supervision with instruction and theoretical training allows for the practical application of theory to practice.

Instructional and theoretical educational requirements

1.1 Select training that is appropriate for the occupational therapist's learning needs. At the beginning, it is expected that the instructional and theoretical components of training provide foundational understanding of the psychoeducational modalities. Afterwards, it may be appropriate to use other methods to continue competence (for example, workshops, professional networks, literature reviews, and continuous quality improvement initiatives). Factors that may contribute to the selection of education options include client needs, evidence-informed approaches, the scope of services, previous training and experience, comprehensiveness, and the relevance of the training.

Practical (supervision) requirements

Supervision is an intentional arrangement where an experienced and qualified provider of psychotherapy assists the occupational therapist being supervised in their professional growth. This structured process allows the occupational therapist to develop foundational competence and the ability to provide safe, ethical, and efficient services. Supervision can be tailored to the occupational therapist's individual needs. Methods of supervision may include one-to-one meetings or supervision in a small group setting. The requirements for supervision are outlined as follows:

1.2 Participate in a period of formal, practical psychotherapy supervision that includes the following:

> **Quantity:** Supervision is a formal arrangement and a long-term commitment. It is to occur at regular intervals for the duration of the supervisory period, with a recommended minimum of 50 hours of supervision over at least the first two years of psychotherapy practice. This may extend longer for an occupational therapist who is not performing psychotherapy full time. Some training institutions may require specific supervision beyond this minimum.

> **Quality:** Supervisors must be experienced, competent to provide supervision, and eligible to perform the controlled act of psychotherapy. Supervisors can be occupational therapists or other health professionals. The supervisor must be a member of the College of Nurses of Ontario, the College of Occupational Therapists of Ontario, the College of Physicians and Surgeons of Ontario, the College of Psychologists of Ontario, the College of Registered Psychotherapists of Ontario, or the Ontario College of Social Workers and Social Service Workers. Supervision needs to align with the occupational therapist's experience and specific psychotherapeutic approach. Occupational therapists who provide supervision do not take accountability for clients. The occupational therapist being supervised is responsible for the client services they provide.

1.3 Have a supervisory agreement which should include:

a. Administrative details (for example, start and end dates and frequency of meetings)
b. Responsibilities of the supervisor and the occupational therapist being supervised
c. Confirmation of accountability for client services
d. Processes to follow in the case of emergency

1.4 Maintain supervisory or meeting notes that do not contain personal information or personal health information. This requirement applies to both the supervisor and the occupational therapist being supervised, and it applies for at least the duration of the supervisory agreement. Notes that contain clients' information must be retained in accordance with the **Standard for Record Keeping**. Meeting notes can include:

a. Meeting dates
b. Summary of any ethical or professional issues addressed
c. Any direction, recommendations, feedback, or evaluation provided
d. Record of payments made for supervision

1.5 During the consent dialogue with clients, inform them of any supervisory arrangements.

1.6 Never participate in supervisory arrangements solely for billing purposes. Financial records should clearly identify who provided the direct services to clients.

1.7 If requested by the College, provide verifiable documentation of the completion of both an educational program and a required period of psychotherapy supervision.

After the required period of formal supervision, the occupational therapist may choose to continue with this supervision or move to a consultation arrangement in their psychotherapy practice.

Consultation enables an occupational therapist to continue their professional growth. Consultation is with an experienced and qualified regulated psychotherapy professional to meet, discuss and review client care and share expertise. Individual or group consultation methods are acceptable. The individuals involved in this arrangement can determine the method of documentation for the consultation process.

2. Practise safely

The Standard for Psychotherapy applies to occupational therapists providing psychotherapy across all sectors and settings. Because settings vary, it is important for occupational therapists to consider the cultural origins of the psychotherapy techniques and modalities being used and use them in culturally sensitive ways. Through the therapeutic relationship, occupational therapists develop an understanding of the client's unique perspectives and personal experiences.

2.1 Before services begin, review the referral information to confirm that the client needs psychotherapy services. The occupational therapist must determine whether they have the competence (knowledge, skills, and judgement) to deliver the appropriate psychotherapy services, including the controlled act of psychotherapy.

2.2 Ensure that clients are aware that they are taking part in psychotherapy services. Obtain ongoing consent.

2.3 Understand and follow the laws and regulations governing the practice of psychotherapy.

2.4 Perform psychotherapy within the occupational therapist's role and the scope of occupational therapy practice. Make referrals to other qualified providers as needed.

2.5 Identify, minimize, and manage the risks associated with performing psychotherapy.

2.6 Establish and maintain professional boundaries as outlined in the **Standard for Professional Boundaries and the Prevention of Sexual Abuse**.

2.7 Hold a general certificate of registration to practise psychotherapy unless permission from the Registrar has been obtained (temporary certificates may be issued to occupational therapists who are registered in another jurisdiction and are providing in-person services in Ontario on a temporary basis).

3. Do not delegate or assign psychotherapy services to others

3.1 Use clinical judgement to determine when or if it is appropriate for students or re-entry candidates (those returning to the profession after a prolonged absence) to be included in psychotherapy practice. While students or re-entry candidates may be able to independently provide general mental health interventions, they can observe psychotherapy or employ psychotherapy techniques with clients only when their supervisor is present.

3.2 Never assign any part of psychotherapy practice or delegate psychotherapy to anyone else, including occupational therapy assistants.

4. Use title appropriately

Section 33.1 of the RHPA permits occupational therapists to use the title “psychotherapist” only if they identify themselves as members of the College by using the title “occupational therapist” as well. This applies to both oral and written communications.

4.1 Determine, based on their competence, when it is appropriate to add the title “psychotherapist.”

4.2 Use acceptable versions of title, such as:

a. First name Last name, OT Reg. (Ont.), Psychotherapist
b. First name Last name, Occupational Therapist, Psychotherapist
c. First name Last name, Occupational Therapist, practising psychotherapy.

Related College documents

Standard for Consent
Standard for the Prevention and Management of Conflicts of Interest
Standard for Professional Boundaries and the Prevention of Sexual Abuse
Standard for Record Keeping
Standard for the Supervision of Students and Occupational Therapy Assistants
Standard for Use of Title
When the Standard for Psychotherapy Applies: Occupational Therapy in Mental Health

References

Occupational Therapy Act, 1991, Statutes of Ontario (1991, c. 33). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/statute/91o33

Ontario Regulation 474/19, Controlled Acts. (2019). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/regulation/190474

Regulated Health Professions Act, 1991, Statutes of Ontario (1991, c. 18). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/statute/91r18

Appendix 1: *Occupational Therapy Act, 1991*

The definition of the controlled act of psychotherapy is set out in section 3.1 (1) of the *Occupational Therapy Act, 1991*:

> A member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to treat, by means of psychotherapy technique delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning.

Occupational Therapy Act, 1991: Ontario Regulation 474/19: Controlled Acts

Psychotherapy technique

1. (1) For the purposes of subsection 3.1 (2) of the Act, a member holding a general practising certificate of registration may treat, by means of psychotherapy technique delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning if the member meets the standards of practice set out in subsection (3) of this section.

(2) For the purposes of subsection 3.1 (2) of the Act, a member holding a temporary certificate of registration who has the approval of the Registrar may treat, by means of psychotherapy technique delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning if the member meets the standards of practice set out in subsection (3) of this section.

(3) It is a standard of practice of the profession that a member referred to in subsection (1) or (2) who performs the controlled act described in those subsections must comply with the following:

1. Either have formal psychotherapy training that includes instructional, theoretical, and practical components or else have a combination of training and experience that in the opinion of the College is equivalent to such training.
2. Maintain competence by engaging in ongoing psychotherapy-based learning activities.
3. Have the knowledge, skill and judgment to perform the controlled act safely, effectively and ethically.
4. Have the knowledge, skill and judgement to determine whether the individual's condition warrants performance of the controlled act.
5. Determine that the individual's condition warrants performance of the controlled act, having considered,
    - i. the known risks and benefits to the individual of performing the controlled act,
    - ii. the predictability of the outcome of performing the controlled act,
    - iii. the safeguards and resources available in the circumstances to safely manage the outcome of performing the controlled act, and
    - iv. other relevant factors specific to the situation.

No delegation

2. A member shall not delegate the performance of the controlled act authorized by subsection 3.1 (1) of the Act.

Appendix 2: When the Standard for Psychotherapy Applies: Occupational Therapy in Mental Health

This table provides a general distinction between psychotherapy and other foundational mental health services that occupational therapists provide. The purpose is to help clarify when the Standard for Psychotherapy applies to practice. While not every scenario is represented below, the factors to consider (left column) can guide occupational therapists with other clinical situations they encounter.

	Psychotherapy (Psychotherapy Standard Applies)	Occupational Therapy Mental Health Services (Psychotherapy Standard Does Not Apply)
Referral and Consent	The referral specifies that the client is to receive psychotherapy services. If not explicitly stated, the occupational therapist determines, based on the clinical information, whether psychotherapy intervention is indicated. Within the consent dialogue outlined in the Standard for Consent, the occupational therapist informs the client that the services involve the use of psychotherapy.	The referral involves enabling the client's overall occupational performance, including, and sometimes primarily, supporting the client's mental health. Consent follows the protocols in the Standard for Consent.
Competence	Providing psychotherapy services is not an entry-level skill. Additional education and supervision are required.	Providing mental health services requires general occupational therapy knowledge, skill, and judgement. Additional training may be required for competence in providing specific approaches.
Description	Occupational therapy services that use psychotherapy are often used to treat mental illness and promote wellness and occupational participation. Psychotherapy can be described as a relational process between a client and the therapist. Specific psychotherapeutic approaches are applied collaboratively to the assessment and intervention of a client's thoughts, emotions, and/or behaviours. The purpose is to promote	Occupational therapy services are aimed at supporting a client's occupational possibilities and participation as they relate to overall mental health and well-being. This is done within the scope of occupational therapy practice.

	occupational participation for better day-to-day functioning in activities and roles meaningful to the client. Psychotherapy is done within the scope of occupational therapy practice. The controlled act of psychotherapy is defined in legislation and can be found in this Standard. See Understanding When Psychotherapy Is a Controlled Act for additional details on the controlled act.		
Approaches	Some of the many approaches or therapies used in psychotherapy are listed below. This is not an exhaustive list. Occupational therapists may refer to the College of Registered Psychotherapists of Ontario for a more complete list. Given the integral value of the therapeutic relationship, occupational therapists should also have a background in safely and effectively sharing their own experiences with clients to help clients understand their own situations. ▪ Cognitive and behavioural ▪ Experiential and humanistic ▪ Psychodynamic ▪ Somatic ▪ Systemic and collaborative		Some of the approaches that are used by occupational therapists to support mental health include: ▪ Case management ▪ Coaching ▪ Encouragement and advice giving ▪ Health and symptom monitoring ▪ Psychoeducation ▪ Skills teaching ▪ Supportive listening
Techniques	While psychotherapeutic techniques are too numerous to provide a comprehensive list, examples of common techniques include ▪ Acceptance and Commitment Therapy ▪ Cognitive Behavioural Therapy ▪ Dialectical Behavioural Therapy ▪ Exposure Therapy		While techniques are too numerous to provide a comprehensive list, examples include: ▪ Activity analysis ▪ Goal-setting methods ▪ Motivational interviewing ▪ Wellness recovery action planning
Practice Scenarios	**Scenario 1**. An occupational therapist works as part of an intensive psychotherapy treatment program for adolescents with eating disorders. The occupational therapist co-facilitates an intensive, long-term treatment group		**Scenario 1**. An occupational therapist who does not have training or competence in psychotherapy is working with a university-aged client who is struggling in school. Although the client has some underlying anxiety, they are managing a part-time job and

	using Dialectical Behavioural Therapy and Emotion-Focused Therapy. **Scenario 2**. An occupational therapist has a private practice offering psychotherapy to individuals diagnosed with an anxiety and/or depression disorder. These disorders seriously impact occupational participation in many domains. The occupational therapist uses various trauma-informed and psychotherapeutic techniques, including Cognitive Behavioural Therapy and Interpersonal Psychotherapy as well as incorporating art and visual expression in treatment.		are passing school with some accommodations. In addition to the primary goal of helping the client to organize their schoolwork, the occupational therapist teaches SMART goal-setting techniques, uses motivational interviewing strategies, and provides education about time use, daily scheduling, and prioritization. **Scenario 2.** An occupational therapist works as part of a community mental health team and provides case management to clients with complex, long-term, and serious psychiatric illness. Supportive listening and encouragement, teaching de-escalation techniques, safety planning, and service referral are commonly used interventions to help clients to reach their occupational goals.

Standard for Record Keeping

Occupational therapists' records are legal documents intended to officially capture the entirety of occupational therapy services provided. Records document the following:

- How occupational therapists are monitoring client health status
- The processes of consent and assessment
- Professional analysis and interventions made
- Client input, intervention plans, and outcomes
- Other clinically significant events

Records are a mechanism to communicate health information to clients and other professionals, partners, and interested parties. They enable interprofessional collaboration and continuity of care. Client records demonstrate the provision of safe, ethical, and effective occupational therapy.

In addition to complying with the Standard for Record Keeping, occupational therapists must complete and retain records according to applicable privacy laws and organization-specific policies and procedures.

Clinical and non-clinical occupational therapists have record keeping responsibilities related to the appropriate management of information and effective communication. In non-clinical settings, documentation needs vary for occupational therapists, and only some record keeping indicators may apply.

Occupational therapists are expected to:

1. Be sensitive to the wording of notes

1.1 When entering information into client records, ensure that all information is truthful and accurate. Consider the subtleties of what is being said and what is not being said and how information is phrased. The occupational therapist should be mindful of their own social positions and refrain from comments that contain biases when documenting about clients.

1.2 Keep in mind how the information in the records will be received by clients and others who will read it. For example, there is a difference in tone between writing that a client "refused" versus "declined" an element of service.

1.3 Keep all parts of records respectful, using professional and culturally sensitive language.

2. Attend to administrative requirements

2.1 Adopt a documentation process that allows for consistent application of the Standards.

2.2 Date and sign every entry.

2.3 Indicate the duration or timing of services provided.

2.4 Keep records that are accurate and complete, clearly organized, legible, and in English or French.

2.5 Explain abbreviations in a note, or refer readers to a list of terms or abbreviations with explanations.

2.6 Complete records in a timely manner in accordance with the clinical need and organizational requirements.

2.7 At clients' request or when lawfully required, provide access to their records or to the process for obtaining them.

2.8 Retain all data that was used to inform clinical decisions but cannot be included or summarized in the record. Note the location of this data (for example, paper-based standardized assessment forms). When converting data to an electronic format, ensure that the integrity of the data is maintained.

2.9 If the information being collected falls under the *Personal Health Information Protection Act, 2004:*

a. Develop and follow policies and procedures for the management of lock box information
b. If acting as a health information custodian, have a contingency plan for unexpected events to ensure that clients continue to have access to their records.

3. Know what details to record

3.1 Document client-identifying information and referral details (for example, source and reason). Confirm client identity and the accuracy of any referral information provided.

3.2 Include the initial and ongoing consent of clients or substitute decision-makers.

3.3 Record all findings, interventions, reports, and service details. Record client input and input from others (obtained with consent) that has clinical value.

3.4 Document relevant clinical information about group therapy in which clients participate (for example, stated goals, client insights, and adverse events). Notes may be made in individual client records or in a group record, such as a file containing a group's purpose, duration, attendance, and resources provided.

3.5 Identify tasks that have been assigned to others (for example, occupational therapy assistants or students), and confirm that client consent was obtained. Include names and titles of the persons assigned if known, or indicate any workplace protocol followed for assignment.

3.6 Document information about any controlled acts delegated to the occupational therapist (referencing medical directives or orders, acceptance of the delegation and outcomes).

3.7 Include relevant details when services are transferred or ending (for example, client status and input, transfer of accountability, resources provided, and recommendations and referrals).

4. Apply signature and designation correctly

4.1 Apply a signature to each entry after verifying that the information is accurate and complete. The signature must include the author's designation and either their full name or, if the full name is referenced or easily available, their first initial and last name or their initials.

4.2 Take steps to ensure the security of all signatures, including those that are electronic.

4.3 Where there are shared and overlapping roles and responsibilities with other professionals and combined reports are created, identify the portion of the report for which the occupational therapist is responsible. If there is no clear delineation, the occupational therapist is accountable for the entire report.

4.4 Review the record keeping completed by occupational therapy assistants to confirm that it is accurate and follows appropriate College Standards and workplace policies. Document this review.

4.5 When co-signing records completed by students, ensure that all entries and signatures are accurate and complete.

5. Use acceptable systems

5.1 Ensure that any digital devices and paper systems used to create and maintain clinical records have the following features:

a. Access records by client's name and a unique identifier (such as date of birth)
b. Produce a copy of any record in a timely manner in print or by secure digital means
c. Allow more than one author or contributor to sign, if applicable
d. Maintain an audit trail that records the date of each entry, the identity of the author, and any changes made to the record—while preserving the original content
e. Protect against unauthorized access
f. Back up digital files and allow for file recovery.

6. Manage record changes appropriately

6.1 Respond in a timely manner to requests for changes. Clients can request changes to the record verbally or in writing. The occupational therapist has 30 days to respond to the request. They are expected to correct factual errors but need not change a professional opinion.

6.2 When a record needs to be changed due to errors, additions, or omissions:

a. Maintain all original entries, or have an audit trail of changes.
b. Identify, date, and sign or initial changes. This is done by the occupational therapist who created the original entry or the person in the organization who is currently responsible for the record.
c. Use an addendum (additional note) to modify a document after distribution. The addendum includes the reason for the changes being made. Send copies of the addendum to everyone who received the original document.

7. Safely store client personal information and personal health information

7.1 Use controls to securely store records (such as locked filing cabinets, restricted office access, a protocol of logging off devices after use, and secure passwords).

7.2 Travel with or transport personal information and personal health information only when it is essential for service delivery. When records and information are in transport, prevent them from being visible to others.

7.3 Store paper records securely, and back up all electronic records.

7.4 Electronically communicate client information confidentially and securely (for example, using encryption, password protection, de-identification, and secure networks).

7.5 Implement physical and technical safeguards to protect the privacy of personal information and personal health information that is disclosed. This includes any financial information

collected for the purposes of delivering services. Safeguards may include:

a. Confirming the recipient's email address or other contact information
b. Periodically auditing and deleting preprogrammed numbers
c. Using transmission receipts or mail tracking
d. Placing a confidentiality statement on outgoing communications, including email, fax, and paper.

8. Manage breaches of confidentiality or privacy securely

8.1 Stay informed of workplace policies and procedures for reporting a privacy breach.
8.2 If the occupational therapist is responsible for clients' personal information and personal health information, ensure that policies and procedures are in place for managing and tracking breaches.
8.3 If personal information or personal health information has been lost, stolen, released to the wrong persons, or accessed without authorization, make reasonable efforts to notify everyone involved.
8.4 Report breaches of confidential client health information as required, either to the employer or to the appropriate privacy commissioner.

9. Properly document financial transactions

9.1 Ensure that all records related to billing and payment are clear and include:

a. Full name and designation of the providers of the services or products
b. Full name of the client to whom the services or products were provided
c. Full name and address of any third party to whom fees were charged, if applicable
d. Items sold or services delivered
e. Date of services or purchases
f. Fee for services or products
g. Method of payment
h. Invoice or receipt of payment
i. Any differential fees charged for services (for example, reduced fees)

9.2 Store financial information in client records, or note the location where the information is securely stored.

10. Keep equipment records

10.1 Maintain documents to show that the equipment used to provide occupational therapy services is safe, clean, and well-maintained (for example, sterilization protocols and routine inspection reports).
10.2 If not directly responsible for ensuring that equipment has appropriate service records, know where to access these records.
10.3 Retain equipment records for a minimum of 5 years from the date of last entry, even if the equipment is discarded.

11. Follow rules for retaining and disposing of records

Record retention and disposal requirements vary based on the privacy legislation that applies to an occupational therapist's practice or services. Records may also include audiovisual, multimedia, and financial records.

11.1 Know the privacy legislation that applies as well as any organizational or employment policies on record retention and disposal. For records governed by the *Personal Health Information Protection Act, 2004:*

a. Ensure that records are accessible and maintained for at least 10 years after the date of the last entry. With pediatric records, they must be maintained 10 years after the client reached (or would have reached) 18 years of age.

b. Ensure that records are maintained longer than 10 years if there is reason to believe that the health information will be needed for a valid purpose (for example, a pending legal proceeding).

c. Follow legal requirements for the secure disposal of records.

d. Maintain a list of files that have been disposed, including names and dates. Destroy the list after 10 years unless organizational or practice policy indicates otherwise.

Related College documents

Standard for Consent
Standard for the Supervision of Students and Occupational Therapy Assistants

References

Personal Health Information Protection Act, 2004, Statutes of Ontario (2004, c. 3, Sched. A). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/statute/04p03

Standard for the Supervision of Students and Occupational Therapy Assistants

Occupational therapists who supervise students or occupational therapy assistants remain professionally accountable for clients receiving safe, appropriate, and ethical care. In all aspects of supervision and assignment, occupational therapists are to consider clients' best interests, the practice setting, and the risks associated with the service components.

The terms "occupational therapy assistant" and "occupational therapist assistant" may be used interchangeably. These Standards uses the term "occupational therapy assistant" as a descriptor for service providers who are assigned occupational therapy service components under the supervision of an occupational therapist. These Standards also apply when supervising and assigning activities in a similar situation to other support staff.

The specific tasks assigned to the occupational therapy assistant must be part of the overall occupational therapy services. The occupational therapy assistant must work under the direction and supervision of an occupational therapist, who must assume responsibility and accountability for the ongoing quality of occupational therapy service delivery. Student occupational therapists and volunteers are not considered to be occupational therapy assistants.

Occupational therapists are expected to:

1. Create an appropriate environment for those being supervised

1.1 Avoid supervising anyone with whom they have a current or former relationship (for example, a family member, friend, or close personal connection).

1.2 Maintain professional relationships at all times per the **Standard for Professional Boundaries and the Prevention of Sexual Abuse**.

1.3 Recognize the power differential between the supervising occupational therapist and the supervisee.

1.4 Model respectful behaviours toward supervisees. Provide a safe and inclusive environment for them.

1.5 Create an environment where supervisees are comfortable and able to raise concerns about unfair, unsafe, or culturally inappropriate experiences. Have a clear process for reporting such problems.

2. Have competence and availability for supervision

2.1 Allocate the time needed for supervision and assignment.

2.2 Assign only components of client care that the occupational therapist is competent to perform.

2.3 If supervising is a new practice activity, seek the support of a mentor or colleague.

3. Be accountable for the services and the supervisees

3.1 Balance the need to encourage autonomy in supervisees with the level of supervision appropriate to the situation.

3.2 Be clear who is assigning and responsible for specific service activities, including when there are multiple supervisors (multiple occupational therapists or other professionals).

3.3 Ensure that supervisees have and maintain the knowledge, skill, judgement, education, and competence to perform all assigned services.

3.4 When assigning activities, comply with organizational policies and ensure that client safety is maintained.

3.5 Never assign any controlled act that is being performed by the occupational therapist, whether authorized by the *Occupational Therapy Act* (for example, psychotherapy) or delegated by another regulated health professional.

3.6 Monitor clients' response to the services being provided by a supervisee. Discuss any concerns with clients.

3.7 Have a process in place for back-up supervision when the occupational therapist is not available.

4. Stop assignment when appropriate

4.1 Stop the assignment if no occupational therapists are available to provide supervision or to oversee the occupational therapy services.

4.2 Stop the assignment if the supervisee's involvement is not effective or is unsafe.

4.3 Stop the assignment if the client withdraws consent to receive services by a supervisee.

Supervision of Students

5. Contribute to the learning and development of students

Having students on placement and acting as student preceptors is a valuable opportunity for occupational therapists to serve as role models and to share practice knowledge. Contributing to the learning of students is outlined in the *Competencies for Occupational Therapists in Canada* (2021).

5.1 Before mentoring and overseeing students, have one year of practice experience.

Traditional Supervisory Placements

In traditional supervisory placements, where occupational therapists are on-site and working directly with the students they are supervising,

5.2 Ensure that sufficient orientation and training are provided. This includes orientation to the facility, organizational policies, and assigned clients or tasks.

5.3 Understand the student's progression within the educational curriculum, including
   a. The program requirements and expectations
   b. The student's current learning needs, previous clinical experiences, and perceived areas for improvement

5.4 Ensure that a documented learning contract is in place. It should outline goals and activities appropriate to the student's competence.

5.5 Put in place and apply a process of observation, instruction, evaluation, and feedback throughout supervision.

5.6 Prioritize tasks assigned to students based on each student's learning needs, not the needs of the supervisor or organization.

5.7 Before co-signing, review all documentation completed by students to ensure that it adheres to the Standard for Record Keeping.

Non-Traditional or Role-Emerging Placements

For non-traditional or role-emerging placements, where the occupational therapist preceptor is off-site and provides consultation and direction to students who have a separate, on-site supervisor who is not an occupational therapist,

5.8 Have an adequate level of comfort and competence to supervise in such a setting, considering the amount and type of supervision that can be reasonably provided.

5.9 To ensure accountability, create a communication and supervision plan. Outline roles and expectations. Collaborate with the on-site supervisor, placement site, students, and educational institutions.

5.10 Identify how client consent will be obtained.

5.11 Determine who will manage client records as well as the client personal information and personal health information generated by students for the required retention period. Make a plan to review and co-sign student documentation where client services have been provided.

5.12 Develop a plan with the on-site supervisor to address emergency situations or issues of safety involving students and clients.

Supervision of Occupational Therapy Assistants

6. Clearly define roles and responsibilities when supervising occupational therapy assistants

6.1 Know the appropriate activities that can be assigned, and ensure that occupational therapy assistants can competently complete them.

6.2 Never assign the following activities to occupational therapy assistants:
   a. Initiation of occupational therapy services
   b. Aspects of assessment requiring the occupational therapist's clinical judgement
   c. Interpretation of assessment findings
   d. Interventions where ongoing analysis and synthesis are necessary to closely monitor and guide client progress

e. Communication of occupational therapy recommendations, opinions, or findings requiring clinical judgement
f. Decisions involving discharge

6.3 Establish appropriate limits for occupational therapy assistants' participation in intervention planning, goal identification, and progressing or modifying an intervention.

6.4 Establish a supervisory plan for providing services, including the following:

a. Roles, responsibilities, and methods of supervision
b. Expectations for reporting by assistants to the occupational therapist
c. Activities that will be assigned to assistants
d. Activities that assistants can carry out if the occupational therapist is unavailable to provide direct supervision.

6.5 Follow the Standard for Record Keeping when supervising and documenting the activities of occupational therapy assistants.

Accountability for Non–Occupational Therapy Assistants

In some practice environments, occupational therapists act in a consulting role. In this role, the occupational therapist **does not** assign occupational therapy service components. Therefore, because the individual carrying out the recommended activities is not acting in an occupational therapy assistant role, the occupational therapist is not directly accountable for that individual. Nor is occupational therapist accountable for the implementation or outcome of the recommendations.

Occupational therapists must be clear on the distinction between situations that involve the use of occupational therapy assistants and situations when the occupational therapist is fulfilling a consultation role. The occupational therapist remains accountable for the quality of the consultation provided.

Related College documents

Controlled Acts and Delegation
Occupational Therapy Assistants Decision-Tree
Standard for Acupuncture
Standard for Assessment and Intervention
Standard for Consent
Standard for Professional Boundaries and the Prevention of Sexual Abuse
Standard for Psychotherapy
Standard for Record Keeping
Standard for Use of Title

References

Association of Canadian Occupational Therapy Regulatory Organizations, Association of Canadian Occupational Therapy University Programs, and Canadian Association of Occupational Therapists. (2021). *Competencies for occupational therapists in Canada*. https://acotro-acore.org/sites/default/files/uploads/ot_competency_document_en_hires.pdf

Occupational Therapy Act, 1991, Statutes of Ontario (1991, c. 33). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/statute/91o33

Standard for Use of Title

Occupational therapists use a protected title that tells the public they are qualified to provide services that meet the profession's Standards. At times, it may be critical that clients have the assurance that a service provider is accountable to a regulator for ongoing competence and complaints.

Occupational therapists are expected to communicate their title clearly, so that the public can easily identify them as registrants of the College. They are also expected to ensure that those under their supervision communicate their own approved titles properly.

Occupational therapists are expected to:

1. Use their title and name correctly

1.1 Accurately present themselves using the protected title "occupational therapist" or "OT Reg. (Ont.)." The French title is "ergothérapeute" or "Erg. Aut. (Ont.)." Alternatively, use the acceptable psychotherapist title per the **Standard for Psychotherapy**.

1.2 Place the protected title in a position of prominence in all communications.

1.3 Stop using any protected title or designation once they have resigned from the profession (see Appendix 1). Occupational therapists who misuse title can be found to be engaging in professional misconduct (*Ontario Regulation 95/07, Professional Misconduct*).

1.4 Use other titles or designations only when the occupational therapist is actively practising. For example, the occupational therapist cannot use "Assistive Devices Program Authorizer" when they are no longer a registered authorizer.

1.5 Practise using only their name as entered in the College's public register (Find an Occupational Therapist). Occupational therapists who wish to use a different name must ensure that their preferred name is recorded with the College and that it appears on the public register.

1.6 When choosing to communicate any educational degrees to clients and the public, display the protected title "occupational therapist" or the designation "OT Reg. (Ont.)" in addition to their degrees. Even if holding a degree in occupational therapy, the individual must register with the College to use any version of the title "occupational therapist."

1.7 When employment requires the qualification of "occupational therapist" but the designation is not part of the job title (for example, Case Manager or Practice Lead), ensure that proper use of title is maintained. One example is "First Name Last Name, OT Reg. (Ont.), Case Manager."

2. Ensure that those they supervise use an approved title

2.1 Ensure that occupational therapy students use only the title "student occupational therapist" or "student OT." The French equivalents are "étudiant(e) en ergothérapie" or "étudiant(e) en erg."

2.2 Ensure that students who are from another profession and under the occupational therapist's supervision present their student title clearly to clients, other professionals, partners, and interested parties.

2.3 Ensure that College applicants completing a refresher program under the occupational therapist's supervision use the title "candidate occupational therapist" or "candidate OT." For an explanation of the different types of applicants, including those not permitted to use these titles, see Appendix 2.

3. Avoid specialist titles, designations, and abbreviations

3.1 Never use a title or designation that indicates or implies that the occupational therapist is a specialist. The College does not have specialist designations. It is considered professional misconduct to use a term, title, or designation indicating or implying specialization in the profession.

3.2 When communicating an area of practice within the profession of occupational therapy to the public, use a term such as "practising in" or "with a focus in." One example is "First Name Last Name, OT Reg. (Ont.), Practising in Driver Rehabilitation."

4. Accurately communicate additional credentials

4.1 Include only credentials that represent a training program that is current, evidence-informed, and theoretically sound.

4.2 Before communicating the credential to the public, ensure that it:

a. Is valid and accurate
b. Applies to the scope of occupational therapy practice
c. Relates to the occupational therapist's current area of practice
d. Depicts the level of credential earned
e. Is verifiable, with evidence to be provided by the occupational therapist upon request

4.3 When communicating with clients and the public, use the protected title "occupational therapist" or the designation "OT Reg. (Ont.)" and the full name of the additional credentials. One example is "First Name Last Name, MSc (OT), OT Reg. (Ont.), Certified Hand Therapist."

4.4 When communicating with an audience who recognizes the credential, use an abbreviation, if desired. For example, an occupational therapist publishing research in a journal on hand therapy may use the abbreviation "CHT" to represent "Certified Hand Therapist."

4.5 Maintain competence associated with additional credentials communicated to the public, and upon request, provide evidence of ongoing competence.

5. Use the title "doctor" correctly

5.1 Use the title "doctor" only as permitted by the *Regulated Health Professions Act, 1991*. The Act permits the use of this title by chiropractors, dentists, naturopaths, optometrists, physicians, and psychologists.

5.2 When holding a doctorate degree such as a PhD or a clinical doctorate of occupational therapy (OTD), use the title "doctor" for only non-clinical purposes. Never use the title "doctor" when providing or offering to provide healthcare services.

Related College documents

Standard for Psychotherapy

References

Association of Canadian Occupational Therapy Regulatory Organizations. (2016). *Backgrounder on use of title in retirement*. http://www.acotro-acore.org/sites/default/files/uploads/otc_backgrounder_on_use_of_title_in_retirement.pdf

Association of Canadian Occupational Therapy Regulatory Organizations. (2017). *Frequently asked questions (FAQ) on use of title in retirement*. http://www.acotro-acore.org/sites/default/files/uploads/acotro_faq_on_use_of_title_in_retirement_with_logo.pdf

Ontario Regulation 95/07, Professional Misconduct. (2007). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/regulation/070095" https://www.ontario.ca/laws/regulation/070095

Regulated Health Professions Act, 1991, Statutes of Ontario (1991, c. 18). Retrieved from the Government of Ontario website: https://www.ontario.ca/laws/statute/91r18

Appendix 1: Resignation from the Profession

The College does not have an “inactive” status that permits occupational therapists to maintain a certificate of registration when they are no longer actively registered with the College. Occupational therapists who have resigned from the College cannot use the protected title.

Former registrants may be called upon to share knowledge with service groups, the public, students, and other occupational therapists or professionals through formats such as presentations, articles, and book chapters. Former registrants should clearly communicate that they were educated as an occupational therapist or used to be an occupational therapist, but do not currently provide occupational therapy services.

Appendix 2: College Applicants

Individuals who have applied for registration with the College but are not yet registered are called “applicants.” Applicants are not legally entitled to work as occupational therapists in Ontario. Applicants awaiting confirmation of registration status from the College, for either a provisional, general, or temporary certificate of registration, are not permitted to use the protected title or designation.

Nor can applicants use the title “candidate occupational therapist.” The “candidate” title is reserved for individuals completing a College-approved clinical refresher placement under the supervision of a registered occupational therapist.

Applicants are also not permitted to start work, training, or orientation for a job as an occupational therapist. This may be considered presenting oneself as a registrant before being registered and licenced to practise.

Glossary of Terms

Co-create
Co-create is to "create (something) by working with one or more others" (Merriam-Webster, n.d.).

Context
Context strongly influences occupational possibilities and healthcare services. There are three layers of context:

1. Micro context refers to the client's immediate environment: their own state of health and function, family and friends, and the physical environment they move through
2. Meso context refers to the policies and processes embedded in the health, education, justice, and social service systems that affect the client
3. Macro context refers to the larger socioeconomic and political context around the client: social and cultural values and beliefs, laws, and public policies

Culturally safer
Culturally safer is a refinement on the concept of cultural safety. Competent occupational therapists do everything they can to provide culturally safe care. But they remain aware that they are in a position of power in relation to clients. They are mindful that many marginalized people—Indigenous people, for example—have a history of serious mistreatment in healthcare settings. These clients may never feel fully safe. Occupational therapists allow those who receive the services to determine what they consider to be safe. They support them in drawing strength from their identity, culture, and community. Because cultural safety is unlikely to be fully achievable, occupational therapists work toward it.

Ecological considerations for care
Occupational therapists consider the wider impact of the tools used to practise in order to support the sustainability of environmental resources. As environmental stewards where possible, occupational therapists recognize the ecosystems on which human health depends and support sustainability as part of a global initiative.

Intersectionality
Intersectionality describes how a person's multiple social identities (for example, ability, age, class, education, ethnicity, gender, geography, immigration status, income, indigeneity, race, religion, and sexual orientation) combine, overlap, or intersect to create different modes of discrimination and privilege. Intersectionality can help occupational therapists understand the myriad factors affecting a client's health and the disparities in access to healthcare.

Power imbalance
Occupational therapists are in a position of trust and authority over their clients. As a result, the client-therapist relationship is inherently unequal, which results in a power imbalance in favour of the occupational therapist. The client relies on the occupational therapist's clinical judgement and experience to address health-related issues, and the occupational therapist knows the client's personal information and has the ability to influence the client's access to other resources and services.

This power imbalance places the client in a vulnerable position in the therapeutic relationship. Occupational therapists are expected to be aware of this inherent imbalance, and ensure that professional boundaries are maintained to protect the client's best interests and keep the client safe.

Vulnerable client
The vulnerability of a client is determined by many factors, including their health status, life stage, social context, ability to access supports and resources, and the overall complexity of their condition and needs. Some indications of client vulnerability in occupational therapy practice may include those people who are at risk of being highly dependent on the occupational therapist or the services they can help them access, and where services may be prolonged or are high risk and intensive.

References

Merriam-Webster. (n.d.). Cocreate. In *Merriam-Webster.com dictionary*. Retrieved November 27, 2022, from https://www.merriam-webster.com/dictionary/cocreate

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