West Virginia Board of Occupational Therapy

3041 University Avenue
2nd Floor, Suite 6
Morgantown, WV 26505
304-285-3150 (fax & phone)
www.wvbot.org

POSITION STATEMENT

SUBJECT: OTR/(C)OTA COLLABORATION

REVIEW OF LEGISLATIVE RULES/PRACTICE ACT: West Virginia Code currently dictates that an OT(R) provide General Supervision. "General Supervision" means initial direction and periodic inspection of the activities of a licensed occupational therapist assistant by the supervising licensed occupational therapist, but does not necessarily require constant physical presence on the premises while the activities are performed. It is the responsibility of the occupational therapist and the occupational therapy assistant to seek the appropriate quality and frequency of supervision to ensure safe and effective occupational therapy service delivery. The specific frequency, methods, and content of supervision may vary by practice setting and are dependent upon the complexity of client needs, the number and diversity of clients, the skills of the occupational therapist and the occupational therapy assistant, the type and requirements of the practice setting, and other regulatory requirements. Direct contact at least every two weeks at the site of work is required when supervising a (C)OTA with less than one year's experience, and at least monthly for an (C)OTA with increased skill development.

At the time of initial licensure, renewals, and at any point when a change of employment or supervision occurs, (C)OTA's must submit completed supervisory statements indicating the general nature of supervision and the names of OTR(s) designated to provide that supervision. OT(R)'s are obligated to list names of (C)OTA's under their supervision. All paperwork pertaining to the practice of occupational therapy completed by the (C)OTA must be cosigned by an OT(R) overseeing that patients' plan of care, goals and progress.

POSITION CLARIFICATION: Inquiries to clarify OT(R)/(C)OTA collaboration are frequently directed to the WVBOT. Questions focus on issues of evaluation, documentation, initiation of treatment and supervision.

Evaluations are the unique responsibility of the OT(R). This should always include assessment data, chart review, a plan of care with planned intervention, goals and specific frequency and duration of care. A (C)OTA, upon demonstration of competency which should be clearly documented, may administer screenings, standardized assessments and conduct chart reviews. This information is then passed along to the OT(R) for review and incorporation into the evaluation and treatment plan. Co-signatures can clearly indicate OT(R) and (C)OTA collaboration on these processes. It is not possible to define

absolutely the specific tests a (C)OTA may conduct but assurance of competency shall include reliability, compliance with standardized administration and scoring and accuracy of findings. An OT(R) holds ultimate responsibility for the evaluation results, plan of care and outcome. The OT(R) and (C)OTA share mutual responsibility to follow the established plan of care, to assure appropriate modifications to the planned intervention and to assure optimal outcomes for all recipients of OT service. It is the position of this Board that no treatment be initiated until a thorough evaluation and plan of care have been completed by the OT(R). Further, there should not be a lapse in time between initiation and completion of the evaluation, nor should there be a lapse in time between completion of the evaluation and initiation of treatment as set forth by the plan of care, exceptions may exist if patient's condition dictates such. Therefore, no treatment, ADL or otherwise should be initiated by a (C)OTA until an evaluation is completed by the OT(R).

OT(R)/(C)OTA COLLABORATION ON DOCUMENTATION MAY OCCUR AS FOLLOWS:

Evaluations: On areas of demonstrated competency a (C)OTA may complete portions of the evaluations or standardized tests, but not the initial summary, plan of care or goals.

Progress Notes: The OT(R) and (C)OTA must confer on the patient's progress /response to care. The (C)OTA or OT(R) may write the progress notes (daily, weekly or monthly) and should include changes to the plan of care and goals. OT(R) and (C)OTA are mutually responsible for the patient's outcome and compliance with all pertinent orders. Co-signatures shall be ascribed to reflect this mutual responsibility.

Discharges: Since the discharge summary reflects the patients response to the initial plan of care and the actual outcomes, the joint decision making and collaboration of the OT(R), (C)OTA, Physician, patient, family and staff should be clear. The (C)OTA may write a discharge summary but they should be cosigned. The OT(R) must be especially prudent in determining the (C)OTA s competency to complete the discharge summary accurately, thoroughly and objectively.

All practitioners are reminded that Practice Acts and Legislative Rules are in place to protect consumers. All OT(R) s and (C)OTA s must comply with licensure laws. However, a particular facility, company or payor of health care may set forth policies, procedures and practices which exceed these laws. Practitioners are legally bound to law and procedurally obligated to comply with employers' policies and procedures. Any practice which broaches the intent of the law should be addressed to the licensure board.

The WVBOT recognizes that the skills and competency of both the OT(R) and (C)OTA are critical. No presumption is made of absolute competency conferred by ones' title. The AOTA code of ethic and standards of care and laws governing state licensure should be paramount to any practitioner. It is always the mutual responsibility of the OT(R) and (C)OTA to assure competent high quality care is conferred upon recipients of our intervention and that optimal outcomes are achieved.