CLINICAL + SYSTEMS TRANSFORMATION
Our path to smarter, seamless care

BC Children's Hospital
BC Women's Hospital + Health Centre

OT CST PowerChart Competency Checklist

Name: **Date:**

Category	Daily OT Workflow	Knowledge & Skills Able to:	Need Learning & Practice	Knowledgeable But Need Practice	Competent	Expert/ Help Others Learn	NA
Daily Preparation & Caseload Management	Open your patient list for the day	Create patient list(s) based on location					
		Create a custom patient list(s)					
		Proxy list(s) to another colleague					
		Add or delete patients from my custom list(s)					
		Change the name of my list(s)					
		Find a list that has been proxied to me					
		Locate an individual patient in the correct encounter					
	Find requests for new consults to OT for my location or caseload	Open Multi Patient Task List (MPTL) & load patient list(s)					
		Set timeframe parameters for my MPTL					
		Find Dysphagia, OT Following and OT Consult tasks in my MPTL					
Chart Review	Open and Review a Patient Chart	Find and review medical history and (new) results					
		Find and review (new) medical orders, diet/nutrition and activity orders					
		Find and review lab results and medical imaging (if applicable)					

		Find and review changes in patient status/vitals					
		Locate social history and community contacts					
		Find and review team member notes					
		Locate and review OT notes (PowerForms and Dynamic Documents and as appropriate Therapeutic Notes)					
OT Orders (Inpatients)	Ensure Dysphagia, OT New Consult and OT Following orders are correctly entered and acknowledged in each patient's chart	Add/Review OT Dysphagia orders (including Oral Motor, Feeding and Bedside Swallowing Observations)					
		Describe indications for the need for Provider Dysphagia Orders					
		Add/Review OT New Consult order					
		Submit a VFSS for Co-Signature					
		Add/Review OT Following Order					
		Acknowledge Order Completion by Charting Done (or Chart Not Done, as appropriate) for Dysphagia and OT Consult on my MPTL					
		Modify or Discontinue an OT Following Order					
		Review OT Referrals					
		Find completed/discontinued orders					
Rehab Assistant	Incorporate a Rehab Assistant(RA) to your patient's care (as appropriate)	Add a RA Following Order					
		Complete an RA Delegation of Function Form from FormFast					

Documentation	Write a note in patient's chart following an assessment, consultation or an intervention	Ensure documenting in the correct encounter					
		Describe information that crosses encounters					
		Correctly Title a Dynamic Document					
		Document using a Dynamic Document including use of auto text					
		Save an in-progress Dynamic Document					
		Modify an incomplete Dynamic Document					
		Modify a completed Dynamic Document					
		Complete, Sign and/or Forward a Multi-Contributor Report					
		Describe information that pulls forward from OT PowerForms					
		Document using a PowerForm (ensuring to complete Analysis and Intervention sections)					
		Save an in-progress PowerForm					
		Modify and sign an incomplete PowerForm					
		Modify a completed PowerForm					
		Unchart a signed Powerform or Dynamic Document					
		Document discrete data in iView					
	FormFast	Document a Group Note (for group interventions) using Therapeutic Note, including documenting attendance.					
	Chartlet Use	Access and print appropriate forms from FormFast					

		Locate and print labels from FormFast Describe 3 types of document labels that may be used					
		Locate and place appropriate labeled forms and documents in the Chartlet					
	Downtime Processes	Describe Downtime Processes and locate Downtime Interdisciplinary form for charting					
	Note Distribution	Describe distribution processes for Notes					
Student Documentation	Review and co-sign notes written by students	Validate student documentation: IView					
		Validate student documentation: PowerForm					
		Validate student documentation: Dynamic Documentation					
		Find student documentation for signing					
Shared Chart Information	Update patient specific information as needed	Update Social History (shared) (as appropriate)					
		Review/Update Contact Information (as appropriate)					
		Add a Process Alert (as appropriate)					
		Review Gender/Pronouns (*only updating with informed consent)					
		Review/Update Indigenous Information (*only updating with informed consent)					
		Review/Update Allergies (*in consultation with team members)					
		Review Infection Control					
		Review Diagnosis (interdisciplinary)					
		Review Problems (interdisciplinary)					

Communication Tools	Communicate with team members as appropriate	Open Message Centre					
		Review documents sent for review/signature via Message Center					
		Send non-clinical messages about a patient via Message Center (opening in Communicate)					
		Document a Phone Message as a Patient Note					
		Review and Update in Team Communication (Discoverable)					
Wayfinding In Power Chart	Find support tools in PowerChart as needed	PSLS Link					
		SHOP Link					
		ePOPs					
		Up-To-Date					
		Care Connect					
		PACS					
		CST Cerner Help					
Other Skills	PICU/NICU - Review entire patient List	Clinical Leader Organizer					
	Cleaning equipment	Cleaning a WOW workstation as per protocol					

Professional Practice Considerations

Category	Daily OT Workflow	Knowledge & Skills Able to:	Need Learning & Practice	Knowledgeable /Skilled But Need Practice	Competent	Expert/ Helps Others Learn	NA
Professional Practice Considerations	Orders (Tasks)	Describe when to request Provider Orders					
		Explain and use correct Order Type (Dysphagia vs New OT Consult vs Following)					
		Describe and document important considerations of delegating OT care to a Rehab Assistant (RA) via RA Following Consult					
	Documentation	Outline and use best practice when Acknowledging Task Completion (i.e. Charting Done/ensuring charting is completed a priori)					
		Describe how to ensure charting is occurring in the correct encounter					
	Initial Assessment, Assessment and Consultation Reports	Explain the importance of *source* and *reason for referral* in notes & include consistently in documentation					
		Describe importance of documentation of informed *consent* & consistently include documentation of: - the *date* consent was obtained (if different than the date of the note), - *from who and how consent* was obtained (in person, virtually, in writing, through use of alternate communication or inferred), - for what *purpose* (assessment or consultation), - notation of *risks and benefits* discussed, and lastly					

		- whether the *opportunity to ask questions* and follow up as necessary was provided					
		If providing services *virtually*, able to describe importance of obtaining *consent* for this method of service delivery & consistently include documentation of informed consent for this type of service delivery.					
		Describe the importance of inclusion of *assessment/consultation procedures*, *results obtained*, and *analysis/conclusion* or professional opinion regarding the patient's status & consistently include documentation of this.					
		Explain importance and include clear documentation of *OT recommendations* and *plans*, formulated in collaboration with the patient/parents/legal guardians.					
	Progress Notes	Elaborate why and include documentation of *initial informed consent for intervention* as well as *maintenance of consent for ongoing intervention.*					
		Describe importance and consistently Include documentation in Progress Notes, indicating the *outcome of an intervention*, as well as any *changes in the patient's condition, problem formulation, or the intervention plan and goals*.					
		Delineate key reasons as well as include sufficient information in documentation so that the intervention plan, as well as goal attainment and noted progress is very clear.					
	Discharge Notes	Explain and include *sufficient documented discharge information* (i.e.: the patient's status at discharge, reason for discharge, and summary of outcomes attained, as well as recommendations such as home					

		program, referral, and an explanatory note when interventions initiated were not completed).					
	Multi-contributor Reports	Describe & include *key regulatory considerations* in multi-contributor reports regarding content/headings, signatures and timeliness of signing (i.e. Name and title by each OT specific section of the report/recommendations, full signature with designation and date & signing within 72 hours)					
	Late Notes	Clarify, list & include key practices with late notes (i.e. Title of late note, correct date of patient contact and date of report)					
	Tagging	List potential cautions with use of tagging and describe alternatives to tagging.					
	Use of message Center for Communication and for Note Distribution	Explain why Message Center should only be used for non-clinical information and clarify confidentiality considerations in attaching a report or note in Message Center.					
	Note Distribution	Explain key considerations regarding note distribution including obtaining consent to release or distribute documentation (Health Records, use of email and/or fax).					