Standardised referral form: restricting community occupational therapists’ client-centred practice?

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Introduction

- To ↑ homecare efficiency, the Ministry of Health and Social Services in Québec, Canada, encourages standardisation of practices\(^1,2\), including those of community occupational therapists (COTs)
- COTs: Go to individuals’ home\(^3\) and identify with them how to ↑ autonomy in their daily and social activities (occupational needs)\(^3\text{-}4\)
- The impact of standardisation is not known and might reduce client-centredness

Objective

This study aimed to explore the content and use of an electronic referral form to standardise COTs’ practice.
Methods

- Institutional ethnography\(^1\)-\(^5\)
- 10 COTs in 3 homecare programs (one urban, two rurals)
- Data collection / analysis:
  - Observations and semi-structured interviews w/ COTs
  - Sequences of activities w/ texts and language + other key-informants and regulating texts
  - Semi-structured interviews w/ 12 other key-informants
  - Collection of texts

Description of two referral forms
Description of actual work w/ forms
Bringing into view institutional discourse and organisation

RESULTS
Description of two referral forms: adoption process

Homecare program 1
- Electronic referral form
- Improve coordination of COT referrals
- Patient’s needs categorised ‘Object of referral’

Homecare program 2
- Electronic/paper form
- Improve communication / avoid duplications
- Patient’s needs categorised ‘Object of referral’
### Description of two referral forms: categories of needs

<table>
<thead>
<tr>
<th>Request for Homecare Occupational therapy services (prgm1)</th>
<th>Internal referral form (prgm2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Autonomy in:</strong> feeding, dressing, bathing, personal care, domestic activities, <strong>transfers</strong>, <strong>mobility</strong>, leisure/communication</td>
<td><strong>Assessment of autonomy in activities of daily living and activities of domestic life, transfers</strong></td>
</tr>
<tr>
<td>Physical environment: <strong>accessibility</strong>, <strong>safety</strong>, functionality for patient’s meaningful activities</td>
<td><strong>Assessment of environment</strong></td>
</tr>
<tr>
<td><strong>Posture</strong></td>
<td><strong>--</strong></td>
</tr>
<tr>
<td><strong>Nature of restraints</strong></td>
<td><strong>--</strong></td>
</tr>
<tr>
<td>Wounds, pain or discomfort</td>
<td><strong>Integrity of skin</strong></td>
</tr>
<tr>
<td>Functional disability due to cognitive / perceptual deficits (assessment, <strong>home safety</strong>, <strong>prevention of wandering or other</strong></td>
<td><strong>Screening for or Assessment of impacts of cognitive difficulties</strong></td>
</tr>
<tr>
<td><strong>Registration in a government program</strong></td>
<td><strong>House adaptation program, Disabled parking permit, Four-wheeled scooter program</strong></td>
</tr>
<tr>
<td><strong>Continuity of rehabilitation services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Services from home health aids</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Bolded:** autonomy in personal care, mobility and safety

**Italicized:** a need of the health care institution or system
I receive referrals from my colleagues who already did the [global and standardised evaluation [...] (OT6)

[…] it’s us, social workers, [...] that assess the global needs. Then, we will look into the specifics (SI1)

Daily and social needs
Restricted to safety and autonomy in personal care and mobility

Referral form
COTs’ colleagues
Description of actual work w/ forms

COTs’ colleagues

Referral form

Clinical supervisor

Daily and social needs
Restricted to safety and autonomy in personal care and mobility

Eligibility + Priority
Imminent safety risks, wound treatment, hospital discharges

Waiting list

[...] often [the object of referral]’s really focused. Or the hospital requests we evaluate safety at home [prior to discharge] (OT9)

Depending on the request for services, diagnoses and object of referral, we will try to prioritize the referral [...] (OT8)
Description of actual work w/ forms

COTs’ colleagues

Referral form

Clinical supervisor

Patient file

Waiting list

Daily and social needs
Restricted to safety and autonomy in personal care and mobility

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COTs
Sometimes the referral [...] doesn’t ask me to assess that [...] it is not evaluated [...] (OT4)

[...] it’s a lot responding to the person’s or the referral form’s needs that will guide us [...] (OT9)

Well, I am an occupational therapist. So, we could say [...] my role is to assess personal care, the person’s dimensions, [...] everything that is in our assessment report template. That’s my role. [takes a pause] But, the caregiver’s exhaustion, I must consider it. And the person’s distress, I must consider it. These are all aspects that are relevant [to my work]. [...] I am not sure it is well perceived when we reach such a large scope because it takes more time and we enter gray areas associated to lots of other professionals (OT6)
Description of actual work w/ forms

COTs’ colleagues

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Eligibility + Priority
Imminent safety risks, wound treatment, hospital discharges

COTs

Consultant (SI3)

Patient file

Patient

Caregivers

[...] [COTs’ role] is greatly determined by the team and what each member of the team does (SI4)

[I am] obligated, if [members of my team] ask me for a service, I will provide it [...] (OT7)

 [...] we are more and more consulted because we intervene less (OT10)

I will try not to duplicate what J [physical therapist] has done (OT3)
Description of actual work w/ forms

COTs’ colleagues

Referral form

Daily and social needs

COTs’ colleagues

Consultant (SI3)

Patient

Caregivers

Clinical supervisor

Waiting list

Eligibility + Priority

Imminent safety risks, wound treatment, hospital discharges

Colleagues’ needs

Patient file

Often we wear that hat [...] where we say to the client that, [...] in order to receive [...] services, he needs, for example, a single bed [...], some criteria like that (OT5)

[...] to determine level of services, if necessary, to adapt so it is safe. Sometimes, they do it. But other times, case managers have doubts. So they say: “Could you go, just to see if it is safe and make recommendations in line with safety?” Lots, lots, lots, of those. (OT4)
Description of actual work w/ forms

COTs’ colleagues

Referral form

Daily and social needs
Restricted to safety and autonomy in personal care and mobility

Clinical supervisor

Waiting list

COTs

Patient file

Patient

Caregivers

Eligibility + Priority
Imminent safety risks, wound treatment, hospital discharges

Work / Leisure: not assessed because not the reason for the referral and not deemed relevant in the present context (OT6)

“[…] Productive work, volunteering work […] we don’t touch those; it is not part of our roles which are in line with keeping the person at home, in the institution directives […] it is all that concerns staying at home. But, in regards to the vision of occupational therapy, it surely could be discussed, eh? (OT9)
Bringing into view the institutional discourses and organisation

“[…] first of all, homecare is related to staying at home. And it is how we prioritize. Why do we see a person faster than another? Well, it’s because his/her capacity to stay at home is compromised. So, it is staying at home and safety” (SI4)

“[…] we’ve restricted ourselves [...] we focus more on [...] Is staying at home compromised or not?” (OT2)

“We could look into leisure and work needs… but we only look into personal care needs” (OT2)
Bringing into view the institutional discourses and organisation

Homecare discourse

“[…] first of all, homecare is related to staying at home. And it is how we prioritize. Why do we see a person faster than another? Well, it’s because his/her capacity to stay at home is compromised. So, it is staying at home and safety” (SI4)

“[…] we’ve restricted ourselves […] we focus more on […]: Is staying at home compromised or not?” (OT2)

Course of Referral form action

“[…] we could look into leisure and work needs… but we only look into personal care needs” (OT2)

Bolded: Textual discourse
Italicized : Language used locally
Bringing into view the institutional discourses and organisation

**Homecare discourse**

- ‘Home: the first choice’
- ‘Priority: the individual’s choice’
- ‘Residential care: the last resort’
- ‘Avoid hospitalisation’
- ‘Time consuming assessment’
- ‘Interdisciplinary work’ ‘Case manager’
- ‘Safety guarantees’
- ‘Urgency’
- ‘Staying at home’
- ‘Avoid hospitalisation / residential care’
- ‘Less / more expensive’
- ‘Urgency’ ‘Autonomy’ ‘Safety’
- ‘Personal care’ ‘Mobility’
- ‘Consultant’ ‘Role’ ‘What is expected of me’

**Bolded:** Textual discourse

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Course of action

Referral form
Bringing into view the institutional discourses and organisation

**Homecare discourse**

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**Efficiency discourse**

- ‘Most efficient, cost-benefit services’
- ‘Challenge of efficiency’
- ‘Improve general performance of the system’
- ‘Limited resources’
- ‘Management levers’ ‘Resources allocation’
- ‘Accountability’ ‘Targets’ ‘Results indicators’
- ‘Management and accountability agreement’
- ‘Following up’ ‘Monitoring’ ‘Measuring’ ‘Assessing’

- ‘I don’t have time’
- ‘It takes too much time’
- ‘Avoid making people wait’
- ‘Do better’
- ‘Optimize’
- ‘Quantifyable’
- ‘Efficient’

**Referral form**

**Course of action**

**Bolded:** Textual discourse

**Italicized:** Language used locally
Conclusion

• One instance of text-based standardisation of COTs’ practice: referral form

• Being ‘consultant’ who do ‘what is requested’ → ↓ consideration of actual needs of patient

• Embedded in the Homecare discourse + Reinforced by the Efficiency discourse → Impact COTs’ potential to be truly client-centred

• Concerted efforts by professionals to question and act upon contextual barriers to client-centredness are needed → Change agent role
Questions?

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