Documenting Occupational Therapy Practice

Third Edition

Karen M. Sames

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THIRD EDITION

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PREFACE

For many years, I wished for a book that could be used by students to learn about documentation, while at the same time be used by clinicians to improve the quality of documentation in the field. Eventually, I realized that I could, and should, write that book. As a university professor, I spend a great deal of time reading written work produced by occupational therapy students. As a peer reviewer, I read client charts that insurance companies are unsure about; the charts that are so poorly written that the insurers cannot be certain the services are medically necessary and appropriate.

For these reasons, I decided to begin the long and challenging task of writing this book. Federal rules and professional standards change constantly. Electronic health records have become more common, adding further changes to the way occupational therapy is documented, forcing me to revise and add topics as the book evolved.

My hope for this book is that it gets used; that it is not simply put up on a shelf. I want it to be written in, to have pages flagged, and to have the spine well broken from repeated use. Normally, I would be appalled at the vision of food-stained, rumpled pages in a textbook. But I think this book is different. If it retains its original pristine condition, then it hasn't served its reader well.

The third edition contains updated information and added features including:

- A new chapter focusing on electronic health records has been added to address the skills and information necessary to prepare students for facilities that utilize digital documentation.
- Updates have been made throughout the text to reflect the recent revision to core American Occupational Association documents.
- Chapter 2 has a new section regarding texting as a form of professional communications.
- Guidelines for correcting errors in documentation have been added to Section III.
- Updates have been made throughout the text to reflect changes to Medicare. Additionally, Appendix B outlines several of the new Medicare standards including G-Codes.
- Supplemental materials are available online including answers to exercises, PowerPoints, and a test bank.

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INTRODUCTION: THE WHO, WHAT, WHERE, WHEN, AND WHY OF DOCUMENTATION

As occupational therapy practitioners, we work with a variety of clients in a variety of settings. In every setting in which we use our skills as trained professionals, we are asked to document what we do in some way. We may do clinical documentation that becomes part of a medical record. We may contribute to the development of an Individual Education Program (IEP) for a grade school student. We may write a report summarizing our activity as a consultant to a company. It is imperative that our writing demonstrates a high level of professionalism.

▼ WHO ▼

The key to professional writing is to know who we are writing for as well as who we are writing about. As indicated earlier, we write for multiple audiences. Some potential audiences include the intervention team, the client and/or surrogates (caregivers, family, or guardians), facility quality management personnel, third-party payers, peer reviewers, accreditation surveyors, administrators, and lawyers. Because the potential audience for our documentation extends far beyond our peers, it is important that we choose our words very carefully. I know of one occupational therapist who mentally says to herself before putting pen to paper, "Ladies and gentlemen of the jury, . . . " Then she begins her documentation. It forces her to think about how her words may be interpreted by others.

▼ WHAT ▼

On my first occupational therapy job, a director of nursing told me repeatedly, "If it's not documented, it didn't happen." It was like her personal mantra. As much as I got tired of hearing it, I have to admit she was right. It was good advice. If I had to be absent from work, and a substitute had to step in for me, I wanted the substitute to be fully informed about what things have been tried already and in what direction I wanted the intervention to proceed. In order for this to happen, there must be accurate, complete, and clear documentation of what has transpired in occupational therapy thus far. Also, documentation that is written at the time of an event is stronger evidence in a court of law than one's memory. How many of you can remember exactly what you did last Tuesday at 10:00 in the morning? A month ago? Eighteen months ago? Who were you with? What were you doing? Were you successful at whatever you were doing? How much force did you use? You get the picture?

Not only do you want to document what was done, but you also want to document the client's reaction to the intervention. Think of it as painting a verbal picture of the occupational therapy session for the reader. You want to document what instructions were given (e.g., for a home program, splint use and care, adaptive equipment use and care, or instructions to caregivers) and whether the person receiving instructions appeared to understand those instructions. Finally, you want to document what the plan is for future occupational therapy service delivery.

With so much to document, it might become somewhat of a balancing act between working hands-on with a client and documenting that intervention. Most occupational therapists go into the profession because they want to help people. I doubt any become occupational therapy practitioners because they love to write notes all day long. In addition, increasing competition for healthcare dollars have pushed some clinics to develop productivity standards for the amount of billable services each clinician needs to provide each day. This results in less time available for doing documentation. Today, a clinician in a clinical setting will generally spend 6 hours or more (out of an 8-hour day) with clients. The rest of the time is usually for meetings and documentation. In educational or community settings, the time spent with clients may be 7 hours or more in an 8-hour day. However, needing to document so much of what we do does not mean we have to spend a lot of time doing it. Sections III and IV of this book will show you some ways of documenting in an efficient and effective manner.

▼ WHERE ▼

In clinical settings, each client has his or her own health record (chart). The chart may be electronic or paper based. Occupational therapy practitioners may document in a section of the chart dedicated to rehabilitation or therapies. In some settings, integrated notes are done, so that each profession documents progress in a progress note section of the chart that is compiled chronologically regardless of which professional is writing. It is important to follow facility standards for where and when to write in the client's chart, regardless of whether the chart is on a computer or is paper based. Standards for good documentation do not change when the format (electronic or paper) changes.

In educational settings, the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) is written annually and reviewed every 6 months. The evaluation report, present levels of performance, and occupational therapy goals are integrated into those documents. The IEP or IFSP then goes into the student's educational record. If the school district is billing third-party payers for occupational therapy services, additional documentation may be required. The school district will have policies for the occupational therapist regarding where any other documentation will be filed and retained.

In addition to the official clinical or educational record, some occupational therapy departments retain copies of everything that is in the official record in a departmental file. These departmental files may also contain test forms, attendance records, and other nonofficial documents. Chapter 8 will go into more detail about records retention.

▼ WHEN ▼

Documentation is typically done as close to the time of service as possible. Some occupational therapists reserve the last 5 minutes or so of the intervention session to document in the client's chart. This works fine for contact or progress notes, but may not be sufficient for doing larger documents such as evaluation or discontinuation reports. These documents are usually done when there are no clients being treated such as at the beginning or end of the day or over the lunch hour. In some settings, the occupational therapist will dictate evaluation or discontinuation notes to be transcribed by secretarial staff. Others write them out longhand or on a desktop, laptop, or handheld computer.

The longer the time span from when the evaluation or intervention occurred to when the occupational therapist sits down to write about it, the more the chance that something will be forgotten. When possible, writing directly in the client's chart at the time of service delivery is best. However, this is not always possible. Some occupational therapists carry small notebooks or pieces of paper with them in their pockets, and jot quick notes about the clients they see during the day. Others use handheld computers. This does help them remember more clearly what happened with each client. As you can imagine, if an occupational therapist sees 12 clients in a day, by the end of the day it can be difficult to remember who said or did what.

WHY

Occupational therapists document for many reasons. We document to show what has happened to the client in a chronological sequence. We want to show what happened first, then second, then the next thing, and so on. Some regulatory and accrediting bodies want to see that things happened in a clinically sound sequence. For example, if you were working with a client recovering from a severe head injury, you would want to show that the client is aware of safety precautions to take when using a knife before you work on how to use a knife. The client's chart will tell any third-party reviewer the story of that client's recovery following an illness or injury, or a client's development in the case of a developmental delay.

We document to show our high level of clinical reasoning. Someone walking by the occupational therapy clinic could see the occupational therapist watching a client make buttered toast. That person might think, "She went to college for how many years to teach that? I could do that without any training." If that person could read the chart, he or she would see that the occupational therapist was really working on sequencing a task, manipulating utensils, safety awareness, and/or energy conservation. The task of buttering toast represents many different learning opportunities for the client. There is often more to occupational therapy than meets the eye.

We document to inform others on the intervention team about what happened during an intervention session. Everyone is busy, we work different shifts, and there is not always time for each of us to talk to other caregivers about each client. By writing down the essence of what happened in the intervention session, others on the team can be informed in their own time. By the same token, we can read the chart and find out what happened that day in other therapy services, or in the lab, medical imaging, or nursing.

We document to demonstrate the effectiveness of occupational therapy for third-party payers. This is a critically important reason to document well, as payment is often based on the quality of the documentation. Third-party payers such as the government (Medicare, Medicaid, CHAMPUS, and other programs) and private insurers (managed care, worker's compensation, indemnity) want to be sure that they are getting what they paid for—results. A payer virtually never observes the client directly, but relies on the documentation of the services delivered to determine effectiveness. If the payers cannot see progress in the documentation, they will often terminate payment, which in effect terminates services, even if you believe the client could still benefit from further services.

Last, but not least, we document for legal reasons. As stated earlier, the medical record, anything written at the time, is stronger evidence of what happened than anything we can remember from a year or two ago. In many states, a client can bring forward a malpractice case up to 2 years after the incident occurred. In those 2 years, we could have treated more than a hundred other clients. Will we remember exactly what we did with that client on that day, or will all the other clients we have seen since then cloud our memory? Depending on what we write, and how well we write it, the clinical record can be used to protect, or to hurt, us as practitioners. There are ways to ensure that what we write is more likely to help than hurt us, and this book addresses them.

STRUCTURE OF THE BOOK

Section I of this book deals with some of the mechanics of writing. It includes tips on word usage, the use of frames of reference, abbreviations, and jargon. It also takes a broad look at how the language of the profession is ever evolving and describes both internal and external influences on the use of language. This section also includes pointers on professional communication in general.

The second section focuses on the ethical and legal issues around documentation, such as confidentiality, record retention, fraud, and plagiarism. This provides a different yet necessary perspective on documentation: payers, reviewers, and attorneys.

Section III deals with the documentation of the occupational therapy process in a clinical setting. Clinical settings include all occupational therapy practice venues where

third-party reimbursement is sought, such as in a hospital, nursing home, clinic, or psychiatric program. Usually, in a clinical setting, there is a physician order or referral, and services are billed for in some way. This is a very broad description of a clinical setting. It excludes services that are paid for with grant money or other funding sources that do not require physician oversight. This section takes you through the occupational therapy process and explains the types of documentation completed at each step of the process. Each chapter describes a type of documentation and includes sections on role delineation and Medicare standards as they apply to that type documentation.

The fourth section is about documentation in school systems. While many school systems are now billing third-party payers to recoup the costs of some therapy services, there are also requirements for certain types of documentation that are unique to school-based services. This section addresses only the documentation requirements of school systems.

The last section deals with administrative documentation. Examples of administrative documentation include policies and procedures, incident reports, meeting minutes, job descriptions, grant writing, and job descriptions. Occupational therapy staff write some of these types of documents, while supervisors and managers generally write others.

If you are reading this book as a required text for a course in an occupational therapy educational program, do not be surprised if your instructor does not require you to read each chapter and do each exercise, in the order in which the chapters appear in this text. In an introductory course in occupational therapy, you may only be assigned the first three or four sections. However, I hope that at some point in your educational program, you will have a chance to work with chapters in the rest of the book. That means that you should hang on to this book even when the course is over. You will undoubtedly have opportunities to practice documentation in several courses in your curriculum, and this book will be a good reference to look back at as you draft your assignments.

If you are a clinician reading this book, I congratulate you on your dedication to the profession and to continuing competence. Depending on how long it has been since you were in school, some of the information in the book will be new to you, some merely a refresher. Each chapter of the book can stand on its own, and you can choose the chapter or chapters on which you want to concentrate. You will also find the material in the appendices especially helpful.

Throughout the book there are exercises to help you develop your skills in documentation. Answers to exercises are included in Appendix F (see Website). While comparing your answers to those in the book can be a good learning experience, it may be even more helpful to get feedback on your answers from an instructor or colleague. An experienced occupational therapist can provide feedback on the subtle nuances that different wording can have on a reader.

As you work through the sections of this book, you will become familiar with principles of good documentation in clinical and educational settings. You will also learn about other types of documentation that occupational therapists may be called on to write during their careers. People form opinions about you as a professional based on how well or how poorly you write. If you want to be thought of as a talented, competent, and skilled professional, you must write like one.

SECTION I

CHAPTER 1

Overview of the Use of Language in Documentation

INTRODUCTION

Documentation requires the use of written words. To document well, one must write well. This involves selecting words that will have meaning to the reader and making the documentation clear, accurate, and relevant to the situation. In the first section of this book, general issues about writing are discussed.

How well you write is one way that others will judge your professionalism. If you write poorly, use outdated terms or excessive jargon, use too many abbreviations, or leave out words, people will think you are either careless or lacking in skill. Appendix A (see website) contains a review of general grammar and spelling considerations that may be a good review for some readers. The American Occupational Therapy Association (2014) has developed a framework for occupational therapy practice that can provide some guidance on the use of terms. Different models or frames of reference used in occupational therapy will shape the way occupational therapists write about clinical or educational progress.

▼ OCCUPATIONAL THERAPY DOCUMENTATION ▼

When documenting occupational therapy practice, it is essential to use language appropriately. Occupational therapy practitioners work in many settings. Some settings, such as hospitals, long-term care, school systems, or home health, have very specific standards for content. Other settings, such as homeless shelters, prisons, or consulting, do not have setting-specific standards, so occupational therapy practitioners may have to create documentation systems to fit the needs of the setting. The American Occupational Therapy Association (AOTA) has guidelines for documentation that can be used in any setting (AOTA, 2013).

In clinical settings such as hospitals, long-term care facilities, home health, outpatient clinics, and psychiatric programs, each step of the occupational therapy process is documented. A referral or physician's order for occupational therapy intervention is typically the first item documented in a clinical record. If an occupational therapy practitioner conducts a screening or makes initial contact with a client, it is documented as a contact note. The occupational therapy evaluation is documented as an evaluation report or evaluation summary. Next, an intervention plan is created. As occupational therapy intervention is provided to the client, the occupational therapy practitioner records progress notes. When occupational therapy intervention is finished, the outcome of that intervention is documented in a discontinuation summary. Section III of this book details these documents.

In educational settings, occupational therapists contribute to team-based documentation of services provided to children with special needs. The services provided to infants and toddlers are documented in an Individualized Family Service Plan (IFSP). The services provided to children between the ages of 3 and 21 are documented in an Individual Education Program (IEP). In addition, every time a team meeting is called, every time a change in the IEP or IFSP is proposed, and every time a child is referred for special education intervention, there are notice and consent forms which document that the child's family has been kept informed of the process. Section IV of this book discusses these documents.

There is also documentation that is necessary, but not related directly to serving clients. We call this documentation administrative documentation. These documents relate to the efficient running of an occupational therapy department. Section V discusses several of these types of documents.

Regardless of setting, occupational therapy practitioners document nearly everything they do. Sometimes, that documentation is very structured; forms tell the occupational therapy practitioner what to document and where. In other situations, the documentation may be less structured; the occupational therapy practitioner uses a blank page to record his or her actions in a narrative format. Sometimes, the documentation is handwritten or done using a word processor, although that is becoming much less common. In more and more settings, the occupational therapy practitioner enters evaluation, intervention, and outcome data on a computer or mobile device.

Electronic documentation is now more common than handwritten or word-processed documentation. Electronic documentation makes the data that is entered instantly available to other members of the healthcare or educational team. Read more about electronic health records in Chapter 12.

▼ STRUCTURE OF THIS SECTION OF THE BOOK ▼

Chapter 2 presents an overview of the types of communication one might use on the job, including memos, letters, e-mails, and phone calls. This chapter discusses the importance of using the proper tone, voice, and language when communicating with other professionals in the workplace. While memos, letters, and e-mails are not generally considered documentation for the purpose of documenting occupational therapy practice, they are an essential part of the work of occupational therapy practitioners. Effectively communicating in writing with referral sources, coworkers, supervisors and supervisees, and colleagues is a skill everyone needs to master.

Chapter 3 will deal with use of language, including buzzwords, jargon, and abbreviations. Lists of common abbreviations are included. This chapter is very specific to occupational therapy practice. Just as certain phrases used in everyday conversations can be trendier than others, so can certain phrases used in occupational therapy.

Chapter 4 relates the language used in documentation to the language used in the primary documents that guide the profession of occupational therapy. These documents are written by the American Occupational Therapy Association and the World Health Organization.

Chapter 5 suggests that the words chosen for documenting occupational therapy services will reflect the model or frame of reference used with a particular client. It includes a brief summary of several different models and frames of reference.

Finally, Chapter 6 includes a checklist for ensuring careful documentation. It deals specifically with documenting clearly and accurately, making the documentation relevant and documenting any exceptions to the way the therapist expected things to go.

The lessons learned in these chapters will help improve documentation regardless of the setting in which the occupational therapy clinician or student works. What is important to remember is that you must always choose your words carefully.

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CHAPTER 2

Professional Communication

Occupational therapy practitioners communicate with others in the workplace using several methods, including face-to-face discussions, letters, memos, e-mails, and phone calls. The word choices and tone of the writing or speech used in professional, or formal, communication are very different from those used with friends.

Professional communication requires a level of respect and formality that is not required while e-mailing or talking to friends. In formal writing, the reader may be unknown to the writer; for example, while you might know the nursing staff who read your progress notes on a client, you might not know the client's attorney or family members who might also read the document (Lincoln University, n.d.). Professional communication avoids slang, contractions, cliché's, sexist or racist terms, and profanity (Lincoln University, n.d.; Word-mart.com, 2010). Informal communication may be written in the first, second, or third person, while formal communication is usually written in the third person. Formal communication often uses longer and more complex sentences and paragraphs. Be careful, however, to not go overboard by using big words and complex sentences just to try to sound impressive because then the writer might start to sound pompous (Lincoln University, n.d.; Word-mart.com, 2010). This textbook is written in a more informal voice, however, clinical, school, or administrative documentation are written in a more formal voice (Table 2.1). When writing a letter to appeal a denial of coverage, an evaluation report, a notice and consent form, or a discontinuation summary, the writer may or may not know the person reading it, so formal writing is called for.

TABLE 2.1 Formal and Informal Writing Examples

	Informal Writing	Formal Writing
Slang or jargon	The guy freaked out when he found out he had to wear the splint every night.	The client yelled and threw his splint when he heard that he had to wear it every night.
Person	I told him he had to wear the splint every night.	The client was told to wear the splint every night.
Sentence structure	He was told to wear the splint every night.	To prevent contractures, the client was instructed to wear the splint every night, watching for any signs of skin breakdown.
Emotion	I knew he'd be upset, and I felt bad about it, but I told him to wear the splint every night anyway.	The client was told to wear his splint every night.
A known reader (or not)	Kerry, my patient, refuses to wear his splint every night.	Mr. Mortez stated he refused to wear his splint nightly.

Specific standards may govern the contents of formal documentation. For example, the Individuals with Disabilities Education Act (IDEA) requires that specific items be included on the Individual Education Program (IEP), and Medicare requires specific documentation elements for occupational therapy reimbursement in long-term care. The Joint Commission (2012) recommends avoiding the use of certain abbreviations because of the likelihood of medical errors caused by misreading abbreviations that are remarkably close in appearance to each other. In addition, one's employer may further direct the method (electronic or paper and pen), timing, placement, and word choices of documentation.

▼ TONE ▼

Tone is the most important consideration in professional communication, whether it is spoken or written. In writing, the message has to stand alone, without the benefit of facial expression or gestures that convey meaning in oral communication. Readers will interpret what is written through their own lens, depending on their own practice setting, educational level, and cultural background. The writer has to consider how the reader is likely to interpret the message. Try to be confident, honest, and respectful (OWL at Purdue University, 2010a). At the same time, try not to be condescending (OWL at Purdue University, 2010a). For example, which of the following statements sounds more professional?

- I am appealing this coverage determination because, based on my clinical judgment, it is critical that Mrs. Rameriz receive additional occupational therapy services. I know when a client has reached her full potential, and this client has NOT yet reached her full potential.
- I am appealing this coverage determination because this client has not achieved her goal of independence in meal preparation, which is essential if she is to return to her previous living situation.

Clearly, the second statement is less condescending, yet honest and respectful. The first statement screams that the writer knows more than the reader, and has some under lying angry feelings toward the person who made the initial coverage decision.

The example also shows emphasis in the form of a word in all capital letters. Using all capitals in writing is like shouting in oral communication (Yale University, n.d.). If you want to emphasize a word or a point, some people suggest putting an *asterisk* around the word or words (Yale University, n.d.). Another way to show emphasis is to put the most important idea first in the letter, paragraph, or sentence (OWL at Purdue University, 2010a). The amount of space you devote to a particular idea also conveys importance (OWL at Purdue University, 2010a).

▼ ACTIVE VOICE ▼

In professional writing, an active voice is preferred to a passive voice. Using active voice in a sentence means that the person doing the action comes first, then the action (OWL at Purdue University, 2011). Active voice is usually more direct and clear than passive voice. Typically, a sentence written in passive voice will have a verb phrase using a "be" word (e.g., have been) (OWL at Purdue University, 2011). Following are two sentences that say essentially the same thing; the first is written in a passive voice, whereas the second uses an active voice.

- Self-care skills have been a concern of this client.
- This client has been concerned with his self-care skills.

▼ NONDISCRIMINATORY LANGUAGE ▼

It is important to use nondiscriminatory language in professional writing (American Psychological Association, [APA] 2010; Lunsford, 2009; OWL at Purdue University, 2010b). This may seem like an obvious statement, but sometimes word a creep into our speech or writing that reflect personal biases in subtle ways. All professional writing, whether it is a progress note, thank-you letter to a referral source, or policy and procedure, needs to be free of language that might be interpreted as sexist, racist, ageist, or otherwise biased on such factors as ethnicity, religion, disability, or sexual orientation (OWL at Purdue University, 2010b). Avoid broad categorizations such as *hemiplegics*, *stroke victims*, or *the blind* when discussing a population (APA, 2010). "Person first" language (e.g., people with hemiplegia, a person with visual deficits) is preferred when discussing a population or a person with a disability (APA, 2010; The ARC, 2012). Use the adjective form of population descriptors rather than the noun form (e.g., elderly people rather than the elderly) (APA, 2010).

It is no longer acceptable to use masculine pronouns (e.g., he, his) to refer to both genders or to refer to all occupational therapists as she (APA, 2010). Other words that can be substituted include *person*, *one*, and *individual*. Another way to get around this difficulty is to restructure the sentence to use plural forms of pronouns such as *they*, *their*, and *them* (APA, 2010; Lunsford, 2009). The last option is to simply eliminate the pronoun, or replace it with an article (APA, 2010; Lunsford, 2009)—for example, a departmental policy might say, "Remove shoes before jumping in the ball pit" rather than "Everyone must remove their shoes before jumping in the ball pit." Of course, if you are writing in a specific person's clinical or educational record, and you know the person's gender, it is fine to use the appropriate gender-specific pronoun.

What is the best way to refer to occupational therapists and occupational therapy assistants? When referring to them in combination, the term *occupational therapy practitioner* may be used (AOTA, 2010). Some people prefer to spell out both levels of practice, and that is fine; it just takes a second or two longer to write out both terms. Be cautious about dropping the adjective *occupational* when talking about occupational therapy practitioners or occupational therapy program. The term *therapist* can refer to a psychologist, a social worker, a marriage and family counselor, and a variety of other professionals. The term *therapy* can refer to physical therapy, psychotherapy, nutrition therapy, or any number of other therapy programs. If, as a profession, we want other disciplines to know and respect us, we need to use our complete title at all times.

▼ MEMOS ▼

Sometimes, an occupational therapy practitioner needs to communicate with people who work on another shift or another building, coworkers who are not available at the time the critical information needs to be conveyed, or the occupational therapist wants to confirm in writing a conversation that took place. The best way to do this is through a memo. The overall purpose of a memo is to convey information in an effective way (OWL at Purdue University, 2010c). A memo may also be used in place of a cover letter when sending a packet of documents to people you know to tell them what is in the packet and why you sent it (Sabath, 2002). A formal letter is preferred if the packet is going to people you do not know.

The first part of a memo is the heading. This is what makes the memo different from a letter. According to OWL at Purdue University (2010c), the heading usually contains four elements:

To: (reader's full name; sometimes includes job titles with proper capitalization)

From: (your name; sometimes includes job title)

Date: (month, day, year the memo was written)

Subject or Re: (brief explanation of the point of the memo; re is the abbreviation for regarding)

Some word processing programs have templates for writing memos that automatically enter the date. Check the spelling of names, and be sure that you are writing to the right person. Make sure the subject is stated concisely and cannot be construed to mean something other than what you intended. You do not want to unnecessarily alarm the reader, but you also do not want to put the entire content of the memo in the subject line (OWL at Purdue University, 2010c).

Bravemen (2006) suggests a basic five-paragraph structure for memos:

- **Introduction:** explain the reason for the memo.
- **Background:** establish the context.
- **Recommendation or request:** what you want the reader to do or what you want to have happen.
- **Rationale:** explain your reasoning behind your recommendation or request.
- **Conclusion:** restate your position.

Make the memo both look good and sound good (Sabath, 2002). Pay attention to the rules of good grammar, such as capitalization, punctuation, and sentence construction. (See Appendix A [see website]). Use one reasonably sized font style that looks professional. Be consistent in your format, such as the indentation of the first line of each paragraph, throughout the document. Although it is generally a good rule to limit a memo to one page, do not squish everything together, decrease font size, or use smaller margins, just to make it fit on one page (OWL at Purdue University, 2006). If it does not look good on one page, then make it two, well-spaced pages (Sabath, 2002). It is most common for a memo to be written with 1-inch margins on all sides, and to use 10- to 12-size font (OWL at Purdue University, 2006). Font style is a matter of personal preference. If your memo is intended to be read on a screen, then a sans serif font such as Arial or Calibri is easier to read. If your memo is on paper, then a serif font such as Times New Roman is a good choice. Whatever font you use, be sure that you use just one font throughout the memo (OWL at Purdue University, 2006). To add emphasis to certain words, use italics rather than all capital letters. Underlining is fine for a print memo, but if the memo will be read on a screen, then underlining looks like a link that could be clicked to take the reader somewhere else.

▼ LETTERS ▼

Much of the advice for writing memos also applies to writing formal letters. Because the recipient of the letter may not be an acquaintance of the writer, letters often take on an even more formal tone. In a formal letter, the heading is replaced by more detailed information. Often a letter is written on company or organization letterhead. When word processing a letter, make sure that you start the letter down far enough on the page that what you write will not print over the letterhead. A good rule of thumb is that you should start the letter at least 2 inches down the page when using letterhead.

The first part of the formal letter is the sender's address. This is optional, because if the letter is printed on letterhead, the address may already be there. If you do choose to type in your address, leave one empty line after your address before adding the date (OWL at Purdue University, 2010c). The date is usually in the format of month, date, year (May 19, 2012) in the United States, and is left justified (OWL at Purdue University, 2010d).

After the date, include the name, title, and address of the person to whom the letter is addressed (OWL at Purdue University, 2010d). This is called the inside address (OWL at Purdue University, 2010d). According to OWL at Purdue University (2010d), the inside address is typed one line below the sender's address or 1 inch below the date, and it is always left justified. Make sure you use the proper title of the person to whom you are sending the letter.

Between the inside address and the body of your letter, you need to greet your reader. This is called the salutation (OWL at Purdue University, 2010d). If you know the person to whom you are sending the letter, it is fine to greet the person by starting the letter with Dear Maria (or whatever the person's first name is). If the letter is going to someone you do not know, or to someone who holds a higher position than yours, then use the person's full name, including

Mr., Dr., Ms, Professor, or other personal title. In a business letter, use a colon after the name rather than a comma (OWL at Purdue University, 2010d). Things get a little dicey when you do not know the gender of the person to whom you are writing, and therefore do not know whether to say Mr. or Ms. When this happens, you have two choices. You can just leave off the personal title and use the person's whole name, or you can use a generic term like "To Whom It May Concern" or "Dear Appeals Review Coordinator" (OWL at Purdue University, 2010d).

There are several formats for business letters; the important thing is to be consistent in the format (Sabath, 2002). A block format uses a blank line between paragraphs but does not indent the first line of each paragraph (OWL at Purdue University, 2010d). A semi-block format also used a blank line between paragraphs, but the first line of each paragraph is indented (OWL at Purdue University, 2010d). A less formal format indents first lines of each paragraph but does not include a blank line between paragraphs.

Because a letter does not include a subject line in the heading, it is good to get right to the point and state the purpose of the letter in the first paragraph (OWL at Purdue University, 2010d). The following paragraphs can include justification for the main point, and background information the reader needs. The last paragraph restates the purpose of the letter, and may include the action you are requesting the reader take (OWL at Purdue University, 2010d).

The closing begins one line below the last paragraph (OWL at Purdue University, 2010d). A typical closing would simply be the word "Sincerely," but "Thank you," or "Respectfully," could also be used. Notice that there is a comma after the closing word(s), and that only the first word is capitalized. Leave 3–4 lines of blank space, then type in your name and title. This allows room for your signature (OWL at Purdue University, 2010d). If you are including other documents with the letter, it is helpful to list those at the bottom of the letter; underneath the signature, type Enc., which is a short for enclosure, or use the whole word Enclosure and then list each enclosed document.

E-MAIL

Most of us have been using e-mail for years, but its use in healthcare is evolving. There are still questions about the security of electronic transmissions, particularly between healthcare providers and their clients. Programs that encrypt e-mails are considered more secure than those that do not. The American Medical Association ([AMA], 2003) has advised its physicians that while e-mail has many advantages, the disadvantages must be addressed. The AMA recommends that prior to using e-mail to communicate with patients, physicians need to make sure that they let patients know about the risks to privacy of any e-mail communication (AMA, 2003). Healthcare providers, including occupational therapy practitioners, need to be conscious of adhering to codes of ethics, particularly to those standards relating to privacy and confidentiality, and to principles of good communication when communicating via e-mail.

E-mail, instant messaging, and text messaging have evolved to create new words, phrases, acronyms (e.g., LOL or CU), and emoticons (e.g., :-) [smile] or <g> [grin]), which are fine to use among friends but should be used sparingly in the workplace (Braveman, 2006; OWL at Purdue University, 2010e). Professional communication, as stated earlier, is more formal. E-mails to colleagues for work purposes need to follow certain conventions. On the other hand, acronyms and emoticons can help convey your intent or help the reader understand the spirit in which the communication was intended (OWL at Purdue University, 2010e).

When replying to an e-mail, think about who should see your reply. You have two options: reply and reply all. Some e-mail systems are automatically set to send the reply to everyone on the original e-mail. Evaluate your response and determine if the response is best sent to one person or everyone in the group, and then choose reply or reply all, as appropriate. Be aware that anything you write in an e-mail can be forwarded, without your knowledge, to others (Scott, 2013). If you are responding to an e-mail that is part of a listserv, but the sender asks for e-mails to come to his or her personal e-mail account, you need to copy and paste that person's e-mail address into the "To" box rather than simply clicking "reply" (OWL at Purdue University, 2010e).

Sabath (2002, p. 55) suggests five e-mail commandments:

E-mail only those people to whom your messages actually pertain (rather than entire address groups).
Make a point of responding to messages promptly.
Always use spell-check and grammar-check before sending messages.
Include your telephone number in your messages.
Learn that e-mail should be used for business rather than personal use.

E-mail is often used in place of memos, letters, phone, and face-to-face conversations; however, it can create as many problems as it can solve in the workplace. E-mails allow the reader to interpret the message in ways the sender never intended; they are open to misinterpretation by the reader. If they are long with few, if any, breaks in the text, they are hard to read. They are easily distributed either by forwarding or by printing and circulating, so they can end up in the hands of people the sender did not want to receive the message. A final consideration is that every e-mail system is different, and what looks properly formatted on one system may look different on another system (Sherwood, n.d.). Box 2.1 lists some tips that can help minimize the potential for misunderstandings.

BOX 2.1 E-Mail Tips

- Never put something in an e-mail at work that would embarrass you if your boss read it.
- Include a clear subject heading, so your message gets attention. "Update" is pretty vague unless it is followed by a description of what is being updated.
- Address the recipient in the body of the message by starting the message with a salutation that includes the person's name.
- Create a signature that includes your name, title, and contact information. You may also include the organization's vision or slogan, or an appropriate quote.
- Be concise but clear.
- When replying to someone's message, include part or all of the sender's message to help the originator remember what he or she said. Do not include entire back-and-forth conversations; delete long strings of past messages.
- Respect the confidentiality of the sender. Remove unnecessary names and e-mail addresses before forwarding it on to someone else.
- Use proper spelling and grammar. Many e-mail systems have a spell-checker option.
- Respond in a timely manner. A good habit to get into is to check your work e-mail at least twice a day.
- Don't SHOUT by using all capital letters. Don't underutilize capital letters, either. If a word or name would be capitalized in printed material, it should be capitalized in e-mail.
- Use Cc and Bcc appropriately. Cc is for including people in the message who have a stake in the topic of discussion; everyone who gets the message knows who else got a copy of the message. Bcc is for e-mailing several people who do not know each other. It is a way to protect each person's confidentiality by not sharing their e-mail addresses with strangers.
- Don't use "Reply to All" unless everyone really does need to see your response. If you are part of a listserv and want to reply just to the sender of a message, do not hit reply at all. Copy the sender's e-mail address and paste it into the To: line of a new message.
- Be careful about sending attachments, especially large ones that take up a lot of space on the system. When you are replying to an e-mail that contains an attachment, use the "Reply without attachment" option if you have it. If that is not an option on your system, delete the attachment before you hit "send." The person who sent you the attachment already has a copy of the document, so he or she does not need another copy of it.

- Do not overuse the "highest priority" option. It ceases to be a priority if it is used daily.
- Keep business e-mails short, a paragraph or two, with sentences that are less than 20 words each. Use bullet points or numbered lists to make the messages easy to read.
- If you are angry when writing an e-mail, save it as a draft and go back and edit it when you have calmed down. Once it's sent, you can't take it back. Expression of extreme emotion in an e-mail is called flaming. Flaming is never a good practice.
- Keep a copy of the e-mails you send. You can set your e-mail system to automatically save all sent mail.

Sources: Oliu, Brusaw, & Alred (2010); OWL at Purdue University (2010e); Scott (2013); Sherwood (n.d.).

▼ PHONE CALLS ▼

When an occupational therapy practitioner needs to communicate with a physician or other team member about a client, a phone call is one of the fastest ways to communicate. It allows the caller and receiver to interact immediately, to ask questions of each other and clarify the actions needed. When using the phone to communicate information about a client, be sure that you are in a place where your side of the conversation cannot be overheard by people who do not have a need to know about the client.

Many healthcare facilities are using a system called "SBAR" (pronounced es-bar) to facilitate communication between departments and between staff and physicians (Guise & Lowe, 2006; "SBAR Initiative," 2005; "SBAR for Students," 2007; Velji et al., 2008). This method of communication can be used in person as well as on the phone. It organizes what a healthcare professional needs to communicate so that it is done quickly and efficiently.

SBAR stands for

- **S**ituation
- **B**ackground
- **A**ssessment
- **R**ecommendations

If this sounds like something the military would use, that's because it was developed by the military years ago to try to standardize communication between soldiers and commanders ("SBAR Initiative," 2005). It was adapted by Bonacum, Graham, and Leonard at Kaiser Permanente as a means to improve patient safety during transfers of responsibility such as during patient hand-offs at shift change or when a patient moves from one unit to another ("SBAR Checklist," 2006). It is now being used for telephone communication in hospitals, nursing homes, clinics, rehabilitation centers, and home care settings.

Let's say that you have to call a client's physician because you noticed that the client has made significant gains in self-feeding. Using SBAR, you would say

Situation**:** "Hello Dr. Gonzales, my name is Karen Person and I am the occupational therapist working with Phoebe Finch at the Pediatric Rehabilitation and Feeding Center."

Background: "Phoebe is a 4-year-old, born 3 months prematurely, who is being weaned off tube feedings. She has been making great progress and is now chewing and swallowing soft foods consistently."

Assessment: "She has not had any incidents of choking, pocketing, or spitting out food in our last three sessions. She appears to want to eat."

Recommendation: "I would like to try introducing more solid and crunchy foods such as chips, boxed cereals, apple slices, and the like. Would you be willing to sign off on changing the order to include solid foods?"