OCCUPATIONAL THERAPY NOW

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Cover image: Sharon Irngaut, community therapy assistant in Igloolik, Nunavut, walks to a home visit.

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MANAGING EDITOR
Janna MacLachlan, OT Reg. (Ont.)
Tel. (613) 523-2268 ext. 266, Fax (613) 523-2552, email: otnow@caot.ca

TRANSLATION
De Shakespeare à Molière, Services de traduction

DESIGN & LAYOUT
JAR Creative

COPY EDITOR
Claire Hurd

Celebrating intraprofessional collaboration in occupational therapy

Dianna Fong-Lee and Heather Gillespie

What an incredible honour it has been to be a part of the planning and production of a special issue of Occupational Therapy Now that celebrates the advances in collaborative practice between occupational therapists and support personnel or occupational therapist assistants (OTAs). There are many reasons to celebrate and this special issue could not have been timed better. First, the number and variety of submissions are a clear indicator that occupational therapists and support personnel or OTAs across Canada have information to share. Secondly, while the submissions reflected diverse topic areas, a consistent theme was the prevalence of focus on OTAs with formal, college-level training. Recent dialogue has led CAOT to the decision to formally recognize the OTA title (see p. 5) - a move worthy of celebration! We will primarily use this OTA terminology throughout this special issue. The term support personnel (which encompasses both those with formal and informal training) continues to be a relevant descriptor for individuals in an occupational therapy support role who have had informal or on-the-job training.

The content of this issue reflects how much the OTA role has evolved in recent years. In 1991, the National Health Research and Development Program of Health and Welfare Canada funded a national interdisciplinary research project to investigate training, use, supervision and future options for support personnel in the rehabilitation disciplines. A review of this "heritage" study compiled by Hagler et al. (1993) provides a basis for reflecting on how practices have changed with regards to training, collaborating with and supervising OTAs, as well as contemplating future directions.

Training and education

When Hagler et al. shared their results in 1993, education to prepare support personnel was largely on-the-job training within a given discipline. As the profession of occupational therapy has evolved over the years, so have the qualifications, roles and responsibilities of OTAs. This includes the progression of education from the first program established in 1953 at Kingston Psychiatric Hospital in Ontario (Maxwell & Maxwell, 1978), to the present, when there appear to be 25 publicly funded programs and 14 programs at private career colleges (there is no central listing of schools offering such programs). The majority offer a combined OTA & PTA two-year diploma program. Such dual-trained support personnel promote flexibility in the provision of services (Canadian Association of Occupational Therapists [CAOT], 1998).

The move to a two-year diploma program offered educators an opportunity to enhance the curriculum and "offer academic attention to a broader scope and depth of OTA practice" (Martin, Dickinson, Marken, & Swinton, 2005, "Frequently Asked Questions," para. 3). Enhancing the curriculum to ensure role clarity and the importance of valuing team members and collaborative relationships has a solid presence in current training programs. Articles in this issue echo this focus, addressing both interprofessional (p. 29) and intraprofessional (p. 28) practice. Prochnau and Mazumder (p. x) offer an example of a broadened curriculum with their innovative delivery of mental health content.

While the breadth and depth of education programs naturally varies across Canada, it should be recognized that the need for quality or consistency of training has developed in two areas. In 2009, CAOT launched the Practice Profile for Support Personnel and around the same time, the Canadian Occupational Therapist Assistant and Physiotherapist Assistant Educators Council (COPEC) initiated a partnership with CAOT and Physiotherapy Education Accreditation Canada (PEAC) to develop program standards for an accreditation process. An update on this process can be found on page x of this issue. Development is ongoing and does not stop at pre-service education; OTAs want access to continuing education opportunities, as Langendoen, Pleasance, Dyrkacz and Heck discuss on page 24.

The role and value OTAs

The roles and contributions of OTAs to the interprofessional health-care team are continuing to evolve in a variety of practice areas and settings. In this issue, innovation in acute care hospitals (p. 16, 23 and 27) and home care community settings (p. 8, 17, 19 and 21) are especially evident. It is inspiring to learn how OTAs are increasing access to, and allowing for expansion of occupational therapy services offered, such as in the food exposure intervention program discussed on p. 6.

The CAOT webpage dedicated to support personnel (http://www.caot.ca/default.asp?pageid=1013) is evidence of the growing appreciation for the value and contribution OTAs bring to occupational therapy practice. We encourage readers to review the resources and explore ways to optimize their own service delivery with OTAs, especially those who have completed a formal education program.

Collaboration and supervision

Guidelines for the supervision of OTAs across Canada have remained consistent with the general principles that were proposed by Hagler et al. (1993); supervision needs to be considered in four areas: method of supervision, amount of supervision, numbers of OTAs being supervised and responsibilities of the employers. Occupational therapists are encouraged to access resources from

CAOT and their regulatory body for assistance in determining appropriate supervision requirements. Employers should ensure that their occupational therapists are competent to work effectively with OTAs and this can be achieved by: 1. including OTA supervision in the job description; 2. ensuring adequate time is available for supervision; and 3. ensuring that occupational therapists receive adequate training in the supervisory process.

The emerging roles and broad-based competencies of formally educated OTAs now require occupational therapists to provide supervision in a way that not only ensures patient safety, but also respects the contribution and growing autonomy of OTAs. This shift stresses the need for role clarity and innovative collaboration practices (e.g., p. 13 and 15)) that support both the OTA and the occupational therapist who remains ultimately responsible for the safe delivery of occupational therapy services.

Where do we go from here?

We have described progress here, however, some would argue that the rate of evolution in training, role or scope of practice, and supervision of OTAs has lagged significantly compared to assistants across the border in the United States (Salvatori, 2001), as well as our physiotherapy counterparts. There is little doubt there is further work needed to facilitate the integration of assistants into the profession.

Title: Recognizing that these team members are not regulated and therefore there is no protection of title, we believe that further clarification of title would benefit OTAs, clients and employers, and significantly increase OTA recognition within our profession.

Career laddering: The pathway to become an occupational therapist involves completing a master's degree, which may be very daunting for college graduates. With new partnerships between colleges and universities, there is room to be innovative and look at developing fast track programs to support credit transfers and career mobility? In this issue, Cathy White provides insight into her personal experience of career laddering (p. 20).

Fieldwork placements for OTAs: Across the country, education programs are struggling to meet the accreditation standards that require students complete a minimum of 30% of fieldwork hours in occupational therapy practice settings. Very few programs can offer OTA and physiotherapist assistant students an equal amount of fieldwork hours in occupational therapy settings as compared to physiotherapy settings, and this may impact the education of the student and future vocational pursuits. We need greater support in this area from occupational therapists. We applaud therapists who employ innovative fieldwork supervision models that promote interaction and partnerships between OTA and occupational therapy students during fieldwork placements (Jung, Salvatori, & Martin, 2008).

Membership in CAOT: CAOT encourages support personnel to become members. We encourage membership recruitment efforts and membership benefits be made more visible to our support personnel colleagues. A larger membership benefits all and could be an effective way to address the continuing education needs of OTAs.

Writing the next chapter involves empowering our OTA colleagues to raise their voices. Do OTAs have access to workforce demographics (e.g., supply, distribution or remuneration) to strengthen their growing role and plan for the future? What representation on a provincial or national level do OTAs feel will best serve their interests? Is there room for a group similar to the Canadian Physiotherapy Association's National Physiotherapy Assistant Assembly? We encourage OTAs and occupational therapists to continue developing collaborative relationships to combine skills and knowledge to enhance service delivery, and to strengthen the contribution of our OTA colleagues.

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About the guest editors

Dianna Fong-Lee, MA, OT Reg. (Ont.), transitioned from clinical practice to teaching almost 24 years ago, first lecturing at Western University's School of Occupational Therapy, and then for the last 18 years she has been on faculty with the Occupational Therapist Assistant & Physiotherapist Assistant Program at Conestoga College Institute of Technology and Advanced Learning, Kitchener, ON. She can be reached at: dfong-lee@conestogac.on.ca

Heather Gillespie, OT, BOT, is an occupational therapist with Home and Community Care, Island Health, Nanaimo, BC, and an instructor in the Therapist Assistant Distributed Learning Program, Medicine Hat College, Medicine Hat, AB. She can be reached at: hgillespie@viha.ca

What's new

CAOT 2015 Annual General Meeting

You are invited to join the Annual General Meeting of the Canadian Association of Occupational Therapists on March 31, 2015, from 12:00 to 1:00 p.m. Eastern Time. Further details to be posted at: http://www.caot.ca/agm.

CAOT Conference app

The CAOT Conference is offering an app this year so people can view the conference program and build a personalized schedule on their tablet, smartphone or laptop. The conference program is searchable and the schedule will be current to include any changes. The app also offers maps of the venues and details exhibitor information. After conference it will allow people to download any presentations that authors submit to CAOT. To download the app, go to: http://www.caot.ca/default.asp?pageid=250

Seeking peer reviewer volunteers

The Occupational Therapist Assistant and Physiotherapist Assistant Education Accreditation Program (OTA & PTA EAP) is responsible for the accreditation of physiotherapist assistant and occupational therapist assistant education programs in Canada. We need eligible volunteer peer reviewers in order to continue to successfully run this accreditation program. If you would like to know more about becoming a peer review team member for the OTA & PTA EAP, please read about eligibility here: http://otapta.ca/english/get-involved/become-a-peer-review-team-member.php

What's new in BC

CAOT-BC published an exclusive member resource in January: the 2015 Private Practice Directory. This resource will be available online and is the best resource to find a private practice occupational therapist in British Columbia. To access this resource, go to: www.caot.ca/caot-bc.

CAOT Lunch and Learn archive certificates

Most CAOT Lunch and Learn webinars are recorded and there are currently over 60 archived Lunch and Learn presentations, on a wide variety of topics. You can now receive a participation certificate for your professional portfolio for all Lunch and Learn archives you attend.

Changes at CAOT relating to OTAs

Since the inception of the Occupational Therapist Assistant and Physiotherapist Assistant Education Accreditation Program (OTA & PTA EAP) in 2012 there has been exponential growth in accreditation of OTA and PTA programs. This has led to a change in the landscape, prompting CAOT to begin a dialogue on a number of issues, including title, membership in CAOT, and advocacy and representation. CAOT would like to honour and recognize the title, profile, education and contribution of individuals who have completed OTA training programs. As of January 2015, CAOT will adopt the title Occupational Therapist Assistant (OTA) for anyone who has graduated from an accredited Canadian OTA/PTA program or a Canadian OTA/PTA program that gains accreditation status within three years of graduation. Watch for news about additional changes and initiatives to come over the next year.

New process for transitioning to practice in Canada

As of May 1, 2015, the Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO) will implement a new process for internationally educated occupational therapists (IEOTs) seeking to transition into practice in Canada, called the Substantial Equivalency Assessment System (SEAS). For more information, go to: http://www.acotro-acore.org

New and revised position statements

The CAOT Board of Directors has approved three new position statements:

1. Autism Spectrum Disorders and Occupational Therapy – This position statement was revised to better reflect current practice with this population and be more inclusive of the broad spectrum of practice models used by professionals in Canada.
2. Obesity and Healthy Occupation – This position statement has been revised to reflect new knowledge in this area of practice.
3. Occupational Therapy and Workplace Health – This position statement will replace the statement on Return to Work and Occupational Therapy and was written to reflect current practice and be more encompassing of biopsychosocial aspects.

All CAOT position statements can be found at: http://www.caot.ca/default.asp?pageid=4

Use of an occupational therapist assistant in food exposure intervention for preschoolers with autism spectrum disorder

Arwen Caines

"Increasing the food that my child eats" is often a high priority goal established by parents of preschoolers receiving services from the Society for Treatment of Autism (STA), a registered charity in Calgary, Alberta. Together, the parents, occupational therapist and occupational therapist assistant (OTA) work to increase a child's food intake and the variety of foods tolerated. Group and/or individual food exposure sessions are used to target food acceptance; these are run by both the occupational therapist and the OTA. Additionally, the occupational therapist establishes goals with parents relating to self-care, play, school skills and recreational pursuits for their child. This article will highlight the importance of the OTA role at STA in food exposure intervention.

Autism spectrum disorder and picky eating

Autism spectrum disorder (ASD) involves persistent limited social communication across all environments, limited interests and engagement in repetitive behaviours within early childhood; it impacts daily functioning (American Psychiatric Association [APA], 2013). Individuals with ASD often have difficulty generalizing skills or developing new skills due to their adherence to routines and patterns (APA, 2013). Picky eating tendencies or restricted food practices are often seen in this population. At STA, parents most often identify a lack of fruits, vegetables and meat products in their child's diet.

STA and food

Food restrictions may start as an aversion to sensory properties of or associated with food (APA, 2013; Case-Smith & Humphry, 2005), or as an adverse reaction due to limited oral motor skills (Case-Smith & Humphry, 2005), but may subsequently develop into a behavioural routine. As such, principles of behavioural modification programming are always used in interventions to address this issue. STA clinicians employ a total communication approach (i.e., pictures, signs and words; Goldstein, 2002) when interacting with clients to ensure individual receptive and expressive communication needs are adequately addressed. Behavioural modification (Applied Behavioural Analysis [Lovaas, 1987]) is a grounding theoretical approach of the agency for its work with children with ASD (STA, 2013), including food exposure programming. Furthermore, developmental theory and play-based opportunities are used in conjunction with approaches stemming from desensitization principles, sensory motor principles and principles of oral motor skill development when addressing food tolerance and acceptance.

As part of the therapeutic role, the occupational therapist develops a relationship with the client and family prior to targeting food exposure; informal STA guidelines recommended spending four months on rapport building prior to starting food acceptance programming. During this time, the therapist conducts initial home visits to provide the family with strategies and suggestions that they may be able to incorporate into their family meal times or use when feeding their child.

A parent checklist (STA, 2012) is used to identify what foods their child currently eats, what foods he or she used to eat but does not anymore and what foods he or she has never eaten. This form was developed by an interdisciplinary food exposure committee including occupational therapists, psychologists, speech-language pathologists and the OTA. Based on information gleaned from the checklist and discussions with parents, the occupational therapist and parents jointly identify their top three "wish" foods for the child to eat.

The STA occupational therapy department believes that it is important that clients increase their food intake in the most relevant environment for them, which is typically in their home with their parents. Providing food exposure in the home allows parents to see different strategies being used and allows them to try the strategies with interdisciplinary support and be part of the food introduction process.

OTA at STA

Developing food acceptance is viewed as a long-term process that requires regular exposure sessions as well as parental involvement. Having the OTA provide a number of the individual sessions allows for more regular sessions, on a twice-weekly or weekly basis, a frequency the occupational therapist would not be able to provide. For clients who are less socially motivated, one-on-one sessions can be more effective, as groups can be overwhelming and ineffective for socialization. Both the occupational therapist and the OTA provide parent training. This includes demonstrating how to play with food at the table, identifying different levels of food acceptance, demonstrating positive interactions with a variety of different foods and showing how to integrate other approaches into a session, such as positive reinforcement, behavioural modification and total communication.

A consistent approach to the implementation of the intervention is important to ensure that the OTA is delivering

programming just as prescribed by the occupational therapists, in line with the agency's philosophy and including learning opportunities for the families. Once the OTA runs a food exposure session, she writes an observational note about the experience including what food (if any) was eaten or explored by the child, behaviours displayed surrounding food, and parental involvement. The occupational therapist then reviews the note and makes recommendations for further treatment. During the treatment period, the occupational therapist may also run sessions with client and family; therapists' clinical notes are written as per usual and then forwarded to the OTA for review so that she is aware of the progress made and any new observations.

Training

The current OTA at STA has worked in this role for approximately three years. She has attended the Sequential Oral Sensory (SOS) Approach to Feeding workshop (Toomey, 2012), which gave her the basic knowledge and techniques necessary for understanding how to run a food group and individual food sessions. It should be noted that at STA, this program is not used exclusively nor exactly as originally designed. The OTA is an active member of the food exposure committee, which allows her the opportunity to work with other disciplines and develop an understanding of an interdisciplinary approach to food exposure. Additionally, she has received education on desensitization and play-based learning from the occupational therapy team.

Supervision

Both direct and indirect supervision are used when the OTA is providing intervention for increasing food acceptance. When providing food intervention programming, the OTA follows the direction of the occupational therapist, as required by the Alberta College of Occupational Therapists (ACOT; 2005). The occupational therapists develop a food plan in conjunction with the OTA to ensure that the food used in exposure sessions meets the needs of the family's goals and is safe for the child to attempt to consume based on assessed oral motor skills as well as developmental and cognitive levels. The occupational therapist and OTA meet to establish a plan of when the OTA will go to the family home, what food will be targeted and the session's goals (such as working on tolerance of new food nearby or acceptance of a new food in the mouth). The occupational therapist and OTA also brainstorm together some of the challenges that may occur (e.g., refusal of all food items, occurrence of maladaptive behaviours, etc.) and discuss specific strategies to be used. The therapist will demonstrate or explain these strategies so that the OTA is then able to demonstrate or explain to the parents. This process is approached in a collaborative manner and is part of the direct supervision process. To ensure the quality of the OTA's work (ACOT, 2005), occupational therapists may be present during OTA-led sessions.

Indirect supervision involves the occupational therapist reviewing observational notes written by the OTA after a session, whether an occupational therapist had been present or not. As sessions most often occur in the home with parents, the OTA may be asked questions about strategies, next steps or different approaches. The OTA forwards these questions to the occupational therapist and encourages the parents to contact the therapist so that their questions can be addressed. The OTA may also encounter parental questions regarding strategies or approaches that are outside an occupational therapist's scope of practice. She will forward these questions to the appropriate interdisciplinary team member to be addressed.

Conclusion

Helping a child with ASD develop food acceptance is a long-term process, requiring collaboration involving the parents, the occupational therapist and the OTA. Having the OTA help provide food exposure is crucial to the success of the intervention, as there is not enough time for the occupational therapist to work in depth on the food issues that a client may have.

STA is fortunate to have an OTA who has had food acceptance training. As a team, the occupational therapy department has developed an effective process to ensure OTA implementation of individualized food acceptance programs is supervised and supported while meeting the needs of the clients and families served.

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About the author

Arwen Caines, OT, graduated from McMaster University in 2011. Following graduation, Arwen started work at the Society for Treatment of Autism, where she works with preschoolers, kindergarteners and adolescents. She can be reached at: cainesa@sta-ab.com

Occupational therapist assistants: Enabling well-being in community power mobility users

Heather Gillespie and Lisa Engel

A power mobility device, such as a power wheelchair or scooter, is often the primary means of basic mobility for a person with a mobility impairment and can be vital to quality of life (Creel, Matthews, Adler, & Monahan, 2013; Dawson, Chan, & Kaiserman, 1994). A new user of power mobility in the community needs to learn driving skills and be aware of safety recommendations to ensure safe and confident operation of the power device. This type of education is often a component of an occupational therapy intervention plan (Dawson et al., 1994). Limitations in funding for occupational therapist positions have created opportunities for the involvement of occupational therapist assistants (OTAs) in power mobility training. OTAs can provide skill training and education as well as promote client confidence under the direction and supervision of the client's occupational therapist (College of Occupational Therapists of British Columbia, 2011). While there is some literature about the involvement of OTAs in occupational therapy services (Lizarondo, Kumar, Hyde, & Skidmore, 2010), there is little published about OTA involvement in a power mobility training program. This article aims to describe the involvement of an OTA in a community rehabilitation power mobility training program in Nanaimo, British Columbia.

Background and rationale

Since 2010, two full-time equivalent therapist assistant positions have been funded within Nanaimo's community home care program, providing service to a city of approximately 87,000 residents. The positions, funded through Island Health, are shared between occupational therapy and physiotherapy. Power mobility training is one intervention assigned by the occupational therapist to the OTA.

The power mobility training program arose as a result of decreased occupational therapist availability secondary to funding constraints and increasing caseload demands. The goal of the program was to ensure safe and confident operation of power mobility devices for clients new to power mobility driving. In the community, we have observed a high demand for power mobility because many members of the aging population are experiencing limitations in mobility and challenges in driving motor vehicles.

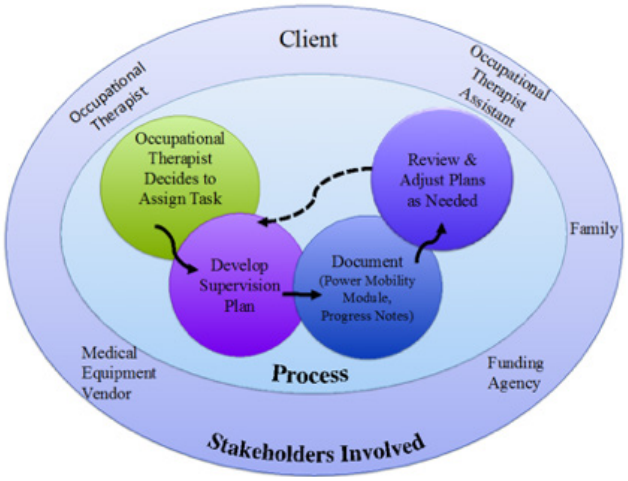

Figure 1. **Power Mobility Training Program Practice Framework (adapted from the Canadian Practice Process Framework [Polatajko, Craik, Davis & Townsend, 2007]).**

Program practice process

A program practice process framework is used to ensure client treatment needs are being met (see Figure 1). Multiple stakeholders are involved in the process to ensure successful outcomes.

Following the occupational therapy assessment and agreement with the client that a power mobility trial will be included in the treatment plan, the occupational therapist decides whether or not to assign safety and driver training to an OTA. The decision-making process is based on risk factors that include the client's status, the environment, the intervention and the competence of the OTA. Based on the degree of risk, the occupational therapist decides whether or not to assign the task of power mobility training to the OTA. If it is assigned and the client gives consent, the occupational therapist develops and documents a supervision plan, which includes 1) the identity of the OTA involved in the assignment, 2) the expected frequency of the intervention, 3) the method and frequency of reporting to the occupational therapist and 4) whether the intervention can occur if the occupational therapist is on a planned or unplanned absence from work.

Documentation by the OTA includes completion of the "Power Mobility Module," adapted from the *Power-Mobility Community Driving Assessment* (*PCDA*; Letts, Dawson, Masters, & Robbins, 2003). This module is an objective record of the client's general driving skills, appropriate use of wheelchair accessories, knowledge of "rules of the road" and predicted decision-making ability in emergency situations. In addition, the OTA documents each client visit in the health record. The occupational therapist regularly reviews the OTA's documentation to determine if the intervention plan should continue as previously assigned or if any alterations to the supervision plan need to be made to achieve the desired outcomes.

The client is the key stakeholder within the program practice process and may also have family members involved to assist in guiding him or her through the process. Other involved stakeholders include the selected medical equipment vendor and possibly an external funding agency, based on the client's eligibility. Funding agencies may include a provincial ministry or department, Veterans Affairs Canada or an extended health benefit plan. The funders have their own policies and processes that the occupational therapist must follow when completing a funding request, and these would be included in the practice process. Based on the success of the power mobility training program, including the client's demonstration of safe and independent operation of the trial power mobility device and the client's reported feelings of confidence and comfort, the occupational therapist recommends a power mobility option and applicable funding for the device.

Benefits

Since the inception of the power mobility training program, many clients have achieved safe driving skills and increased their knowledge of safe power mobility driving. Other benefits have also been observed. First, the program has fostered a collaborative relationship between the occupational therapists and the OTA, combining their skills and knowledge to enhance service delivery (Glantz & Richman, 1997). Although the occupational therapist is responsible for the intervention, the OTA in this program has developed skills and knowledge required for power mobility training through experiences with other occupational therapists and clients within the home care program. The OTA has become vital to the learning experience of current clients.

Second, clients are now given individualized attention that would not be available in the occupational therapist's schedule and caseload. The client has the opportunity to problem solve barriers associated with community access with an experienced paraprofessional. The OTA is involved in this type of intervention on a regular basis, resulting in an increased familiarity with the community and expertise in offering these specialized services. The OTA can often provide individualized suggestions to the client, such as those relating to route choices, navigation through certain areas (e.g., parking lots) and access to public transit. Further, there may be a decreased perceived authority differential between the client and the OTA compared to the client and the occupational therapist, and this can foster a good therapeutic relationship.

Third, recommendations for power mobility purchases are based on evidence from the client's practice with the requested power mobility device. Individualized training and practice provide objective evidence to external funding agencies of the appropriateness and benefits of the device for the client.

Challenges

There have also been challenges to the ongoing success of this program. As in many programs across Canada, the therapist assistant positions are susceptible to funding changes and this program would be unable to operate without an OTA. Currently, OTA availability can be limited, as the therapist assistant positions are shared between occupational therapy and physiotherapy. This can create scheduling difficulties involving the client, the OTA and the medical equipment vendor who is providing the trial power mobility device.

The client's home environment and infrastructure within the city can pose significant challenges, which at times have limited the opportunities for the client to practice using power mobility safely. Discussions of accessibility concerns with city officials have resulted in some positive structural changes.

The weather can impact scheduling of outdoor power mobility practice, particularly during the winter months, resulting in an extended time period before the appropriate recommendation for purchase can be made.

Case examples

"Mary" lives with her husband in a downtown apartment. She experiences mobility limitations and severe anxiety. She has agreed to trial a power wheelchair as her ambulation has become more impaired. The OTA was able to assist her to learn how to access local stores, businesses and public transit using a power wheelchair. The client commented, "I resisted having to use a power wheelchair, but with the assistant's help, I now feel safe driving the wheelchair."

"Fred" lives alone in a condo located in a high volume traffic area. At the age of 91, he requested power mobility to promote his independence in instrumental activities of daily living, such

About the authors

Heather Gillespie is an occupational therapist in Home and Community Care with Island Health in Nanaimo, British Columbia. She is also an instructor with the Therapist Assistant Distributed Learning Program at Medicine Hat College in Medicine Hat, Alberta. She can be contacted at: heather.gillespie@viha.ca

Lisa Engel is currently pursuing her PhD at the University of Toronto and the Rotman Research Institute, part of Baycrest Health Sciences, in Toronto, Ontario, focusing on the areas of rehabilitation, brain injury, instrumental activities of daily living and cognitive neuroscience. Prior to commencing her doctoral studies, Lisa worked as an occupational therapist at Nanaimo Regional General Hospital in various areas of practice. She can be contacted at: lisa.engel@mail.utoronto.ca.

as shopping and banking at the local mall. Observation of his power mobility operation initially inspired concern, as he was unaware of possible risks and easily distracted, requiring frequent cueing. Following repeated practice with the OTA, his performance improved dramatically, resulting in safe and confident operation of the power wheelchair.

Future steps and conclusion

Since the involvement of an OTA in the community rehabilitation power mobility training program, client outcomes have been positive. Clients have reported increased self-confidence in power mobility use, and the occupational therapist and OTA have observed increased safe driving skills in clients who have completed the training program. This provides preliminary evidence for the effectiveness of the program, which helps with advocacy for OTA funding.

Collaboration with a researcher is needed to further validate the use of OTAs in a power mobility training program. Using both qualitative and quantitative methods to evaluate the effectiveness of the program, research could include cost analysis, outcome measures and consideration of the clients' perspectives. As the OTA positions are vulnerable to funding changes, it is vital that the program be able to show evidence of effectiveness in order for its organizers to advocate for continued funding. The ongoing availability of this program is essential for clients' continued access to a valuable resource that supports safety and mobility.

The success of a power mobility training program, such as the one described in this article, can be ensured by the presence of a collaborative relationship between the occupational therapist and the OTA, use of a practice process that is transparent to all involved, and ongoing and open communication with all stakeholders.

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Occupational therapist assistants in occupational therapy: An update on the Occupational Therapist Assistant and Physiotherapist Assistant Education Accreditation Program

Kathy Davidson

The Occupational Therapist Assistant and Physiotherapist Assistant Education Accreditation Program (OTA & PTA EAP) is responsible for the accreditation of Canadian occupational therapist assistant (OTA) and physiotherapist assistant (PTA) education programs. Its early development was described in the March/April 2012 issue of *Occupational Therapy Now* (Burnett, 2012). Now, over five years from its inception, the program continues to grow and evolve. It has been exciting to see the impact accreditation is having on stakeholders and on the disciplines of occupational therapy and physiotherapy themselves.

Program overview

Education accreditation involves several steps, and includes submission of a Self Study Report by the education program and completion of both an off-site review of the report and an on-site review of the program by a team of four peers. The program is expected to provide evidence to demonstrate compliance with the established accreditation standards and criteria (OTA & PTA EAP, 2012). This evidence is triangulated and confirmed by the peer reviewers through on-site interviews with a variety of stakeholder groups (e.g., students, graduates, employers, preceptors), as well as with faculty, staff and administrators. The interviews are conducted in a non-threatening manner that fosters collaboration, and the peer reviewers seek consistency in the responses received from the various interviewees. The ultimate goals of accreditation are the assurance of quality education for current and potential students and the assurance of competent graduates for employers and the public. In the absence of regulation for these professionals, an accreditation award for their education programs acts as a measure of quality and competence.

Program evolution

The accreditation program was launched in 2009 with the appointment of a program manager and subsequent development of accreditation standards and accreditation policies. Two education programs agreed to pilot the standards and the review process, and these pilot reviews were completed in early 2012. The standards and policies were modified based on evaluative feedback from the pilot process and the current accreditation standards were published in November 2012 (OTA & PTA EAP, 2012). At that time, there were 19 education programs committed to the accreditation process – two with accreditation status and 17 with candidacy status awaiting a full accreditation review.

As of December 2014, there were 10 accredited programs and 22 with candidacy status (see the list of programs at: www.otapta.ca). Geographically, these programs span the country from British Columbia (4) through Alberta (4), Ontario (20), Nova Scotia (3) and Newfoundland and Labrador (1). Three programs are francophone; all programs except one are designed to graduate dual-trained OTA/PTAs. Eleven programs are situated in private institutions and 20 are publicly funded. As of December 2013, the total number of students enrolled in programs with either accreditation status or candidacy status was 1419.

The OTA & PTA EAP receives inquiries each week from potential students who seek clarification about the accreditation program and the value of attending a program with accreditation status or candidacy status. As of December 2014, the OTA & PTA EAP had heard from at least five additional education programs preparing submissions for candidacy status in the next six months. Should these programs be successful in receiving candidacy status, the total number of programs committed to the accreditation process will rise to 37. This is an increase of over 90% since early 2012 when the pilot reviews were conducted.

Governance

The OTA & PTA EAP is administered by Physiotherapy Education Accreditation Canada (PEAC), the organization that accredits physiotherapy programs; however, the OTA & PTA EAP is jointly governed by PEAC and the Canadian Association of Occupational Therapists (CAOT). The Joint Accreditation Committee (JAC) is a standing committee of both the PEAC and CAOT Boards of Directors. The JAC has representation from PEAC, CAOT, the Canadian Occupational Therapist Assistant & Physiotherapist Assistant Educators Council (COPEC) and from the public. The committee's roles are to:

Members of the OTA & PTA EAP Joint Accreditation Committee at a 2014 meeting in Victoria, British Columbia.

- Review applications and award candidacy status to education programs demonstrating compliance.
- Review accreditation reports and make accreditation award recommendations.
- Review accreditation standards and make recommendations for revisions.
- Review policies and procedures related to the OTA & PTA EAP and make recommendations for revisions.
- Present accreditation award recommendations, standards revisions, and policy and procedure revisions to the Boards of Directors of PEAC and CAOT for review and approval.

When presented with recommendations from the JAC at their regular board meetings, PEAC and CAOT are responsible for awarding accreditation status and approving new and revised documents.

A Governance Advisory Committee consisting of representatives from CAOT (president, executive director and staff liaison), PEAC (president and executive director) and the OTA & PTA EAP (chair of the JAC and program manager) meet once annually to broadly oversee any governance issues that may arise throughout the year.

As the program continues to evolve, input and feedback are sought from the education programs involved in the accreditation process and from COPEC. An annual education session is offered face-to-face and free of charge to education programs interested in information about the OTA & PTA EAP. Programs at any stage of the accreditation process are invited to attend.

Impact of accreditation

Since the inception of the OTA & PTA EAP, there have been two significant shifts in the OTA/PTA practice environment, which demonstrate an awareness of the value of accreditation by key stakeholders in the profession:

- Since April 2013, the Vancouver Coastal Health Authority (VCH) only accepts OTA/PTA students from education programs with accreditation or candidacy status for fieldwork placements.
- As of 2011, the Board of Directors of the Canadian Physiotherapy Association includes one member who is a PTA.

Current challenges

Fieldwork placements

Education programs are required to provide their students with 500 fieldwork placement hours (OTA & PTA EAP, 2012, criterion 3.4) in order to receive candidacy status and later to be awarded accreditation status. Specifically, 150 of those hours must be OTA-specific fieldwork hours, 150 must be PTA-specific fieldwork hours and the remaining 200 hours can be in either discipline or in combined OTA/PTA contexts. Fieldwork placements are challenging for education programs to acquire, not only in OTA/PTA education, but in many other health-care education programs, such as occupational therapy and physiotherapy. Education programs report that OTA fieldwork placements are especially difficult to secure in comparison to PTA placements, in part because of the frequently consultative nature of occupational therapy practice and in part because, nationally, there are fewer practising occupational therapists than physiotherapists. This discrepancy limits the OTA placement opportunities and can put the accreditation status of an education program at risk despite its ability to demonstrate a high-quality educational experience and curriculum. Fieldwork placement coordinators would be happy to hear from any occupational therapists willing to supervise OTA students (contact information for education programs is available at www.otapta.ca).

Resources

Volunteers: Each accreditation review requires a team of four volunteer peer reviewers. With the accreditation schedule set at between six and nine reviews per year by 2017, the program will need to recruit, train and appoint up to 36 volunteers a year to accreditation Peer Review Teams. The eight volunteer Joint Accreditation Committee (JAC) members participate in two two-day meetings face-to-face each year. As the number of reviews per year increases, it is likely that these volunteers will either have to lengthen each meeting or add one more face-to-face meeting to the annual schedule.

Staff: With the quick evolution of the accreditation program, it has been challenging to keep up with human resource needs. Currently, the program is run by the program manager (15 hours per week) and an administrative assistant (10 hours per week). The hours allocated to these positions will increase significantly in the coming two years in order to ensure that the needs of the program are met.

Accreditation resources: The accreditation program has developed information, templates and examples of the various reports required from programs through the accreditation process. Because most of the faculty members of these programs have never experienced accreditation either as recipients or as peer reviewers, there is an ongoing need to provide guidance and training for everyone involved. With limited human resources this has been a challenge, but the repository of information is growing slowly. Staff are also always available to answer questions by email or phone in a timely way. It is a priority of the program to be sure that necessary information is easily available to those who need it.

Summary

The OTA & PTA EAP has filled a need in the context of OTA/PTA education in response to education programs seeking a measure of quality. It is a constantly growing and evolving program, which poses challenges given the rate of change, but it also demonstrates clear successes as increasingly more programs are awarded accreditation status.

To learn more about the OTA & PTA EAP, go to: www.otapta.ca. For additional information, to apply to the program accreditation process or to submit an application to be a Peer Review Team member, please contact Kathy Davidson, program manager, at: kathy.davidson@otapta.ca

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Occupational therapists as practice managers, assistants as primary providers of therapeutic interventions: It's time to talk

Melanie Blake, Debbie Park and Lisa Brice-Leddy

With health-care spending in Ontario increasing at a rate that cannot be sustained, hospitals are looking to innovative care models to reduce spending while responding to patient care needs (Ontario Ministry of Finance, 2012). One strategy to meet these changing health-care needs in acute care settings is the use of support personnel, such as occupational therapist assistants and physiotherapist assistants (OTA/PTAs), to provide patient care without further stressing hospital budgets (Loomis et al., 1997). A systematic review by Lizarondo, Kumar, Hyde and Skidmore (2010) highlights the benefits of introducing support personnel for both process and service outcomes. Benefits include increased patient satisfaction, increased intensity of clinical care, more free time for allied health professionals to focus on complex tasks and improved clinical outcomes. While the use of OTA/PTAs appears promising, it is important to consider areas of concern, such as clarity of the OTA/PTA role, training and supervision requirements and protectionism of allied health professions (Lizarondo et al., 2010). This article describes how a group of occupational therapists adapted to a new model of care in an acute care medicine environment wherein the OTA/PTAs are the main providers of therapy.

Changes in the interest of patient care

In the fall of 2011 our large community teaching hospital engaged in an innovative practice change. This included an enhancement of the OTA/PTA role to support early patient mobilization and engagement in functional activities. A seven day per week therapy service was implemented whereby occupational therapy and physiotherapy interventions are provided almost exclusively by the OTA/PTA. The role of the occupational therapist transitioned to patient assessment, treatment planning and discharge planning, a different way of managing occupational therapy services.

An environmental scan and comprehensive literature search found no evidence of this level of service provided by OTA/PTAs in other acute care settings. Relying on resources and guidance from the College of Occupational Therapists of Ontario (COTO), our preparation activities included establishing the competency of OTA/PTAs, developing assignment processes and clearly defining scopes of practice.

Establishing baseline competency

In the new model of care, all assistants are required to be competent in both occupational therapy and physiotherapy aspects of the OTA/PTA role. Establishing a baseline competency was essential as occupational therapists are now assigning to five rotating OTA/PTAs on each unit and it is not unusual for one therapist to cover more than one unit. We recognized that our current OTA/PTA staff had varying levels of experience in the OTA role.

A learning needs assessment (LNA) was developed based on the *Practice Profile for Support Personnel in Occupational Therapy* (Canadian Association of Occupational Therapists [CAOT], 2009) and the *Competency Profile, Essential Competencies for Physiotherapist Support Workers in Canada* (Canadian Alliance of Physiotherapy Regulators and Canadian Physiotherapy Association, 2002). The LNA was then circulated to all staff. A response rate of 100% was a hearty indication that the OTA/PTAs were eager to address their learning needs.

Occupational therapists were integrated into the LNA process and quick to foster an environment of increased clinical learning and training on the units. As this process evolved they were able to confirm OTA/PTA competencies were attained and grew more confident in the skills of their new OTA/PTA team members. Concurrently, a partnership was struck with a local college that developed and provided a truncated, four-day upgrade course based on the collated results of the LNA. Behavioural observations, seating and positioning, and activities of daily living retraining skills were three areas of focus.

Additionally, the LNA identified several PTAs who were not formally educated in the OTA role. Several PTAs participated in an online course for single stream education in order to achieve dual OTA/PTA status. The occupational therapy professional practice leader provided support in both clinical learning and the coordination of clinically relevant placements within the organization to complete the requirements of the program.

The assignment process

To facilitate the process of assigning, maintain the standards of COTO and meet the communication needs of the triad of occupational therapist, OTA/PTA and physiotherapist, assignment documents and flow sheets were created. These documents were customized for different patient populations, practice environments and communication requirements

of allied health teams. A second communication tool is daily occupational therapist, OTA/PTA and physiotherapist huddles where information is exchanged, caseloads prioritized and assignments clarified.

Role clarity

The increased presence of the OTA/PTAs caused concern for the occupational therapists regarding job security and potential for erosion of their role. The OTA/PTA is now the more accessible therapy resource to the team and patient. It became important to ensure all team members understand that OTA/PTAs are unregulated support personnel and that occupational therapists maintain responsibility for the delivery of occupational therapy interventions.

A document was created outlining the roles and responsibilities of the OTA/PTA and what is not within their scope of practice. The document is posted on each unit and provided to the occupational therapists and OTA/PTAs as a resource to educate others on the team with respect to what they are and are not qualified to do. This document has been particularly useful in addressing questions OTA/PTAs are asked regarding patient readiness for discharge and functional transfers.

Implications

OTA/PTAs are encouraged to work to their full scope of practice. Working with acutely ill patients necessitates OTA/PTAs have detailed knowledge of the patient population, and specifically, an awareness of their patient's current status and response to intervention. Part of the OTA/PTA role now includes making the decision of when to proceed with treatment and when not to. This often means reviewing the patient chart and making specific inquiries of the primary nurse. These activities were previously done by the occupational therapist. Is this contributing to the confusion between the occupational therapist and the OTA/PTA for the patient and the rest of the health-care team? Is there potential for erosion of the occupational therapist role?

Occupational therapists have moved into a consultant role with regard to patient care. Through OTA/PTA assignments, more therapy is provided and occupational therapists are able to progress the patient's care plan. OTA/PTAs provide up-to-date clinical observations and often attend team rounds on the occupational therapist's behalf. Occupational therapists are often not in frequent direct clinical contact with the patient and make clinical judgments on the basis of the observations of others. This requires a certain amount of clinical expertise, trust and experience. Is this something that entry-level occupational therapists are prepared for? What are the skills required to manage care with less direct patient interaction?

The occupational therapist role has evolved from managing their individual practice to managing occupational therapy services on their units. Within the clinical competency of practice manager they must now assess and monitor the clinical practice of multiple OTA/PTAs, in addition to their own. They must ensure an accurate representation of the occupational therapy clinical assessment, critical thinking, intervention goals and planning are communicated to the patient, their family and the rest of the health-care team. They must gather accurate patient information, develop and progress their treatment plan and make discharge arrangements, often at some distance from the patient. A new level of skilled communication and collaboration is required by the occupational therapist.

In the context of the *Profile of Practice of Occupational Therapists in Canada* (CAOT, 2012), this represents an increase in the occupational therapist's roles as practice manager, communicator and collaborator. Is this skill set sufficiently developed in entry-level occupational therapists? What could this mean for future graduates?

Perspectives of those working in this model

Some of the questions posed in this article surfaced from a qualitative inquiry into the roles in the new model of care. The first phase involved interviewing OTA/PTAs and occupational therapists in order to develop a description of each team member's roles. This description serves as a platform to develop a better understanding of the competencies required for the roles. Understanding competencies will help us create job descriptions and identify essential qualities for new staff. Interestingly, our research participants identified the importance of communication, trust and the ongoing need for role clarity to practice in their new roles.

While our research inquiry was not done to evaluate the value of this change in model of care, the participants felt strongly that patients are being seen more frequently and benefitting from the enhanced services of OTA/PTAs. As we move forward in an environment of economic uncertainty, we are all beginning to understand the need to explore new ways of providing safe and quality care. What remains clear is that both OTA/PTAs and occupational therapists are fully committed to providing the best patient care possible, and working together to build a model where this can happen.

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About the authors

Melanie Blake, OT Reg. (Ont.), is the professional practice leader (PPL) for occupational therapy, **Debbie Park, PT Reg., BScPT,** is the PPL for physiotherapy and **Lisa Brice-Leddy, PT Reg., MSc(RS),** is the educator for allied health at Mississauga Hospital, Trillium Health Partners. Melanie can be contacted at: melanie.blake@trilliumhealthpartners.ca

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Editor's note

The authors pose thought-provoking questions about the implications of their service delivery model. How would you respond to these? Send your thoughts on this and any other article you read to: otnow@caot.ca

Occupational therapist assistants: Snapshots of innovative practice

Innovation in the education of mental health professionals

About the authors: Cassie Prochnau, MScOT, program chair and associate professor, MacEwan University; Robin Mazumder, MScOT, instructor, MacEwan University. prochnauc@macewan.ca

With an increase in the incidence of mental illness (World Health Organization, 2001), recruitment and retention of mental health professionals is essential. Post-secondary educators are faced with dispelling the ambiguity of the mental health role and alleviating anxiety in an attempt to prepare future mental health professionals (Hercelinskyj, Cruickshank, Brown, & Phillips, 2014). Educational labs provide safe environments for students to practice reflecting on their abilities, sharing experiences and engaging in peer learning. Experiential learning through the use of standardized clients can promote increased confidence and decreased anxiety for students (Doolen, Giddings, Johnson, de Nathan, & O Badia, 2014). As noted by Craik and Austin (2000), positive experiences are vital to successful recruitment and retention of mental health occupational therapists.

The Therapist Assistant Program at MacEwan University is using standardized clients to prepare students to work in mental health settings. We hope that as students have the opportunity to reflect on their comfort in working in mental health, they will be open to the possibility of working in this field.

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Communication: From low tech to high tech

About the authors: Cory Feenstra, occupational therapist assistant, The Ottawa Hospital; Nicole Grouchy, OT Reg. (Ont.), The Ottawa Hospital. cfeenstra@toh.on.ca

Occupational therapists and occupational therapist assistants in acute care need to have great communication skills. Working in a large facility poses barriers to communicating as assistants and therapists are spread throughout the hospital. Some of us remember the day of pagers or still use them - dial the number and leave a number to call back. This takes time. Several staff members at The Ottawa Hospital now have the privilege of "going high tech" with the use of iPads. iMessaging on the iPad is an easy way for users to send texts, documents, photos, videos and group messages. This has facilitated easy communication between therapist and assistant in real time, for example, to plan when and where to meet to see a patient and bring necessary equipment. We have also used FaceTime, a video conferencing application, to solve a problem quickly, for example, to show a wheelchair and consult on which lap tray it would require. This has made communicating easy and timely, and helps assistants to only make one trip with the right supplies.

Another benefit of the iPad has been the use of a spreadsheet on Google Docs as a tool to request occupational therapy equipment for patients. Patient privacy is kept by using only the patient's medical record number. Therapists enter their requests into the iPad while on the inpatient unit and the assistant can view them from the workshop computer. The therapist can use the tool to track the status of requests and ask for assistance with wheelchair transfers. The tool is time saving for therapists, requires assistants to be accountable for the tasks assigned to them and helps track equipment inventory within the occupational therapy department.

All in a day's work: Occupational therapist assistants in urban acute care

Kristin Broadhead, Tyrone Gordon, Jeena Parmar and Diana Seko-Challenger

The following is a descriptive account of a day in the life of an occupational therapist assistant (OTA) in an urban acute care hospital. It illustrates the various patient populations and some of the many roles and responsibilities of the OTA in this setting through fictitious scenarios that reflect real everyday situations that OTAs in urban acute care often encounter.

In the groove…8:30 a.m. I check my email where I am reminded of our Occupational Therapy Council meeting tomorrow. One of the items on the agenda reads, "OTAs to sign up for their student fieldwork placement." I really enjoy being a part of a teaching hospital.

I log into the electronic documentation system to gather information to prepare for the day ahead. I look for new referrals and check the status of the patients that I've been seeing for any significant changes and to see if any of them have been discharged from the hospital over the weekend. The occupational therapists arrive back from rounds with the health-care team and we go over our new patients and those that I will see for the day.

And so it begins…9:00 a.m. Every day is a new adventure. Two of my patients are leaving today. They had occupational therapy equipment assigned to them, so I pick it up, clean it and update our inventory. I briefly stop in to follow up with a 19-year-old patient with a traumatic spinal cord injury. On Friday, I had set up a call bell with an adapted switch for him and had him practice using it to call the nurse. Today I verify that he was able to continue to activate it over the weekend.

Never a dull moment…9:20 a.m. It is another busy day so I prioritize my caseload. My first patient is Mr. S., who has a new below knee amputation. He was assessed by the occupational therapist and is now ready for a wheelchair, which I will assist in setting up for proper positioning. Prior to seeing the patient, I review the chart and consult with the nurse on his status. I then provide him with the wheelchair and education on its safe use. As this is Mr. S.'s first time in the wheelchair, the occupational therapist joins me to teach him how to transfer in and out of the wheelchair. We begin to work on activities of daily living – grooming, dressing and toileting. While preparing for these tasks, I see in the corner of my eye that Mr. M., another one of my patients, has forgotten something… his clothes. I help Mr. M. get a robe before returning to Mr. S. who now has become tangled in his clothes. We both chuckle and start again one step at a time.

After speaking with Mr. M.'s nurse about the recent events, I visit my next patient, Mrs. H. She has been admitted due to "failure to cope at home" and has been recently diagnosed with dementia. Together we update her memory book, allowing her to keep track of her daily visitors and activities. I bring in a calendar to assist her with orientation. When she becomes emotional, I stop the session and provide some active listening.

Hip hop into action…11:15 a.m. Mr. T., my next patient, was assigned to me by the occupational therapist for education after his hip surgery. Prior to commencing, I explain that I am here to help him practice lower body dressing techniques with assistive devices. Next, we move on to safe transfer techniques for his bathtub and car.

Calling all disciplines…1:30 p.m. The team has asked me to attend Mr. O.'s family meeting. I have worked with this patient for a month now while providing education to his family about their loved one's functional abilities, and how they can assist him safely. At the end of the meeting, as Mr. O. and his family thank us for sharing our information, I am reminded of how important the holistic approach is when providing the best care for the patient.

The rest of the day goes without difficulty, and I am able to see two more patients.

As the day winds down…4:00 p.m. I ensure that the therapists are aware of any changes in patient status before coming back to the office. I complete my daily charting and take some time to reflect on the day, feeling lucky to work at a hospital that allows me to use my skills in a way that is rewarding and patient centred. All in a day's work!

About the authors

This article is a collaboration of three OTAs **(Kristin, Tyrone and Diana)** and one OTA/PTA **(Jeena)** who work at St. Michael's Hospital in Toronto. The authors can be contacted at: challengerd@smh.ca

Involvement of support personnel in occupational therapy home care services in Québec: Methods that comply with regulations and support prevention and health promotion

Annie Carrier and Mélanie Levasseur

Ensuring home care for people with disabilities is a priority for policymakers and for all Canadians. Occupational therapists play a key role in that endeavour by promoting the health and well-being of their clients through engagement in meaningful occupations. However, the occupational therapy resources available are insufficient to meet the health promotion and prevention (HPP) needs of clients living at home. One solution to help bridge the gap between needs and resources is to use support personnel, that is, personnel who are not qualified occupational therapists but assist in the delivery of occupational therapy services (Canadian Association of Occupational Therapists [CAOT], 2009). In Québec, health and social service aids (HSSAs) – support personnel who are not members of a regulatory board – are often called upon to carry out assessments of functional independence in self-care (Guay, Dubois, Desrosiers, Robitaille, & Charest, 2010). This practice has caused some controversy, however, and questions have been raised as to whether support personnel should be involved in the assessment process (Guay, 2012). The purpose of this article is not to address this controversy, but to explore alternate ways of engaging support personnel in the delivery of home care occupational therapy services and, more specifically, in HPP activities.

Responsibilities in the Québec health-care system and the role of occupational therapists in the community

In Québec, the 94 Health and Social Services Centres' (HSSCs) mandate includes HPP (Carrier, Levasseur, & Mullins, 2010). Home care occupational therapists may deliver several HPP activities (see Table 1). By promoting health through engagement in meaningful occupations and preventing the loss of functional independence, occupational therapists' interventions contribute directly to the mission of the HSSC, and are in line with CAOT guidelines (Townsend & Polatajko, 2013). Occupational therapists can use support personnel to assist with these interventions.

Involvement of support personnel

A broad array of occupational therapy activities can be assigned to support personnel. However, an assessment of functional independence carried out pursuant to a statute (e.g., assessment of clients injured in industrial or traffic accidents) is a reserved activity in Québec (Professional Code, 1973, last revised in 2014, section 37.2) and only designated professionals may perform it. CAOT and OEQ have issued guidelines regarding involvement of support personnel in occupational therapy activities.

According to CAOT guidelines (2009), support personnel

Table 1

Prevention and health promotion activities carried out by occupational therapists in the community and possible involvement of support personnel

Health promotion and prevention activities of occupational therapists*	Possible involvement of support personnel
Promotion	
Recommendations relating to: • meaningful occupations • healthy diet • regular physical exercise • healthy lifestyle	• Support in maintaining occupations and a healthy lifestyle • Support in carrying out meaningful activities (e.g., social engagement)
Prevention	
Recommendations relating to: • environmental modifications (e.g., prevention of falls) • methods of preventing injuries (e.g., transfers, mobility and engaging in activities of daily living) • strategies to prevent injuries in caregivers while moving persons with reduced mobility • positioning strategies for individuals at risk of developing pressure ulcers or contractures • strategies for protecting joints and preventing joint pain • strategies for saving energy and preventing excessive fatigue • assistive devices and training in their use to improve the independence of people with disabilities • customized exercise programs to promote the maintenance of a person's functional status • stimulation programs for people with cognitive impairment to promote the maintenance of their functional status	• Follow-up on environmental modifications • Consolidation of training in: o use of equipment o transfer methods and mobility o principles of joint protection, energy conservation, etc. • Support for physical exercise programs • Assistance with cognitive stimulation using customized activities

*Adapted from Filiatrault and Richard, 2005.

must complement, not replace, occupational therapists. Certain activities (e.g., initial assessment, interpretation of assessment results) must not be assigned to support personnel and supervision from occupational therapists is required.

In Québec, the OEQ guidelines (2005; 2008) reiterate that support personnel should not replace occupational therapists. Some activities cannot be assigned to support personnel (e.g., identifying relevant information for assessment and interpreting or analyzing assessment results). Unlike CAOT guidelines (2009), assessment can be assigned. However, occupational therapists must exercise the appropriate level of supervision for the assigned activity.

As indicated above, home care personnel who are not occupational therapists and who have been trained on the job are involved in assessing clients' self-care independence in Québec (OEQ, 2005), a practice engaged in by 57% of HSSCs (Guay et al., 2010). The vast majority of such personnel (82%) are HSSAs who are not members of a regulatory organization. As part of their 975 hours of training at the high school level, HSSAs develop skills in providing care to clients with a range of pathologies (Inforoute de la formation professionnelle et technique, n.d.). Their training includes aspects that can support occupational therapy interventions for HPP, such as establishing a caregiving relationship, working with clients to assist with occupations, providing housekeeping assistance, and adapting interventions to the individual's family and social situation. At a time when government policy is geared towards using HPP activities to improve public health and reduce health-care expenditures, and in order to support the delivery of home care occupational therapy services for HPP, there is a need to explore new ways of involving HSSAs.

New avenues to explore

Under the regulatory guidelines outlined above, the involvement of support personnel in home care must be overseen by occupational therapists and must be restricted to activities that can be supervised on an occasional basis and from a distance. Table 1 contains a non-exhaustive list of activities that can be delegated to home care HSSAs to support occupational therapists' HPP goals. To free up time for occupational therapists, administrative activities can also be carried out by HSSAs or assistants. For example, to assist with equipment, HSSAs could do the legwork involved in receiving quotes, preparing equipment requests, and delivering and installing equipment in the client's home. Assistants could manage the stock of equipment, transcribe voice recordings of assessment reports and notes for client files, or do statistical data entry on clinical activities.

Conclusion

Occupational therapists play a crucial role in delivering home care and HPP activities, which are key governmental and social priorities. In Québec, the shortfall between the demand for occupational therapy services and the resources available to meet that demand have led to assessment activities being assigned to support personnel, a practice that has sparked controversy. In light of this controversy and considering the importance of HPP activities, there is a need to consider alternate ways of engaging support personnel to support the work of home care occupational therapists. Seizing this opportunity to find innovative solutions will further enhance best occupational therapy practice.

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About the authors

Annie Carrier, MSc, LLM, BA(Psy), OT(C), is a PhD candidate in clinical sciences in the Faculty of Medicine and Health Sciences of the Université de Sherbrooke and the Research Centre on Aging, and a lecturer in the School of Rehabilitation, Université de Sherbrooke. She can be reached at: Annie.Carrier@USherbrooke.ca

Mélanie Levasseur, PhD, OT(C), is a researcher at the Research Centre on Aging, Sherbrooke, and an associate professor in the School of Rehabilitation, Université de Sherbrooke.

On the road together: Community occupational therapists and occupational therapist assistants working to provide the best care

Avril McCready-Wirth, Carol Hepting, Wendy Ng, Cathy Haney, Lisa Bratkoski and Dianne MacAusland-Berg

The home care therapy team described in this article works in both urban and rural communities, covering a large geographical area in southern Saskatchewan. Both therapists and therapist assistants are publically funded by the Government of Saskatchewan through Regina Qu'Appelle Health Region. This article highlights how the competencies of the occupational therapist assistant (OTA) contribute to the interdisciplinary team and client outcomes.

OTAs in the home care setting

Occupational therapists in home care provide assessments, set up treatment programs and requisition equipment to enable clients to maintain the highest level of independence possible in their home. To ensure the safety of the clients, their families and the home care staff, occupational therapists assess and document which type of transfer and equipment is required for all clients receiving personal care assistance. In home care, this varied and busy practice of occupational therapy is enhanced by support from the OTAs. The OTA title falls under the broader category of support personnel, defined as individuals who are "not qualified occupational therapists but are individuals who have the job-related competencies to support occupational therapists in delivering occupational therapy services" (CAOT, 2009, p. 3).

The solitary nature of the home care setting necessitates experienced occupational therapists and OTAs. Furthermore, mutual trust needs to be built between the therapist and assistant for effective and efficient service delivery. The occupational therapist needs to have observed the OTA performing a specific task in order to achieve a comfort level with their ability to work without direct supervision. The therapist needs to be open to revising the treatment plan based on the OTA's observations of changes in the client's abilities. In each case, ongoing collaborative communication between the occupational therapist and OTA is essential. On occasion, the therapist and assistant jointly provide service to a client, which enables further development of mutual trust and problem solving to address the clients' needs.

In this setting, charting is done using an electronic record. This allows the whole team to communicate in a timely fashion and provides access directly at the point of care or in the office. In the electronic record, the occupational therapist receives and documents consent from the client to have the assistant involved in their treatment, as well as the assessment and treatment plan with specific instructions for the OTA. The assistant documents changes in the client's occupational performance and their responses to treatment. Less formal ongoing communication between the therapists and assistant occurs via casual "sticky notes" placed on a client's physical file and face-to-face discussions as needed. Occupational therapists and assistants are able to contact each other by phone within a few moments, if necessary, to address immediate concerns while with clients.

The OTA role

The following vignettes illustrate how occupational therapists and OTAs travel along the same road to enhance client outcomes. They demonstrate how OTAs can employ key competencies, such as communication, change agency and collaborative problem solving (CAOT, 2009) to create optimal client outcomes.

A client suffered a stroke that affected her right side. She had recently returned to her apartment in a seniors' building where she was receiving daily morning and evening care from home care continuing care assistants. Following the occupational therapist assessment, the OTA began treatment by practicing dressing and other self-care skills with the client. The client's independence with these tasks improved and she no longer required daily home care assistance. The occupational therapist designed a program for the client to work on dexterity of the affected arm, balance, memory and coordination, which was carried out by the OTA. The client regained function in her affected upper limb and was thrilled when she was once again able to prepare her own meals.

A typical day in the life of an OTA in a home care setting might look like the following. The OTA begins the day by driving 50 km outside the city to practice sliding board transfers and wheelchair mobility with a man residing in a private care home requiring a high level of personal care following a stroke. The goal is to regain enough independence so that he can return home. From there the OTA travels back to the city to see a young woman with an acquired brain injury to work on learning the steps involved in taking a shower so that she no longer requires assistance from others. The next client is a man with severe rheumatoid arthritis. The assistant sets up a tub transfer bench ordered by the occupational

therapist and practises the tub transfer with the client and his wife. The final visit of the day is a with a young man with Parkinson's disease who has a pressure sore on his coccyx. The assistant provides a ROHO (pressure relieving) cushion ordered by the occupational therapist, correctly inflates it and teaches the client and family correct use and care of the cushion.

Another example of collaboration between the occupational therapist and OTA is the case of a woman in her 70s with skin breakdown on her heels. This client was referred to occupational therapy by the wound resource team, who felt the breakdown was caused by pressure on the client's heels while lying in bed. Through joint problem solving, the occupational therapist and OTA discovered the cause of the breakdown was the client self-propelling her wheelchair in bare feet, which were rubbing on the hub of the axle and the footplates. After padding the offending parts of the client's wheelchair, the wounds eventually healed.

The OTA plays a critical role in providing education to clients regarding equipment (e.g., for the bath, hospital beds, ceiling track lifts, slings, etc.) that the occupational therapist recommends and requisitions. The OTA visits a client to demonstrate and practice safe ways to use the equipment. This support helps to decrease the family's stress of integrating the therapist's recommendations and helps the client feel that they are less of a burden to their caregivers.

Another role of the assistant in this setting is in maintaining the occupational therapy inventory. This involves caring for cushions and other pieces of equipment to ensure that each item is clean, safe and available as needed. This task aligns with the support personnel core competency of using "human, financial and physical resources effectively" (CAOT, 2009, p. 8).

Conclusion

Occupational therapist assistants provide an invaluable contribution to the practice of occupational therapy in the community. OTAs provide another pair of eyes and hands to assist the occupational therapist to recognize concerns and promote engagement in occupation. The relationship between occupational therapist and OTA is more than the assignment of a task. It requires trust, understanding, an exchange of ideas and working together to provide the best care for the client.

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About the authors

This article was created in a joint collaboration of **Avril McCready-Wirth,** occupational therapist assistant, and **Carol Hepting, BScOT, OT Reg. (SK), Wendy Ng, MScOT, OT Reg. (SK), Cathy Haney, BScOT, OT Reg. (SK), Lisa Bratkoski, BScOT, OT Reg. (SK),** and **Dianne MacAusland-Berg, BScOT, OT Reg. (SK),** a diverse group of occupational therapists at various stages of their careers in Regina, Saskatchewan. The authors can be contacted at: avril.mccreadywirth@rqhealth.ca

You can call me "doctor"... now

Cathy White

About the author: ***Cathy White*** *is now an assistant professor at Dalhousie University in Halifax, NS. Cathy.White@Dal.Ca*

When I was hired as an occupational therapist assistant at the local veteran's unit, I was so excited I did a cartwheel in my living room! As I met the veterans and heard their stories, I wanted to do everything possible to make their day-to-day lives better, even if it was in a hospital setting. I loved the work so much that I snuck in on the weekends to work extra, for free. I loved learning how the occupational therapist might adapt activities to make it possible for each person to participate, sometimes clamping a project to the table so someone with a stroke could do it with one hand, or using a magnifier for someone with limited vision. I even sewed Velcro condom catheter straps so the men could be more independent in toileting - a small thing, but something that restored dignity.

I was soon transferred to the hospital setting and worked with the occupational therapists on the psychiatry unit and throughout the general hospital. All kinds of new learning opportunities emerged, from splint preparation to cooking, implementing back-to-work programs and adapting clothing. I took advantage of in-service training and read as much as I could, but after three years of working as an occupational therapist assistant, I knew I would need further education if I was to have a more active role with clients. I applied to the Dalhousie University School of Occupational Therapy, not knowing if I would be able to go. It all worked out in the end, and in 1995 (with a few bumps along the way), I graduated. To make a long story short, I went on to get a master's degree, and then another, and somehow decided I should pursue a PhD! So, I guess now you can call me "doctor."

ABORIGINAL PEOPLE AND OCCUPATIONAL THERAPY IN CANADA

COLUMN EDITORS: ALISON GERLACH AND JANET JULL

Community therapy assistant: Supporting rehabilitation services in the remote arctic community of Igloolik, Nunavut

Katie Bellefontaine, Michelle Hurley and Sharon Irngaut

Providing quality health care in Canada's north is often challenging. This is particularly true in Nunavut's small, remote communities like Igloolik – a hamlet of 2,007 people in Canada's eastern Arctic (Nunavut Bureau of Statistics, 2014). Delivering occupational therapy services of the same scope and quality as elsewhere in Canada is difficult. The Qikiqtaaluk Region's two occupational therapists (the first and second authors) are based in the territory's capital, Iqaluit, and together serve almost 15,000 people spread over 12 communities, in a geographic area roughly the size of Ontario. The provision of occupational therapy services in one of these communities is made possible in part by the support of Sharon Irngaut, a community therapy assistant (CTA) based in Igloolik (the third author). This paper will outline Sharon's role as a CTA working remotely in a rural setting, as well as share some of her perspectives on that role.

The need for CTAs

The Qikiqtaaluk Region's small communities (ranging from about 163 people living in Grise Fiord to 2,007 in Igloolik [Nunavut Bureau of Statistics, 2014]) do not have the population to support permanent, on-site allied health professionals, such as occupational therapists, physiotherapists, audiologists and speech-language pathologists. Each community has a health centre staffed by nurses, but the allied health professionals live in Iqaluit and travel to the other communities once or twice a year. Between visits, therapists rely on live video conferencing (telehealth) to follow up with clients. This technology is helpful, but does not replace the need for having trained individuals working directly with clients.

Recognizing these challenges in service delivery, in 2008 the Government of Nunavut's Department of Health and the Nunavut Arctic College developed and launched a one-time 16-month program to train local community members as CTAs. The program consisted of courses in four rehabilitation disciplines (occupational therapy, physiotherapy, audiology and speech-language pathology) and included classroom and lab components, as well as fieldwork placements. The occupational therapy curriculum touched upon such topics as the scope of the discipline, the assignment and reporting relationship between the therapist and assistant, and how to deliver interventions with specific populations. Supporting courses in areas such as medical translation and English writing rounded out the curriculum (while each student was bilingual, Inuktitut was their first language, as it is for many Nunavummiut [1]).

Seven students graduated from the program in 2009. While many have moved on to other opportunities, two graduates continue to support the region's rehabilitation team. Ningeola Tiglik works in Iqaluit as an audiology assistant. Sharon Irngaut lives in Igloolik, the Qikiqtaaluk Region's second largest community. From delivering physiotherapy, occupational therapy and speech-language programs to completing hearing screening tests, Sharon helps support a range of rehabilitation services in Canada's far north.

The CTA role

Sharon takes on a number of tasks assigned to her by occupational therapists. For example, she facilitates fine motor programs with children, and exercise and activity re-activation programs with adults; installs assistive devices and provides training on their use; and helps maintain mobility aids. When allied health practitioners are in town, Sharon acts as a language interpreter during their in-person client visits. Sharon also supports these therapists, who have relocated to this region from southern parts of Canada, to develop a more nuanced understanding of local practices and knowledge in relation to health and health care.

Working together with such a significant distance between therapists and assistant requires different approaches than used

Community therapy assistant, Sharon Irngaut, delivers a shower chair to a client via snowmobile.

[1]Nunavummiut is the Inuktitut word used to refer to residents of Nunavut.

within many Canadian health-care settings. Practitioners complete "task sheets" to communicate client information, the practitioner's findings and program requirements to Sharon. These sheets also track the execution of various tasks and Sharon's client interactions for the practitioners' client files. Sharon participates in monthly phone meetings with supervising practitioners to review client cases, outstanding tasks and next steps.

Benefits and challenges

Perhaps not unsurprisingly given Nunavut's geography, there are a number of challenges related to delivering occupational therapy services with the support of CTAs. The distance alone delays information sharing and limits opportunities for timely feedback, direct skill transfer and spontaneous collaboration. Therapists rely largely on telephone, email and fax to communicate with Sharon. Arctic communication infrastructure is far less developed than elsewhere in Canada, which means technical glitches are part of everyday life. Also, in the hands-on world of occupational therapy, it is often difficult to fully explain tasks without the advantages of in-person instruction and demonstration, for example, as with wheelchair repairs. Opportunities for continued professional development are also limited: not only in terms of formal courses or workshops, but also the opportunity for informal exchanges of information and experiences with other rehabilitation assistants.

As a CTA, Sharon is an important member of Nunavut's rehabilitation team. She delivers services that off-site practitioners are unable to provide. Being in the community— where she was born and raised — means Sharon is aware of each client's changing situation, and can notify practitioners when follow-up is warranted.

Sharon is a strong local advocate for occupational therapy services and helps Igloolik's clients and nurses better understand the rehabilitation services available. She is a leader in her community, providing direct health-care services and a valuable resource for clients. She is also valuable resource for practitioners, who have had the opportunity to work and learn from Sharon's approach and understanding of her community's members and needs.

Q & A with Sharon Irngaut

The following are excerpts from a conversation with Sharon about her role as a CTA, edited and condensed for clarity.

Q: What made you interested in becoming a CTA?
A: When I was young my father advised me to help people when I was grown-up. When I thought about my grandmother, I knew that people like her needed help with mobility around their home. I always wanted a position like the CTA, but I was told there was no job like this. But I kept believing there was a need for this job. Then one day I found out about the CTA program and I thought "this is my dream job." I had to take the course because watching Elders or others with disabilities is always hard to see. I am glad I have become a part of the rehabilitation team to help our people in the community.

Q: What is a typical day like as a CTA in Igloolik, Nunavut?
A: My days are very different. In the mornings I go to our Continuing Care Centre to complete exercises with our clients. In the afternoons I go on home visits where I complete exercise programs with clients, and deliver and install equipment. After my visits I do my paperwork, review emails and clean equipment. During telehealth sessions I help to ask clients questions and explain the therapist's recommendations about equipment, wheelchair training and transfers. Sometimes we plan for me to go to the home to demonstrate and install equipment recommended by the occupational therapist.

Q: What is the most difficult part of your job?
A: The most difficult part is when I try to repair equipment and there are no spare parts. When equipment is broken I notify the therapist and send pictures if needed. But it takes a while to get parts, and this can mean long wait times for repairs.

Q: What is the best part of your job?
A: The best part of my job is when my clients are happy and successful with their equipment or with the service that I give.

Q: How do you feel having a CTA position in Igloolik impacts your community?
A: Having a CTA gives a lot of support for people in our community. It helps the people who need to complete exercises or have equipment installed properly. Also, for children this position is so important – so that we can provide support to the parents and help the children improve quickly. Having a CTA means so much to the community.

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About the authors

Katie Bellefontaine, OT Reg. (Ont.), and **Michelle Hurley, OT Reg. (Ont.)**, are occupational therapists working in Iqaluit, Nunavut. They can be reached by email at: kbellefontaine@gov.nu.ca and mhurley@gov.nu.ca **Sharon Irngaut** is a community therapy assistant working in Igloolik, Nunavut. She can be reached by email at: sirngaut1@gov.nu.ca

The emerging role of occupational therapist assistants at The Ottawa Hospital

Leanne Vo and Cory Feenstra

With heavy workloads and an ongoing need for quick patient discharges from hospital, occupational therapists benefit from working in collaboration with occupational therapist assistants (OTAs) to allow them more time for assessments and discharge planning. The advancement of formalized training has allowed the OTA discipline to expand its role across The Ottawa Hospital (TOH), a multi-site teaching hospital with more than 1000 beds. Despite this, it became apparent that the nature and extent of the OTA role differed across campuses, as well as different areas of practice. This article will share activities undertaken at TOH to support and develop the OTA role.

A group of OTAs at TOH elected to determine how OTAs were being engaged across various areas of practice in acute care. Data of OTA responsibilities and time spent on each task was collected from five OTAs from various acute care units over a six-month period in 2011 to 2012. Analysis of the data revealed that half of the assistants' time was dedicated to seating interventions. This time was spent collaborating with occupational therapists to ensure that patients were provided with an optimal wheelchair and performing necessary adjustments and modifications. The OTAs' time was also spent providing wheelchair mobility training, including how to use the wheelchair (e.g., applying the seat belt, using the brakes, etc.) and how to mobilize independently using foot or hand propulsion, as well as providing education regarding how to weight shift in the wheelchair to prevent skin breakdown.

One quarter of the OTA time was spent in a support role, which includes many different administration and organizational responsibilities. These include cleaning all equipment and wheelchairs as per infection control guidelines, maintaining and repairing all equipment and wheelchairs, budgeting for needed supplies, monitoring inventory of supplies and reordering as needed, and contacting and meeting with vendors when ordering new equipment to stay current with new products. The support role also includes maintaining the stock of printed material in the occupational therapy department, including all patient handouts, educational booklets and assessments tools. This role may also include participating in interdisciplinary rounds, monthly staff meetings, committees and in-services, as well as completing all statistics, attendance records and progress notes regarding patient intervention.

The last quarter of the time was spent engaging in various direct patient care activities, including patient positioning, providing training in activities of daily living or transfers, reviewing educational materials (e.g., energy conservation strategies), implementing programs (e.g., an upper extremity exercise program) and facilitating therapeutic groups.

As a result of our data collection, we were surprised to find that over half of the OTA time was spent on seating interventions. To provide occupational therapists at TOH with the opportunity to further develop their understanding of the role and benefit of an OTA, a *Reference Guide to the Roles of an OTA* was created. This was helpful to show therapists all the services that OTAs could provide within their broad scope of practice. The guide outlines how to best use OTAs to their fullest potential in an acute care organization. It also emphasizes that the role of an OTA should be expanded beyond just seating interventions and support roles to include more direct patient care in order to better apply the OTAs' knowledge and training.

The transition towards a broader role that encompasses more direct patient care has been facilitated by the development of an Assistant Education Committee (ACE). In response to the need for continuing education for OTAs and the lack of such opportunities in Ontario, a group of OTAs at TOH organized eleven educational sessions over three years for assistants working in various acute care areas.

In the two years since the data collection, TOH has changed the model of how physiotherapy and occupational therapy is supported by assistants. OTAs are now spending more time on direct patient interventions other than seating and positioning on most of the inpatient units. This has enabled the occupational therapists to focus more on new consults and discharge planning. The emerging and expanding role of the OTAs continues to develop and has been greatly supported within TOH.

For more information on the *Reference Guide to the Roles of an OTA*, please email Cory Feenstra at: cfeenstra@toh.on.ca

About the authors

Leanne Vo, OTA, works on medicine, surgery, vascular, trauma and intensive care units at The Ottawa Hospital. She can be contacted at: levo@toh.on.ca

Cory Feenstra, OTA, works in geriatrics at The Ottawa Hospital. She can be contacted at: cfeenstra@toh.on.ca

The post-professional education needs of support personnel in Ontario

Trudy Langendoen, Candy Pleasance, Andrea Dyrkacz and Carol Heck

In Canada, occupational therapists and physiotherapists are assisted by support personnel with differing degrees of professional preparation. Currently, there is no mandatory national standard of education for support personnel. Formalized training programs vary in both length and content of curriculum and are provided at either publicly funded colleges or for-profit trade schools. Because of the variety of educational programs that prepare these team members, they are referred to by a number of titles, including occupational therapist assistants (OTAs), physiotherapist assistants (PTAs) and rehabilitation assistants (RAs). The title given to these support personnel is dependent on their employer and their educational background.

Canadian support personnel have relatively few options for post-professional education. There is no structured or standardized post-professional education programming designed to promote ongoing competent practice and meet the needs of variously trained and skilled support personnel. Generally, they may be expected to attend department and hospital in-services and workshops in an effort to maintain competencies or advance skills. To a significant extent, occupational therapists and physiotherapists have surmised what the post-professional education needs of support personnel are and have designed courses and workshops for them — sometimes, but not always, with input from support personnel.

There are no published studies that have identified or addressed the post-professional education needs of support personnel in Ontario. For an emerging professional group, this lack of focus on continuing education needs may be hampering the development of effective post-professional educational programs. To address this knowledge gap, a study was undertaken by a team of investigators at Toronto's University Health Network, a large, multi-site acute care and rehabilitation organization. Support personnel were asked to identify their education needs and preferred methods of instruction. This article will discuss the results of the survey and how this information may inform the future provision of post-professional education for support personnel in Ontario and beyond.

Literature review and the North American context

A literature search was undertaken using the databases CINAHL, Medline and PubMed, and the professional services of University Health Network's information specialists, using the following keywords: occupational therapist assistant, physiotherapist assistant, rehabilitation assistant, support worker, support personnel, education and continuing education. Only papers written in English were included in the literature review. The investigators found a limited number of articles pertaining to support personnel in general. A total of 25 articles were reviewed and only six mentioned ongoing post-professional education.

This review confirmed that the literature pertaining specifically to the post-professional education needs of support personnel is limited. A number of articles mention the need for ongoing education, and suggested that this programming should become more formalized and prescriptive regarding content, methods of presentation, etc. (e.g., Coyne, 2008; Carpenter-Davis, 2003). However, there is an emerging base of literature from the United States, where the roles of these paraprofessionals are well-established. Individual state licensure boards specify roles and mandate the education required to become an OTA or PTA, and in most states, OTAs and PTAs are required to pass a licensure examination to practice (American Physical Therapy Association, 2015; National Board for Certification in Occupational Therapy, 2015). Because of licensure, there is a greater emphasis on the need to demonstrate the maintenance of competence and, therefore, more established post-professional educational programming for American support personnel.

In Canada, support personnel are not yet subject to licensure, and processes to accredit programs providing post-secondary education to support personnel are evolving and voluntary. Notwithstanding, both the Canadian Association of Occupational Therapists (CAOT) and the National Physiotherapy Advisory Group (NPAG) have published documents that outline the essential competencies required for support personnel (CAOT, 2009; NPAG, 2012). Additionally, in the CAOT Position Statement titled *Support Personnel in Occupational Therapy Services*, encouragement is given to "those who work in a support capacity in occupational therapy to continuously develop skills and knowledge needed to provide safe and effective support services" (CAOT, 2011, para. 6). As well, the *Practice Profile for Support Personnel in Occupational Therapy*, states that support personnel are required to be scholarly practitioners, and to be thus must "engage in knowledge and skill development through life-long learning" (CAOT, 2009, p. 13). However, CAOT has not yet gone beyond affirming the general need for support personnel to engage in ongoing education by offering opportunities directed specifically at this group.

No literature was found that specifically addresses the post-professional education needs of physiotherapist support

personnel. While the Canadian Physiotherapy Association (CPA) supports a National Physiotherapist Assistant Assembly (formerly the National Support Worker Assembly), which seeks to address the general needs of Canadian physiotherapist assistants, relatively few PTAs join this voluntary group (CPA, 2011).

The lack of a clearly articulated and prescriptive direction for the ongoing educational needs of support personnel is a troubling gap, with the potential to impact the maintenance and enhancement of key competencies and, therefore, the quality of health care provided to Canadians. The review of the literature also shows that support personnel as a group have not been asked for input related to their own ongoing post-professional education.

Study design

The study followed a descriptive, quantitative, cross-sectional design and consisted of a web-based survey of support personnel employed in Ontario in 2010. The University Health Network Research Ethics Board approved the study, and funding was provided through a grant received from the University Health Network's Allied Health Research Committee.

The survey was developed by the investigators and included items to describe the demographics of respondents and their perceived post-professional educational needs. It was pilot-tested on practising occupational therapists, physiotherapists and support personnel. The sampling timeframe for this study was from November to December, 2010.

For the purposes of this study, respondents had to work in Ontario and have one of the following job titles: occupational therapist assistant, physiotherapist assistant, occupational therapist/physiotherapist assistant (OTA/PTA) or rehabilitation assistant. Invitations to participate in the survey were sent by Humber College's School of Health Sciences and Mohawk College's Institute for Applied Health Sciences to their alumni. As well, respondents were asked to forward the electronic survey link to colleagues to capture on-the-job trained support personnel and those who studied at other public and private post-secondary institutions. As there is no database of support personnel in Ontario, it was not possible to reach all possible respondents or know the response rate of the survey.

Once all data was received, descriptive analysis was completed for all demographic characteristics. T-tests were conducted for between-group differences (significant difference of $p<0.05$).

Results

The survey had 145 respondents. Respondents were primarily female, with an average group age of 35.2 +/- 9.8 years. 97.2% had either a college certificate or diploma, indicating profession-specific education, with the remaining respondents indicating they were on-the-job trained. The well-established role of publicly funded colleges in Ontario is reflected in the finding that 83.3% of survey respondents received their support personnel-related education in a publicly-funded college. The participation of Humber and Mohawk Colleges in the distribution of the survey link likely also affected the very high percentage of respondents from publicly funded colleges.

Most respondents (64.2%) had a certificate or diploma as their highest level of post-secondary education. However, 27.6% indicated having a bachelor's or master's degree, reflecting the number of support personnel who seek a diploma as a post-degree career path.

In terms of job title, 43.1% indicated they were employed as an OTA/PTA, 28.5% reported being an RA, 20.1% reported working as a PTA and only 8.3% of respondents indicated they worked solely as an OTA.

On average, survey respondents indicated that they were employed in a full-time position and had worked for 8.1 +/- 5.2 years, with 95.6% working in general hospitals or rehabilitation centres. When asked to indicate their practice contexts, the majority of those who responded reported that they spent at least some of their work day in a rehabilitation setting, with orthopedics being the most common focus of practice. 79.2% held one position only, but 17.0% held two or more part-time, casual or contract positions.

In response to questions about their attitudes towards ongoing education, 78.4% of respondents stated that post-professional education was very important to them. A wide range of reasons for engaging in post-professional education were given by those who completed the survey (see Figure 1).

The most common reason given for attending a post-professional education day was that it was in their area of interest. Respondents indicated that having material that was clinically focused and practice-oriented was most important when selecting post-professional educational offerings, with 97.0% reporting that it was very or somewhat important that educational content was directly applicable to clinical areas of interest and pertinent

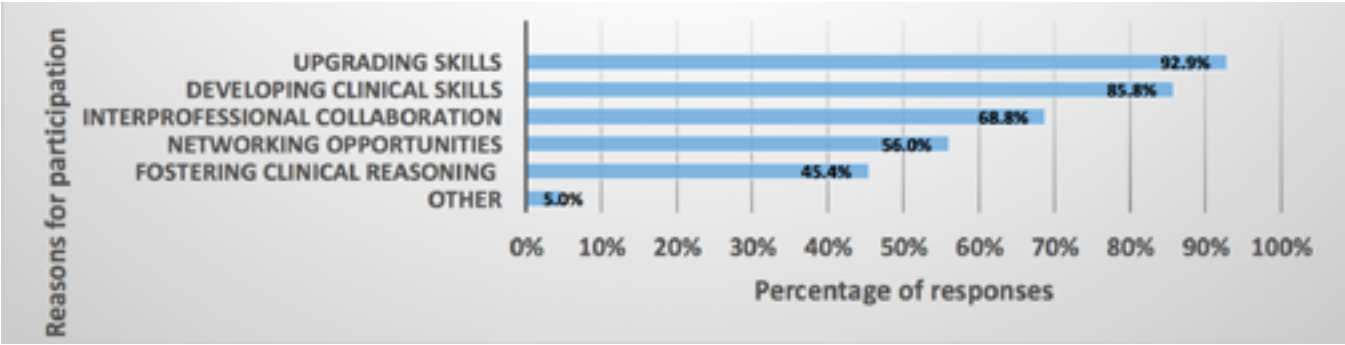

Figure 1. **Reasons for participating in post-professional education. Note: more than one answer was accepted.**

to practice. While the majority of survey respondents indicated that stroke and general topics in neurology were of interest, there were differences in choices made based upon years of clinical experience. More experienced support personnel tended to indicate an interest in attending sessions focusing on the areas of stroke/neurology and bariatric care. Less experienced respondents were more likely to choose the categories of working relationships/boundaries/life balance, lab values, transfer/positioning and spine/bracing as preferred topics. Experienced respondents were more likely to pick pertinent content as a reason for attending educational offerings, while less experienced respondents indicated that they valued networking opportunities provided at educational events (see Figure 2).

Workshops with the opportunity to learn "hands-on" skills as well as didactic or lecture-based education were both endorsed by survey respondents, regardless of level of experience. Educational opportunities that were supported by employers were also highly preferred, as the majority of those completing the questionnaire indicated that financial support (82.8%) and paid education time (81.6%) influenced participation in post-professional education.

Application of survey results

This survey, the first known to seek out the educational wants and needs of support personnel, has already been used to inform educational programming at University Health Network. While a semi-annual education day had been previously planned by support personnel at UHN, programming was based on presenter availability and interest, rather than being data-driven. An opportunity to review this practice presented itself with the union of University Health Network and Toronto Rehabilitation Institute in 2011 and the resulting amalgamation of staff and education programming.

The insights gained through the questionnaire led to the development of an assistant-focused workshop in September 2013 by the UHN OTA/PTA Education Committee. Content was planned to reflect the interests of support personnel as outlined in the survey and with a special focus on enhanced skills, such as working safely in the intensive care environment, infection control and the development of policies and procedures to support practice. The workshop sold out in a matter of days, with a significant waitlist.

In light of the popularity of the first evidence-informed workshop at UHN, discussion has ensued regarding the best means to increase and develop educational opportunities for support personnel, particularly those outside of larger urban areas, potentially through the use of video conferencing and recording.

Conclusion

Although support personnel have been encouraged to actively participate in post-professional education, there has been little content specifically designed and offered to meet the needs of this rapidly growing group of practitioners. Once a cadre of on-the-job trained health-care workers, support personnel are now predominantly graduates of college programs. A voluntary accreditation process has been developed for Canadian OTA & PTA education programs, which has an important role in promoting the recognition of excellence in OTA & PTA education, and is foundational in the ongoing professionalization of this group of health-care workers. Now, graduates of these accredited programs are beginning to assume responsibility for determining their own post-professional educational needs and taking steps to maintain and enhance professional competence through the design and provision of self-directed learning opportunities.

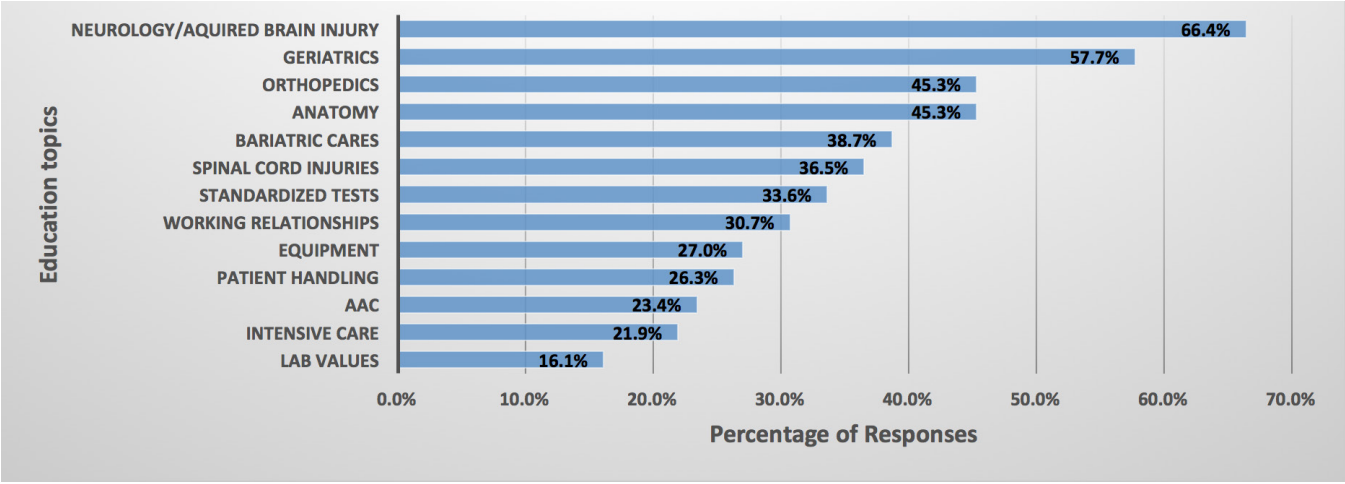

Figure 2. **Preferred education topics. Note: more than one answer was accepted.**

About the authors

Trudy Langendoen, OTA/PTA, Candy Pleasance, OTA, Andrea Dyrkacz, OT Reg.(Ont.) and Carol Heck, PT, are all employed at University Health Network in Toronto, Ontario. They each teach extensively at the pre- and post-professional levels and engage in a variety of clinically relevant research areas. For further information please contact: trudy.langendoen@uhn.ca.

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Creating and sustaining change: Partnering to protect patients

Candy Pleasance, OTA, and Andrea Dyrkacz, OT Reg. (Ont.).
andrea.dyrkacz@uhn.ca

University Health Network's Toronto Western Hospital (TWH) has become a leader in the management of a shared, multi-patient use resource – its wheelchair seating and mobility pool. As both a general hospital and specialized neurosciences centre, TWH patients' needs are complex. Meeting the seating and mobility needs of diverse populations and ensuring that the equipment provided meets or exceeds accepted standards for skin health, positioning and infection control has been a task requiring strong leadership and ongoing professional and organizational support.

At TWH, the goal of achieving excellence in the management of this shared resource has required sustained effort by the entire occupational therapy team over the last 14 years. Lead by an occupational therapist assistant (OTA), the team has faced challenges that served as opportunities to create change and improve practice.

A number of distinct drivers lead to the creation of an integrated seating and mobility pool management program. The first allowed us to determine the status of the equipment pool. In the daily rush to provide patient care, wheelchairs and cushions were literally scattered throughout TWH with no tracking system in place. The millennial Y2K inventory mania provided tools to undertake an accounting of all wheelchair-related equipment and the development of a simple sign-out system.

However, in assessing the wheelchairs, it was apparent that most were in poor repair. As occupational therapy staff lacked the expertise to undertake the required repairs, funds were allocated to pay skilled technicians to assess each wheelchair, repair what was salvageable, and to make recommendations for disposal and replacement. This now annual event has lead to a tracking system to verify wheelchair safety – an important means of reducing patient risk and organizational liability. Additionally, this annual review improved planning as replacement costs could be anticipated.

In 2004, the SARS (severe acute respiratory syndrome) outbreak illustrated the need to reduce the potential for shared resources to act as a means of pathogen transmission. Cleaning protocols were enhanced and all open-cell foam cushions were disposed of and replaced with closed-cell and sealed products.

A subsequent infection outbreak lead to the realization that all personal-style wheelchair back and head rests were made of open-cell foam covered in moisture-wicking fabric, and therefore, posed a risk for the spread of infection. A market review demonstrated that no closed-cell or sealed back and head rests were commercially available. A fabric that is used to cover pressure-redistributing mattresses was located, and all TWH back and head rests were disposed of and replaced with new products covered with this neoprene-like material. Lab tests demonstrated the efficacy of the covers in preventing the transmission of pathogens into the open-celled foam. Durable and able to withstand years of cleaning with harsh disinfectants, this cover has become a commercial product available as a standard option for back and head rests across North America.

With the expertise of TWH's OTA in equipment management, policies have been written and revised to support each change in practice and ensure therapist accountability. These policies and procedures are reviewed regularly with occupational therapy staff to ensure that they reflect changes in practice and that compliance is achieved.

The sustained leadership of TWH's OTA, and the support of the occupational therapy team and allied health leadership have created a culture of change and innovation. Policies, procedures and time-tested equipment management tools have been disseminated at national and international conferences, but most importantly, shared at educational events for support personnel to demonstrate how OTAs can create positive change and sustain excellence in practice.

Working together: Today's dynamic duo!

Jennifer Stephenson

A dynamic professional partnership between an occupational therapist and an occupational therapist assistant or other support personnel is evident when each person is equally contributing to the relationship and the knowledge, skills and abilities of each person are understood and respected. Classic pop culture duos such as Thelma and Louise, Frodo and Sam, and Butch Cassidy and the Sundance Kid illustrate these characteristics with neither partner having sidekick status.

This article will explore some key characteristics of a successful occupational therapist and therapist assistant relationship, and suggest the possible link between a good working relationship and increased job satisfaction. Some of the information shared is from my qualitative research project, titled *Characteristics of a Successful Intraprofessional Relationship* (Stephenson, 2010), completed to fulfil the requirements of the University of British Columbia Master of Rehabilitation Science program.

"Intraprofessional" refers to the relationship of individuals *within* the same profession (e.g., occupational therapist and occupational therapist assistant) while "interprofessional" refers to the relationship between individuals from different professions (e.g., occupational therapy and nursing). The phenomenon of interest in my research project (Stephenson, 2010) was the perceived characteristics of a successful working relationship *between* occupational therapists and occupational therapist assistants, and physical therapists and physical therapist assistants. This research suggests two key characteristics are essential to these intraprofessional working relationships: good communication skills and a comprehensive understanding of each other's roles and responsibilities.

This project showed evidence of mutual reliance by the therapist and assistant on four types of communication: patient-specific, work-related, peer-based and personal. Patient-specific communication refers to the assignment of tasks, updates on clients and priorities, health and safety concerns, treatment planning, equipment needs and training of new skills. Work-related communication refers to scheduling and assignment of indirect or support functions and organizational tasks. Peer-based communication refers to interactions with colleagues. The therapists identified their peer group as occupational therapists, physical therapists, physicians, psychiatrists, nurses and pharmacists. Assistant communication occurred most frequently with therapists, personal care staff and nurses. Personal communication is not clinically based but refers to sharing information on personal topics such as health, family and interests. Effective communication in all four areas allows the therapist and assistant to engage in relationship building.

The other important characteristic of this intraprofessional relationship, as identified in my research, is the mutual understanding of each other's roles and responsibilities. The therapist is responsible and accountable for task assignment and supervision of the assistant, as required by professional regulation. The assistant in the support role works with clients as assigned, communicates with the therapist on progress or change in client status and engages in indirect support functions. Understanding each team member's professional responsibility and accountability helps strengthen the intraprofessional relationship and builds mutual trust.

There was unanimous agreement by the research participants that job satisfaction is closely related to good working relationships. Comments such as "enjoying working together with clients," "trusting each other's skills," "feeling part of the therapeutic process," and "utilizing effective communication skills" support the association between working relationships and job satisfaction.

For optimal engagement of the assistant by therapists, department or program managers and organizations, there must be an understanding of the assistant's education, scope of practice, roles and responsibilities. Opportunities for team building activities should be considered to promote intraprofessional and collaborative team development. Collegial learning opportunities, such as joint program planning and encouraging the therapist and assistant to attend continuing education sessions together, can promote discussions regarding the application of content to intraprofessional practice.

Exploring the function of assignment and the responsibilities of both parties can be a valuable continuing education experience. Educators of occupational therapy, physical therapy and therapist assistant programs are encouraged to explore intraprofessional education opportunities. Problem-based learning sessions and joint fieldwork placement experiences are avenues for exploring roles and responsibilities, task assignment, supervision, effective communication and the value of intraprofessional relationship building - all of which are necessary components to working together and becoming the next generation of dynamic duos!

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About the author

Jennifer Stephenson, MRSc, BScOT, OT(C), is an occupational therapist, and instructor and current chair of the Therapist Assistant Diploma Program at Okanagan College. This program is celebrating it's 25th anniversary this year. Jennifer can be reached at: jstephenson@okanagan.bc.ca

The role of occupational therapist assistant and physiotherapist assistant students on an interprofessional education unit

Debi Francis and Colin Strader

Interprofessional education (IPE) is defined as "when two or more professions learn with, from and about each other to improve collaboration and the quality of care" (Centre for the Advancement of Interprofessional Education, 2002, para. 1). Interprofessionalism is demonstrated as an inherent, holistic, client-centred practice within the profession of occupational therapy (Canadian Association of Occupational Therapists, 2013). Over the years, the profession of occupational therapy has demonstrated a collaborative partnership between occupational therapists and occupational therapist assistants (OTAs) with the intent of enhancing student, practitioner and client experiences (Jung, Sainsbury, Grum, Wilkins, & Tryssenaar, 2002). Liaising with other members of the interprofessional team enhances the practitioners' knowledge with respect to the scope of practice of each profession, as well as regarding how each profession can work collaboratively to produce optimal client outcomes (Canadian Interprofessional Health Collaborative [CIHC], 2010). This paper presents the perspective of an occupational therapist assistant and physiotherapist assistant (OTA & PTA) student during his fieldwork placement on an interprofessional unit in the Niagara Region in Ontario.

Interprofessional education in the Niagara Region

In 2011, a 10-member steering committee was formed in the Niagara Region to develop a plan for integrating interprofessional education into core training for all professions involved in the clinical setting, while simultaneously providing high quality, client-centered care. The steering committee was composed of academic partners (Niagara College, Brock University and the Niagara campus of the McMaster University Michael G. DeGroote School of Medicine), the Niagara Health System (NHS) and the Hamilton Niagara Haldimand Brant Local Health Integration Network. The steering committee created an interprofessional education unit on the internal medicine and nephrology inpatient unit within the new St. Catharines Site of the NHS (formerly the St. Catherines General Hospital). The unit has student learners from at least one of the following programs at any given time: medicine, nursing, occupational therapy, physiotherapy, and OTA & PTA. The premise of this unit is to provide student learners with an immersion in interprofessional practice while they simultaneously learn discipline-specific competencies. The new hospital opened in March 2013 and the first OTA & PTA student from Niagara College was assigned to an eight-week placement there in the spring of 2014, where he had both an occupational therapist and a physiotherapist as preceptors.

Preparation for interprofessional practice

In preparation for fieldwork placements, students in the OTA & PTA program are enrolled in the Introduction to Interprofessional Education and Practice course during their second term of study. This unique core course is offered to all students enrolled in the practical nursing, personal support worker and allied health programs at Niagara College. The course introduces students to the skills necessary to collaborate effectively as a member of a health-care team, leading to optimal client outcomes through a focus on client safety (Niagara College, 2014).

The theoretical basis of this introductory interprofessional course is built on essential concepts such as caring relationships, collaborative communication, client-centred care and team dynamics, consistent with the CIHC competency framework (CIHC, 2010; Niagara College, 2014). Students from Niagara College are randomly assigned to a team composed of students from each of the identified programs to learn with, from and about one another. Faculty and community health-care professionals facilitate weekly sessions to discuss the scope of practice of their professions, their interactions as an interprofessional team member and the strengths and areas of development within their respective areas of practice. The exposure to a variety of health-care professions optimally positions the OTA & PTA students to understand each professional's role on the interprofessional team, including their own, prior to completing fieldwork placements.

While on placement on the IPE unit, the student OTA & PTA integrates theory and practice by demonstrating competencies within the practice areas of occupational therapy and physiotherapy. The student has two preceptors (an occupational therapist and a physiotherapist) with whom they work throughout the duration of the placement. He or she will also work with other support personnel (including OTAs, PTAs and rehabilitation assistants), gaining first-hand knowledge of their role, carrying out treatment plans, documenting in clients' medical records and liaising with the supervising therapist. During the placement on the unit, the student works collaboratively with students enrolled in various health profession education programs from each of the three affiliated academic institutions. All of the students attend IPE-related activities, including IPE rounds and role presentations, to enhance their appreciation of interprofessionalism, communication, role clarification, and conflict recognition and negotiation (CIHC, 2010).

IPE from a student OTA & PTA perspective

As a student OTA & PTA who completed a fieldwork placement on the IPE unit at the St. Catharines Site, I (the second author)

experienced a number of opportunities and challenges that enhanced my learning with respect to interprofessional practice. The opportunity was highly educational, as it facilitated collaboration with other health-care professionals with a focus on the delivery of high quality health care. The structured background established by the IPE Steering Committee encouraged me to interact with students enrolled in other health-care professional programs during client interactions as well as the established IPE unit activities. Specific IPE activities included bullet rounds and the Team Observed Structured Clinical Encounter (TOSCE©), a tool that assesses students' interprofessional competencies in a team setting (McMaster University, 2014). Initially, I felt apprehensive regarding my role on the IPE unit in relation to other health-care professionals, especially having had no prior interaction with the other students.

Through the progression of the placement, my role on the interprofessional team evolved from simple interaction to true collaboration. My background from the IPE course at Niagara College enabled me to establish trust with professional colleagues, grounded in a firm understanding of the other professions' scopes of practice. The role of the OTA & PTA is not always well understood by members of the interprofessional team—these integral members of the health-care team, who provide rehabilitation services under the supervision of a registered occupational therapist and/or physiotherapist, may not always be seen as the competent practitioners they are. The OTA & PTA implements treatment plans with clients by carrying out a variety of activities, which may include, for example, exercises, client positioning, teaching use of adaptive equipment and the calibration of pressure distribution surfaces. The enhancement of each client's quality of life, and ultimately the efficacy of the health-care system, is contingent on professionals working in concert with one another, demanding trust and mutual respect.

Lessons learned

The necessary implementation of interprofessional practice for OTA & PTA students, as well as all other student health-care professionals, promotes the building of professional working relationships with future co-workers. When health-care professionals work in an integrated and client-centred manner, the outcome is optimal health care for clients (Romanow, 2002). During this student OTA & PTA's IPE experience at the St. Catharines Site, clients commented positively on their level of comfort when working with collaborative teams of students. As a student OTA & PTA, I feel that this valuable method of integrating education and practice ensures that the OTA & PTA graduate is prepared for entry to practice as a productive, collaborative and client-centered member of the interprofessional team. I would strongly agree that the student OTA & PTA has a valuable role on the IPE unit.

In addition to the benefits of having a placement on an IPE unit, there were also some challenges related to some staff and preceptors not being entirely comfortable with the principles of IPE. In order for the fundamentals of IPE to flourish and enhance student and client interactions, preceptors may benefit from further exposure, education and strategies to help facilitate this unique experience (e.g., through workshops, seminars or online modules). During the inception of the IPE unit, there were activities to introduce the goals of the program and prepare the staff for the transition to the new unit. However, with human resource turnover and a potential lack of exposure to IPE among some professionals, ongoing education for staff might help to ensure that all preceptors understand the unit expectations for both students and clients, as well as have an "awareness of existing resources such as the CIHC" (Jung & Steggles, 2014, p. 12). Finally, we would encourage others to establish IPE units in hospitals across Canada. Increased opportunities and support for IPE across the country would enable OTA & PTA education programs to provide their students with the foundational knowledge and skills necessary to demonstrate optimal interprofessional competence.

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About the authors

Debi Francis, BHScOT, OT Reg.(Ont.), is a professor and program coordinator in the Occupational Therapist Assistant and Physiotherapist Assistant (OTA & PTA) program at Niagara College, and a member of the Niagara Region Interprofessional Education (IPE) Unit Steering Committee. She can be contacted at: dfrancis@niagaracollege.ca

Colin Strader is a graduate of the OTA & PTA program at Niagara College. He completed a placement on the IPE Unit at the St. Catharines Site of the Niagara Health System and is a student member on the Niagara Region IPE Unit Steering Committee. He can be reached at: colin.strader@gmail.com

Update from the Canadian Occupational Therapy Foundation

Attention: Occupational therapists with a special interest in mental health

The Marita Dyrbye Mental Health Award was established in 2001 to support innovative occupational therapy practice and is administered by COTF. The award was created in memory of an extraordinary colleague, Marita Dyrbye, to reflect her dedicated and resourceful efforts in psychiatric rehabilitation programming in Edmonton, Alberta. The fund is committed to supporting deserving individuals in both research and practice-based projects. The value of the award is $1,000, and will be offered this year, 2015. (The award is offered on each odd year.) The application deadline is October 1, 2015.

It is important to emphasize that one of the primary purposes of the award is to support practice-based projects that will immediately enhance community mental health programs. The Marita Dyrbye Mental Health Award Committee is looking forward to receiving many applications this year, including some that propose the use of the money for direct client benefit. This type of resource is rarely accessible for program enhancements.

Please visit the COTF website for additional details, application deadlines, etc. (http://www.cotfcanada.org/index.php/other-awards). Interested applicants may also contact: skamble@cotfcanada.org or amcdonald@cotfcanada.org

Conference 2015

2015 COTF Session: The Karen Goldenberg Leadership Impact in Research Grant (with the economic evaluation of occupational therapy)

Presenter: Karen Goldenberg, COTF founding member and 2014 Member of the Order of Canada
Date: May 29, 2015
COTF will launch The Karen Goldenberg Leadership Impact in Research Grant (with the economic evaluation of occupational therapy) in 2016. This grant is established to honour Karen Goldenberg, one of COTF's founding members and a 2014 Member of the Order of Canada. This grant will be open only to clinicians; its purpose is to meet clinicians' need for research on issues directly related to their practice. The importance of leadership will be a major focus of the grant, and projects must also contain a plan for an analysis of the economic impact of the proposed research. Economic analysis of occupational therapy interventions is critical to determining the best outcome for clients, systems of care and society at large. In this session, you will learn the importance of leadership in research and how economic evaluation can be built into a grant proposal. This session is geared to clinicians who are interested in research, who have a practice question that they want to investigate or who are planning to apply for this new grant.

Lunch with a Scholar

COTF is thrilled to announce that Jacquie Ripat will be this year's scholar at COTF's annual Lunch with a Scholar. Jacquie is an associate professor in the Department of Occupational Therapy at the University of Manitoba. Her research focuses on understanding the interaction between people who use assistive technologies and their environments. The intended outcome of this work is to develop and implement ways to use assistive technology and to modify environments in order to promote community participation of people with disabilities. Jacquie also engages in research to understand and facilitate occupational therapists' and occupational therapy students' ability to develop their client-centredness.

Jacquie's topic:
Occupational therapists often guide clients to select and use assistive technologies that promote occupational performance and engagement within their environment. Less attention has been placed on understanding the meaning that people ascribe to assistive technology, a key consideration in how technology is viewed and used. In this presentation, Jacquie will discuss how she has used client-centred methods such as photovoice and go-along interviews to understand assistive technology use within a broader socio-cultural context. Drawing on examples from her research, she will share findings that emphasize the importance of recognizing and valuing the interdependent relationship between individuals who use assistive technology and their socio-cultural environment.

Other COTF events

Remember to stop by the silent auction tables from May 28-29, come to the social event at the Canadian Museum of Human Rights on May 28 to be part of the live auction, and on May 30, attend COTF's Annual General Meeting (1-1:30), immediately following Jacquie's presentation (11:30-1:00).

COTF is the only organization that provides funding solely to occupational therapists who are CAOT members! Make a donation now! www.cotfcanada.org