OCCUPATIONAL THERAPY NOW

OCCUPATIONAL THERAPY NOW VOLUME 18.1

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Allan Klassen trains for 100-mile trail races by running on local trails, in all seasons, regardless of the weather. He is energized by being outside and in nature, even when the ground is covered by a deep layer of snow, as it was in this photo when he took on a training run in Edmonton.
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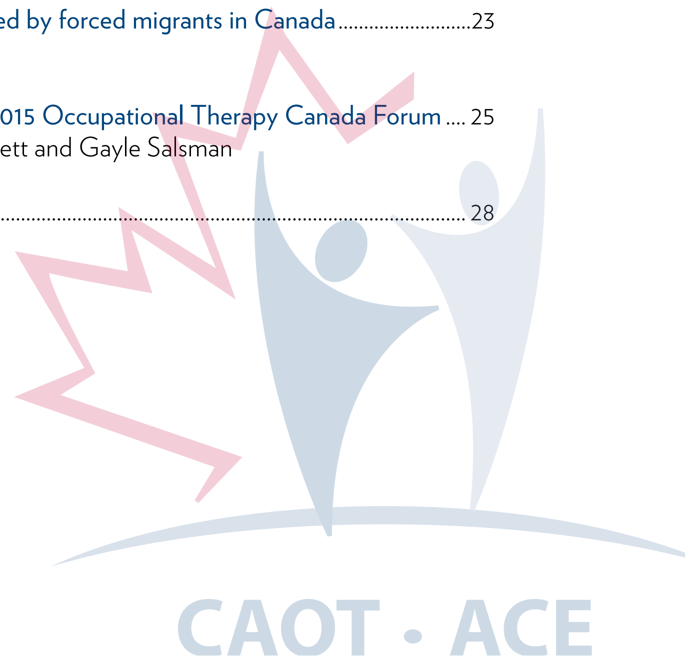

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What's new

Find an OT

A brand new search tool is here!

The Canadian Association of Occupational Therapists (CAOT) has created a new platform to help Canadians search for an occupational therapist. *Find an OT* is a new member-exclusive benefit open to occupational therapists who are members of CAOT. This new search tool allows you to be found by referral agents, clients, colleagues and any Canadian looking for specific occupational therapy services. Some key features of *Find an OT* are:

- easy-to-use online searchable format
- an interactive map
- multiple search parameters, including areas of practice, city and contact information
- additional content, including logo, photo, brief biography and social media links
- four listing options to meet the varied needs of Canadian occupational therapists

If you haven't already set up your listing, CAOT encourages you to sign up for *Find an OT*. To find out more about registration, visit: www.caot.ca/findanOT Don't miss your chance to be included! *Find an OT* will be the best resource for finding and contacting an occupational therapist in Canada.

News from CAOT

CAOT's 90th anniversary – 2016 marks 90 years that the Canadian Association of Occupational Therapists has been dedicated to advancing excellence in occupational therapy. CAOT has been very fortunate to work with members and stakeholders across Canada to advance this mission. This is a milestone to be celebrated! CAOT will be publishing a number of articles in *OT Now* throughout 2016 in celebration of this milestone. The first can be found in this issue on page 5.

Charting New Ground: Interprofessional Approaches to Dysphagia Management - CAOT, Dietitians of Canada (DC) and Speech-Language and Audiology Canada (SAC) offered this groundbreaking interprofessional workshop to a sold-out audience in Toronto in October 2015. The workshop targeted experienced practitioners seeking to advance their knowledge and skills in dysphagia assessment and management.

CAOT member forums - Janet Craik and Lori Cyr had a busy fall reaching out to members across the country. Between them, they had the pleasure of connecting with occupational therapists in Alberta, Nova Scotia, New Brunswick, Ontario, Prince Edward Island, Quebec and Yukon. Member forums will be scheduled in 2016 for Saskatchewan, Manitoba and Newfoundland and Labrador.

Open member forum with the CAOT President - On March 23, 2016, at noon Eastern Daylight Time, join CAOT President Lori Cyr, the Board of Directors and members of the National Office staff for an open web forum. Register by March 16 at: http://www.caot.ca/CAOT_water_cooler_detail.asp?pageid=3969&eventsID=90

AGM – The 2016 CAOT AGM will take place on March 30, 2016, at noon Eastern Daylight Time. Join in via webinar or at a site across Canada. More information to come at: www.caot.ca/agm

Assistive Mobile Technology Initiative - March of Dimes Canada (MODC) and CAOT have partnered on the Assistive Mobile Technology Initiative. MODC and CAOT will plan and deliver an open competition in which individuals with disabilities can apply for funding for tablets and associated apps to enable them to lead a more independent life. More information can be found at: http://www.marchofdimes.ca/EN/events/special/Pages/Assistive-Mobile-Technology-Initiative.aspx

CAOT recognizes Stannah stairlifts

Jim Closs and Martin Stevenson showcasing Stannah's CAOT Seal of Recognition.

CAOT is proud to formally recognize Stannah's Siena, Starla, Sadler and Scout stairlifts with its official Seal of Recognition. Stannah stairlifts are designed for people with mobility impairments, balance or equilibrium issues, or low energy and limited endurance. By providing a way for people to get up and down the stairs in their

home, stairlifts can allow people to "age in place" and avoid the financial and personal implications related to moving.

CAOT's report on the Stannah stairlifts can be found at: http://www.caot.ca/productrecognition/Stannah_PR_Report.pdf For more information about the CAOT Product Recognition Program please contact: dwessman@caot.ca or call (800) 434-2268 ext. 242.

News from *OT Now*

***OT Now* call for papers: Recovery-oriented psychosocial rehabilitation practice -** The September 2016 issue of *OT Now* aims to provide a broad audience with information on the contribution occupational therapists make in recovery-oriented psychosocial rehabilitation. Submission deadline: April 1, 2016. To view the call for papers, go to: http://www.caot.ca/default.asp?ChangeID=25&pageID=7

***OT Now* cover image contest -** For the first time ever, *OT Now* is inviting submissions for its cover images! Submission deadline: January 12, 2016. For more details go to: http://www.caot.ca/default.asp?ChangeID=25&pageID=7

Occupational therapists as agents of change: Improving the lives of Canadians - The September 2015 consumer issue of *OT Now* is now online with free public access. It features articles about working with Indigenous Canadians, caregivers, military personnel and Veterans, and people living in poverty. It also profiles solutions for increasing access to pediatric services and offers strategies for working with clients at end of life. Please share this link widely: http://www.caot.ca/default.asp?pageid=394 If you have suggestions for which stakeholders should receive this issue or a specific article within it, please contact: otnow@caot.ca

Let's celebrate!

The University of Toronto class of 1966 will be celebrating their 50th anniversary reunion in 2016. This class included a number of exceptional graduates, such as Karen Goldenberg and Barbara Quinn, founders of Community Occupational Therapy Associates (COTA). The Governor General's wife (Sharon Johnston) was also in this class. CAOT would like to hear from you if you are celebrating a special anniversary. Post messages to Facebook or Twitter, or email us at: membership@caot.ca

Happy 90th anniversary CAOT!

Janet Craik, CAOT Executive Director

Dr. Goldwin Howland, CAOT's first president.

For the past 90 years, the Canadian Association of Occupational Therapists (CAOT) has been has been providing services, products and networking opportunities. This year marks CAOT's 90th anniversary. This is a milestone to be celebrated! CAOT has been very fortunate to be in a privileged position to work with members and stakeholders to advance excellence occupational therapy in Canada. Much has changed since 1926 and we have much to look forward to. This brief article takes a look back to highlight some of CAOT's key accomplishments over the years and delivers a snapshot of where the association is at present.

Governance

CAOT was formed in 1926 and Dr. Goldwin Howland, a prominent Toronto neurosurgeon, became its first president. Doctors held the post of president until 1966 when Thelma Cardwell became CAOT's first elected occupational therapist to have the role.

The first annual general meeting (AGM) was held in October 1930. Until 2014, the AGM was held in conjunction with CAOT's annual conference. In 2015, CAOT held its first virtual AGM, which was broadcasted online from the National Office and hosted in a number of sites across Canada.

Friedland, Robinson and Cardwell (2001) gave us a snapshot of the office and staffing in the early days of CAOT:

> *Until late in the 1930s, there was no office or office staff for CAOT and all of the work was done by the members on a volunteer basis. . . . After much lobbying, the Association received a grant which allowed it to have a central office and in 1939 Ethel Clarke Smith, an occupational therapy graduate from 1930, was hired as its Executive Consultant. . . . The title, Executive Consultant, was retained until 1972 when it changed to that of Executive Director (pp. 17-18).*

CAOT had its national headquarters in Toronto from 1939-1995. In 1995, the Association moved its office from Toronto to Ottawa in order to be closer to federal decision-makers and other national groups. From 1995-2015, CAOT rented space from Carleton University. In 2015, after purchasing and renovating a building at 34 Colonnade Road in Ottawa, the CAOT National Office staff moved into the new facility. It is a beautiful space equipped with offices, common areas and meeting rooms, where staff, volunteers and stakeholders can meet and work to advance CAOT's mission.

Publications

Friedland, Robinson and Cardwell (2001) recount that "in 1932, CAOT considered producing a textbook on occupational therapy but decided to launch a journal instead" (p. 18). The first issue of the *Canadian Journal of Occupational Therapy (CJOT)* was published in September 1933. This journal is the longest running occupational therapy journal in the world, and CAOT proudly produces five issues per year. February 2013 was the first issue of *CJOT* produced by SAGE publications. In addition to offering *CJOT*, CAOT has leveraged partnerships with many of our international partners to offer members free full-text access to the American, Australian, British and New Zealand occupational therapy journals.

In addition to publishing a scientific journal, CAOT has hosted a number of communication vehicles to promote member news and relevant practice information. In 1939, CAOT began producing a newsletter for occupational therapists, initially called *The Newssheet*, then *The Newsletter* and, finally, *The National*. The practice columns and special issues of *The National* were so popular that the decision was made to replace the newsletter with a practice magazine, *Occupational Therapy Now*. Established in 1999, this magazine is published six times per year. Special issues of *Occupational Therapy Now* are dedicated to profiling CAOT's annual conference activities, as well as timely and emerging professional topics.

Corporate branding

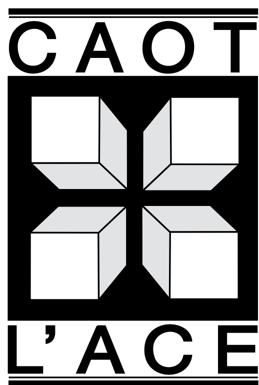
In 1934, CAOT was incorporated under the name of Canadian Association of Occupational Therapy! The logo adopted at that time included the Latin phrase, *Permentem et manus ad sanitatem* – through mind and hands to health.

CAOT logo: 1932-1963

In 1961, CAOT's name was changed to the Canadian Association of Occupational Therapists. In 1963, the logo design was adapted to include the name of CAOT.

CAOT logo: 1963-1968

In 1968, there was a new design and a commitment as a national association to be bilingual. The new design included "L'ACE," the abbreviation for l'Association canadienne des ergothérapeutes.



CAOT logo: 1968-2004

In 2004, dramatic changes were made to the logo – adding elements of colour, the Canadian maple leaf and images of people interacting. This logo symbolizes the dynamic relationship occupational therapists have with their clients as they enable occupation.

CAOT logo: 2004-present

Looking into the future

Isobel Robinson said in her 1981 Muriel Driver Memorial Lecture, "The Canadian Association of Occupational Therapists has given us a magnificent heritage; we must remember it well, build upon it and continue to expand the horizons envisaged by our forebears" (p. 151). As an association, we have grown from a group of volunteers working off the corners of their desks to a staff of almost 30 now working from our own building. CAOT has grown to over 9000 members, with numerous affiliates and corporate associates, our first provincial chapter (CAOT-BC) and an annual operating budget of over $4 million. At CAOT, we are proud of the successes we have collectively achieved. We are well positioned to take on challenges and embrace opportunities that come before us as we continue to strive toward our vision of making occupational therapy valued and accessible across Canada. In 2015, CAOT hired an external consultant to help develop a roadmap with a three-year outlook, to guide our resources and implementation tactics to enable us to achieve our objectives. This critical activity will clearly lay out CAOT's aspirations and approaches for achieving them – how CAOT can deliver value to its members, engage members of all generations and interests, stay relevant and be a sustainable association for many years to come. CAOT is proud of its past 90 years and we look forward to our next 90 in service of advancing excellence in occupational therapy.

Happy birthday and best wishes for many, many more years to come!

Table 1. *CAOT history at a glance*

	Then	**Now**
President	1926 – the first president: Dr. Goldwin Howland 1966 – the first occupational therapist president was elected: Thelma Cardwell	CAOT elects a new president every two years. Lori Cyr is the current CAOT president. A listing of past CAOT presidents and boards of directors is available at: https://www.caot.ca/default.asp?pageid=2427
AGM	First occurred in October 1930 Coincided with annual CAOT Conference	2015 – CAOT hosted its first virtual AGM.
Staff and National Office	1939 – first staff member was hired and CAOT set up an office in Toronto 1995 – National Office moved to Ottawa 1972 – chief staff officer title was changed to executive director	2015 – CAOT moved into its own building at 34 Colonnade Road in Ottawa.
CJOT	Began in September 1933	Published by SAGE, five issues per year Impact factor= 0.915 Dr. Helene Polatajko is the current editor-in-chief.
Member news/ communications	1939 – CAOT produces a newsletter for members.	*OT Now* publishes six issues per year. CAOT produces *OT Weekly* e-newsletter for members and hosts a number of social media platforms.
Name	1934 – CAOT was incorporated under the name of Canadian Association of Occupational Therapy.	Today we are the Canadian Association of Occupational Therapists/ L'Association canadienne des ergothérapeutes.

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TOPIC EDITORS: HEATHER COLQUHOUN AND KEIKO SHIKAKO-THOMAS

Pediatric family-centered services: How can we make it happen?

Anna Murray-Labriola, Giovanni Arcuri, Lauren Silver, Andrea McMullan, Franzina Coutinho and Noemi Dahan-Oliel

Family-centered service in pediatric health care

The last few decades have seen an important shift in the delivery of pediatric services. Previously, services were predominantly situated within the medical model, with parents making very few decisions in their child's medical care (Bamm & Rosenbaum, 2008). Today, services have evolved such that parents are increasingly recognized as equal stakeholders in their child's care, and individual rights and capacities are respected (Bamm & Rosenbaum, 2008). This philosophy of care is referred to as family-centered service (FCS) and has become best practice in pediatric health care across North America and Australia (Law et al., 2005; Raghavendra, Murchland, Bentley, Wake-Dyster, & Lyons, 2007). FCS recognizes the involvement of parents in the decision-making process related to all aspects of their child's care. Both research and advocacy have highlighted the invaluable insights parents can provide in their child's care (Rosenbaum, King, Law, King, & Evans, 1998; Franck & Callery, 2004; King, King, & Rosenbaum, 2004). Studies reporting implementation of FCS date back to over a decade ago (Lawlor & Mattingly, 1998) and indicate obstacles related to clinicians' understanding of this type of practice.

Several resources exist related to FCS to help clinicians, program managers and families to better understand this service delivery model (e.g., CanChild, 2015). Nevertheless, in the clinical milieu, there is still little understanding about this practice. The literature shows that systematic FCS implementation requires a major shift in how services are offered, a shift that necessitates significant changes at the organizational level (Franck & Callery, 2004). While FCS is an evidence-based treatment model, with multiple benefits to pediatric health care, it is currently not being fully used by occupational therapists for many reasons. This points to a knowledge-to-action gap within current practice models.

The aims of this commentary are: 1) to emphasize the continuing need to implement FCS in pediatric care, 2) to describe the challenges associated with the implementation process, 3) to illustrate these challenges through the work undertaken by this team, including that which promotes an improved understanding of facilitators and barriers to FCS and, finally, 4) to propose solutions to problems preventing its full implementation in practice that focus on employing knowledge translation (KT) models, using guidelines and engaging stakeholders.

The challenges associated with implementing FCS

A review of the literature performed by King, Teplicky, King, and Rosenbaum (2004) demonstrated that FCS is a critical component of service delivery, positively impacting quality of life for parents and child. Despite the empirical support for this approach, the literature illustrates a myriad of barriers to the implementation of FCS within the pediatric milieu. FCS implementation barriers include a vague definition of the concept, pre-existing institutional attitudes and a lack of tested implementation guidelines (Franck & Callery, 2004). Furthermore, health-care institutions face a number of difficulties in adopting FCS, such as the integration of previous practice models with the FCS philosophy, disparities in attitudes concerning best practice in client care and difficulties associated with parents' knowledge about medical procedures (Franck & Callery, 2004; Lawlor & Mattingly, 1998). Researchers have also argued that the FCS philosophy cannot be easily incorporated within current health-care systems, considering the challenges associated with changing service delivery models in a limited resources system (Lawlor & Mattingly, 1998). Lastly, parents' and health-care providers' attitudes and beliefs regarding their roles within service provision add complexity to the implementation of FCS (Bamm & Rosenbaum, 2008).

Lessons learned from a local investigation of facilitators and barriers

The authors of this paper recently investigated the local barriers and facilitators to the implementation of FCS in a pediatric rehabilitation centre (Arcuri et al., in press). Experiential accounts of FCS service provision were obtained through individual interviews with parents and a focus group of health-care providers. Findings demonstrated that parents and health-care providers at a pediatric rehabilitation centre perceived facilitators and barriers to the implementation of

FCS to be similar to those described in the existing literature. Generally, respondents indicated that FCS is facilitated by supportive direct interactions between parents and the health-care provider, parental collaboration in care and respect of familial diversity. Along with facilitators, respondents also indicated barriers, which were predominantly linked with systemic and institutional features. These barriers included the organization of care delivery, the use of excessive medical jargon and limitations on available time and resources. Family respondents felt that time constraints impacted health-care providers' capacity to meet the varying parental psychosocial needs that arose following a diagnosis. In addition, lack of time reduced the health-care provider's ability to provide summarized and simplified assessment results. Health-care providers were in agreement that institutional organization and workload levels prevented them from fully meeting varying parental needs, such as for simplified supplementary materials and psychosocial support. These barriers can prevent the use of FCS, which, in turn, potentially reduces parental satisfaction with services. This study provides a deeper understanding of the barriers and facilitators to FCS as perceived by both parents and health-care providers. Unlike existing literature on barriers and facilitators to FCS, our study gathered personal narratives of users and providers of FCS. The results of this study and review of the existing literature have increased our awareness of many aspects of care that may facilitate FCS locally, as well as the aspects that may pose barriers (Arcuri et al., in press).

Bridging the gap using the knowledge-to-action cycle

The Canadian Institutes of Health Research (CIHR) defines knowledge translation as "a dynamic and iterative process that includes the synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system" (CIHR, 2015, para. 5). In addition, optimizing health-care service delivery and increasing recognition of barriers can contribute to improved health outcomes (Straus, Tetroe, & Graham, 2009a).

The knowledge-to-action cycle (Straus, Tetroe, & Graham, 2009b) guides one through the steps to using knowledge in the clinical setting, implementing change and measuring this change. It includes the following steps: 1) identifying a problem; 2) adapting knowledge to local context; 3) assessing barriers to knowledge use; 4) selecting, tailoring and implementing interventions; 5) monitoring knowledge use; 6) evaluating outcomes and 7) sustaining knowledge use. Since this cycle is iterative, any of the steps may be revisited at any given time and further interventions may be carried out to ensure knowledge uptake. Through the use of the knowledge-to-action cycle, the barriers and facilitators to the implementation of FCS within practice may be identified and recommendations may be developed, thereby allowing for an increased consistency in the uptake of FCS. A potential example includes the following initial steps:

Step 1 – Identifying a problem: FCS is an evidence-based practice that has not been widely implemented in pediatric care.

Step 2 – Adapting knowledge to local context: Test how the current FCS model has been implemented in one setting and identify the adaptations that were necessary in the care delivery model (e.g., costs, time management for clinicians, patient flow).

Step 3 – Assessing barriers to knowledge use: Identify which barriers are present in the given context.

Studies to date have not explicitly used a KT process, which would provide researchers with a framework to develop, implement and monitor outcomes of FCS implementation. Consistent with the knowledge-to-action cycle is the use of stakeholder engagement to facilitate the process (Camden, Rivard, Pollack, & Missiuna, 2015). The involvement of all stakeholders, including parents, health-care providers, researchers, health-care administrators, members of governments and policy-makers is a potential approach to increase the adoption of FCS. Such an approach would ensure that the perspectives of all stakeholders are reflected, thus allowing for all needs to be met.

The implementation and evaluation of guidelines

It has been our experience that efforts to implement FCS are not always supported within institutions and facilities. The complexity of implementing a truly family-centred service requires a major shift in an organization, with the support of all of its levels (decision-makers, managers, administrators, directors and service providers). Evidence-based guidelines (e.g., CanChild, 2015) do exist for FCS; however, they have not been systematically tested through implementation studies. Encouraging the use of such guidelines as well as the initiation of implementation studies to evaluate best practices for this use would be advantageous and could assist health-care providers to incorporate FCS into everyday practice. Practice guidelines, adapted to the local context, could be

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created with the involvement of health-care providers, users, researchers and decision-makers, and could provide succinct, tangible ways in which FCS would be applied in the practice setting.

Conclusion

This paper argues the benefits of using a KT model of change for supporting the implementation of FCS in pediatric rehabilitation practice, including the use of stakeholder engagement and the development of practice guidelines adapted to the local context. The knowledge-to-action cycle may facilitate the synthesis of research findings, the use of guidelines and the implementation and monitoring of strategies to increase the use of FCS in practice.

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ADULTS

TOPIC EDITOR: PATRICIA DICKSON

Supporting recovery: Integrating components of community re-engagement into resources for health-care providers and persons with stroke

Donna Cheung and Jocelyne McKellar

The needs and issues faced by persons with stroke (PWS) are multi-dimensional and complex. The literature suggests that patients are often reluctant to ask questions or simply don't know what questions to ask their health-care team regarding their recovery needs (Flessiga, Glassera, & Lloyd, 1999). A recent study revealed that PWS feel dependent on health-care providers to guide their care and recovery, but often have difficulty obtaining the support and information they need to re-engage in meaningful activities once in the community (Cheung et al., 2012). For the purposes of this article, community re-engagement (CR) is defined as "a holistic approach to the reorganization of physical, bio-psycho-social characteristics so that an individual can resume well-adjusted living after illness" (Wood-Dauphinee & Williams, 1987, p. 492). This article highlights the benefits of incorporating the concept of CR into resources for both health-care providers and PWS to support recovery and re-engagement in the community following stroke.

Trigger tool for health-care providers

Stroke best practices identify the following components or areas of CR be considered when providing client-centered care: health management, support network, environment, life roles, mobility, caregiver network and communication (Heart and Stroke Foundation of Ontario, 2003). Financial management is also important to include in such a list, given its potential impact on the other components. We used these components to develop a trigger tool for health-care providers called Supporting Stroke Survivors in Community Re-engagement that includes questions relevant to each component. The intentions of the trigger tool were to: 1) encourage health-care providers to reflect on the breadth of care needs following stroke and 2) facilitate meaningful conversations with PWS and caregivers to support re-engagement into the community.

A study conducted in 2010 evaluated the impact of an education intervention, which integrated this tool with the concepts of interprofessional collaborative care, on health-care providers' day-to-day practice (Cheung et al., 2012). Health-care providers reported integrating the components of CR into practice through their assessments, discharge planning and interprofessional team rounds. They acknowledged increased confidence in working with PWS and addressing components of CR they had not previously considered or had felt were out of their scope of practice prior to the intervention. Furthermore, health-care providers felt the education intervention facilitated a common language within and across teams, contributing to a more holistic approach in their delivery of care (Cheung et al., 2012).

What emerged from this study was the need to develop a question prompt tool for PWS to use, using the same components of CR. Health-care providers proposed that such a tool would enable PWS to better anticipate and self-manage their care needs (Cheung et al., 2012). This recommendation is consistent with literature suggesting that patients who ask questions are more likely to elicit useful information, which consequently leads to an increase in self-efficacy and a greater sense of confidence and control over their care (Smith et al., 2008).

Trigger tool for persons with stroke

In 2012, the trigger tool for health-care providers was tailored for PWS and caregivers and named Community Re-engagement Cue to Action Trigger Tool (CRCATT). Its purpose is to serve as a starting point for PWS to have meaningful conversations with their health-care teams to better self-manage and anticipate their needs as they transition to community living.

A randomized control trial, completed in 2013, explored if PWS who received the CRCATT would report higher participation in valued activities and more positive experiences in their re-engagement process than those who did not receive

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the CRCATT. The study also explored if the CRCATT would: 1) prompt PWS to have discussions with health-care providers concerning components of CR, 2) enable PWS to better anticipate their needs and 3) enhance PWS' inquiry into stroke-related services and information (McKellar, Cheung, Huijbregts, & Cameron, 2015).

This multi-site study was conducted in three rehabilitation facilities in Toronto. The experimental group received the CRCATT, in-person instructions on how to use the tool, a tip sheet on how to communicate with health-care providers and a booklet developed by the Heart and Stroke Foundation of Canada; the control group received only the booklet (McKellar et al., 2015).

The study used both quantitative and qualitative data to gain perspectives on PWS' experience with CR. The Return to Normal Living Index (RNLI) quantitatively measured participants' satisfaction with CR. After statistically controlling for variables such as age, gender, education, caregiver support and English as a first language, no between-group differences were observed (McKellar et al., 2015).

Qualitative data were obtained through semi-structured interviews designed to elucidate participants' experiences using the CRCATT and its influence on CR. Analysis revealed a multitude of internal and external factors that emerged as salient to recovery and individuals' ability to re-engage into the community. External factors included the availability of formal and informal social supports to help adapt to the consequences of stroke and address reported feelings of isolation. Participants in the study also indicated that they found interactions with health-care providers and the ability to access information to be important. Internal factors included personal outlook and attributes such as willpower, motivation to overcome limitations and dedication to hard work. Participants judged their recovery by the degree to which they felt independent, felt a sense of control over their recovery and found themselves able to participate in activities meaningful to them.

The interplay of the CRCATT with each of these factors was explored to understand the tool's impact on CR. Participants perceived the CRCATT to be a useful tool, which enhanced their awareness and anticipation of needs, as well as provided a sense of control over their recovery by helping them to take a more self-directed role in their care. Data revealed how the tool allowed some participants to ask questions about several components of CR they may not have previously considered. Several recipients of the CRCATT spoke of its usefulness in generating conversations with family members, keeping track of their recovery and encouraging them to seek out available services, as illustrated by the following quote from a participant.

> *I found it helpful . . . it organized things a lot better. It was all there when I needed it. You know, caregiver support, how are they dealing with it, are they showing signs of depression or burnout? . . . It was useful to make sure everything was covered that they told me . . . you would need this, it would be 100% essential.* (McKellar et al., 2015, p. 141)

Summary of research

The two studies introduced in this paper demonstrate the value of incorporating the eight components of CR into trigger tools for health-care providers and PWS. These tools were found to:

- Encourage a common understanding of the components that should be considered to support recovery and re-engagement in the community
- Guide health-care providers and PWS to engage in meaningful interactions
- Raise health-care providers' awareness of the multiplicity of factors that influence PWS post stroke
- Empower PWS to take a more active role in their care by considering their overall needs and drawing on their internal strengths to facilitate decision-making and goal setting

Both trigger tools can be found at: http://www.tostroke.com/for-professionals/research/

Looking to the future

The concept of CR is gaining interest locally and provincially. The components of CR have been integrated by the Toronto Central Local Health Integration Network (LHIN; Ontario's regional system of funding health services) into the online Healthline that it funds (www.torontocentrahealthline.ca). This site includes information that enables health-care providers, PWS and caregivers to better navigate and access stroke services and resources. Subsequent Healthlines throughout Ontario's other LHINs are also adopting a CR approach.

The CRCATT has been integrated into a self-management resource created by the Toronto Stroke Networks called *My Guide for Stroke Recovery* (2015; formerly *My Stroke Passport*). This resource will be provided to PWS in the acute or rehabilitation stages of recovery by stroke team members working in Toronto facilities. Ongoing work within the Toronto Stroke Networks will see the components of CR incorporated into the development of community and secondary prevention models of care.

Including the components of CR in trigger tools and other new and existing resources can facilitate a more integrated approach to caring for PWS. Health-care providers may find that using these resources enables them to improve their ability to support recovery and re-engagement in the community for PWS.

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OLDER ADULTS

TOPIC EDITOR: SANDRA HOBSON

A critical collaboration: Exploring the relationship between health-care aides and occupational therapists in long-term care facilities

Lynda Wolf

An increasing number of Canadian occupational therapists are being employed by long-term care (LTC) facilities to address the complex needs of frail elderly residents (Banergee, 2007). These therapists are frequently hired into part-time positions without access to trained occupational therapy support personnel. Instead, these therapists must rely on health-care aides (HCAs) to carry out recommendations arising from the occupational therapy assessment process. Therefore, it is helpful if therapists understand the role and function of these health-care providers and the factors that influence their performance in the workplace.

HCAs, also known as nursing assistants and resident attendants, are unregulated health-care workers who provide most of the direct care to residents in LTC facilities (Coogle, Parham, & Young, 2007; Cranley et al., 2012). In all instances, these health-care providers report to nursing supervisors who determine their work schedule and responsibilities. Occupational therapists in LTC facilities usually develop an informal working relationship with HCAs with oversight from a nurse manager.

HCAs carry out 70-80% of the direct care provided to residents of LTC facilities (Coogle et al., 2007; Cranley et al., 2012). Typical LTC residents are frail older adults with multiple chronic medical conditions and some degree of cognitive impairment (Banergee, 2007). HCAs assist these residents with personal care activities such as mobilizing, dressing, bathing, grooming and eating. HCAs often work within severe time constraints (Banerjee, 2007), having, for example, only a few minutes to spend with each resident during morning care. In addition to providing direct care, these workers are expected to observe and report changes in residents' health, functioning and behaviour (Aitken, 1995; Browne & Braun, 2008). In the course of providing care, HCAs acquire extensive knowledge about each resident, including his or her personal experiences, abilities and limitations. The care provided by HCAs impacts many aspects of residents' well-being, including pain management, skin care, urinary health and food intake, as well as mental status and general quality of life (Cranley et al., 2012; Kitwood, 1997).

Most HCAs working in the United States are middle-aged females who are fairly recent immigrants from a variety of countries. Some have professional credentials from their home country, which are not recognized in North America, thus necessitating a move to lower paying, non-professional jobs. A significant number of these HCAs are the sole wage earners in their families, with many working multiple part-time jobs with more than one employer (Browne & Braun, 2008). Although a comprehensive study of HCAs working in Canada has yet to be conducted, separate studies reveal a similar demographic profile for Canadian HCAs (Estabrooks, Squires, Carleton, Cummings, & Norton, 2015). Browne and Braun (2008) reported that up to 12% of foreign-born nursing assistants in the United States are not able to speak English well. Such language deficits have an impact on interactions with residents, family members, peers and supervisors. However, studies do not indicate a difference in the quality of care provided by foreign-born HCAs compared to care provided by HCAs born in North America (Browne & Braun, 2008).

Inadequate job preparation is a major issue for HCAs (Aubry, Etheridge, & Couturier, 2013; Morgan, Stewart, D'Arcy, Forbes, & Lawson, 2005), with new graduates often not prepared for the heavy workloads and fast paces of work they encounter (Aubry et al., 2013). In 1995, Aitken observed that an individual HCA performs up to 40 lifts and transfers in a day, or the equivalent of moving 2000 pounds. Mallidou, Cummings, Schalm, and Estrabrooks (2013) found that HCAs spend much of their time on task-oriented activities, leaving little time to address the emotional and social needs of residents. As a result of their limited training, HCAs may fail to understand the needs of elderly residents or to recognize their capacitites and strengths (Winzelberg, Williams, Preisser, Zimmerman, & Sloane, 2005).

Because residents with dementia may exhibit agitated and challenging behaviours, HCAs are at risk of physical injury. Many have not been trained to interact effectively with residents exhibiting disturbed behaviours (Morgan et al., 2005). Up to 73.4% of HCAs who worked in an LTC without a special

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care unit have experienced some form of physical assault (Chrzescijanski, Moyle, & Creedy, 2007).

Despite training limitations, Cruttenden (2006) commented upon the critical thinking ability often demonstrated by these workers through insights grounded in their experiences with residents and the culture of the facility. Aubry and colleagues stated that "nursing assistants are not passive individuals . . . but rather active participants contributing to the creation and development of their practice within the scope of their work teams" (2013, p.4). Aubry and colleagues also described how these workers develop informal task distribution strategies to cope with workload demands and how they support new staff members and orient them to these practices. They also observed that HCAs play a critical role in the implementation of changes proposed by management (Aubry et al., 2013). However, these strengths are not always recognized by other team members, and many HCAs experience low self-esteem (Coogle et al., 2007).

Unlike occupational therapy support personnel (Canadian Association of Occupational Therapists, 2009), HCAs are not held responsible for incorporating the principles of enabling occupation (Townsend & Polatajko, 2013) in the care they provide to residents, as they are not directly supervised by occupational therapists. At the same time, an occupational therapist in a LTC facility must depend largely on HCAs to implement many recommendations resulting from the occupational therapy assessment process. To fulfil the goals of enabling occupation while supporting the well-being of residents, the therapist needs to learn to interact strategically with residents, HCAs and nurse managers. The following example, derived from the author's experience, is used to illustrate these complex relationships:

An occupational therapist is employed by a long-term care facility to provide part-time service to three separate nursing units. The therapist has conducted a functional performance assessment with a resident with dementia. The therapist recommends that, as part of the resident's morning care routine, the resident be encouraged to wash her face, brush her teeth and comb her hair, with supervision. The therapist is mindful of the limited time an HCA can spend with each resident. However, because the therapist believes in the benefits of such a plan to the resident, but is unable to be present most mornings, the therapist solicits support for this plan from the nurse manager and then from the resident's HCAs. Only after the supervisor supports the care plan and agrees to make any necessary changes to the HCAs' work schedule does the therapist discuss the plan with the appropriate HCAs. The therapist, acting as a colleague and collaborator, explains the recommendation to the HCAs (Cranley et al., 2012), pointing out how they will promote the resident's cognitive and physical function and quality of life by enacting the plan. The therapist acts as coach and mentor, demonstrating the appropriate words, gestures and strategies to be used with the resident. The therapist realistically expects some inconsistencies in the implementation of the care plan and provides positive feedback and redirection as needed.

This example illustrates that occupational therapists working in LTC facilities need to have strong practice skills, and equally strong interpersonal skills in order to act as collaborator, mentor and coach. With these skills, and recognition of the work stressors and challenges encountered by HCAs, occupational therapists will be able to acknowledge competent, insightful and committed colleagues on whom they can rely to promote enabling occupation with frail older adults living in LTC facilities.

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EVERYDAY STORIES

Supervising students in a specialized practice setting: A new Alberta therapist invests in his profession

Cori Schmitz and Jarett Stastny

Jarett Stastny

Jarett Stastny has been practicing as an occupational therapist at Millard Health Rehabilitation Centre in Edmonton, Alberta, since he graduated from the University of Alberta master of science in occupational therapy (MScOT) program in 2011. Despite being early in his career, Jarett has supervised numerous occupational therapy students and has earned himself an appointment as a clinical lecturer with the University of Alberta's Faculty of Rehabilitation Medicine.

Millard Health Rehabilitation Centre is the main Workers Compensation Board service provider in Northern Alberta. Jarett initially worked in their hybrid return-to-work program, then in their hand therapy program and, most recently, joined their Traumatic Psychological Injury (TPI) program. Clients in the TPI program have experienced psychological injuries related to their work, including injuries caused by industrial or motor vehicle accidents, or the impact of being first responders or victims of sexual or physical assault. The occupational therapist's role in this program is to facilitate *in vivo* (real world) exposure therapy sessions in which clients safely and gradually confront fears from the trauma, as well as to support clients' overall return to work.

Jarett has taken the initiative to offer fieldwork placements in each of these Workers Compensation Board practice settings, which has contributed significantly to the breadth of experiences available to students in the University of Alberta MScOT program in recent years. Cori Schmitz, the University of Alberta's academic coordinator of clinical education, interviewed Jarett to learn more about how he has managed to facilitate student fieldwork placements in this emerging area of occupational therapy practice and in a program where placements had not previously been offered.

Cori: The TPI practice setting is intense and not a typical placement. How would you describe the TPI placement experience for a student?

Jarett: I would certainly say [it's] challenging. I think it challenges students' rapport building skills since that is an incredibly crucial element when working with this clientele. Interviewing skills are also important: the ability to get the information they need, to draw out certain details and to listen. Students need to be patient while clients are processing their trauma during exposure therapy sessions; they have to challenge the client while also being careful not to expect or demand more than the client is comfortable with. I think the students are also challenged just in terms of hearing the trauma stories that people are bringing with them. It can be taxing on care providers to hear about the things that people have gone through.

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Cori: Given the presence of trauma and the fact that their therapeutic use of self is so important in the TPI setting, how do you support your students for success?

Jarett: It is important to give them a heads up about those potential challenges. You, the university placement coordinator, assist us to identify students who are specifically interested in this type of work. Having the right students involved is vital, as is being permitted to set up a pre-placement interview to give them an idea of what the setting is all about and what they may need in terms of support during the placement. When the preceptor(s) first meet with students, we discuss caregiver burnout and the risks of dealing with trauma stories. We also familiarize them with the resources that we have here on-site, including a quiet room. We teach students the same relaxation techniques that we teach our clients. We encourage them to take their lunches and breaks, and to make use of the staff gym and exercise classes. We encourage them to have a balanced lifestyle. Practice what you preach, right? We also encourage students to speak up if there is a situation that hits a little too close to home given their own personal history. There are workarounds available that can be used if they are not comfortable with a particular situation.

Cori: Six- or seven-week placements are pretty short for a setting like this. How do the placements unfold?

Jarett: Our clients' length of stay is typically longer than our students' length of stay. We have difficulty introducing students to the caseload in a chronological way so instead we have them jump right in. Typically we start with some observation and get students familiar with the different types of appointments that we do: intake meetings, exposure sessions, fear hierarchy sessions and case conferences. There's probably a longer period of observation in this setting than in other placements and, realistically, the preceptor will always need to be present. One of the biggest challenges we debated when we first considered taking students into this setting was their ability to actually be involved to the degree that the university expects in terms of percentage of caseload management and complete independence. Initially we consulted with you [Cori] about that and had to relax our objective measures and be strategic about student involvement. We now focus on having them take a lead role when possible. We deconstruct the process and find parts that are accessible to student participation and intervention.

Cori: Are there certain characteristics, traits or skills that really come to the forefront when students are in this setting?

Jarett: Creativity in activity analysis and grading. We collaborate with the client to create a fear hierarchy, a list of items that they are afraid of or distressed by, and creativity is needed to find strategies to tackle those challenges in exposure therapy sessions. I really value the students' contributions to this creative process. I appreciate students that are collaborative, client-focused and feel comfortable to work openly and transparently with me and with the client.

Cori: You were only a student five short years ago and I'm sure can still remember your own fieldwork experiences. Do you have any advice or words of wisdom for how to maximize student learning and engagement during placements?

Jarett: As a student, I was always shared by multiple preceptors and I have always offered placements where I share student supervision with another therapist. It's helpful to have another person and another caseload involved to increase learning opportunities and for students to learn to prioritize their time. Another thing we've found very helpful is taking the time to look thoroughly through the student's online ePortfolio. It's interesting to know where they've been for previous fieldwork and to learn about their life experiences. I find it helpful to know about their learning styles and preferences, and their perceived strengths and challenge areas. I talk to the student about those things and, as best we can, work on or capitalize on them during the placement. We also intentionally schedule time each week to meet with the student. A lot of processing needs to go on in mental health practice and they need time to "digest" all that they have experienced.

Cori: Do you have an occupational therapist "hero" or someone who has mentored you in your own practice or in the greater occupational therapy community?

Jarett: I would be remiss if I did not mention my colleagues here at Millard Health. Having readily accessible psychologists has been phenomenal, especially because this is an emerging area of occupational therapy practice. Our involvement with TPI clients in supporting their occupations is relatively new, so the literature and clinical experience has existed primarily in psychology.

During our interview, it was apparent that Jarett is excited to be a part of mental health service provision. He explained that he enjoys being involved in shining a light on mental illness, challenging stigma and being part of the movement to facilitate awareness and client recovery. Jarett explained that he makes a deliberate effort to relay his excitement to his students. He has found a way to give back and grow our profession by championing an exceptional educational experience for students who are intrigued by this specialized area of practice.

EDUCATION AND FIELDWORK

TOPIC EDITOR: CATHERINE WHITE

Simulation in occupational therapy education

Jonathan Harris

Simulation is being used to prepare occupational therapy students for real-life practice scenarios while minimizing risk to clients (Zachry, Booker, & Woods, 2015). Maran and Glavin (as cited in Bradley, Whittington, & Mottram, 2013) define simulation as "an educational technique that allows interactive, and at times immersive, activity by recreating all or part of a clinical experience without exposing patients to the associated risks" (p. 43). Practice-based simulation allows educators to grade the difficulty and content of experiences, provide uniform experiences for all students and enable the repetitive practice of key skills (Bokken, Rethans, Scherpbier, & van der Vleuten, 2008). Furthermore, simulation can be particularly effective for practicing the delivery of bad news and other sensitive skills (Bokken et al., 2008). Recently, occupational therapy accreditation guidelines in Australia and New Zealand have allowed for the replacement of student clinical fieldwork hours with carefully-structured simulated learning activities (Rodger, Bennett, Fitzgerald, & Neads, 2010; Occupational Therapy Council, 2013a, 2013b). In short, simulation offers unique benefits and is used in occupational therapy education, sometimes as an adjunct to practice-based learning.

However, as recent literature indicates, there are relatively few published studies examining the characteristics of effective simulation in occupational therapy (Bethea, Castillo, & Harvison, 2014; Haracz, Arrighi, & Joyce, 2015). Consequently, the remainder of this article samples from the abundance of simulation literature in other health disciplines to suggest that: 1) carefully-crafted simulation activities offer effective learning opportunities, 2) the characteristics of effective simulation are well defined and 3) occupational therapy educators should determine how this knowledge can be used to enhance and develop existing or potential occupational therapy simulations.

Carefully-crafted simulation activities offer effective learning opportunities

Physiotherapy education literature has shown that a portion of clinical time can be replaced with simulated learning experiences while maintaining student learning outcomes. For example, one recent randomized controlled trial compared the learning outcomes of three groups of physiotherapy students using three combinations of simulated patient encounters and practice-based clinical learning in a musculoskeletal setting (Watson et al., 2012). The first group of students had the first week of a four-week clinical placement replaced with a simulated caseload. A second group was exposed to a combination of simulated and clinical learning experiences during the first two weeks of the four-week placement. A third group participated in four weeks of clinical learning as usual. Interestingly, students in both simulation groups enjoyed the same level of success in clinical competencies as those in the purely clinical learning group (Watson et al., 2012).

Similarly, recent nursing education research has investigated the effects of replacing clinical hours with simulation exercises in pre-licensure nursing students (Hayden, Smiley, Alexander, Kardong-Edgren, & Jeffries, 2014). Simulation characteristics included clear learning objectives, problem-solving components built into the scenarios, fidelity with learning objectives and structured debriefing following each scenario. Results from this study suggest that up to 50% of undergraduate nursing clinical hours can be replaced while preserving student outcomes related to practice competency (Hayden et al., 2014).

The characteristics of effective simulation are well-defined

There are a seemingly endless number of ways to approach practice-based simulation. Fortunately, a systematic review was completed that describes the characteristics of effective high-fidelity medical simulation as reported in studies conducted between 1969 and 2003 (Issenberg, McGaghie, Petrusa, Lee Gordon, & Scalese, 2005). These characteristics included the provision of feedback, repetitive practice, curricular integration, a range of difficulty levels, multiple learning strategies, capturing clinical variation, controlled environments, individualized learning, defined outcomes and simulator validity. Although the

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studies included in this review tended to involve technologically-based simulation (e.g., high-tech mannequins) rather than simulated clients, the lessons learned may be transferable to simulation in general. Subsequent work suggests that the provision of feedback is the single most important aspect of high-fidelity clinical simulation in medical education (Issenberg & Scalese, 2007).

With simulated client encounters identified as the simulation modality bearing closest resemblance to clinical fieldwork practice for student occupational therapists (Occupational Therapy Council, 2013a), understanding the characteristics of effective simulated client encounters is essential. Unfortunately, less research has examined this simulation modality. Results of one of the few studies to examine simulated patients in medical education suggests that whereas most studies have reported positive outcomes, more rigorous studies are required to determine the specific value of simulated patients (May, Park, & Lee, 2009).

In order to generate guidelines for simulation in occupational therapy in Australia and New Zealand, educators underwent an extensive consultative process, involving numerous clinical and university stakeholders from across the two countries (Rodger et al., 2010). Based on these discussions, the Australia/New Zealand accreditation body has adopted policies on simulation that allow for appropriately designed simulation activities to count toward up to 20% of the 1000 fieldwork hours required by the World Federation of Occupational Therapists (Occupational Therapy Council, 2013a, 2013b). There are a number of guidelines that dictate the nature of the simulated experiences that may be counted towards fieldwork requirements, including the preferential use of simulated patients (rather than videos of simulated or real patients) and the development of simulation activities in collaboration with the occupational therapy workforce (Rodger et al., 2010; Occupational Therapy Council, 2013a). Although these guidelines are not based entirely on published evidence, they are generally consistent with published evidence from nursing (Hayden et al., 2014) and medicine (Issenberg et al., 2005). The interested reader may refer to the *Occupational Therapy Accreditation Standards Explanatory Guide* (Occupational Therapy Council, 2013a) for a full list of requirements.

What does this mean for the education of occupational therapists in Canada?

High-quality simulation activities offer effective learning opportunities and have a number of unique benefits. The guidelines provided by our colleagues in Australia/New Zealand (Occupational Therapy Council, 2013a) might serve as a useful framework for developing high-quality simulation activities in Canada, or for improving the quality of existing simulation activities. As occupational therapy educators at one institution in the United Kingdom reported, the "investment to understand the context and principles of simulation has resulted in enhancements to student learning, supported by student feedback" (Bradley et al., 2013, p. 46). Occupational therapy educators should determine how knowledge about simulation can be used to enhance and develop existing or potential occupational therapy simulations.

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The use of verbal communication in enablement: Results and reflections from practicing occupational therapists

Jenny Hardy and Pam Jung

Occupational therapists use specific and special skills when helping clients to reach their goals, which we call enablement skills (i.e., adapting, advocating, coaching, collaborating, consulting, coordinating, designing/building, educating, engaging and specializing; Townsend et al., 2013). However, enablement skills do not exist in isolation from other important skills. In order to enable clients to reach their goals, occupational therapists need to have proficient verbal communication skills (e.g., paraphrasing, listening). Eklund and Hallberg (2001) found that occupational therapists use verbal communication in all steps of the therapeutic process. While strong verbal communication skills are recognized as an important ingredient in supporting clients, little is known about how occupational therapists specifically use verbal communication. A profession-specific understanding has been recognized in other areas. For example, physician-patient communication has been reviewed by many researchers. Understanding physician-patient communication has allowed physicians to reflect and improve on their own use of communication, and has supported medical school training (Levinson, Lesser, & Epstein, 2010). A similar focus in occupational therapy is needed, given the unique nature of the occupational therapist-client relationship, including the focus on enablement. By gaining knowledge of the use of verbal communication in practice, occupational therapists will be able to advance their knowledge of enablement and create new opportunities for professional development. The purpose of this paper is to explore, through reflection, verbal communication skills used during the enablement process. We will then reflect on the use of these skills in occupational therapy practice.

Learning through research

In the final year of our master of science in occupational therapy (MScOT) program, we carried out a study to explore how occupational therapists use verbal communication in the enablement process (Hardy, Jung, & Davis, 2013). In this study, participant dyads completed an activity working toward a mutually agreed-upon occupation-based goal. The participants were occupational therapists or student occupational therapists. During this activity, both participants were blindfolded, allowing us to isolate verbal communication. One participant instructed the other on how to build a physical structure using five multi-shaped pieces. We used this activity to represent a similar process that occurs in occupational therapy practice: two persons working together on a pre-determined occupation-based goal. Both individuals were interested in reaching the goal; however, one person was facilitating the process while the other was being guided to accomplish the goal. After reaching the goal, participants switched roles, repeating the activity. The activities were video-taped and participants provided input on their experiences as they watched the replay of their videos.

We identified 25 verbal communication strategies used by

Table 1. ***Verbal communication strategies used during completion of a mutually agreed-upon occupation-based goal (Hardy et al., 2013)***

Purpose	**To directly teach or learn a skill**	**To plan**	**To cope with own emotions**	**To manage or monitor the other's emotions**	**To ensure a mutual understanding**
Strategies	• Describing details • Repeating own instructions • Discussing other senses • Using metaphors • Rephrasing • Requesting specific information • Asking for or providing clarification	• Defining goals • Establishing language • Using transitional statements	• Speaking slowly when apprehensive about the next step • Gesturing • Using silence to collect own thoughts • Seeking validation • Laughing • Apologizing	• Speaking slowly to allow time for the other to follow • Allowing time (silence) • Checking in • Providing validation • Complimenting	• Repeating the other's instructions back using the same words • Debriefing • Confirming • Providing a progress update

both instructor and instructee through an analysis of the activity session videos and participant interviews. As we explored these strategies, we recognized that they were used for different purposes: 1) to directly teach or learn a skill, 2) to plan, 3) to cope with own emotions, 4) to manage or monitor the other's emotions and 5) to ensure a mutual understanding (see Table 1; Hardy et al., 2013). The strategies and purposes listed here are not exhaustive; however, they represent those that were observed repeatedly during the sessions.

Reflections from practice

Over the past two years since graduation, we have been working in very disparate roles as occupational therapists, at opposite ends of the age spectrum and separated geographically. Our daily responsibilities differ as well; Pam works with children in a school setting to enable classroom participation while Jenny is working as a coordinator of a project focused on promoting the mental health of older adults. Below, we discuss how the strategies we uncovered in our study are relevant to our practice and enablement skills (which are identified in italic font).

Pam

Over the past year working as a school-based occupational therapist, I have come to recognize the essential nature of verbal communication strategies in enabling children's classroom participation. While I use some more frequently than others, I have observed all 25 strategies throughout the therapeutic process. I will discuss four of them: using metaphors, establishing common language, complimenting and providing a progress update.

To engage students in therapy sessions, I focus on tailoring activities to match their interests. Using metaphors makes activities fun and helps students to understand and remember concepts. It helps me to *engage* and *educate* students, therefore, using two of the enablement skills. When facilitating a class on interrupting, I introduce the term "volcano mouth," based on the book *My Mouth is a Volcano* (Cook, 2008). Using these metaphors also helps to establish a common language in the classroom that is understood by all children and teachers. Teachers and students continue to use the language introduced in therapy sessions to facilitate carry-over of the skills to their everyday classroom activities.

Children referred to occupational therapy services are often aware of their occupational struggles. Too often, I hear students say "I am not very good at this." To increase their confidence, I provide them with compliments specific to the targeted skill along with tangible reinforcement. For example, I may say to a child, "Great job pinching the tip of your pencil," and give them a sticker. Providing specific compliments tells the child exactly what he or she did well, whereas a sticker alone could leave uncertainty as to what is being rewarded.

After each therapy session, I find it valuable to provide a progress update to the teacher and suggest classroom-based strategies. I find that verbal communication is the most efficient method to communicate this information. Using verbal communication affords the teacher an opportunity to take a more active role in the conversation and *collaborate* on ideas. Follow-up emails or a written summary can supplement the verbal conversation to ensure that details are remembered.

These verbal communication strategies weave their way into my work in new ways each day. They help me to develop and enact my knowledge and skills as an occupational therapist, and I am excited to discover how they will influence my third year of practice.

Jenny

As an occupational therapist working as a project coordinator for an Ontario-based pilot project for older adults experiencing low mood and anxiety, I have recognized that communication is extremely important in enabling communities to run this innovative mental health promotion program. I acknowledge that a large part of my work involves developing strategies, plans and policies electronically, therefore reducing my use of verbal communication. However, I do communicate verbally with key stakeholders, including community centre staff, research assistants, program facilitators, steering committee members and the broader research community.

The key verbal communication strategies that I use in my practice fall within the purpose of ensuring a mutual understanding. These help me to optimize my enablement skills relating to *educating* stakeholders, *coordinating* services and *engaging* communities. During in-person and telephone conversations, I commonly use the strategies of debriefing, confirming and providing a progress update. Unlike Pam, during telephone conversations, elements of non-verbal communication such as physical demonstrations, posture and eye contact are removed, leaving me with only verbal strategies. When I communicate verbally, the content and strategies need to be especially strong, clear and articulate.

Debriefing is important to use at project milestones because I cannot physically be at each community site. By debriefing, I learn what occurred and if it could be made easier the next time. I gather information by asking questions such as, "How did that go?" or "Were there any challenges?" From there, I can explore ways in which I can improve my support to staff during future milestones. This also helps *engage* communities, as they recognize that their feedback is important, highlighting their work as an important piece of the overall project. The strategy of providing a progress update works in the reverse. Instead of learning from the community site,

Two occupational therapy students attempt to create identical structures while blindfolded. As vision is eliminated, verbal communication is the only tool they have to reach this mutual goal.

the community site is being *educated*. With this strategy, I can share what I know with stakeholders to ensure that they have the appropriate tools and information to run the program effectively, or with the program partners so that they are aware of its successes and challenges. Last, the strategy of confirming is important for pilot projects, as they hold a sense of unfamiliarity. By confirming questions during a phone call, I can verify that a community staff member is confident in undertaking a certain task. When staff members running the program feel more confident, older adults will benefit, which is my ultimate goal. These three strategies ensure that despite geographical distance, we all understand one another and are open about what has happened and needs to happen. These verbal communication skills help me *coordinate* the overall program effectively.

Conclusion

Reflecting back on our study's findings and our first years of practice, we recognize how the use of verbal communication shapes the enablement process. Of course, the value of non-verbal communication cannot be overlooked. It was challenging for the participants in our study to achieve the task given that non-verbal communication was removed. Similarly, in describing our commonly used strategies in practice, we both felt that we needed to mention non-verbal strategies as well. Pam often uses gestures and demonstrations with her students, and Jenny often depends on electronic written communication. We understand non-verbal communication is important for enablement, and yet, the goal in our study was still achieved by all participants without it. The participants were creative and relied on the feedback of the other person, most often via questioning. The process was collaborative not because it should be, but because it had to be to accomplish the task.

When we are granted the gift of observation, we rely less on verbal communication. One might not ask for a progress update, for example, if one can see the progress of the client. But as our study demonstrated, verbal communication can elicit detailed responses to assist with planning, teaching, collaborating and managing emotions. It is unclear whether the same information would be conveyed had a therapist been able to observe the process.

In this article, we were able to reflect on the verbal communication skills we use in practice. Ultimately, we recognized that all of these verbal communication skills have important ties to enablement skills, validating the fact that these skills are more interrelated than we may understand. Pam and Jenny could not collaborate, educate, engage or coordinate in their occupational therapy practice without verbal communication. These findings warrant further reflection regarding the use of verbal communication strategies. Further understanding of verbal communication skills used by occupational therapists, and their link to enablement skills, would offer therapists new opportunities to grow and help to prepare student occupational therapists for practice.

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The production of precariousness through policy: Occupational injustice faced by forced migrants in Canada

Suzanne Huot

In light of the increased attention global refugee crises have recently received in the media, this paper will outline issues faced by forced migrants, highlight how policies within receiving societies may exacerbate their already precarious situations, and provide relevant references and resources for occupational therapists. The World Federation of Occupational Therapists (WFOT; 2014) defines human displacement as "the enforced departure of people from their homes due to situations such as war, persecution, and disaster" (p. 1). Forced migration is a conceptual category encompassing different groups of people experiencing displacement, including refugees, asylum seekers, internally displaced persons and individuals displaced by development, environmental conditions or disasters (Castles, 2003). The United Nations High Commissioner for Refugees (UNHCR; 2014) documented a record number of approximately 51.2 million displaced people worldwide in 2013.

While forced migrant populations are diverse, relating to the varied causes of their displacement, they are characterized by "the limited choice available to them and the pressured decisions they are compelled to make as they leave their homes in an effort to ensure their own, and their family's, [sic] survival" (Grove & Zwi, 2006, pp. 1931-1932), which often leads to occupational loss (Polatajko et al., 2013). They may leave with little resources and no idea if, or when, they will be able to return. In addition to the difficult conditions contributing to their displacement, and experiences within liminal spaces such as refugee camps, forced migrants who arrive in host countries (e.g., resettled through the UNHCR, making an asylum claim) experience a number of challenges related to occupation. These challenges are often exacerbated by structural conditions that create occupational injustices for forced migrants who may be "restricted from experiencing occupational rights, responsibilities, and liberties" (Nilsson & Townsend, 2010, p. 58).

Challenges can result from isolation and inability to engage due to language barriers, an unfamiliarity with the new environment, inadequate social supports, poverty, discrimination and inaccessible services (Simich, Beiser, Stewart, & Mwakarimba, 2005; Whiteford, 2005). Simich and colleagues (2005) argued that forced migrants' social exclusion contributes to limited awareness of available options, loneliness, discouragement and loss of identity. Similarly, Campbell and Turpin (2010) found that "refugees experience higher levels of emotional, psychological and physical distress" and that occupational therapists "working with refugees in many contexts feel unprepared and overwhelmed" (p. 425). These therapists' sense of unfamiliarity may also be related to the unique health-care needs and issues these populations face, including language and interpretation issues, shortage of health-care services, needs for culturally competent care, complex health insurance coverage and medical backgrounds, economic barriers and isolation, as well as exposure to violence, trauma and torture (Gushulak & MacPherson, 2006; McKeary & Newbold, 2010).

In the Framework for Occupational Justice (Stadnyk, Townsend, & Wilcock, 2010; Townsend, 2012), conditions of occupational injustice are conceptualized as arising from the combination of individual contextual factors with broader structural factors (e.g., economy, cultural values, policies, health and community supports, recreational facilities, transportation). Therefore, recent changes to Canada's refugee determination system have implications for forced migrants who arrive here, since varying degrees of protection and access to services are available depending on what legal status is obtained (Grove & Zwi, 2006). In several Western nations, including Canada, policies have been enacted to deter asylum seekers from entering or remaining within the country (Gibney & Hansen, 2003). In 2012, the Canadian federal government altered the Interim Federal Health program (Government of Canada, 2014) to limit health-care services available to these populations, and also passed Bill C-31, which created specific categories of forced migrants, such as those from "designated countries of origin," who face limited access to appeals for their claims, or those arriving as "designated irregular arrivals," who face mandatory arrest and detention without a warrant, among other restrictions, such as loss of the right to sponsor family members for a five-year period even if their claims are successful (Bill C-31, 2012; Huot, Bobadilla, Bailliard, & Laliberte Rudman, 2015). However, the newly appointed Minister of Immigration, Refugees and Citizenship, John McCallum, has recently announced that the federal government will restore the previous health-care cuts ("Liberals to Fully Restore," 2015).

While a number of articles have been published addressing the experiences of forced migrants from an occupational perspective (e.g., Burchett & Matheson, 2010; Mirza, 2012; Suleman & Whiteford, 2013), there remains a dearth of studies being conducted in Canada (e.g., Connor Schisler & Polatajko, 2002). More research must be conducted that addresses the systemic barriers to meaningful occupational engagement that forced migrants continue to face. In 2012, Wilberg published a call to action for occupational therapists "to boldly go" into a new frontier for occupational therapy that includes refugee sponsorship, settlement and support. More recently, a workshop on "doing" human rights (Hocking et al., 2015) was held, during which forced migrants were featured as a key population with whom occupational therapists could work toward the aim of promoting a more inclusive society. Advocating against the increased precariousness forced migrants face as a result of policies, such as the Protecting Canada's

Immigration System Act (Bill C-31, 2012) and the occupational injustices it produces for an already vulnerable population, is an essential task for occupational therapists to take on. Those interested in working with forced migrant populations can begin by contacting local community organizations that offer settlement services. They can also get involved in broader organizations and associations such as the Canadian Association for Refugee and Forced Migration Studies (http://carfms.org) and Occupational Opportunities for Refugees and Asylum Seekers (http://www.oofras.com). For more details on the federally funded health coverage available to forced migrants in Canada, visit: www.cic.gc.ca/ifhp

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Economic evidence for occupational therapy services: Reflections from the 2015 Occupational Therapy Canada Forum

Andrew Freeman, Giovanna Boniface, Donna Collins, Lori Cyr, Marjorie Hackett and Gayle Salsman

The 2015 Occupational Therapy Canada (OTC) Forum, held on May 27, 2015, in Winnipeg, Manitoba, took the form of a reflection day entitled *Economic evidence for occupational therapy services: Crunching the numbers, describing value*. With the facilitation of Dr. Colleen Metge (director of the Centre for Healthcare Innovation Evaluation Platform at the Winnipeg Regional Health Authority), 27 representatives from the Association of Canadian Occupational Therapy University Programs (ACOTUP), the Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO), the Canadian Association of Occupational Therapists (CAOT), the Alliance of Canadian Occupational Therapy Professional Associations (ACOTPA) and the Canadian Occupational Therapy Foundation (COTF) participated. The OTC Forum was organized by a working group comprising representatives from these five organizations.

How the OTC Forum theme was chosen

This year's reflection day was a logical follow-up to the two previous OTC Forum discussions that took place in Victoria, British Columbia, in 2013 and Fredericton, New Brunswick, in 2014. The objective of the 2013 discussion was to gain a fuller understanding of the educational, practice, regulatory, political and economic implications of occupational therapy competencies, proficiencies, advanced practice, and specialization, from the perspectives of a range of stakeholders in our profession in Canada. A variety of themes, as well as topics for future collaborative action, were identified by the participants (Freeman et al., 2014). In turn, the 2014 discussion focused on identifying occupational therapy's unique contribution, defining a common vision congruent with this contribution and articulating a plan to realize the common vision (Rappolt et al., 2015).

The focus of the 2015 OTC Forum was on economic evidence for occupational therapy services. There is strong agreement within our profession in Canada and elsewhere about the need to strengthen this body of evidence (Lambert, Radford, Smyth, Morley, & Ahmed-Landeryou, 2014; Macdonald, 2006; Rexe, McGibbon Lammi, & Von Zweck, 2013). It is necessary not only to demonstrate that occupational therapy makes a difference for clients, but also that it makes economic sense. As articulated during the 2013 OTC reflection day, "occupational therapists, occupational scientists and occupational therapy organizations must invest in initiatives to build evidence of effectiveness and cost effectiveness of occupational therapy practices. . . ." (Freeman et al., 2014, p. 27). At the 2014 OTC reflection day, one of the five key principles identified was the following: "Economic evidence: A top priority for the occupational therapy profession in Canada is the demonstration of the economic value of the effectiveness of occupational therapy services for all ages and populations served by occupational therapists" (Rappolt et al., 2015, p. 24). Subsequently, one of OTC's four priority actions identified was "demonstrating outcomes and cost benefits: As both public servants and private practitioners, occupational therapists must account for their assessments, interventions and clinical and economic outcomes. Producing evidence of the effectiveness and cost benefits of occupational therapy services is a top priority" (Rappolt et al., 2015, page 25).

"It is necessary not only to demonstrate that occupational therapy makes a difference for clients, but also that it makes economic sense."

In proposing a structure to engage representatives of Canada's five leading organizations in a strategic reflection about economic evidence for occupational therapy services, the planning group believed that one obstacle impeding our profession's progress in this area is a limited collective level of expertise. That is, while acknowledging the important efforts already made to help occupational therapists develop expertise (e.g., Law, Law, & Watson, 2014) and the gradually evolving body of research evidence (e.g., Sampson, James, Whitehead, & Drummond, 2014), many members are not necessarily equipped to participate knowledgeably in discussions about this area and thus help to advance the discussion. Consistent with this conclusion, Dr. Colleen Metge was asked to help facilitate the OTC Forum, with a view to helping participants develop a common knowledge base.

How the day was organized

The 2015 OTC Forum was divided into three broad sections. During the first section, Dr. Metge covered the following subject areas to help participants to develop their ability to use health economics to interpret findings about the value of occupational therapy:

- definition of economics and health economics;
- three important concepts for understanding economic evaluations: opportunity cost, benefit, cost;
- cost-effectiveness: measuring the value of health-care services;

- key aspects of economic evaluations: costs, benefits, synthesis of costs and benefits;
- handling the uncertainty in cost-effectiveness analysis;
- judging the value of health economic evaluations; and
- explaining the findings of an economic analysis.

The focus of the second section was to identify the applicability of the information for each of the five occupational therapy organizations in Canada, in terms of its congruence with their respective mandates. The representative of each of these groups presented their reflections to the entire group of participants.

Finally, the objective of the third section of the day, setting collective profession priorities and committing to an action plan, was carried out by all participants together. Detailed notes of all these discussions were subsequently transcribed and analyzed in order to arrive at the following summary of the findings.

Findings

The discussion confirmed that this year's topic, economic evidence for occupational therapy services, is a logical continuation of the discussion held at the 2014 OTC Forum. That is, advancing the development and transfer of knowledge regarding economic evidence for occupational therapy services must be aligned with the profession's reflections about its unique contribution and the populations that are believed to benefit most from this contribution. Thus, the importance of continuing to build profession-wide consensus around these two topics was strongly reinforced, while nevertheless recognizing regional variations regarding population priorities.

It was recognized that economic evidence for occupational therapy services should build upon research evidence about the efficacy of these services. In other words, occupational therapy services ultimately need to be supported by research evidence pertaining both to their efficacy and economic benefits.

There was agreement that in order to advance the priority of economic evidence, the profession's collective capacity must be developed. To this end, two distinct, yet complementary, objectives were proposed:

1. Develop an occupational therapy economic evidence base case

It would be highly beneficial to have an occupational therapy economic evidence "base case" that would model the general parameters to be included in economic evidence studies. Such a case would serve as a general template to be used by different stakeholders within the profession to advance this area. This case should be situated within an occupational therapy service that clearly reflects this profession's distinctive contribution and should pertain to a population group that is believed would clearly benefit from this contribution.

The development of a useful base case will require the contribution of knowledge from partners within and outside the profession. This may include, for example, expertise in health economics, in addition to the expertise provided by Canada's occupational therapy organizations (e.g., researchers, provincial/national associations).

It was recognized that it probably is not necessary to start this process from the very beginning. It will be important to scan the literature for existing useful examples and other elements; graduate students in both research and professional programs have a potential role to play in advancing this cause.

In recognizing the steps required to achieve this goal, and the fact that the profession's organizations will contribute in different ways, consistent with their respective mandates, it was not possible for the participants to propose a specific timeline. However, it was recommended that one of the OTC's priorities should be to play an overall coordinating role to ensure that this goal is achieved as quickly as possible.

2. Further develop CAOT's clearinghouse capacity with respect to economic evidence for occupational therapy services

It seems clear that advancing the development and transfer of knowledge about economic evidence for occupational therapy services in a meaningful way will require collective effort and the contribution of each of the profession's organizations. However, given these multiple contributions, maintaining coordination may be a challenge. To this end, the important role played by CAOT as a "knowledge clearinghouse" within the profession in Canada was recognized. It is recommended that CAOT continue to exercise this role as the economics evidence cause is advanced. As a starting point, CAOT already has a page on its website devoted to economic evidence: http://www.caot.ca/default.asp?pageid=1012 The content of this web page could be augmented to include the base case, a reference list (updated on an ongoing basis by different profession stakeholders) and links to useful resources.

Summary

It is clear that the work carried out at the 2015 OTC Forum is merely one step in the process of advancing the important priority regarding economic evidence for occupational therapy services. Nevertheless, we strongly believe that it is a crucial step in creating collective energy and engagement in our profession

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in Canada. We invite all members to help build this expertise as we move forward.

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Recommendations to foster standardization for the completion of Algo

Mélanie Ruest, Annick Bourget, Nathalie Delli-Colli and Manon Guay

The context of Quebec's health and social services network features various organizational constraints (e.g., a current lack of occupational therapists to meet the growing needs of an aging population), which has lead to calling upon non-occupational therapist workers to provide services that have normally been delivered by occupational therapists (Guay, 2012). In the home care sector, occupational therapists collaborate with support staff and members of interdisciplinary teams, among others, when determining the need for assistive devices for their clients' personal hygiene activities (Guay, Dubois, Desrosiers, Robitaille, & Charest, 2010).

Considering this situation, Algo (short for clinical algorithm) was recently developed by Guay and colleagues (Guay, Dubois, Robitaille, & Desrosiers, 2014; Guay, Dubois, & Desrosiers, 2014). Algo is a tool designed for non-occupational therapist workers to support them during the selection of assistive devices for personal hygiene, for clients who represent "straightforward cases" (Guay, Dubois, Desrosiers, & Robitaille, 2012).

This article aims to foster the standardization of the completion of Algo. Specifically, recommendations will be provided for the tool's items to reduce rating discrepancies between users. Before presenting these recommendations, Algo will be outlined for the benefit of health professionals working outside Quebec.

Algo

Algo (Guay, Dubois, Robitaille, & Desrosiers, 2014; Guay, Dubois, & Desrosiers, 2014) includes a decision tree and a series of yes/no questions addressing occupation, person and environment, used to identify how best to set up a bathroom environment, including the addition of assistive devices. The tool aims to promote the safe performance of personal hygiene at home by clients who represent a so-called "straightforward" clinical situation. A straightforward case is that of an adult with typical morphology exhibiting predictable occupational performance difficulties while performing personal hygiene in his or her bathtub or shower stall. In the first section of Algo, twelve criteria allow the operationalization of this definition. The criteria relate to the occupation (e.g., "The person accepts not sitting on the bottom of the bathtub to wash."), the person (e.g., "The person can rise and stand for five seconds.") and the environment (e.g., "The bathroom used has standard bathtub.") (Guay et al., 2012; Guay, Dubois, Robitaille, & Desrosiers, 2014). In "complex" situations or when uncertain, Algo suggests consulting with an occupational therapist. Algo can be viewed online in French and English at http://www.ergotherapie-outil-algo.ca/en/home, along with its accompanying user's guide and reference manual.

Algo can be used in each of two service provision models proposed by the Ordre des ergothérapeutes du Québec (OEQ; the Quebec regulatory body for occupational therapists). In the first model, Algo is a component of the occupational therapy care plan performed by occupational therapy support personnel. According to the skills framework of the OEQ (2010), the occupational therapist asking for the participation of occupational therapy support personnel is responsible for determining the training, supervision and tools (as well as their respective reliability) that are made available to them. Home health aides are the workers generally involved in supporting occupational therapists in the first service provision model (Guay et al., 2010). In the second service provision model, Algo can be an intervention performed by a member of an interdisciplinary team in parallel with occupational therapy services (OEQ, 2005; Guay, 2012; Guay, Dubois, Robitaille, & Desrosiers, 2014). In these situations, the professionals most often called upon in the interdisciplinary teams are physiotherapists, physical rehabilitation therapists, social workers and nurses (Guay et al., 2010).

Recommendations for the standardization of the completion of Algo

A qualitative study was performed with eight non-occupational therapist workers trained to use Algo (two home health aides, two physical rehabilitation therapists, three social workers and one auxiliary nurse) in order to explore their reasoning when completing Algo. They were filmed while performing Algo at the homes of standardized clients, that is, people who were paid and trained to play a specific role (May, Park, & Lee, 2009). Then, for two of the standardized clients who received differing recommendations for assistive devices from the participants who used Algo, explanatory discussions (Vermersch, 2006) were held with the help of the videos. These explanatory discussions allowed for investigation of the flow of participants' reasoning, that is, a specific description of the sequence of cognitive actions performed and information considered while performing Algo. In total, 16 explanatory discussions (with eight participants regarding two standardized clients) were: 1) transcribed verbatim, 2) coded using a grid, which was refined through an iterative process and 3) analyzed in depth by following Yin's steps for intracase, then intercase analysis (2009).

Table 1 presents highlights of the analysis in the form of recommendations. These offer concrete direction to foster the standardization of the completion of Algo by improving the instructions provided in the accompanying user's guide and reference manual (Guay, Desrosiers, Dubois, & Robitaille, 2013).

Table 1. ***Recommendations to standardize the completion of Algo***

Questions from Algo	Recommendations
Section No. 1: Clientele	
The person is able to get to the bathtub OR shower stall, alone. *	Specify that the move to be observed is between the initial meeting place in the home and the bathroom.
The person is willing to not sit at the bottom of the bathtub.	Specify that the opinion of the person must be collected prior to proceeding to other questions.
The person is 18 years of age or older. The person weighs less than 250 pounds.	Specify that this information must be collected from one of the two following information sources: -the person being met -the medical file
The person is able to stand up and remain standing for five seconds.*	Take into account various moments during the visit when the person is standing up in order to objectively determine his or her standing endurance.
The person can use a bar for support.	Objectively determine hand grip strength (e.g., ask the person to squeeze your hand as hard as possible for five seconds).
The person understands the instructions.	Check that instructions and other important ideas are understood throughout the meeting (actions requested, thread of conversation, etc.).
The bathroom used has a standard shower stall OR bathtub.	Specify that the bathroom must be observed before checking off this item. Insist on the importance of verifying all features of a non-standard shower stall or bathtub, such as podium, whirlpool and diagonal (presence of corner(s)).
The bathroom used can accommodate two grab bars.	Specify that the bathroom must be observed before checking off this item. In cases where the bathroom includes complex architecture (e.g., the presence of a window in the back wall of the bathtub), recommend consultation with an occupational therapist.
Section No. 2: Selecting a seat	
The person can transfer from one chair to another.*	Specify that the transfer must be observed completely, including the person's capacity to stand up and sit down, before checking off this item. Specify that grasping some kind of support is allowed to perform this item.
The person wants to shower in a shower stall OR in a bathtub.	Specify that the opinion of the person must be collected before checking off this item.
The person can spread his/her feet about 12 inches apart.*	Use a measure such as the width of the user's guide to observe this item. Specify that grasping some kind of support is allowed to perform this item.
The person can raise his/her feet to the height of the stall sill OR the height of the bathtub's outer rim. *	Use a tape measure to determine the height of the bathtub or the stall before performing this item. Specify that grasping some kind of support is allowed to perform this item.
When sitting with eyes closed, the person can move his/her trunk without losing balance.	Specify that it is necessary to observe all movements (with eyes open and eyes closed) to pass this item: 1. Lean the trunk from left to right, then front to back; 2. Raise arms in the air; 3. Look at the ceiling. Insist on the importance of performing these tests from a seated position without being able to grasp anything while leaning the trunk sideways.
The person shows no fatigue, dizziness or shortness of breath during the task or visit.	Specify that the opinion of the person and the observation of these signs must be considered together for this item. Distinguish whether "the person does not become tired, [...] during the task" versus "during the visit."
The person can reach his/ her legs and feet when standing.*	Specify that the movement must be observed completely, from beginning to end. Specify that the person is allowed to raise his or her leg to himself or herself before performing the motion.
The width at the bottom of the bathtub or shower stall is at least 18 inches.	No approximation is allowed for this measurement.
Installation of [the chosen equipment] is possible.	Take a critical look at all the observations included in Algo before checking off this item.
In cases where a "stop" occurs during the completion of Algo (indicating the user should consult an occupational therapist before continuing the process): Users should still perform the assessment items that do not pose a threat to their safety or that of the person, so as to optimize the usefulness of the visit and to support the process of the occupational therapist, who will continue the intervention.	

*For these items, pay attention to the signs and symptoms that may constitute potential "red flags" that jeopardize the safe performance of hygiene in the bathtub (e.g., pain, loss of balance, loss of grip strength and/or strength in the lower limbs, shortness of breath, dizziness, fatigue and limited endurance, etc.).

Essentially, these recommendations are to: 1) specify the relevant information for users of Algo to collect, 2) objectively define the way in which this information must be collected and 3) encourage the triangulation of the information considered while performing Algo. On the one hand, these recommendations can support the occupational therapist in his or her role of trainer or supervisor of occupational therapy support personnel. On the other hand, they aim to foster the skills development of the users of Algo, who facilitate, as part of their job, the maintenance of personal hygiene of people living in their homes.

To our knowledge, a growing number of interdisciplinary teams in Quebec are adopting Algo, but this tool has not yet been used outside Quebec. However, we propose that occupational therapy support personnel who have basic or broad-based competencies could collect data with Algo in order to support the occupational therapy assessment process, as mentioned in the Canadian Association of Occupational Therapists' (2009) *Practice Profile for Support Personnel in Occupational Therapy.* Points A1.2.7 and B1.2.7 of this document describe the role of support personnel in collecting data as assigned by the occupational therapist, as part of the broader role of "expert in enabling occupation." As Algo is a tool to support data collection and does not require the administrator to use clinical reasoning in order to follow the decision tree, and the supervising occupational therapist may review the outcome and confirm the equipment recommendation, its use fits within the parameters of the *Practice Profile*. Initiatives from other Canadian provinces would enable verification of this hypothesis.

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Editor's note: To learn more about supervision of support personnel and assigning service components, please refer to CAOT's *Guidelines for the Supervision of Assigned Occupational Therapy Service Components:* https://www.caot.ca/default.asp?ChangeID=1&pageID=579

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