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Revision of the Australian Competency Standards for Occupational Therapists is the reflection of contribution and commitment of many within the profession. Initially, those who recognised the need and laid the foundations with the broad based, consultative and collaborative scoping project which provided invaluable feedback on the existing Competency Standards and future directions. However, without ongoing support and funding from Occupational Therapy Australia, these initial steps would not have translated into the current revision of the Competency Standards.

This Revision of the Australian Minimum Competency Standards for New Graduate Occupational Therapists has been directed by a Project Team led by Professor Sylvia Rodger, in collaboration with a Steering Committee representing Occupational Therapy Australia and a Reference Group representing members of the Australia and New Zealand Council of Occupational Therapy Educators (ANZCOTE), the Occupational Therapy Council, and the Australia and New Zealand Occupational Therapy Fieldwork Association (ANZOTFA).

This project has been characterised by ongoing consultation and collaboration, a process which would not have been possible without the invaluable contributions of many occupational therapists representing all aspects of the profession. Feedback was provided at all stages of the revision process by individual clinicians and practitioners, educators, State and Territory Occupational Therapy Associations and Special Interest Groups, and regulatory bodies. A full list of contributors is provided in Appendices 1 and 2.

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An Introduction to Occupational Therapy Practice in Australia

Key Purpose

“Occupational therapy is a client-centred health profession concerned with promoting health and well being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement.

Occupational therapists have a broad education in the medical, social behavioural, psychological, psychosocial and occupational sciences which equips them with the attitudes, skills and knowledge to work collaboratively with people, individually or in groups or communities. Occupational therapists can work with all people, including those who have an impairment of body structure or function owing to a health condition, or who are restricted in their participation or who are socially excluded owing their membership of social or cultural minority groups.

Occupational therapists believe that participation can be supported or restricted by the physical, affective or cognitive abilities of the individual, the characteristics of the occupation, or the physical, social, cultural, attitudinal and legislative environments. Therefore, occupational therapy practice is focused on enabling individuals to change aspects of their person, the occupation, the environment, or some combination of these to enhance occupational participation.”

(WFOT, 2004).

Occupational therapists believe that participation in meaningful life roles, occupational performance and occupational engagement provide meaning and value to everyday life, and improve health and well-being. Therefore, the goal of occupational therapy practice is to enable and enhance participation in meaningful activities and occupations by addressing relevant aspects of the client, the occupation and the environment, which may be supporting or inhibiting optimal occupational performance. Implicit in this focus on occupation is recognition that the values and philosophies of occupational therapy are themselves understood within a particular cultural and philosophical context.

Engaging and working in partnership with clients is considered a critical part of occupational therapy practice. Depending on the practice context, the client may be an individual, family and/or significant other(s), groups, organisations, communities, and/or populations. Respect for the client’s cultural, spiritual, physical and social contexts and beliefs is key to client-centred practice, whilst recognising that the way in which clients understand occupation and find it meaningful will differ according to their context. Outcomes of occupational therapy are diverse, client-driven and measured in terms of improved occupational performance, participation and satisfaction. Outcome measurement must be meaningful to the client, his/her/their occupations and his/her/their participation in life roles.
Scope of Occupational Therapy Practice

In Australia, occupational therapists work with individuals throughout the lifespan or with groups, organisations, communities or populations in a wide variety of institutional, organisational and community-based settings, involving broad ranging issues which concern the client’s actual or potential occupational performance. Occupational therapy roles include, but are not limited to, clinician or practitioner (private or public), educator, practice educator, supervisor, administrator, manager, project officer, consultant, policy-maker, practice education co-ordinator, faculty programme director, researcher-scholar, entrepreneur, student, advocate, and support staff member. Although individual occupational therapists may work in different roles, with different client groups, and in different work settings, common to all is the understanding of occupation and application of the occupational therapy process, which is underpinned by core occupational therapy knowledge, skills and attitudes.

Occupational therapists understand the importance and necessity of inter-professional teamwork for effective and efficient practice. In contemporary work environments, occupational therapists are often members of multiple teams, which may include other occupational therapists, health professionals, and/or non-health professionals. Consequently, individual occupational therapists must be able to co-operate, collaborate and communicate effectively with other members of these team(s) to develop, provide, co-ordinate, and evaluate services which best meet client needs.

Australian occupational therapy practice is dynamic and continues to evolve in response to changes in national priorities and legislation, population demographics, health and information technology, and work environments. Australian occupational therapists are committed to the provision of culturally appropriate care to all clients. They work within a multicultural society, remaining cognisant of their own cultural values whilst also striving to understand and respect the particular cultural context of their clients. Culture itself is viewed as “the complex interplay of shared meanings that represent and shape the individual and collective lives of people” (Iwama, 2006, p. 19); a common sphere of experience.

Occupational therapists practicing in Australia acknowledge the impact of history and the social determinants of health that underpin the disadvantage of First Australians and the ongoing losses experienced through the impact of illness, laws, and policies imposed as part of colonisation. However, they also recognise that despite the disadvantage experienced by many First Australians, there remains a strong cultural identity and sense of community which has equipped and afforded many with an admirable resilience, along with their kinship systems and local knowledge that supports engagement in life roles. First Australians may draw on a range of cultural knowledges beyond what some may view as “traditional Indigenous knowledge” in their everyday lived experiences and this may vary according to geographical location, age, gender, etc. Nakata’s (2007) notion of the cultural interface can be helpful in conceptualising the ways in which people navigate complex and different ways of knowing and being. It is also recognised that occupational therapy has much to learn from the lived experience of First Australians in making services safe and appropriate.

Culturally safe service provision is determined by the service recipient and founded upon an awareness and sensitivity to diversity of cultural values, beliefs and communication styles. Cultural safety extends beyond awareness or sensitivity to a deeper level of interaction which empowers the cultural identity and well-being of an individual. Culturally safe practice can be provided when working with individuals, organisations and communities. Culturally secure services are ones in which cultural safety principles are extended to a system wide approach at the organisational level (Coffin, 2007; Hall, 2010).
Throughout this document Aboriginal and Torres Strait Islander People will be referred to as First Australians and people other than Aboriginal or Torres Strait Islander will be referred to as Australians. This avoids the reference to people as non-entities, for example: non-Indigenous (Nelson, et al., in press).

The Australian Minimum Competency Standards for New Graduate Occupational Therapists (2010) refers to the constructs of Person (client), Environment (physical, social, cultural and temporal contexts) and Occupation. These underpin the majority of occupational therapy theoretical models (e.g., Person-Environment-Occupation Model (PEO) [Law, Cooper, Strong, Stewart, Rigby, & Letts, 1996], Model of Human Occupation (MOHO) [Kielhofner, 2008], Occupational Performance Model (Australia) (OPM(A)) [Chapparo & Ranka, 1997], Canadian Model of Occupational Performance and Engagement (CMOP-E) [Townsend & Polatajko, 2007]). The Standards do not advocate for one particular model of practice over others, rather, they refer broadly to these constructs that are germane to all models. It is recognised that these models draw from ‘Western’ ways of knowing and that there are other models such as the Kawa Model (Iwama, 2006) that present an eastern and collectivist cultural perspective. Australian occupational therapy practice is consistent with international occupational therapy standards, as documented in the Minimum Standards for the Education of Occupational Therapists (World Federation of Occupational Therapists, WFOT, 2002) and the Entry-Level Competencies for Occupational Therapists (WFOT, 2008), and international perspectives such as the International Classification of Functioning, Disability and Health (ICF) (WHO, 2001).

As the peak professional and regulatory bodies representing the interests of occupational therapists across the country, Occupational Therapy Australia (formerly OT AUSTRALIA) and the Occupational Therapy Council (OTC), formerly the Council of Occupational Therapy Registration Boards (COTRB), respectively are responsible for the development and maintenance of contemporary minimum standards for new graduate occupational therapists. Both Occupational Therapy Australia and the OTC require occupational therapists to practice according to codes of professional ethics and conduct and within Australian legislative requirements. The National Occupational Therapy Board has responsibility to ensure the individual occupational therapist is able to practice competently and safely.

Accreditation and Registration Process

Competence to practice occupational therapy is a requirement for registration. The minimum competencies embodied in this document provide a key tool for determining competence for registration purposes and for the assessment of overseas qualified occupational therapists applying to practice in Australia. Competency standards are also a cornerstone of the accreditation process for Australian occupational therapy entry-level education programmes.

Professional Competence

Competency standards are expected to reflect the shared perceptions of competent performance ascribed to by the diverse members of the profession (Standards Australia, 2005). They are a public declaration of the cognitions and processes which underpin occupational therapy services, and also identify aspects of task performance which are observable in the workplace. The Australian Minimum Competency Standards for New Graduate Occupational Therapists (2010) represents the minimum knowledge, skills and attitudes the profession believes are essential for adequate safe and competent practice in new graduate occupational therapists. The concept of competence focuses on what is expected of an occupational therapist. A
compétent professionnel is one having the relevant knowledge, skills and attitudes necessary for job performance which meet professional, legal and community expectations of competent performance.

Competence in professional practice is much more than the accomplishment of a number of discrete and separate tasks. It is a complex interaction and integration of knowledge, judgment, higher-order reasoning, personal qualities, skills, values and beliefs. In their everyday work, competent professionals will recall and apply facts and skills, evaluate evidence, create explanations from available facts, formulate and test hypotheses, and synthesise information from a rich and highly organised knowledge base. Thus, the competent occupational therapist is expected to execute both specific cognitive processes and practical skills to a minimum standard, in cognisance of ethical, social, cultural, legal and moral obligations. Professional competency also embodies the ability to generalise competence or transfer and apply skills and knowledge from one situation and environment to another. As such, it is a construct that is both abstract and tangible.

Competency standards represent the minimum expectations for performance held by all members of the profession, and so definitions of competence must be sensitive to contextual variations. Whilst occupational therapy is characterised by a body of knowledge, skills and attitudes, demonstration and interpretation of competent performance by an occupational therapist is highly contingent on multiple circumstances. These include the disposition of the individual practitioner, the individual and type of client, the professional role and task, the environment and relevant legislation and policies.

Initial Development of the Australian Competency Standards for Entry-Level Occupational Therapists (OT AUSTRALIA, 1994)

To promote a versatile, productive and internationally competitive workforce, the Commonwealth Government recommended that national industries adopt competency standards and established the National Training Board (NTB) in 1990 to supervise this venture. Subsequently, the national occupational therapy professional body, The Australian Association of Occupational Therapists (now known as Occupational Therapy Australia), supported by the National Office of Overseas Skills Recognition (NOOSR), endeavoured to produce a set of competency standards applicable to locally and internationally trained occupational therapists practising in Australia.

The development of the competencies involved standard research methodology and extensive consultation with the profession Australia-wide. The project was conducted in three stages. Stages 1 and 2 focused on the development and validation of competency standards through consultation workshops and field studies including observation and interview methods. Further refinement and validation of the standards together with the identification and trialling of assessment strategies were the aims of Stage 3. A pilot test was conducted to achieve these aims. A full report of the three stages of the project is available from Occupational Therapy Australia.

The Australian Competency Standards for Entry Level Occupational Therapists (OT AUSTRALIA, 1994) embodied the standards of the occupational therapy profession at the time (mid 1990s), but recognised that periodic review and revision would be necessary in order to retain currency and alignment with contemporary practice trends and philosophies. However, the first review did not occur until 2007-08, by which time the nature of Australian occupational therapy practice had evolved, rendering many of the practice paradigms underpinning these Competency...
Standards outdated. It must be acknowledged that the 1994 Competency Standards were innovative for their time and served the profession well for over a decade. Australia was in fact one of the first English-speaking countries to adopt a set of competency standards for occupational therapy entry-level practice (Rodger, Clark, Banks, O'Brien, & Martinez, 2009a).

Review of the Australian Competency Standards for Entry-Level Occupational Therapists (OT AUSTRALIA, 1994)

In 2007, a team of researchers was awarded funding from the Australian Learning and Teaching Council (ALTC) to undertake a study entitled Mapping the future of occupational therapy education in the 21st century: Review and analysis of existing Australian competency standards for entry-level occupational therapists and their impact on occupational therapy curricula across Australia. A key component of this larger project was to evaluate the utility, relevance, appropriateness and currency of the 1994 Competency Standards, and determine the extent of revision required to align these with contemporary requirements.

The approach to this investigation comprised three key tasks. First, a comprehensive literature review was undertaken which included benchmarking the 1994 Competency Standards with competency standards of practice, internationally and nationally, within and across disciplines. Second, an online survey directed to key stakeholders who were sufficiently familiar with the document to provide informed comment was completed. Third, a national series of focus groups was conducted to solicit perspectives from members of the professional community. These participants represented a diverse range of practice areas, work settings and professional roles, namely academics, practitioners/employers who supervised students or new graduates, recent graduates, local OT AUSTRALIA members and OT AUSTRALIA programme accreditation panellists, and Occupational Therapy Registration Board members where applicable. The full report of this project is available from the ALTC website (http://www.altc.edu.au/).

This project provided a comprehensive evaluation of the 1994 Competency Standards which was characterised by regular, extensive solicitation of national stakeholders’ perspectives. Consequently, the project produced a detailed set of recommendations for revision which had national ownership and support.

Development of the Australian Minimum Competency Standards for New Graduate Occupational Therapists (2010)

In 2009, Occupational Therapy Australia funded the revision of the Australian Competency Standards for Entry-Level Occupational Therapists (OT AUSTRALIA, 1994) based on the recommendations from the 2007-08 project (Rodger, Clark, Banks, O’Brien, & Martinez, 2009b). This detailed set of recommendations was prioritised by the project team as a critical reference; however, consultation with and input from the professional community at a national level continued throughout the revision process.

The recommendations from the review were used to develop a first draft, which was then widely distributed to key stakeholders for comment. These stakeholders included Occupational Therapy
Australia National and State Associations, individual State Occupational Therapy Registration Boards and the COTRB, now the OTC, Heads and academics from each Occupational Therapy School (representing the interests of the Australian and New Zealand Council of Occupational Therapy Educators (ANZCOTE) and broader national networks of the professional community. Feedback from these stakeholders was utilised to develop a second draft, which was then made publicly available on the Occupational Therapy Australia website for all Occupational Therapy Australia members to review. Final adjustments were made to the Competency Standards based on this feedback, and then submitted to Occupational Therapy Australia for ratification in August 2010.
Overview of the Australian Minimum Competency Standards for New Graduate Occupational Therapists (2010)

Uses

The key functions of the Australian Minimum Competency Standards for New Graduate Occupational Therapists (ACSOT) (2010) are to:

a) inform the accreditation process for Australian occupational therapy education programmes;

b) inform the design of curriculum content and assessment within these programmes;

c) assist individual therapists and/or workplaces to inform processes within their local contexts. This may include developing advanced level and/or more specific competency standards;

d) inform the assessment process of internationally qualified occupational therapists;

e) support performance management of individual occupational therapists;

f) assist the development of new graduate job descriptions; and

g) inform the Registration Boards (and National Board from 2012) in relation to ensuring that all occupational therapy practitioners provide competent care to members of the Australian public.

A companion document, the Performance Record for the Australian Competency Standards for Occupational Therapists (PRACSOT) (Occupational Therapy Australia, 2010) has been developed as a reflective tool for use in conjunction with the ACSOT to:

a) assist individual therapists and supervisors to inform supervision and appraisal processes within their local contexts to support and enhance individual performance;

b) assist workplace processes to develop advanced level and/or more specific competency standards;

c) support individual occupational therapists returning to the workforce; and

d) assist the development of new graduate job descriptions.
Review Cycle

As practice adapts to accommodate public health care and social needs and values, perceptions and standards of competent performance need to be regularly revisited and redefined. Nationally, there is an expectation that competency documents will be regularly reviewed, revised or even withdrawn (Standards Australia, 2005). A five year review cycle will be established for the ASCOT. This commitment to a regular review and re-evaluation will enable the occupational therapy profession to capitalise on opportunities for further development, and allow for the emergence of new practice areas and specialties.

In developing these standards, every effort has been made to ensure that the depth and breadth of entry-level occupational therapy practice at present and in the near future has been represented. Feedback and suggestions are welcomed at all times by contacting Occupational Therapy Australia (info@ausot.com.au).

Maintenance of professional standards is a responsibility shared by individual therapists, organisations providing occupational therapy services, the professional association, organisations educating occupational therapists and the registration authority. To date, as the peak body representing occupational therapists, Occupational Therapy Australia has developed and implemented standards for occupational therapists in Australia. These standards comprise part of the Occupational Therapy Australia programme accreditation process.

Format

The format of the Competency Standards is consistent with the Australian Qualifications Framework (Standards Australia, 2005); the format adopted by the NTB and NOOSR for Australian competency standards. This format comprises a Unit of competency and its derived components of Elements of Competency, Performance Criteria, and Cues. While the Units, Elements and Performance Criteria are written in linear order, they are not meant to indicate an order of importance or to be treated as discrete or exclusive entities. Considerable overlap occurs. At any one time a number of Elements of Competence may be performed simultaneously.

The competency standards are not separate parts of a function but components of a whole occurring together, often simultaneously. It is only for the purpose of documenting them as standards that discrete items are written.

As indicated above, Australian occupational therapy is diverse and practised in a range of settings and contexts, with a broad range of clients. Therefore, please note the following definitions of important terms used in the competency standards:

A **Client** refers to a consumer of occupational therapy services, which may be an individual, family and/or significant other(s), group, organisation, community or population.

A **Team** refers to a group within the working environment whose members (including the occupational therapist) share and work towards common goals through co-operation, co-ordination and collaboration. Composition may be intra-professional, inter-professional or inter-agency and thus may be comprised of occupational therapists, or occupational therapists along with clients and their carers’, other health professionals and/or administrators, other non-health professionals, client advocates, and representatives from other agencies involved with client care.
A **Unit** of competency is a discrete component within a standard and reflects significant major functions. It is expressed as a title. Units should not be viewed in isolation.

**Elements** of competency constitute the building blocks of the unit of competency and, as such, continue the description of the key purpose of the unit itself. They describe in outcome terms the lowest logical, identifiable and discrete sub-groupings of actions and knowledge which a person requires to fulfill the unit of competency. Elements sub-divide the Unit into manageable and meaningful components that are observable in workplace performance. Elements provide the context for the Performance Criteria.

**Performance Criteria** are evaluative statements which specify the required level of performance. They set out the prescribed outcomes by which the element or unit as a whole, can be judged as being performed to the level acceptable in employment. Performance Criteria must always be viewed within the context of the overarching element.

**Cues** are examples which provide descriptions of the contextual features or critical aspects of competent performance. Note that these cues are examples only, and are in no way meant to be comprehensive or limiting, but to act as a guide to contextual application of performance criteria. These are only provided where further explanation has been considered necessary.
Glossary of Terms

**Advocacy**
An enablement activity enacted with or for people to represent their concerns and interests by raising critical perspectives, prompting new forms of power sharing, lobbying, or making new options known to key decision makers. This includes empowerment to enable people to better represent themselves.

**Anti-Discrimination**
State and federal governments have passed legislation which aims to protect individuals from certain kinds of discrimination in public life and from breaches of human rights. These areas include: age, disability, race and gender. Many workplaces have used these documents to create their own local policies and procedures to ensure the rights of individuals (Australian Human Rights Commission, 2009).

**Australian Qualifications Framework**
A quality assured national framework of qualifications in the school, vocational education and training (VET) and higher education sectors in Australia. The Framework links together all these qualifications and is a highly visible quality assured national system of educational recognition which promotes lifelong learning and a seamless and diverse education and training system (AQF, n.d.).

**Client**
A client refers to a consumer of occupational therapy services, which may be an individual, family and/or significant other(s), group, organisation, community or population.

**Client centred**
A collaborative approach that respects the desires, knowledge, experiences, beliefs and priorities of clients and enables their active participation in service planning, development and delivery. The term “person-centred” is alternatively used to describe this approach.

**Collaboration**
Co-ordinated and co-operative approach involving an ongoing partnership working together to solve problems or provide services and share experiences (World Health Organization Study Group on Interprofessional Education and Collaborative Practice, 2008).

**Communities of practice**
Communities of individuals engaged in a common practice, with a shared repertoire and history that interact over a period of time on a regular basis to share ideas and strategies, determine solutions and build innovations. Practice may be developed through a variety of methods including sharing of information and assets, discussion, networking and visiting, mapping knowledge and identifying knowledge gaps (Lave & Wenger, 1998).

**Competence**
Competence is a complex interaction and integration of knowledge, judgment, higher-order reasoning, personal qualities, skills, values and beliefs expressed in the ability to execute both specific practical skills and cognitive processes in cognisance of ethical, social, legal and moral obligations. Each competency within the Competency Standards integrates intellectual and interpersonal competence against the backdrop of public, academic and professional duties.
Competency Standards
Authoritative documents that explicitly and implicitly communicate a professional critical philosophy, purpose and scope. They describe and reflect professional and community expectations of competent performance and are a public declaration of the cognitions and processes which underpin service, and identify aspects of task performance which are observable in the workplace (Standards Australia, 2005).

Confidentiality
Maintained privacy and security of information pertaining to a client or workplace which has been obtained directly, indirectly, or as a consequence of one’s position within the workplace. Relevant workplace, professional and legal protocols should be followed to maintain confidentiality.

Continuing professional development
Encompasses planning, activities, and requirements to facilitate ongoing growth and development of occupational therapy professionals (Jacobs & Jacobs, 2004).

Cues
Examples of practical considerations and contextual features which impact upon competent performance (Rodger et al, 2009b). Cues are in no way meant to be comprehensive or limiting, but to act as a guide to contextual application of performance criteria.

Cultural awareness
An individual’s awareness of the diversity of cultural values and beliefs and sensitivity to similarities and differences existing between two cultures which may be used to enable effective communication with members of another cultural group (Coffin, 2007; Hall, 2010).

Cultural competence
Awareness of, sensitivity to, and knowledge of the meaning of culture. It is characterised by a willingness to engage with this by a respect for differences, ongoing self-assessment of perspective, alertness toward differences, continuing growth of cultural knowledge and resources, and adaptations to services (Dillard et al., 1992; Murden et al., 2008).

Cultural safety
Cultural safety is a concept originating from the Nursing Council of New Zealand (2002). The principles of cultural safety include reflection on one’s practice, seeking to minimise the power differentials between oneself and the client, engagement with the client to understand their needs, beliefs, understandings and preferred ways of doing things, and acknowledging the impact of colonisation on practice. Culturally safe services can only be defined by those who receive the service and does not diminish demean or disempower cultural identity and well-being (Nursing Council of New Zealand, 2002; Taylor & Guerin, 2010). Cultural safety is increasingly recognised for its appropriateness in the Australian context.

Cultural security
A system wide approach to the planning and provision of services offered by the health system to ensure that services do not compromise the legitimate cultural rights, values and expectations of Indigenous persons (Hall, 2010).

Duty of Care
Involves meeting one’s responsibilities for those one interacts within the work environment.
**Element**
The building blocks of the unit of competency and, as such, continues the description of the key purpose of the unit itself. They describe in outcome terms the lowest logical, identifiable and discrete sub-groupings of actions and knowledge which one requires to fulfil the unit of competency. Elements sub-divide the unit into manageable and meaningful components that are observable in the workplace performance. Elements provide the context for the Performance Criteria.

**Environment**
Physical, social, institutional and cultural context in which occupation occurs and is given meaning.

**Equal Opportunity**
The principle that all members of the community have equal rights for opportunity and access, regardless of age, race, gender, culture, ethnicity, religion or disability.

**Evaluation**
A crucial ongoing professional activity integral to the entire occupational therapy process, involving the acquisition and interpretation of data to ensure the efficacy, efficiency and quality of services provided to clients.

**Evidence-based practice**
Evidence-based practice requires the integration of the best research evidence with clinical expertise and the patient’s unique values and circumstances (Straus, Richardson, & Haynes, 2005). It involves using clinical reasoning to integrate information from four sources: research evidence, clinical expertise, the client’s values and circumstances and the practice context (Hoffmann, Bennett, & Del Mar, 2010).

**First Australians**
Aboriginal and Torres Strait Islander People will be referred to as First Australians and people other than Aboriginal or Torres Strait Islander will be referred to as Australians. This term supports the view that people should not be referred to as being a non-entity, for example: non-Indigenous (Nelson et al., in press).

**Informed participation**
Involves the client receiving adequate information regarding the purpose, benefits and risks of involvement with occupational therapy services.

**Inter-professional**
Involves practitioners from different professions working together with a common purpose, commitment and mutual respect. When working as a team they “deliver services and coordinate care programmes in order to achieve different and often disparate service user needs. Goals are set collaboratively through consensual decision making and result in an individualised care plan which may be delivered by one or two team members. This level of collaborative practice maximises the value of shared expertise and minimises the barriers of professional autonomy... The team meets regularly to evaluate outcomes and quality of care delivery” (World Health Organization Study Group on Interprofessional Education and Collaborative Practice, 2008).
**Intervention**
The process and skilled actions taken by the occupational therapist in collaboration with the client to implement the plan and facilitate engagement in occupation related to health and participation. Specific strategies selected are based on the client’s desired outcomes, evaluation outcomes and evidence. Intervention may include, but is not limited to, engagement in individual occupational activities, group activities, provision of equipment, environment modifications, education, consultation and recommendations.

**Intra-professional**
Collaboration that may occur between colleagues within one profession, sharing a common professional identity, education, values, socialisation, and experience.

**Key Performance Indicators**
Predetermined, quantifiable measures that reflect critical success factors of the work organisation. They are used to inform decision making, for quality improvement initiatives and interventions, and to guide continuous quality improvement.

**Lifelong learning**
All professionals need to keep updating their knowledge and skills throughout their professional life. Lifelong learning refers to recognising the need to always learn more, wanting to learn more, and having the skills to locate relevant knowledge and skills, and to understand them and apply them in practice (WFOT, 2002).

**Occupation**
All of the things that people do that are meaningful, named, organised and given value within personal or cultural contexts. Occupations are subjectively experienced activities, tasks and occupational roles which serve the purpose of self care, productivity and leisure. Engaging in occupation is integral with the environment, influencing it and in turn being influenced by it (WFOT, 2002).

**Occupational engagement**
Involvement or active participation in occupation. “Involvement for being, becoming or belonging as well as performing or doing occupations (Wilcock, 2006)” (Townsend & Polatajko, 2007, p. 370).

**Occupational Health and Safety**
Duty of employers, employees and other duty holders to provide and maintain, as far as is reasonably practicable, a working environment that is safe and without risks to health. Occupational Health and Safety is regulated by individual state and territory legislation and local workplace policies.

**Occupational justice**
The universal right of individuals to flourish in diverse ways by doing what they decide they can do, that is most meaningful and useful to themselves and their families, communities and nations (Wilcock & Townsend, 2009).
<table>
<thead>
<tr>
<th><strong>Occupational performance</strong></th>
<th>The “result of a dynamic interwoven relationship between persons, environment, and occupation over a person’s lifespan; the ability to choose, organize, and satisfactorily perform meaningful occupations that are culturally defined and age appropriate for looking after oneself, enjoying life, and contributing to the social and economic fabric of a community” (CAOT, 2002, p. 181).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Occupational therapy framework</strong></td>
<td>A profession specific frame of reference for organising inter-related theoretical concepts used in practice.</td>
</tr>
<tr>
<td><strong>Occupational therapy</strong></td>
<td>Occupational therapy is a client-centred health profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement (WFOT, 2004).</td>
</tr>
<tr>
<td><strong>Occupational therapy process</strong></td>
<td>A profession specific multiphase process that involves active participation and collaboration with the client to achieve their vision and goals. It includes determining priorities for intervention, selecting the most appropriate approach based on information gathering and the best available evidence, professional reasoning, implementation, and evaluation of intervention.</td>
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<tr>
<td><strong>Occupational well-being</strong></td>
<td>An experience of personal and social well-being, that is derived from satisfaction in engagement in meaningful life occupations (Townsend &amp; Polatajko, 2007).</td>
</tr>
<tr>
<td><strong>OT Australia Code of Ethics</strong></td>
<td>Refers to the document created by Occupational Therapy Australia (OT AUSTRALIA, 2001) to provide clear moral and ethical parameters under which occupational therapists should practice. It is designed to promote and maintain high standards of ethical behaviour.</td>
</tr>
<tr>
<td><strong>Performance Criteria</strong></td>
<td>Evaluative statements which specify the required level of performance. They set out the prescribed outcomes by which the element or unit as a whole can be judged as being performed to the level acceptable in employment. Performance Criteria must always be viewed within the context of the overarching element.</td>
</tr>
<tr>
<td><strong>Privacy</strong></td>
<td>Confined to, or intended only for the person or persons immediately concerned, (i.e., confidential), typically governed by workplace policies.</td>
</tr>
<tr>
<td><strong>Professional reasoning</strong></td>
<td>A multifaceted process used by occupational therapists to plan, direct, perform and reflect on client care (Boyt Schell, 2009).</td>
</tr>
<tr>
<td><strong>Qualitative evaluation</strong></td>
<td>An evaluation that occurs using subjective, personally derived data.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Quality assurance</strong></td>
<td>The constant evaluation of performance quality against predetermined expectations or standards of service to identify potential issues requiring attention and further development.</td>
</tr>
<tr>
<td><strong>Quality improvement</strong></td>
<td>An ongoing process to improve the standard of services provided through quality assurance processes.</td>
</tr>
<tr>
<td><strong>Reflective practice</strong></td>
<td>A critical analysis of working practices to improve competence and promote professional development.</td>
</tr>
<tr>
<td><strong>Risk management</strong></td>
<td>Developing and following established policy and procedures regarding minimisation or elimination of risk and harm to individuals in the work environment.</td>
</tr>
<tr>
<td><strong>Team</strong></td>
<td>A group of individuals that work collectively to a common purpose in a co-ordinated and collaborative manner. It may be comprised of occupational therapists, or occupational therapists along with clients and their carers', other health professionals and/or administrators, other non-health professionals, client advocates, and representatives from other agencies involved with client care.</td>
</tr>
<tr>
<td><strong>Transcultural</strong></td>
<td>Transcultural practice “implies a bridging of notable differences in culture and communication styles, beliefs and practices” (Wells &amp; Black, 2000, p. 284).</td>
</tr>
<tr>
<td><strong>Unit</strong></td>
<td>A discrete component within a standard that reflects significant major functions. It is expressed as a title.</td>
</tr>
<tr>
<td><strong>WFOT Code of Ethics</strong></td>
<td>Refers to the document created to provide clear moral and ethical parameters under which occupational therapists should practice (WFOT, 2005). It is designed to promote and maintain high standards of ethical behaviour.</td>
</tr>
</tbody>
</table>
Acronyms used within the *Australian Minimum Competency Standards for New Graduate Occupational Therapists* (2010)

**ALTC**
Australian Learning and Teaching Council

**ACSOT**
Australian Minimum Competency Standards for New Graduate Occupational Therapists

**ANZCOTE**
Australian and New Zealand Council of Occupational Therapy Educators

**AQF**
Australian Qualifications Framework

**AT**
Assistive Technology

**CMOP-E**
Canadian Model of Occupational Performance and Engagement

**COTRB**
Council of Occupational Therapists Registration Boards

**CPD**
Continuing Professional Development

**ICT**
Information Communication Technology

**ICF**
International Classification of Functioning, Disability and Health

**MOHO**
Model of Human Occupation

**NOOSR**
National Office of Overseas Skills Recognition

**NTB**
National Training Board

**OPM(A)**
Occupational Performance Model (Australia)

**OTC**
Occupational Therapy Council

**PEO**
Person-Environment-Occupation Model

**PRACSOT**
Performance Record of the Australian Competency Standards for Occupational Therapists

**VET**
Vocational Education and Training

**WFOT**
World Federation of Occupational Therapists

**WHO**
World Health Organization
## Australian Minimum Competency Standards for New Graduate Occupational Therapists

### at a Glance

1. **Occupational Therapy Professional Attitudes and Behaviour**
   - 1.1 Adopts a client-centred approach to practice
   - 1.2 Practices in a culturally safe professional manner
   - 1.3 Practices in a professional manner that meets ethical and legal responsibilities
   - 1.4 Promotes and facilitates occupation through the application of professional knowledge, skills, attitudes and evidence appropriate to the practice context
   - 1.5 Incorporates best available research evidence and professional reasoning into occupational therapy practice
   - 1.6 Maintains and enhances competence through lifelong learning and continuing professional development activities
   - 1.7 Demonstrates professional knowledge, skills and attitudes appropriate for the working environment
   - 1.8 Contributes to the promotion and advancement of occupational therapy

2. **Occupational Therapy Information Gathering and Collaborative Goal Setting**
   - 2.1 Performs a relevant, comprehensive, assessment of occupational performance
   - 2.2 Engages in critical, collaborative, professional reasoning processes to determine priorities for intervention
   - 2.3 Develops, communicates and implements an effective, efficient plan for occupational therapy intervention
   - 2.4 Selects and implements intervention strategies and methods appropriate to the working environment
   - 2.5 Utilises available community resources, facilities and services
   - 2.6 Respects and supports the role(s) of significant other(s)

3. **Occupational Therapy Intervention and Service Implementation**
   - 3.1 Demonstrates client-centredness during intervention
   - 3.2 Promotes client occupational performance and participation
   - 3.3 Selects and implements intervention strategies and methods appropriate to the client
   - 3.4 Selects and implements intervention strategies and methods appropriate to the working environment
   - 3.5 Utilises available community resources, facilities and services
   - 3.6 Respects and supports the role(s) of significant other(s)

4. **Occupational Therapy Service Evaluation**
   - 4.1 Incorporates perspectives of multiple stakeholders in evaluation of occupational therapy service provision
   - 4.2 Demonstrates ability to understand and conduct multiple evaluation methods and techniques
   - 4.3 Demonstrates an understanding of and commitment to principles and methods of quality improvement
   - 4.4 Utilises evaluation outcomes to make recommendations for future practice
   - 4.5 Utilises available community resources, facilities and services
   - 4.6 Respects and supports the role(s) of significant other(s)

5. **Occupational Therapy Communication**
   - 5.1 Facilitates active participation of the client in service provision
   - 5.2 Adopts a communication approach appropriate to the working environment
   - 5.3 Documents and reports relevant aspects of service provision
   - 5.4 Shares professional information responsibly
   - 5.5 Utilises available community resources, facilities and services
   - 5.6 Respects and supports the role(s) of significant other(s)

6. **Occupational Therapy Professional Education and Development**
   - 6.1 Engages in lifelong learning processes and activities to maintain professional competence
   - 6.2 Contributes to education and professional practices of students
   - 6.3 Utilises available community resources, facilities and services
   - 6.4 Shares professional information responsibly
   - 6.5 Utilises available community resources, facilities and services
   - 6.6 Respects and supports the role(s) of significant other(s)

7. **Occupational Therapy Professional Practice Responsibilities**
   - 7.1 Adopts an efficient, effective and systematic approach to daily workload management
   - 7.2 Works effectively within the structure of the workplace environment
   - 7.3 Contributes to quality assurance and service development

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Unit 1: 
Occupational Therapy Professional Attitudes and Behaviour

Fundamental to occupational therapy is the importance of meaningful occupations and occupational engagement for individuals and groups, communities and populations. Consequently, the focus of occupational therapy services is to facilitate clients’ participation and mastery of meaningful occupations, with interventions that address relevant aspects of the client, the environment, and the occupation. A client may be an individual, family and/or significant other(s), group, organisation, community or population. Occupational therapists value and respect their clients and all those they encounter in the course of their practice, which is demonstrated through cultural competence and acceptance of diversity.

Occupational therapists practice as autonomous professionals providing a unique contribution to service provision in a variety of settings and in a variety of roles. However, regardless of practice context, occupational therapists share an approach which is client-centred and aims to optimise clients’ occupational performance. This is achieved by developing a partnership with clients, and often by working in collaboration with other members of inter- and intra-professional teams.

Competence is achieved through education and assimilation of the profession’s value system, philosophy, models and frames of reference. Occupational therapists are educated to be cognisant of available bodies of knowledge, to work collaboratively and efficiently within financial and resource constraints, to observe relevant legal, ethical and cultural standards, and to be aware of the impact of political and industrial issues on clients and the profession. Consequently, there is a requirement to maintain and extend practice competence, validate practice and manage a broad range of professional issues. In addition, the demonstration of sound judgment based on professional reasoning, respect of human rights, and commitment to empowerment within working relationships, through genuine care and assistance is required. Occupational therapists also advocate for the profession and educate the general public about the profession.
Element 1.1  Adopts a client-centred approach to practice

Performance Criteria

1.1.1 Occupational therapy intervention enables and empowers clients through enhancing their participation in meaningful occupation(s) and life roles.

*Cues:* Individual goals are addressed to enhance participation
Community participation in active healthy lifestyle is encouraged
Opportunities for promoting strengths within the wider community are identified to ensure occupational justice issues are addressed, (e.g., to develop new roles with refugee children within school programmes)

1.1.2 Occupational therapy intervention planning and service selection are led by clients, with their families, representatives and/or significant others as appropriate.

1.1.3 Clients' significant strengths, as well as cultural values, beliefs, behaviours and attitudes are identified, respected and considered.

*Cue:* Clients’ interests and strengths (including culturally significant roles) are identified and sought from clients or families

1.1.4 Understanding and respect for the individuality, uniqueness and worth of clients in the context of their environment(s) and communities is demonstrated by the occupational therapist.

*Cue:* Differences between therapist and client behaviour and values are able to be reflected upon by the therapist and the situation resolved or practice modified to achieve a mutually acceptable outcome

1.1.5 Understanding and respect for the collective needs of communities/populations within their contexts is demonstrated by the occupational therapist.

1.1.6 In situations where a client’s decreased capacity impacts on performance, appropriate action is taken by the occupational therapist to reduce the impact on the client and others.

*Cues:* Work practices are changed following worksite assessment
Recommendations for license withdrawal are made following driving assessment

1.1.7 Clients and clients’ opportunities for safe and meaningful occupational engagement are advocated for by the occupational therapist.
1.1.8 Steps are taken to develop rapport and empathy, and judgments are recognised and suspended, which contribute to the maintenance of a positive working partnership with clients.

_Cues:_ Clear language, uncomplicated by jargon is used and judgmental body language avoided. Aboriginal health workers and others are used to help enhance culturally appropriate communication.

1.1.9 Clients are not discriminated against on the basis of their age, culture, disability, gender, sexuality, social status, economic status and means, language or ethnicity, consistent with legislative requirements.

1.1.10 A range of communication skills, including, but not limited to, negotiation, conflict management and resolution, are used effectively to facilitate a positive working partnership with clients.

**Element 1.2 Practises in a culturally safe professional manner**

**Performance Criteria**

1.2.1 An awareness of his/her own culture and its impact upon their interaction with the client is demonstrated by the occupational therapist.

1.2.2 An awareness of the history, experience, culture and rights of the client is demonstrated by the occupational therapist.

_Cues:_ Sense of loss of the Stolen Generation and subsequent generations is acknowledged and its impact on current occupational roles and suspicion of mainstream health services or access to health services is understood. Broader understanding of family to include aunts, uncles, cousins and grandparents and established client kinship system is recognised and included during planning and delivery of services. Impact of cultural ways of being, knowing and doing that clients bring to service provision is recognised.

1.2.3 The individual practitioner’s own effectiveness in addressing the needs of people from all cultural and/or social backgrounds is monitored by the occupational therapist.
1.2.4 The potential impact of power imbalance within the relationship between the occupational therapist and the client is recognised and addressed.

*Cues:* Strong and respectful partnerships with Aboriginal health workers and First Australian colleagues and health bodies are actively sought and nurtured to minimise power imbalances
Open, honest and respectful relationships are developed with clients
Information about local cultural protocols is sought
Awareness of relevant trans-cultural support groups is developed

1.2.5 Work with individuals, organisations and communities by the occupational therapist utilises skills that promote culturally safe services that empower clients’ cultural identity and well-being.

*Cues:* Permission is sought to enter First Australian communities
Eye contact appropriate to the cultural norm is used: therapist follows the example of the client
Language used is not prejudicial or exclusive of clients
Diverse views are sought through extended community consultation

1.2.6 The level of cultural safety brought to the therapeutic relationship by the occupational therapist is known and acted on accordingly.

*Cues:* Partnerships with Aboriginal health workers and other First Australian colleagues, local elders and others who can provide mentoring and guidance are sought and developed to enhance awareness of culturally safe practice
Attitude of cultural humility, without assumptions and with a willingness to learn cultural protocols is manifest in engagement of clients

**Element 1.3 Practises in a professional manner that meets ethical and legal responsibilities**

**Performance Criteria**

1.3.1 Conduct of the occupational therapist is consistent with nationally and internationally accepted standards of best practice, as documented by Occupational Therapy Australia, the Occupational Therapy Council, and the WFOT in their Codes of Ethics. Expected professional behaviours include honesty, integrity, compassion and respect.

*Cue:* Appropriate Registration and professional indemnity are current

1.3.2 An approach to practice which is client-centred, goal-oriented and collaborative, enabling effective working relationships and partnerships is adopted by the occupational therapist.

*Cue:* Individual needs are considered in context with whole of community health and well-being (e.g. adherence to "dry community" policies)
1.3.3 Professional behaviour is consistent with ethical and legal requirements.

1.3.4 Professional behaviour is in accordance with the expectations of the working environment, employing organisation and other stakeholders. Where legitimate concerns regarding organisational practices exist, these are addressed appropriately.

1.3.5 Privacy, confidentiality and consent/permission of client, family, significant others, colleagues and the employing organisation is respected and maintained.

1.3.6 In situations of duress, a professional manner is maintained through the application of stress management and conflict resolution strategies, and assistance is sought when necessary.

**Element 1.4 Promotes and facilitates occupation through the application of professional knowledge, skills, attitudes and evidence appropriate to the practice context**

**Performance Criteria**

1.4.1 A focus for occupational therapy intervention is advocacy, identification, support, and enablement of the client’s occupational performance and participation in meaningful and valued life roles.

1.4.2 The practice context is considered by the occupational therapist when selecting and implementing occupational therapy frameworks, models, knowledge, skills and attitudes.

1.4.3 Understanding and application of the occupational therapy process is demonstrated, attending to relevant aspects of the client, the environment and the clients’ occupations.

1.4.4 An understanding of the principles and use of occupation as a means to improve health and well-being is demonstrated to ensure occupational justice and minimise deprivation.

*Cue:* Development of a work co-operative is facilitated to provide opportunities for women living in poverty to learn skills for employment.
Element 1.5  Incorporates best available research evidence and professional reasoning into occupational therapy practice

Performance Criteria

1.5.1  Models and frameworks appropriate to occupational therapy practice from occupational therapy and other fields (e.g., neuroscience, psychology) are applied by the occupational therapist.

1.5.2  A systematic approach using best available research evidence and professional reasoning, which encompasses recognising and considering client preferences, is demonstrated by the occupational therapist.

   **Cue:** Client’s values and priorities, the practice setting, therapist’s knowledge and skills and available human and financial resources are recognised

1.5.3  The methodological quality and results from the best quality and most relevant research studies that are available are appraised, interpreted, and implemented as appropriate into daily practice.

1.5.4  In instances of limited research evidence, a rationale for practice decisions based on sound professional reasoning including his/her own clinical experience, expert opinion and the client’s values and preferences is provided by the occupational therapist.

   **Cue:** A range of sources of information, (e.g., evaluation reports, therapists systematic documentation of practice, practice evidence), are utilised in the absence of traditional research evidence

Element 1.6  Maintains and enhances competence through lifelong learning and continuing professional development activities

Performance Criteria

1.6.1  An awareness of the boundaries of his/her professional competence and responsibilities, seeking advice, education and training, further support and supervision when required is demonstrated by the occupational therapist.

   **Cue:** Continuing professional development and mentoring completed when commencing work in a new area

   See Element 6.1
Element 1.7  Demonstrates professional knowledge, skills, and attitudes appropriate for the working environment

Performance Criteria

1.7.1  Knowledge, skills and attitudes commensurate with the level of occupational therapy experience are applied in client service delivery and other aspects of service provision.

1.7.2  Professional behaviour appropriate to the practice context is demonstrated.
   
   **Cue:** Degree of formality and attire are tailored to suit the practice context

1.7.3  Legislation and regulations relevant to the practice context are understood and adhered to.
   
   **Cues:** Occupational Health and Safety expectations are met
   
   Client confidentiality and privacy are respected by ensuring client information is appropriately safeguarded

1.7.4  Co-operative and collaborative relationships within teams are fostered and facilitated by understanding, respecting and supporting the roles and responsibilities of different team members, including awareness of group dynamics within that team.

1.7.5  Differences within teams and between colleagues are acknowledged and assistance sought to deal with any conflicts.

1.7.6  The impacts of past, present and impending political, legal and industrial issues on the profession, employing body and client groups are sought and understood by the occupational therapist.
   
   **Cue:** Impending organisational changes to health policy and funding are understood and integrated into existing systems
   
   Legislation impacting on refugees and asylum seekers and First Australians is understood in terms of access to health services
   
   Funding for specific client groups is advocated and optimised (e.g., Medicare items)

1.7.7  Principles of social and occupational justice are understood, upheld and incorporated.
   
   **Cue:** Inequalities within service provision are identified (e.g., ability to access services by clients from culturally and linguistically diverse backgrounds)
Element 1.8  Contributes to the promotion and advancement of occupational therapy

Performance Criteria

1.8.1  Current occupational therapy practice is reflected upon and constructively critiqued to identify knowledge gaps and highlight areas requiring further improvement and/or development.

1.8.2  Commensurate with experience, research and evaluation, activities are undertaken to contribute to the validation and advancement of occupational therapy practice.

  Cues: Relevant literature is accessed, critiqued and applied to practice
         New practice areas are identified and promoted
         Assistance with research/evaluation design, methodology and data analysis is sought
         Research findings/results are submitted for publication

1.8.3  Professional activities and organisations are engaged with to contribute to the promotion and advancement of occupational therapy.

  Cues: Professional organisations are supported through membership
         Displays are created for Occupational Therapy Week and other promotional opportunities
         Professional interest groups are supported and engaged with
         Availability and advantages of occupational therapy services are promoted and marketed to community groups and organisations
Unit 2: Occupational Therapy Information Gathering and Collaborative Goal Setting

In all practice settings occupational therapists adopt a client-centred, systematic, reflective professional reasoning process to gather relevant information about clients, their environments and occupations in order to engage in collaborative goal setting and intervention planning. A client may be an individual, family and/or significant other(s), group, organisation, community or population. Occupational therapy services provided to specific individuals and groups of individuals may appear quite different to services provided to organisations, communities and populations. However, the occupational therapist engages in a similar professional reasoning process to determine intervention priorities.

Throughout information gathering and goal-setting, the occupational therapist collaborates with the client, significant other(s), other team members and/or other service providers. The occupational therapist collects, analyses and interprets information about the client; specific and potential occupational roles, occupations, and activities; and relevant physical, social, cultural, institutional and temporal aspects of the environment. This information is used to plan and implement interventions which target the relevant aspects of the client, environment(s) and occupation(s) to best meet the client’s identified need(s).
Element 2.1 Performs a relevant, comprehensive assessment of occupational performance

**Performance Criteria**

2.1.1 A client-centred approach is undertaken to identify and target the client’s key occupational roles and occupations.

*Cue:* Client’s important life roles and activities are acknowledged (e.g., mother, carer, school volunteer, sportsperson)

- Organisation’s corporate philosophy, market share, employee relationships workforce composition and service standards are appreciated
- Unique cultural family systems and their impact on clients’ life roles are acknowledged

2.1.2 Clients who are individuals or groups are actively engaged as collaborative partners during the information gathering phase to clarify their values and specific personal context(s).

2.1.3 Clients who are organisations, communities or populations are actively engaged and consulted as collaborative partners during information gathering to clarify their structural, institutional and societal context(s), values and service expectations, in order to establish intervention priorities.

*Cue:* Community needs analysis is conducted with key community stakeholders

2.1.4 Relevant physical, cultural, personal, social, institutional and temporal aspects of the environment are assessed to determine their impact on the client, their roles, occupation(s) and subsequent occupational performance.

2.1.5 Strengths, challenges and barriers in current and/or desired occupational performance are identified through interview, structured observation, appropriate standardised and non-standardised assessments, and developed through professional reasoning.

2.1.6 Appropriate assessments and information gathering processes are selected, proceed according to guidelines and are administered in a safe and responsible manner. Appropriate details are addressed and interpretations made.

*Cue:* Awareness of limitations in formal assessment development and standardisation is considered in selection, use and interpretation of assessment information (e.g., make-up of standardisation group including culture, age and gender)

2.1.7 Assessment results and interpretation of strengths, challenges and barriers are discussed with the client and/or advocate for clarification and confirmation.
Element 2.2 Engages in critical, collaborative professional reasoning processes to determine priorities for intervention

Performance Criteria

2.2.1 Priorities for intervention are developed in collaborative partnership with the client, and with informed consent with significant others and team members, and are informed by assessment outcomes.

2.2.2 The decision making process is based on a systematic, problem-solving approach, which is informed by the outcomes of the information gathering process and assessment results, best available evidence, relevant occupational therapy and other theories, sound professional reasoning and collaboration and consultation with relevant stakeholders.

Cue: Goals for an organisation or community group are identified and prioritised collaboratively

2.2.3 When determining intervention priorities, clients’ needs and values, available financial and human resources, workplace/agency scope and service expectations are taken into consideration and collaboration and consultation with relevant stakeholders is undertaken.

Element 2.3 Develops, communicates and implements an effective, efficient plan for occupational therapy intervention

Performance Criteria

2.3.1 Realistic short-term and long-term measurable goals are established collaboratively with the client and the team.

2.3.2 Intervention goals are communicated clearly to appropriate stakeholders (with client's consent) and specific measurable and achievable outcomes are identified.

2.3.3 Assessment results and identified priorities are used to develop an effective and efficient plan for occupational therapy intervention.

Cue: Methods and strategies are included in the intervention plan

2.3.4 The occupational therapy intervention plan to address relevant aspects of the client, his/her environment and occupations is consistent with the overall service provision of the team or agency.

Cues: Protocols of the employing organisation are followed when conducting assessment and delivering recommendations

Team members are consulted to determine appropriate timing for home visits
Unit 3:
Occupational Therapy Intervention and Service Implementation

A client of occupational therapy services may be an individual, family and/or significant other(s), group, organisation, community or population. A key principle underpinning occupational therapy practice is optimising client occupational performance, engagement and well-being. Occupational therapists must advocate and provide services that enable and support access to, and opportunities for, occupational engagement and participation and optimise well-being. Professional, client-centred reasoning should be used to select the most appropriate interventions, (including implementation strategies and methods) through successive goal setting.

Occupational therapists work in a large variety of roles and are expected to apply both generic and discipline-specific skills in practice. Therefore, the selection of appropriate interventions, including implementation strategies and methods, will be informed not only by relevant theoretical and practice models, but will also be congruent with relevant workplace practice protocols and legislation. The importance of client-centredness, effective communication and professional reasoning is implicit within all interventions.

Education of clients is a major area of practice and should be informed by educational/adult learning theories and appropriate educational content and delivery format in all areas of practice. Occupational therapists also advocate for and educate the general public about the profession.
Element 3.1  Demonstrates client-centredness during intervention

**Performance Criteria**

3.1.1 Selection of appropriate strategies is underpinned by a shared understanding of meaningful occupations and occupational performance issues with the client, with consideration of the client’s cultural, spiritual, physical, social, and psychological needs and environments. Where possible, intervention should occur in suitable ecological contexts.

3.1.2 Specific client issues are targeted by strategies that incorporate intervention goal(s) that have ideally been collaboratively developed and agreed upon by the client and team.

3.1.3 Clients are actively and regularly consulted, and educated to facilitate their continuing informed participation during occupational therapy interventions.

Element 3.2  Promotes client occupational performance and participation

**Performance Criteria**

3.2.1 The client’s right to access and engage in meaningful occupations is advocated and endorsed.

_Cue:_ Strategies that enable clients and their support networks to self-advocate are utilised

3.2.2 Occupational well-being is promoted by addressing the relevant health practices and attitudes of clients and/or other stakeholders, as well as the physical, social, cultural, economic, and institutional aspects of the environment(s) that influence a client’s occupational performance.
Element 3.3 Selects and implements intervention strategies and methods appropriate to the client

Performance Criteria

3.3.1 Intervention strategies and methods encompass relevant aspects of the client, occupation and environment.
   
   Cue: Dietary preference and food preparation requirements are considered within the context of intervention

3.3.2 Professional reasoning processes which utilise relevant contemporary practice models and frameworks are applied to determine efficient and effective strategies.
   
   Cue: Practice models which are relevant to the client’s context are adopted

3.3.3 Throughout intervention appropriate therapeutic use of self and awareness of how this impacts upon client outcomes is demonstrated by the occupational therapist.
   
   Cue: Appropriate cultural protocols and/or personal comfort levels are sought regarding touch, greetings and communication style

3.3.4 Impact and implications of intervention on the client, significant others and stakeholders are acknowledged and considered.
   
   Cues: Costs of housing modifications and alternatives are discussed and negotiated with the client and family
   Learning strategies and classroom supports are negotiated with the teacher
   Recommended physical changes to the working environment are discussed with the employer before implementation
   Community elders/stakeholders are consulted regarding health promotion initiatives
   Strategies for building skills and enhancing independence in supportive accommodation are developed in collaboration with family and support workers

3.3.5 Specific client factors, which include specific performance skills and may include body functions and structures, are addressed to promote optimal occupational performance. This may involve, where appropriate, strategies to enhance development, and remediate or otherwise compensate for limitations in physical, cognitive, perceptual, sensory, neuromuscular, interpersonal and behavioural skills or abilities.

3.3.6 Specific occupation factors are addressed to promote optimal occupational performance. Possible interventions may include, but are not limited to, using task analysis to make additions, reductions or other adaptations to process; changes in or other modifications to resources used; and relinquishing/replacement of unsafe occupations.
   
   Cues: Additional rest breaks are incorporated into the work routine
   Recommendations are made for client to cease driving due to unsafe driving practices, with alternative options for transportation then explored
3.3.7 Specific environmental factors are addressed to promote optimal occupational performance, including physical, cultural, social and temporal aspects. Possible interventions may include, but are not limited to, developing, enhancing or otherwise promoting enabling features; eliminating or otherwise minimising inhibiting features; and acknowledging, embracing and or challenging relevant cultural and social behaviours and attitudes.

*Cues:* Universal design principles are used to create community gardens
Community is involved to increase access and willingness to engage with health services
Culturally sensitive daily survival skills information targeted towards at risk youth is developed

3.3.8 Assistive technologies (ATs) and devices are selectively and appropriately utilised to enhance occupational performance, participation and achievement. This may include prescription, design and fabrication, application, training and education in use and care, and ongoing monitoring.

3.3.9 Requirements of confidentiality and privacy are used where consultations/recommendations to a third party are provided.

*Cues:* Intervention recommendations are communicated to client and respite carers with consent
Ergonomic recommendations are communicated to workplace supervisors with client consent

3.3.10 Teaching/learning principles are applied in designing education and health promotion strategies which effectively and efficiently support and enhance occupational performance and well-being.

*Cues:* Group sessions are organised for clients with common information needs
Participation in health promotion activities is facilitated for all children (e.g., Walking School Bus)

3.3.11 Interventions are implemented in a safe, ethical, efficient, effective and culturally appropriate manner.

*Cue:* Intervention may take place in a small group of peers/family members rather than individually where this is deemed appropriate

3.3.12 An ongoing reflective, evaluative approach is adopted throughout intervention to monitor and evaluate client progress, and review, change, and adapt strategies as required.
Element 3.4  Selects and implements intervention strategies and methods appropriate to the working environment

Performance Criteria

3.4.1  The process for selecting and implementing intervention strategies is consistent with relevant legislation and workplace procedures and protocols.

*Cues:* Workplace budgets and funding sources are considered
Clinical pathways are recognised and followed
Credentialing requirements for specialised interventions are met

3.4.2  Interventions are selected and developed in consideration of client’s needs and within the parameters of the working environment.

*Cues:* Parent education sessions are delivered in group formats and at appropriate times to meet the similar needs of different clients
Teleconferencing and telerehabilitation/health equipment/processes are used during intervention for clients in remote areas
Referrals are made to other service providers for interventions beyond the scope of the occupational therapy role within the organisation

3.4.3  Intervention priorities and strategies are integrated within, and congruent with, the overall service provided by the team

3.4.4  The frequency, intensity and duration of the intervention is appropriate with regards to the nature of the client’s need, ability to access other community services and available resources.

3.4.5  Risk assessments are undertaken to determine appropriateness and safety of interventions.

*Cues:* Discussion with medical staff to confirm medical status is undertaken prior to accompanying client on home visit from hospital
Appropriate protective equipment is procured before work site visit
Appropriate venues are chosen for groups in accordance with access and safety needs of clients and families
Element 3.5 Utilises available community resources, facilities and services

Performance Criteria

3.5.1 Community-based resources, facilities and services that can enable occupational performance and engagement and are accessible to the client, are identified.

Cues: Awareness of online support and relevant advocacy groups is developed
Local AT information, trial sites and providers are identified
Available supports for clients from remote/regional areas are investigated and alternatives are considered
A meeting with representatives from culturally diverse groups is convened

3.5.2 Client access and connection with appropriate community-based resources, facilities and services, which will support and facilitate occupational performance and occupational participation, is advocated and supported.

Cues: Older clients linked with appropriate home supports prior to discharge from inpatient services
Service provision for First Australian clients occurs within an Aboriginal health or education context such as Aboriginal medical service where possible or with an Aboriginal health worker present

Element 3.6 Respects and supports the role(s) of significant other(s)

Performance Criteria

3.6.1 Within the limits of confidentiality, significant others are informed, educated, counselled, consulted and supported as required, to enable a client’s occupational engagement and facilitate effective implementation of interventions.

Cues: Spouse/partner/extended family is engaged when determining discharge plan and support needs
Most relevant/appropriate family member(s) is determined in collaboration with clients
With client’s permission, teachers are informed and educated about how specific interventions help children in the classroom and playground (e.g., children with developmental co-ordination disorder or at risk of obesity)
Community services are engaged with to facilitate access to specific population groups
Neighbourhood representatives are engaged to discuss issues related to community well-being
Element 3.7  Plans cessation/ completion of services/ effective handover

Performance Criteria

3.7.1 Decisions regarding ceasing intervention are negotiated and made in collaboration with client, inter-professional team and other relevant stakeholders (e.g., family, client’s employer, other service providers).

3.7.2 Relevant stakeholders are engaged in case/workload handover and planning in preparation for staff changes.

3.7.3 Decisions are justified, communicated and documented according to criteria such as goal achievement, agreed outcomes, motivation, professional reasoning and future benefits of intervention.
Unit 4:
Occupational Therapy Service Evaluation

Evaluation and reflective practice contributes to the development of individual occupational therapists and their practices, occupational therapy services and the larger professional community. Evaluation is a critical professional activity to ensure the efficacy, efficiency and quality of services provided to clients. A client, may be an individual, family and/or significant other(s), group, organisation, community or population. Interventions and services should be evaluated from the perspectives of all key stakeholders. Many approaches can be taken to performing evaluation activities, and occupational therapists must be able to undertake and understand such activities as part of evidence-based practice and quality improvement. Evaluation of intervention(s) and services is closely related to quality improvement activities. Quantitative and qualitative evaluation methods are relevant to the goals, strategies, processes and outcomes of services.

While research methodologies may be employed to evaluate services, research is also a distinct activity which is also conducted to advance professional knowledge and understanding and practice evidence.

Importantly, evaluation outcomes must be used to inform recommendations for future development of occupational therapy interventions and services which are appropriate for the practice context.
Element 4.1  Incorporates perspectives of multiple stakeholders in evaluation of occupational therapy service provision

Performance Criteria

4.1.1 Feedback on the effectiveness, efficiency and quality of intervention and overall service is actively sought from the client and all relevant stakeholders.
   
   **Cues:** Client progress is discussed with client during intervention  
   Significant others are asked to report on changes in client’s performance  
   Client satisfaction is measured formally and objectively and key stakeholder focus groups/meetings are convened at regular intervals  
   Feedback from clients and stakeholders is used to determine effectiveness of services in meeting needs of people from diverse cultural and social backgrounds

4.1.2 Effectiveness, efficiency and quality of occupational therapy interventions and services are evaluated in consideration of the overall goals and priorities collaboratively developed by the team.

   **Cues:** Potential and or existing role overlap within the team is identified and negotiated/managed  
   Impact of team dynamics and functioning is recognised and responded to appropriately and professionally  
   First Australian health workers are consulted as part of the team evaluation where relevant

4.1.3 Effectiveness, efficiency and quality of intervention and overall service is evaluated in consideration of organisational priorities, processes, resources and expectations of the occupational therapy role.

   **Cue:** Achievement planning is considerate of organisational priorities and reviewed regularly

4.1.4 Reflection, independently or with support, is engaged in by the occupational therapist to evaluate professional conduct and performance (including within the team), and subsequently, areas for further personal and professional development are identified and improvement implemented.

   **Cues:** Supervision sessions are sought and regularly used to reflect upon performance and identify areas and strategies for improvement  
   Mentorship is sought and developed
Element 4.2 Demonstrates ability to understand and conduct multiple evaluation methods and techniques

Performance Criteria

4.2.1 Factors influencing service outcomes are identified as a basis for ongoing reflection and service evaluation.

Cues: Past experiences are considered when negotiating access and utilisation of services by refugees
Family schedules are considered in developing home programmes for children

4.2.2 Evaluation of interventions and overall service follows an evidence-based process, utilising relevant professional knowledge and techniques and formal evaluation methodologies within a research framework.

Cues: Key performance indicators are utilised where relevant
Current service is benchmarked against other organisations
Competency Standards are used to evaluate own performance

4.2.3 Appropriate techniques and methods of evaluation (formal and informal) are applied.

Cues: Approaches to service are discussed and compared with successful examples of working with First Australians or other culturally diverse groups
Quantitative and qualitative methods are employed
Consumer/client surveys and focus groups are conducted

Element 4.3 Demonstrates an understanding of, and commitment to, principles and methods of quality improvement

Performance Criteria

4.3.1 Quality improvement activities are documented and explained in terms of their objectives, process and results.

4.3.2 Quality improvement activities are conducted with a specific purpose to measure, evaluate and/or improve the effectiveness, efficiency and/or quality of services.

4.3.3 Relevant performance evaluation and development processes, occurring within the workplace and the profession, are engaged with as appropriate.

Cues: Contemporary practice models are accessed and used
Organisational processes for workload measurement are participated in
Census/survey activities and research are participated in
Relevant and contemporary research/literature is read, understood, critically appraised and incorporated into practice
Element 4.4 Utilises evaluation outcomes to make recommendations for future practice

Performance Criteria

4.4.1 Outcomes from evaluation activities are used to make recommendations to improve future occupational therapy services, at individual, local and/or broader professional community levels.

*Cues:* Findings from evaluations are disseminated (e.g., newsletters, special interest groups, and journals)

Client information handouts and their distribution are revised based on feedback from clients

4.4.2 Recommendations for changes to practice are developed using a systematic, evidence-based process, including critical appraisal of evidence from evaluation activities, relevant advances in the field of practice and feedback from relevant stakeholders.

4.4.3 Recommendations for future directions, goals and priorities of practice are considered taking into consideration relevant legislation and organisational priorities, protocols and resources.

4.4.4 Identified gaps in evidence are acknowledged and addressed through recommendations for further research.

4.4.5 A plan for implementation of recommendations from evaluation is contributed to as appropriate.

*Cue:* New graduate/s partner with more experienced colleague/s to develop and implement evaluation findings/recommendations

4.4.6 Outcomes from evaluation activities and subsequent recommendations are communicated clearly and in a timely manner to all relevant stakeholders.

4.4.7 In instances of limited empirical evidence, recommendations for service development are made by the occupational therapist, based on professional knowledge and experience, the characteristics of the client group(s), their identified needs and values, relevant literature and trends, and or organisational priorities and resources.

4.4.8 Evaluation outcomes are communicated appropriately to all interested stakeholders.

*Cues:* Confidentiality of information is maintained

Information is presented via a communication medium suitable to the target audience
Unit 5: Occupational Therapy Professional Communication

Communication is critical to professional occupational therapy practice. Occupational therapists must possess a broad, well-developed range of communication skills which can be applied, adapted and changed to accommodate the needs and requirements of different stakeholders and different practice contexts.

As part of client-centred practice, occupational therapists must be able to communicate clearly and respectfully with clients in order to develop and maintain a working partnership and to facilitate active participation of clients in service planning. A client may be an individual, family and/or significant other(s), group, organisation, community or population. Occupational therapists commonly work as members of intra-professional, inter-professional, and inter-agency teams, and therefore must be able to convey important and relevant information efficiently and effectively to multiple team members.

In all practice settings occupational therapists must engage with different stakeholders including individuals, families, carers, other health professionals, work colleagues, community and government organisations, and members of the public. These interactions may occur one-on-one, within groups, or within public community forums. Communication may take a range of forms, including verbal, written, non-verbal and electronic means. Whilst dissemination and communication of information is critical, principles of confidentiality and privacy must always be upheld.

Occupational therapists must be able to select and justify appropriate communication approaches which meet the needs of different stakeholders. These approaches must also meet the requirements of workplace policies and protocols and relevant legislation surrounding informed consent, confidentiality, privacy, professional conduct and other medico-legal, professional and ethical issues. Occupational therapists should also be aware of the potential for cultural issues to impact on the communication process. Communications should be culturally appropriate and competent.

To promote greater understanding of the occupational therapy profession and advance its knowledge base, occupational therapists should seek and utilise opportunities to disseminate professional information which is evidence-based and reflects the importance of occupation, the occupational therapy process and occupational therapy services.
Element 5.1  Facilitates active participation of the client in service provision

Performance Criteria

5.1.1  All important information is conveyed in a respectful, appropriate and thoughtful manner, which takes into consideration the cultural, spiritual, religious and personal context(s) of the client.

Cues:  Location of meeting is appropriate (e.g., convenient, private)

- Appropriate cultural protocols are observed (e.g., permission asked from community elders, observance of religious practices)
- Relevant stakeholders are present (e.g., family, carer, teacher)
- Recognition that community consultation needs to occur over a period of time to enable a diverse range of views within the community to be expressed

5.1.2  Information is presented clearly and concisely, using language which is easily understood. Specific occupational therapy terms are explained.

Cue:  Level of communication is adjusted for recipient (e.g., language level, diagrams, photos, pictures)

5.1.3  Barriers to communication are identified (e.g., language, hearing loss, lack of effective communication system, gender of interviewer) and addressed to minimise impact on client’s informed participation in the service.

Cues:  Environmental features are adapted or considered (e.g., noise levels, privacy)

- Interpreter is used to provide both translation and appropriate cultural context interpretation
- Client comprehension of information is confirmed
- Alternative and augmentative communication methods are considered and utilised as appropriate

5.1.4  Additional resources are used as required to enhance and reinforce client’s understanding.

Cues:  Written information sheets are provided commensurate with client’s level of health information literacy

- Translated written information is presented where possible and necessary
- Visual/practical demonstrations are provided
- Appropriate websites are recommended

5.1.5  The client is encouraged to share his/her priorities and goals to inform service delivery.

Cue:  Where complex communication needs are recognised (i.e., barriers to communication beyond hearing impairment or English as a second language) decision making and goal setting is facilitated through use of augmentative AT communication as appropriate to the client’s preferences
5.1.6 The client is made aware by the occupational therapist of how personal information is recorded, used and stored.

Cues: Consent to discuss client with other stakeholders is obtained
Confidentiality processes are explained

Element 5.2 Adopts a communication approach appropriate to the working environment

Performance Criteria

5.2.1 With client’s consent, effective, collaborative and co-operative relationships are developed and maintained within teams, with colleagues and other stakeholders to achieve common and client-driven goals.

Cue: Time is taken to develop relationships with First Australian clients and their families (e.g., therapist provides appropriate information about him/herself)

5.2.2 All important and relevant information is communicated to relevant colleagues and clients in an efficient, appropriate and timely manner that meets confidentiality requirements.

5.2.3 Language and media that are relevant, appropriate and meaningful to the intended target audience is used by the occupational therapist.

Cues: Information handouts are available in the most common language(s) of the client group
Visual supports are made available and used as appropriate in accordance with principles of Universal Design

5.2.4 Communication is of a standard which meets the requirements of workplace protocols, procedures and legislation.

Cues: Progress notes are legible, accurate, signed and dated
Emails and any attachments are appropriate and professional

5.2.5 Information and Communication Technology (ICT) and other electronic communication tools (e.g., mobile phones, emails, internet, social networking sites, paging systems) are used responsibly in accordance with privacy and confidentiality, and workplace and legislative requirements, to support occupational therapy practice.
5.2.6 All client information is secured and maintained according to workplace and legal requirements of privacy and confidentiality.

*Cues:*
- Workplace database is password-protected
- Identifying client information is not discussed in public areas, including mobile phone conversations
- Client records are stored to ensure restricted access
- Results from community needs analysis are not discussed with stakeholders without client consent

**Element 5.3 Documents and reports relevant aspects of service provision**

**Performance Criteria**

5.3.1 All relevant aspects of the occupational therapy service are routinely, objectively, legibly and concisely documented in accordance with privacy and confidentiality, workplace and legal standards/requirements.

5.3.2 Service outcomes are recorded and evaluated. Appropriate recommendations are prepared and presented to relevant stakeholders within negotiated timeframes.

*Cue:*
Methods of presentation are negotiated with stakeholders (e.g., oral presentation, written documentation, group discussion)

**Element 5.4 Shares professional information responsibly**

**Performance Criteria**

5.4.1 Information that supports evidence-based practice and enhances the occupational therapy profession is disseminated.

*Cues:*
- Professional information is shared during inservice sessions
- Online interest groups are accessed and engaged with
- Continuing professional development activities are engaged with
- Support groups are formed

5.4.2 Opportunities to discuss, demonstrate and advocate the role of occupational therapy to clients, colleagues and other stakeholders are sought and utilised.

*Cues:*
- Relevant community-based events (e.g., Occupational Therapy Week, Carers’ Day) are supported and contributed to
- Relevant websites are promoted
- Opportunities to explain role in occupational language within work contexts are used (e.g., explaining to worksite manager or to teachers on school visits)
Unit 6: Occupational Therapy Professional Education and Development

The practice and knowledge base of occupational therapy (as with all health professions) continues to evolve over time. Occupational therapists must therefore engage in a process of lifelong learning and commit to continuing professional development in order to maintain and further their personal expertise, and in so doing contribute to the advancement of the profession. Opportunities for new learning should be regularly pursued, new evidence critically evaluated, shared, and integrated as appropriate, into professional practice.

Different areas of practice and specialty areas may require context-specific skills and knowledge which are beyond the scope of this document, and it is incumbent upon the occupational therapist to seek out further learning opportunities to ensure he/she has a level of competence commensurate with the requirements of the specific setting.

Occupational therapists have a professional responsibility to facilitate and contribute to the learning of other health professionals, particularly occupational therapy students. As appropriate to their specific context, occupational therapists are expected to contribute to student learning activities including, but not limited to, support and engagement with student placements, presentations/lectures within occupational therapy programmes, and tours and demonstrations of facilities.
Element 6.1 Engages in lifelong learning processes and activities to maintain professional competence

Performance Criteria

6.1.1 Opportunities for improving professional knowledge and skills are identified and capitalised on throughout his/her professional life.

_Cues:_ Communities of Practice are engaged with in person or through online networks
  Potential mentors are sought and regularly utilised and engaged with
  Relevant Continuing Professional Development (CPD) courses, self-study, or postgraduate opportunities are undertaken
  Interest groups relevant to practice are joined and supported
  Opportunities to develop cultural safety are identified and utilised, including opportunities to seek out and foster partnerships with Aboriginal health workers and/or key community members and others who can provide mentoring and guidance

6.1.2 New information and knowledge is critically evaluated, shared with others (formally and informally) and integrated into current practice as appropriate.

_Cues:_ Newly acquired knowledge is reviewed and discussed with others and, with support, is incorporated into practice as appropriate
  Journal club is started or attended
  Assessment tools, new interventions, equipment such as ATs are reviewed, critiqued and workplace recommendations made

6.1.3 A reflexive and reflective approach to practice is adopted by the occupational therapist by critically evaluating personal performance, seeking and utilising supervision effectively, identifying ongoing learning needs and undertaking lifelong learning.

_Cues:_ Strategies for practice enhancement are discussed during supervision sessions
  Personal values are reflected upon and evaluated in terms of their impact on practice
  Professional portfolio is maintained
  Rural and sole practitioners engage with online Communities of Practice to network with supervisors and mentors
Element 6.2  Contributes to education and professional practices of students

Performance Criteria

6.2.1 Commensurate with level of experience, occupational therapy theories, concepts, and techniques are demonstrated and explained to students.

6.2.2 Student learning activities and processes occurring within the workplace are engaged with, and contributed to, as appropriate to the occupational therapist’s role and level of experience.

   Cues:  Appropriate OT role behaviours are modelled
          Preparation for student supervision is undertaken
          Workshops convened by individual universities to develop student supervisory skills are attended
Unit 7: Occupational Therapy Professional Practice Responsibilities

Sustainable occupational therapy services rely on an efficient, effective and systematic approach to practice. Occupational therapists are accountable for performance of daily work tasks and must demonstrate timely, effective management of their workload, and personal and workplace resources.

As part of their daily practice, occupational therapists face numerous competing demands. To effectively and competently manage their workloads, practitioners must be sufficiently skilled in clinical reasoning, prioritisation, time management, problem-solving, adaptability, negotiation and delegation. Effective, collaborative and co-operative relationships with stakeholders including clients, families, groups, colleagues, supervisors and senior staff are critical to quality service development and provision.

The responsibilities of professional practice will vary across different working environments. Occupational therapists must conduct themselves and perform work tasks to a standard that meets the requirements of workplace protocols, procedures and legislation. Occupational therapists are expected to work in a safe manner, and engage in community consultation, risk assessment and management and evaluation to promote a safe physical, personal, social and cultural environment.

In accordance with the principles of evidence-based and best practice, it is expected that occupational therapy services and practice will evolve over time. Occupational therapists must be aware of these trends and be prepared to contribute to, and participate in, quality assurance/improvement and research activities within their working environment.
Element 7.1 Adopts an efficient, effective and systematic approach to daily workload management

Performance Criteria

7.1.1 Daily work tasks and responsibilities are performed in an organised, timely and goal-driven manner.

7.1.2 Daily workload is effectively managed using a range of professional skills, including professional reasoning, prioritisation, problem-solving, adaptation, negotiation and delegation.

7.1.3 Changing circumstances are managed effectively, flexibly and efficiently by reassessing work priorities and adapting work practices.

Cues: Responsibilities of an absent colleague are shared and redistributed

When a client does not attend an appointment, time is used in efficient practices such as client case review

Service is taken to First Australian clients in a flexible framework (e.g., “drop-in mornings” may be used rather than rigid hourly appointment times)

7.1.4 Time is effectively and efficiently managed so that necessary work tasks are completed according to expected performance standards and timeframes.

7.1.5 Contributions to the team enable effective service integration, focused on shared client-centred goals.

Cue: Joint intervention sessions are held with speech and language pathologist to address multiple client goals

7.1.6 Skills and expertise of team members, volunteers and support staff are recognised, utilised and understood effectively, supported and developed.

Cue: Collaboration with support staff to maximise optimal frequency and duration of client’s participation in rehabilitation

7.1.7 Resources within the workplace are used efficiently, safely, appropriately and responsibly to support practice. In accordance with the expectations of the practice setting, occupational therapists assume responsibility for development, management and maintenance of resources within financial constraints.

Cue: Content downloaded from internet relates directly to work tasks and responsibilities
Element 7.2  Works effectively within the structure of the workplace environment

Performance Criteria

7.2.1 Personal conduct and performance of work tasks is of a standard commensurate with the requirements of relevant workplace protocols, procedures and legislation, such as Occupational Health and Safety, Disability Services, Equal Opportunity and Anti-Discrimination.

7.2.2 Essential administrative duties are completed accurately, systematically and within established timeframes.

7.2.3 Established communication systems and protocols within the working environment are used responsibly and effectively to support practice.

Cues:  Group emails are sent to co-ordinate a meeting time
       In/out boards are updated frequently
       Meetings with stakeholders are made with flexibility using appropriate technology for each context

7.2.4 A safe working environment is promoted and appropriate risk management strategies are adhered to for clients, colleagues and others who enter the workplace, in accordance with legislative duty of care requirements.

Cues:  Threatening/aggressive behaviour is reported
       Potentially culturally unsafe practices are identified and addressed
       Trip hazards are identified and reported

7.2.5 The role of occupational therapy within the working context is understood; duties are performed accordingly, and an understanding of service priorities and objectives is demonstrated.
Element 7.3  Contributes to quality assurance and service development

Performance Criteria

7.3.1  Effective, evidence-based programmes and services are developed to a standard commensurate with experience, support and workplace expectations.

  Cues:  Ongoing supervision and mentoring is sought and utilised
          Input is provided at meetings
          Constructive feedback is provided and received
          Supervision of others is provided (e.g., volunteers, assistants)

7.3.2  The principles and processes of quality improvement and assurance are understood and promoted by participating in relevant workplace and professional quality improvement activities.

  Cues:  Existing client information handouts are reviewed and revised
          All stakeholders are encouraged to provide formal and informal evaluation of services at regular intervals
          Workplace development and evaluation of culturally secure practices is contributed to
References


OT AUSTRALIA. (1994). *Australian Competency Standards for Entry-Level Occupational Therapists*. Melbourne, Victoria: OT AUSTRALIA.

OT AUSTRALIA. (1999). *Australian Competency Standards for Occupational Therapists in Mental Health*. Melbourne, Victoria: OT AUSTRALIA.


### Appendix 1: Reference Group Members

<table>
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Appendix 2: List of Contributors to Australian Minimum Competency Standards for New Graduate Occupational Therapists

The Project Team acknowledges the contribution of the following individuals and organisations for their ongoing support and provision of feedback in revision of the Australian Competency Standards for Occupational Therapists.

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Queensland Department of Education and Training Occupational Therapists

Occupational Therapy Council
Northern Territory Occupational Therapy Registration Board

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Curtin
Edith Cowan
James Cook
Monash
Newcastle
Southern Cross
University of Queensland
University of Western Sydney

* Responses from some Occupational Therapy Departments included individual and whole of staff responses as well as broader clinical consultation.