

OCCUPATIONAL
THERAPY GUIDE TO
GOOD PRACTICE:

**Working
with
Children**

OCCUPATIONAL THERAPY GUIDE TO GOOD PRACTICE:



Working with Children

Occupational Therapy Australia's National Paediatric Taskforce

About Occupational Therapy Australia

Occupational Therapy Australia is the professional association for occupational therapists in Australia.

Our members are qualified occupational therapists employed throughout the public and private sectors. They provide health care, vocational rehabilitation, and consultancy to clients.

Our mission is to provide member benefits through access to local professional support and resources, and through opportunities to contribute to, and shape, professional excellence.

For more information about Occupational Therapy Australia, visit www.otaus.com.au.

© Occupational Therapy Australia 2016

This work is copyright. You may download, display, print and reproduce this material in unaltered form only (retaining this notice) for your personal, non-commercial use or use within your organisation.

Apart from any use as permitted under the Copyright Act 1968, all other rights are reserved.

Occupational Therapy Australia reviews its publications on a staged basis. The *Occupational Therapy Guide to Good Practice: Working with Children* is due for review in May 2017.

Requests for further authorisation should be directed to *The National Manager: Professional Practice and Standards*, care of:

Occupational Therapy Australia
6/340 Gore Street
Fitzroy VIC 3065

or

standards@otaus.com.au

Context

The Guide to Good Practice for Working with Children was developed by Occupational Therapy Australia's Paediatric Taskforce over 18 months. It incorporates current evidence and practice knowledge and has undergone consumer review.

The primary intent of the Guide is to inform occupational therapists about good practice principles in the absence of formalised clinical practice guidelines, and in response to Occupational Therapy Australia data on practice queries.

The Guide will be reviewed in one year with a view to inclusion of other child-based practices and settings, and other aspects based on feedback.

Acknowledgements

Occupational Therapy Australia acknowledges the expertise and input of the following members of the Occupational Therapy Australia Paediatric Taskforce in authoring the Guide to Good Practice:

Nicole Brown; Nikki Chegwyn; Rachelle Coe; Elizabeth Edgar; Dr Elspeth Froude; Cate Hilly; Deb Hopper; Dr Fiona Jones; Dr Annette Joosten; Aneesa Kathrada; Erin Kelly; Emma King; Caroline Mills; Jacky Peile; Celeste Riach; Liz Springfield; Lisa Vale; and Tara Whiteford.

Introduction

The Occupational Therapy Guide to Good Practice for Working with Children provides practice guidelines for occupational therapists who work with children (aged 0-18 years) and their families/caregivers. This can be used as a reference for occupational therapists, consumers, and organisations. It outlines expectations for good practice.

The need for a good practice guide was identified by Occupational Therapy Australia's Paediatric Taskforce, which was established in July 2014 to advise the National Professional Practice and Standards Portfolio and the Board of Occupational Therapy Australia on issues relevant to paediatric practice. The Guide was developed by the National Paediatric Steering Group of Occupational Therapy Australia with input from the National Paediatric Reference Group and a range of other key stakeholders including the Board of Occupational Therapy Australia.

The Guide incorporates information from a range of sources: experienced occupational therapists practicing in the field, researchers, academics, current evidence, and governing bodies relevant to occupational therapy practice and children.

The information in this Guide was developed to be used by occupational therapists who work with children and their families/caregivers to articulate what is expected of occupational therapists who work with these individuals. Particular acknowledgement is made of the *2007 UK Guide to Good Practice for Paediatric Physiotherapists* (Association of Paediatric Chartered Physiotherapists), which informed the framework for this document.

The Guide is intended to complement other key documents including the AHPRA *Code of Conduct*, the Occupational Therapy Australia *Code of Ethics* (2001), and the Occupational Therapy Australia *Competency Standards for Entry-Level Practitioners* (2010). A range of other regulatory and legislative documents may apply depending on jurisdiction, service type, and employment structure.

Table of contents

Context	3
Acknowledgements	3
Introduction	3
Table of contents	4
SECTION 1: Occupational therapy as a profession	6
What is occupational therapy?	6
Occupational therapy with children	6
SECTION 2: Occupational therapy practice	7
Legal and ethical frameworks	7
Consent in occupational therapy	7
What is the role of the occupational therapist in safeguarding children?	8
Checking staff against criminal registers	8
Respect, privacy, and confidentiality	8
Cultural safety and responsiveness	8
Fees	8
Advertising	9
Use of titles and descriptors	10
Continuing professional development	10
SECTION 3: Occupational therapy practice with children	11
Evidence-based practice: knowledge for practice, applying knowledge in practice, competencies, and standards	11
Collaborative practice	12
Settings and contexts	12
Autonomy and delegation	12

SECTION 4: Providing high quality services for children and their families	13
What do occupational therapists do?	13
Occupational therapy process	13
How do occupational therapists deliver their services?	14
Record keeping and documentation	14
SECTION 5: Child-related policy	18
Safeguarding children	18
Standards for disability services	18
Education	18
SECTION 6: Funding Schemes	19
Access to Allied Psychological Services (ATAPS)	19
Better Access to Mental Health (BAMH)	19
Better Start for Children with Disability Initiative	19
Chronic Disease Management Plan	19
Enhanced Primary Care	19
Helping Children with Autism	19
Medicare	19
National Disability Insurance Scheme (NDIS)	19
SECTION 7: Useful general information	20
Useful terms and definitions	21
References	23

SECTION 1: Occupational therapy as a profession

What is occupational therapy?

Occupational therapy is a client-centred health profession concerned with promoting health and wellbeing through occupation. Occupations refer to the everyday activities that people do as individuals, in families, and with communities to occupy time and bring meaning and purpose to life. Occupations include things people need to, want to, and are expected to do (World Federation of Occupational Therapists, 2011). The primary goal of occupational therapy is to enable people to participate in their daily occupations or activities.

Occupational therapists complete a university degree at undergraduate or graduate entry Masters level that provides them with a knowledge base in occupational therapy theory and science, neurology, anatomy, physiology, kinesiology, lifespan including child development, sociology, psychology, psychosocial development, activity-task-environment analysis, and therapeutic techniques.

Occupational therapy with children

Occupational therapists enable children to do the activities they need or want to do (performance), and to facilitate children's engagement in their roles (participation) within their everyday lives. Occupational therapists aim to enable and optimise children's occupational performance and participation to fulfil their life roles.

Occupational therapists who work with children require specific knowledge and skills in the areas of:

- child and adolescent development
- occupations of children (schoolwork, play/leisure, self-care, rest/sleep)
- child- and family-centred practice
- assessment and outcome measurement
- goal setting and occupational therapy process
- evidence-based interventions.

Occupational therapists may work in the child's home and community including early intervention, educational settings such as schools and universities, hospital and health settings, and in private practice.

SECTION 2: Occupational therapy practice

Legal and ethical frameworks

WHAT ARE THE LEGAL AND ETHICAL FRAMEWORKS THAT GOVERN OCCUPATIONAL THERAPY?

Occupational therapists are registered health professionals who are required to adhere to rules and standards of the Occupational Therapy Board of Australia, and the relevant legal and policy frameworks of the country.

In Australia, there are several types of laws that therapists need to follow and it is important to be aware of the relevant law for the state or territory where the therapist is practicing. It is the responsibility of the therapist to be aware of state, territory, and national law for both the profession and general consumers.

The *Health Practitioner Regulation National Law Act 2009* (the National Law) came into effect on 1 July 2010. The National Law enabled a National Registration and Accreditation Scheme, established the Occupational Therapy Board of Australia, appointed a Tribunal for the purpose of law, imposed standards of conduct for the health professions, and placed restrictions on how health services can be advertised.

WHO REGULATES OCCUPATIONAL THERAPY PRACTICE?

The Australian Health Practitioner Regulation Agency (AHPRA) supports the Occupational Therapy Board of Australia in regulating the occupational therapy profession.

Occupational therapists must ensure they meet the relevant registration guidelines annually. Therapists must declare an annual statement and pay a fee to remain registered. The declaration in the annual statement includes whether:

- the therapist has met the recency of practice requirements stated in the Board's registration standard
- the therapist has met the Board's continuing professional development (CPD) requirements as set out in the Board's CPD registration standard during the previous registration period
- the therapist has practised in accordance with the requirements of the Board's professional indemnity insurance (PII) arrangements registration standard, and whether the therapist commits to practise in accordance with that registration standard if registration is renewed
- there was any change in the therapist's criminal history during the previous registration period
- the therapist has any other criminal history that has not been disclosed to AHPRA.

The Occupational Therapy Board of Australia provides a *Code of Conduct* to guide practice and assist in the delivery of effective services within an ethical framework (Occupational Therapy Board of Australia, 2012). Within this Code there are sections to help shape practice including working with children (Occupational Therapy Board of Australia, 2012). This Code aims to help protect the public by setting and maintaining standards of good practice that must be adhered to by registered occupational therapists. Failure to comply with these standards may have consequences for registration.

www.occupationaltherapyboard.gov.au/Codes-Guidelines/Code-of-conduct.aspx

ETHICAL FRAMEWORK THAT GOVERNS OCCUPATIONAL THERAPY

Occupational Therapy Australia uses a *Code of Ethics* that provides clear and moral ethical parameters for occupational therapy practice (OT Australia, 2001) to promote and maintain high standards of ethical behaviour. Adherence to the Code of Ethics supports practice aligned with bio-ethical principles of beneficence, non-maleficence, honesty, veracity, confidentiality, justice, respect, and autonomy.

Consent in occupational therapy

Occupational therapists need to be aware of obtaining consent when working with children. It is the responsibility of the occupational therapist determine which departmental rules apply (for example Department of Education), and which state/territory and federal legislation is current and applicable.

Consent to assess and intervene must be given voluntarily, without any duress or force or deceit. A person providing consent must be able to understand and comprehend the situation and requirements. Consent can

be provided verbally or non-verbally depending on the child's abilities. Full consent is required unless otherwise mandated under National Law.

What is the role of the occupational therapist in safeguarding children?

Occupational therapists are expected to apply their professional expertise to observe, monitor, and report situations where the well-being of their client/s is at risk in order to provide advocacy and protection for the child. Within Australia occupational therapists need to appraise themselves of and comply with federal and state legislation regarding reporting of suspected child harm within the jurisdiction that they practice.

From an international perspective, occupational therapists working with children need to be aware of the *United Nations Convention on the Rights of the Child* (*United Nations Treaty Collection, Convention on the Rights of the Child*, 1989) which is a universally agreed set of non-negotiable standards and obligations for all children. The rights of the child are also reflected in the *United Nations Convention on the Rights of Persons with Disabilities* (2006), which has been ratified by Australia. Additionally, this Convention offers specific guidance upon rights to a range of disability supports. It is available from www.un.org/disabilities/convention/conventionfull.shtml.

Checking staff against criminal registers

Each Australian state jurisdiction has different compliance requirements for a Working with Children Check. This Check is generally mandatory and needs to be completed prior to commencement of practice with children. It is the responsibility of the occupational therapist to ensure they comply with the laws in the jurisdiction and the organisation that they are working within. Links to information on Working with Children Checks for each state/territory can be found online.

Respect, privacy, and confidentiality

Occupational therapists are required to comply with AHPRA guidelines, state and federal laws, and their employer in regard to the maintenance and protection of their client's privacy and confidentiality. Further information can be found at: www.occupationaltherapyboard.gov.au/Codes-Guidelines.aspx

Cultural safety and responsiveness

Culturally safe practices focus on the level of safety felt by an individual seeking health care with an emphasis placed on assisting the health worker to understand processes of identity and culture, and thus how power imbalances can be culturally unsafe (Downing, Kowal & Paradies, 2011).

Occupational therapists are expected to provide services that are responsive and appropriate in the cultural context in which they practice. Occupational therapists recognise the uniqueness of each client, family, and community they work with by ensuring that all aspects of their service provision respect cultural values and beliefs. This requires occupational therapists to work in partnership with clients, families, and communities to tailor communication, occupational therapy assessments, and interventions to meet the needs of the child and family's cultural context. Occupational therapists need to understand the occupations, tasks, and routines of the child's and family's daily life, and deliver a service that is culturally appropriate and meets the family's needs.

The delivery of culturally appropriate services in partnership with Australian Aboriginal and Torres Strait Islander people is of particular focus to support the health and well-being of these communities. This requires time to build a relationship with the child and family, ensure ease of access to services and the referral process, and culturally appropriate assessment, intervention, and documentation.

In terms of responsiveness to family culture, occupational therapists are expected to provide services within the context of the family and its cultural beliefs and values, understanding that the modern family unit is a diverse and changing configuration of involved caregivers and children. For example, choice of culturally inclusive words to describe significant others may include next of kin, circle of support, kinship carer, and/or parent/caregiver.

Fees

Information regarding fee for services must be clearly documented and available. It can sometimes be difficult to provide accurate pricing for occupational therapy services due to the nature of services and number of variables in intervention. If fees and price information are advertised then price information should be clear, with all costs involved and out of pocket expenses clearly identified with any conditions or other variables disclosed. Fees might vary depending on the assessment forms required, specialised or consumable equipment that needs to be

used, or reporting requirements additional to an occupational therapy report. If a private practice occupational therapist is required to assume a case manager or key worker role, fees may be charged for contributing to additional requests for communication such as engaging in meetings, writing reports, and providing consultation to other team members in conjunction of the family and child.

Advertising

Advertising is a useful way to communicate about occupational therapy services so families can make informed choices. As per the AHPRA guidelines, advertising should not be false or misleading. Advertising includes paper based, web-based and social network media.

Advertising may include:

- office details and contact hours
- fees
- qualifications and experience of occupational therapists
- memberships of professional associations.

Advertising **should not**:

- include testimonials from former clients of the service
- offer gifts, prizes, or bulk discounts for taking part in therapy services
- encourage indiscriminate or unnecessary use of occupational therapy services
- create unreasonable expectation of benefits of treatment
- make “time limited” offers that encourage a person to make decisions under the pressure of time and money and not about their health care needs.

Caution should be taken in using scientific information in advertising. Clear information should be provided regarding the evidence base of any intervention being offered.

HELPFUL QUESTIONS TO CONSIDER WHEN ADVERTISING

Practitioners who are considering the use of titles, words, or letters to identify and distinguish themselves in advertising (other than those professional titles protected under the National Law for their profession) are encouraged to ask themselves the following questions:

- Is it appropriate for me to use this title, qualification, membership, words or letters in advertising material?
- Am I skilled in the services I am advertising?
- If I display or promote my qualifications in advertising materials, is it easy to understand?
- Is there any risk of people being misled or deceived by the words, letters, or titles that I use?
- Is the basis for my use of title, qualification, membership, or other words or letters:
 - ◆ relevant to my practice?
 - ◆ current?
 - ◆ verifiable?
 - ◆ credible?

www.occupationaltherapyboard.gov.au/Codes-Guidelines/Guidelines-for-advertising-regulated-health-services.aspx

Use of titles and descriptors

Providing information about qualifications and experience may assist families in choosing an occupational therapy service for their child.

The title “Occupational Therapist” is protected under the National law. Occupational therapists cannot call themselves a “specialist” occupational therapist or practitioner or imply that they are one. Using the phrase “specialising in X” may be misleading. Occupational therapists should not use words, letters, or titles that may mislead a family or consumer into thinking that the therapist is more qualified or competent than another professional occupational therapist with the same registration. Guidelines from AHPRA suggest occupational

therapists should advertise the amount of experience they have working with particular children. (For example, “Specialist Occupational Therapist for children with autism” may be misleading and cannot be used; instead, “Occupational Therapist with more than 10 years’ experience working with children with autism” would be more suitable.)

Where occupational therapists use the title “Dr”, they should clarify that they are not a medical practitioner by stating “Occupational Therapist” or stating whether they hold a doctorate (e.g. HScD or PhD).

Continuing professional development

Continuing professional development (CPD) is the means by which therapists maintain, improve, and broaden their knowledge, expertise, and competence, and develop the personal and professional qualities required throughout one’s professional life.

All practising occupational therapists must undertake a minimum of 30 hours of CPD annually as a requirement of registration.

CPD REQUIREMENTS

From 1 December 2013, all registered occupational therapists must complete 30 hours of CPD each year (every 12 months).

KEY POINTS: CPD

- CPD activities should have clear goals and outcomes
- Keep evidence of completed CPD activities in a CPD portfolio, and retain this evidence for five years
- Comply with the Occupational Therapy Board of Australia’s CPD registration standard, so make sure you familiarise yourself with this document and the accompanying CPD guidelines and fact sheet
- Make a declaration at registration renewal about CPD activities. A false statement is grounds for the Board to refuse registration.

www.occupationaltherapyboard.gov.au/Codes-Guidelines/Continuing-professional-development.aspx

SECTION 3: Occupational therapy practice with children

Evidence-based practice: knowledge for practice, applying knowledge in practice, competencies, and standards

Scope of practice is the level at which all graduates of Australian occupational therapy programs can work.

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 (Occupational Therapy Australia, 2010, p3.). There are seven units of competence:

- Professional Attitudes and Behaviour
- Roles, Performance, and Functional Level of Individuals and Groups
- Implementation of Individual and Group Interventions
- Evaluation of Occupational Therapy Programs
- Documentation and Dissemination of Professional Information
- Professional Education
- Management of Occupational Therapy Practice.

Occupational therapists work collaboratively with the family and the child to address the child and family's occupational needs and goals based on their priorities.

Occupational therapists are evidence-based practitioners who integrate the best research evidence with clinical expertise and with the values and circumstances of the person with whom they are working (see *Useful terms and definitions* on page 21 for explanations).

Occupational therapists must adhere to evidence-based practice as (a) it is part of their registration requirements; (b) clients expect and deserve services based on best available evidence; and (c) funding bodies require evidence for continuation of services.

Occupational Therapy Australia supports the following considerations:

- Occupational Therapy Australia recognises that the strength of evidence for the effectiveness of any specific occupational therapy intervention or approach is a function of a number of factors. These include relevant research studies, as outlined in the GRADE criteria (www.bmj.com/content/336/7650/924), including: the study design; risk of bias; directness of the evidence; consistency and precision of the results; and risk of publication bias
- The quality of the available evidence impacts on the profession's standing in the health and general communities and is the responsibility of the profession and our association
- Occupational Therapy Australia acknowledges that limited or absence of research regarding an occupational therapy intervention does not always mean that it is ineffective or inappropriate
- When there is no evidence for effectiveness of an intervention, parents should be advised and the intervention should be used with regular reviews to ensure that the intervention is meeting the goals of the client, using an outcome measure
- Occupational Therapy Australia acknowledges that occupational therapists have a range of clinical questions that extend beyond those about intervention effectiveness. These may include questions about the accuracy of an assessment/s, prognosis (i.e. the likely outcome for a client, either with or without intervention), clients' experiences and concerns for a particular situation, or the frequency, aetiology, or risk factors for a condition occurring
- The best available evidence should be used as the default position for all practitioners. Where there is evidence that an intervention is not effective, that intervention should not be implemented by a registered occupational therapist

- Within the evaluation of the evidence, occupational therapists should consider family priorities, cost effectiveness, and context. This is in accordance with the Code of Conduct (1.2 and 2.2h) to ensure that practitioners act ethically with regard to the wellbeing of their clients
- Occupational Therapy Australia recommends that competent and responsible occupational therapy practice includes reasonable efforts to base clinical decisions on a critical review of all relevant evidence, including research evidence, expert consensus, and professional experience.

Occupational Therapy Australia expects that therapists will collaboratively set measurable occupational goals and use contemporary evidence-based outcome measures with all children and families to ensure that they receive systematic feedback on the effectiveness of their services.

Collaborative practice

Occupational therapy for children is best provided in the context of collaborative practice with the family, the education and health systems, and with other organisations providing service for children.

Occupational therapy can be delivered within different contexts, and can be provided as part of a team or by a single profession. Regardless of the context in which the service is provided, goals for the child and/or family need to be clearly defined and communicated to all team members involved in providing a service to the child and family. Collaboration and joint goal setting will ensure that services are not duplicated, and that all available resources to support the child and family are expended efficiently and effectively.

Settings and contexts

In Australia, occupational therapy may be delivered to individuals and groups, and occupational therapists work in a wide range of public and private settings. It is important to provide occupational therapy within the ecological or natural environments of the child. Therefore, occupational therapy services to children may be delivered in their homes, in the community, and within educational settings.

Autonomy and delegation

Occupational therapists function as autonomous practitioners. They are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process. Occupational therapy students and occupational therapy or allied health assistants may also deliver occupational therapy services under the supervision of, and in partnership with, the occupational therapist.

www.otaus.com.au/advocacy/position-statements#AHA

SECTION 4: Providing high quality services for children and their families

What do occupational therapists do?

Regardless of whether the recipient of occupational therapy is an individual, group, community, or whole society, the focus of occupational therapy is participation in the meaningful occupations of everyday life in the areas of:

- **Self-care:** this includes activities such as showering, toileting, dressing, grooming, eating; or activities such as chores, getting a snack for self and others
- **Productivity:**
 - ◆ Education/school-based occupations, including activities that allow a person to participate as a student in a learning environment
 - ◆ Work – participating in either paid or voluntary work
- **Play and leisure:** this includes participating in non-obligatory, discretionary, and intrinsically rewarding activities; pleasure and amusement
- **Social participation:** this includes participating in activities with others.

When working with children, occupational therapy practice is person-focussed and family-centred. It may be delivered directly with individuals and groups of individuals, or strategically to communities and on a societal level. Family-centred practice is a set of values, skills, behaviours and knowledge that recognises the family as the experts in the lives of children. It is grounded in respect for the uniqueness of each child and family, and is a commitment to partnering with families. It is based on the following premises:

- Families and professionals share responsibility and work collaboratively
- The service provider gives supports and resources that strengthen family functioning
- Practices are individualised and flexible to families' needs
- Practices are strengths based and use families' strengths as the foundation for intervention.

www.dhs.vic.gov.au/___data/assets/pdf_file/0007/737566/01_familycentredpracguide_foundation_guide_1012.pdf

<http://familieswiki.pbworks.com/f/Family-Centred+Practice.pdf>

Occupational therapy process

The goal of occupational therapy services provided to children and families is to enable childhood participation. Occupational therapists collaborate with the child and family to identify occupational performance goals and provide appropriate interventions to achieve these goals. This requires understanding and assessment of performance (doing). This may also require assessment of the person (body structure and function level), the environment (barriers and facilitators), and an analysis of the occupation. Some interventions may need to focus on impairment level, but always in the context of occupational based goals.

The occupational therapy process involves:

1. Developing a positive therapeutic relationship
2. Analysing and identifying the occupational roles, strengths, needs, and challenges necessary for children to engage in their everyday activities and participation in life roles
3. Evaluating factors affecting occupational performance activities in the contexts and environments in which those activities and occupations occur, including:
 - ◆ human factors, including body functions and structures such as neuromuscular, sensory and cognitive systems, and habits, routines, roles, social, emotional, and behavioural
 - ◆ cultural, physical, virtual, social, temporal, spiritual contexts or environments, and activity demands that affect performance
 - ◆ performance skills and communication/interaction skills

4. Planning appropriate occupation-based intervention to promote occupational performance through:
 - ◆ the establishment, remediation, or restoration of physical, cognitive, neuromuscular, sensory functions, and behavioural skills that have not yet developed or are impaired
 - ◆ the compensation, modification, or adaptation of activity or environment to enhance performance and independence
 - ◆ the promotion of health and wellness to enable or enhance performance in everyday life activities
 - ◆ maintenance and enhancement of capabilities without which performance in everyday life activities would decline; and prevention of barriers to performance, including secondary disability prevention
5. Evaluating outcomes. Outcomes of intervention need to be measured and reported in relation to the goals set utilising standardised outcome measures.

In addition to service provision, occupational therapists also have a range of skills in conducting service management such as quality improvement, team management, policy development, project management, and conducting research.

How do occupational therapists deliver their services?

Occupational therapists collaborate with children and families to enable participation in life situations through:

- therapeutic use of occupations, activities, and exercises. This may include therapeutic use of self (including one's personality, insights, perceptions, and judgments) as part of the therapeutic process
- supporting development of self-care, social, and self-management skills required for participation in home, school, and in the and community
- education and support of individuals, including family members, caregivers, and others, through collaborative and consultative partnerships, and family-centred approaches
- care coordination, case management, transition services including discharge planning, advocacy, liaison with other agencies including schools, and onward referral to relevant services
- modification of physical environments (e.g. home, school, community) and adaptation of processes, including the application of ergonomic principles
- intervention in social, cultural, and temporal environments (e.g. addressing attitudinal barriers such as stigma or expectations of others), or procedural barriers (e.g. timetables)
- assessment, prescription, customisation, and supervision of equipment provision including assistive devices and training in the use of assistive devices
- community mobility, including the use of public transport and driving
- use of natural contexts for assessment and intervention (i.e. home, school classrooms, community settings)
- measurement of client and service outcomes.

Record keeping and documentation

Good practice involves:

- keeping accurate, up-to-date, factual, objective and legible records that report relevant details of clinical history, clinical findings, investigations, information given to patients or clients, medication, and other management in a form that can be understood by other health practitioners
- ensuring that records are held securely and are not subject to unauthorised access, regardless of whether they are held electronically and/or in hard copy
- ensuring that records show respect for patients or clients and do not include demeaning or derogatory remarks
- ensuring that records are sufficient to facilitate continuity of care
- making records at the time of events or as soon as possible afterwards
- recognising the right of patients/clients to access information contained in their health records and facilitating that access
- promptly facilitating the transfer of health information when requested by patients or clients.

(Occupational Therapy Board of Australia, *Code of Conduct*, 2014)

Occupational therapists are responsible for knowing and complying with their professional requirements. Professional documentation requires that occupational therapists comply with various laws and regulations and follow the basic fundamentals of documentation and record keeping (Clark, 2013). Reports, notes, and other documentation that form part of occupational therapy services are legal documents and form an integral part of delivering occupational therapy services.

Occupational therapists may provide reports for children, including but not limited to:

- following initial assessment and goal setting of a child
- review of goal attainment at regular intervals during the child's involvement with occupational therapy
- when referring to another service provider or professional
- to support a child in an educational setting
- when supporting a referral to a tertiary setting
- when advocating for funding or equipment submissions
- to support a legal case.

The following provides a guide for headings that may be included in an occupational therapy report:

● **Purpose**

- ◆ Clear statement of report **purpose** included, e.g. reason for assessment, intent of report and confidentiality

● **Client information**

- ◆ Introduction includes sufficient details regarding the child and family (may include previous or related report/s)
- ◆ Introduction includes sufficient "story" of service delivery and context so prior knowledge is not required

● **Brief occupational profile**

- ◆ Priorities of the child and family
- ◆ Goals of the child and family
- ◆ Child's strengths determined from evaluation presented prior to needs
- ◆ Current areas of occupation that are successful – strengths-based
- ◆ Contexts and environments that support and hinder occupations and participation
- ◆ Needs expressed in occupational/functional terms versus deficit statements
- ◆ Brief medical/educational history
- ◆ Developmental profile
- ◆ Occupational history

● **Request for service information**

- ◆ Clear indicators of contextual relevance in report
- ◆ Reasons for request for service; goals of the child; concerns of the referring family/caregiver; concerns of referring professional, e.g. school teacher; links to educational relevance

● **Comprehensive occupational profile**

- ◆ Evidence of occupational evaluation process with strong links between goals, outcomes, and review
- ◆ List evaluation methods e.g. file review, interviews, observations in playground/classroom
- ◆ List assessment tools used
- ◆ Results of assessments

● **Occupational performance and interpretation**

- ◆ Explicit evidence of contextual relevance in summary and/or recommendations, e.g. relates to the achievement of educational goals and the child or youth's ability to learn; curriculum links
- ◆ Evidence of inclusive framework, e.g. access/participation focus; least-restrictive alternatives from social/inclusion perspective

- ◆ Evidence of follow-up subsequent to written report/collaboration and contact information provided by reporter to recipients (Clark, 2013)

● **Goals**

- ◆ Occupation-focussed
- ◆ Family-centred/collaborative
- ◆ Specific, measurable, achievable realistic and timely
- ◆ Include information about parent/therapist clinical discussion about developing goals
- ◆ Regularly reviewed
- ◆ Used as a key outcome measure

● **Recommendations/issues identified**

- ◆ Key assessment findings

● **Service plan**

- ◆ Single task-based action items related to achieving the above mentioned goals.

Overall check of content and presentation:

- Correct use of professional therapy templates/banners and current logos
- Clearly titled as *Occupational Therapy Report/Summary* and *Confidential*
- Appropriate to intended audience/readers' experience
- Language used is objective, functional, and non-judgmental
- Writing style is clear, concise, and easy to read (written to express not impress; clichéd terms, jargon, and unnecessary words avoided)
- Page numbers (e.g. 1 of 3) are provided in footer
- Dated
- Signed
- Report dissemination clear in cc list (as per *Permission for Reports* form).

Key features of family-centred reports:

1. Functional/meaningful headings
 - ◆ Link reason for request for service to assessment results
2. Individualise – clear picture of the child
 - ◆ Strengths and barriers to participation in occupations
3. Integrating information from assessment tools into the context of daily performance
4. Strategies that can be implemented immediately
5. Clear plan of action
6. Readability
7. Maintains confidentiality (Copley & McLaren, 2015)

It is acknowledged that reports need to be targeted to the audience and in some instances concise information may be indicated through a brief report. The following points cover essential documentation within brief reports.

Brief reports may be utilised but should include:

- Formatting
 - ◆ The therapist's name
 - ◆ The therapist's AHPRA registration number
 - ◆ Business logo (if available)
 - ◆ Contact details (phone, email, and post address)
 - ◆ Date report written
 - ◆ Signed by therapist

- ◆ Statement about sharing confidential materials
- ◆ Size 11-12, easily readable font
- ◆ Two (2) pages
- Who/why
 - ◆ Referral from...
 - ◆ For concerns related to...
- Purpose/reason
 - ◆ Explain the “occupational context” – what activities/tasks are impacted by the child/parent/teacher
- Relevant information/education
 - ◆ Medical and developmental history
 - ◆ Links to additional information/education resources that explain diagnosis
 - Specific intervention approaches
 - General suggestions to support parent/teacher concerns
- Goals
 - ◆ Occupation-focussed
 - ◆ Family-centred/collaborative
 - ◆ Specific, measurable, achievable, realistic, and timely tailed
 - ◆ Include information about parent/therapist clinical discussion about developing goals
 - ◆ Regularly reviewed
 - ◆ Used as a key outcome measure
- Recommendations/issues identified
 - ◆ Key assessment findings
- Plan
 - ◆ Dot points
 - ◆ Single task-based action items related to achieving the above-mentioned goals.

SECTION 5: Child-related policy

Occupational therapy service provision for children within Australia is guided and supported by national, state, and local government policy. These policies enable access to services, determine funding for services, and ensure the quality of service provision and the safety of children in receipt of services. Policies at all levels of government are regularly updated and it is incumbent on individual occupational therapists to ensure they are familiar with the current policies for the region and client group for which they are providing a service.

Australia is a signatory to the *United Nations Convention on the Rights of the Child* (1989) and the *United Nations Convention on the Rights of Persons with Disabilities* (2006).

Policy around occupational therapy service provision for children also occurs within the context of several key pieces of national legislation, namely:

1. The *Sex Discrimination Act (1984)*, which prohibits discrimination on the basis of sex, marital status, pregnancy, or potential pregnancy
2. The *Disability Services Act (1986)*, which provides a framework for employment services for people with a disability and standards for service delivery (Disability Services Standards)
3. The *Disability Discrimination Act (1992)*, which provides protection against discrimination based on disability
4. The *National Disability Insurance Scheme Act (2013)*, which provides parameters for the establishment, guidelines, and implementation of the National Disability Insurance Scheme (NDIS)
5. The *National Standards for Disability Services (2013)*, which provides nationally consistent quality standards to applicable to the disability sector and addressing rights, participation and inclusion, individual outcomes, feedback and complaints, service access, and service management.

The key policy framework guiding service provision is the *National Disability Strategy 2010-2020*, a ten year national policy framework focussed on individuals with disability, their families, and carers. Aligned with this framework are a number of policy initiatives and programs that directly influence service provision by occupational therapists working with children.

Safeguarding children

The *National Framework for Protecting Australia's Children 2009-2020* (the National Framework) aims to reduce child abuse and neglect and ensure the safety and wellbeing of Australian children through actions by the Commonwealth, State and Territory governments, non-government organisations, service providers, and individuals. Six outcomes and strategies for their achievement are identified, including that children are able to live in safe and supportive families and communities; that adequate supports are available to promote safety; that interventions are available early, risk factors are addressed early, and sexual abuse is prevented; and that survivors receive adequate support.

Legislation underpinning child protection policies is unique to each state and territory and can be accessed online: www3.aifs.gov.au/cfca/publications/australian-child-protection-legislation

Standards for disability services

Further to professional and workplace responsibilities, occupational therapists work within the *National Standards for Disability Services (NSDS)*, which provide consistent quality standards throughout the disability sector.

www.dss.gov.au/our-responsibilities/disability-and-carers/standards-and-quality-assurance/national-standards-for-disability-services

Education

Occupational therapists working with children within an educational context need also be cognisant of the national *Disability Standards for Education*. These are developed from the *Disability Discrimination Act (1992)* and clarify obligations of service providers in ensuring the equal access and participation in education of all students. Individual states and territories have policies relating to implementation of these Standards that impact the nature of service provision by occupational therapists. <https://education.gov.au/taxonomy/term/2145>

SECTION 6: Funding schemes

A number of government funded programs offer relevant support services for children and their families. These include:

Access to Allied Psychological Services (ATAPS)

ATAPS enables GPs to refer consumers to ATAPS mental health professionals who deliver focussed psychological strategies services. www.health.gov.au/internet/main/publishing.nsf/Content/mental-boimhc-ataps

Better Access to Mental Health (BAMH)

Occupational therapists may obtain BAMH endorsement which allows them to provide reimbursable services to people with social and emotional/behavioural concerns. www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-fact-pat

Better Start for Children with Disability Initiative

The Better Start for Children with Disability Initiative has been established to provide early intervention services to children less than six years of age with disabling conditions including deaf-blindness, cerebral palsy, microcephaly, and a range of specific genetic disorders. www.dss.gov.au/our-responsibilities/disability-and-carers/program=services/for-people-with-disabilities/helping-children-with=autism

Occupational therapists wishing to provide services to these children and their families are required to apply for membership to the Early Intervention Service Provider Panel. www.dss.gov.au/our-responsibilities/disability-and-carers/applications-for-membership-of-the-early-intervention-service-provider-panel

Chronic Disease Management Plan (five sessions)

Occupational therapists with a Medicare provider number may offer reimbursable services to children with a chronic disease under a Chronic Disease Management Plan written by the child's GP. www.health.gov.au/internet/main/publishing.nsf/content/mbsprimarycare-chronicdiseasemanagement

Enhanced Primary Care

A range of programs and items available to support people with complex care needs and chronic conditions. www.health.gov.au/internet/main/publishing.nsf/content/health-medicare-health_pro-gp-pdf-allied-cnt.htm

Helping Children with Autism

Occupational therapists providing services specifically to children with Autism Spectrum Disorder should be familiar with the "Helping Children with Autism" package, designed to provide support for children with autism and their families to access services. www.dss.gov.au/our-responsibilities/disability-and-carers/program=services/for-people-with-disabilities/better-start-for-children-with-disability-initiative

Medicare

Occupational therapists may obtain a Medicare provider number which can also be used for private health fund rebate.

National Disability Insurance Scheme (NDIS)

Occupational Therapists providing services to children and their families should be aware of the scope and function of the National Disability Insurance Scheme (NDIS) and its implementation in their region. www.ndis.gov.au/people-disability

SECTION 7: Useful general information

Other resources which may be of use to occupational therapists and consumers include:

Therapy Choices:

www.therapychoices.org.au

Find an OT:

www.otaus.com.au/find-an-occupational-therapist

Resources available from Ageing, Disability and Home Care (FACS NSW):

www.adhc.nsw.gov.au/sp/delivering_disability_services/core_standards

Children and young people with Disability Australia, a national representative body for children and young people with disability who are aged 0 to 25 years:

www.cda.org.au

The Raising Children network:

www.raisingchildren.net.au

Useful terms and definitions

Evidence-based practice	<p>One of the most widely known definitions of evidence-based practice acknowledges that it involves the integration of the best research evidence with clinical expertise and the patient's unique values and circumstances (Straus, Richardson, Glassziou et al., 2011). It also requires the health professional to take into account characteristics of the practice context in which they work (Hoffman, Bennett, Del Mar, p3).</p> <p>Evidence-based practice is not just about research evidence, as some critics of it may suggest. It is also about valuing and using the education, skills, and experience that you have as a professional. Furthermore, it is about considering the patient's situation and values when making a decision, as well as considering characteristics of the practice context (for example, the resources available) in which you are interacting with your patient. This requires judgement and artistry, as well as science and logic. The process that health professionals use to integrate all of this information is clinical reasoning. When you take these four elements and combine them in a way that enables you to make decisions about the care of a patient, then you are engaging in evidence-based practice (Hoffman, Bennett, Del Mar, p3).</p>
Goal Attainment Scales (GAS)	<p>Individualised goals with a range of specified possible outcomes for each goal with the aim of having equal interval between each level of outcome. Only one change (variable) should be measured in each goal (Cardillo & Smith, 1994).</p>
Kinship care	<p>Refers to the placement of children with relatives (kin), with persons without a blood relation but who have a relationship with the child or family, or with persons from the child's or family's community (kith). Kinship care is also referred to as "relative care", "kith and kin care", and "family and friends as carers". In the context of kinship care, the term "related child" is used to define a child who has a prior relationship with a carer, although this may not necessarily be a blood relation.</p>
Occupation-focussed goals	<p>Goals related to occupations that the client wants to be able to do (Fischer, 2013).</p>
Occupations	<p>"are groups of activities and tasks of everyday life, named, organised and given value and meaning by individuals and a culture; occupation is everything people do to enjoy themselves, including looking after themselves (self-care), enjoying life (leisure), and contributing to the social and economic fabric of their communities (productivity); the domains of concern and the therapeutic medium of occupational therapy (CAOT, 1997; 2002); a set of activities that is performed with some consistency and regularity: that brings structure and is given value and meaning by individuals and a culture" (adapted from Polatajko et al., 2004; Zimmerman et al., 2006).</p>

Occupational performance	Occupational performance is the act of doing and accomplishing a selected action (performance skill), activity, or occupation (Fischer, 2009; Fischer & Griswold, 2014, Kielhofner, 2008) that results from the dynamic transaction among the client, the context and the activity. Improving or enabling skills and patterns in occupational performance leads to an engagement in occupations or activities" (AOTA, 2014).
Occupational profile	A summary of the client's occupational history and experiences, patterns of daily living, interests, values and needs
Occupational therapy process	"Is the process occupational therapists engage in to form a therapeutic relationship to improve the person's occupational performance and participation and involves the use of theory and evidence, evaluation, defining the issues, intervention planning and implementation re-evaluation" (- & Boyt-Schell, 2014).
Participation	involvement in life situations
Performance capacity	"ability to do things provided but the status of underlying objective, physical and mental components, and corresponding subjective experience" (Bout-Schell, Gillen, G. & Scaffa, 2014, p1238)
SMART goals	Goals with the characteristics of being specific, measurable, achievable, realistic/ relevant and timed (SMART)
Top down/bottom up approaches	The top-down assessment approach considers a global perspective and focuses on the child's participation in the current context to determine what is important for the child and family (Brown & Chien, 2010). This means that concerns are identified initially at a broader level and that the focus of the occupational therapy assessment is to identify strategies to support the child's participation in the relevant context.
Top down assessment	Focusses on understanding a person's occupational performance issues (occupations person finds problematic) first, and only evaluating performance components if necessary to know how to intervene (Hocking, 2001).

References

The definitions provided in the previous section have been taken from various sources and readers should cite the original authors when referring to these definitions:

- American Occupational Therapy Association (2014). Occupational therapy practice framework: Domain & Process (3rd ed.). *The American Journal of Occupational Therapy*, 68 (Suppl.1), S1-S48.
Accessed 20 March 2016 from <http://dx.doi.org.10.5014/ajot.2014.682006>
- Bromfield, L. M., & Osborn, A. (2007). *“Getting the big picture: A synopsis and critique of Australian out-of-home care research (Child Abuse Prevention Issues No. 26)”*. Melbourne: Australian Institute of Family Studies, National Child Protection Clearinghouse.
Accessed 30 August 2015 from <https://aifs.gov.au/cfca/publications/kinship-care>
- Brown, T. and Chien, C.-W. (2010). Occupation-Centred Assessment with Children, in *Occupation-Centred Practice with Children: A Practical Guide for Occupational Therapists* (ed S. Rodger), Wiley-Blackwell, Oxford, UK. doi: 10.1002/9781444319699.ch7
- Cardillo J, Smith A. (1994). Psychometric issues. In: Kiresuk T, Smith A, Cardillo J, editors. *Goal attainment scaling: applications, theory, and measurement*. Hillsdale, NJ: Lawrence Erlbaum Associates; pp173–212
- Chisholm, D. & Boyt-Schell, B.A. (2014) Overview of the occupational therapy process and outcomes. In B.A. Boyt-Schell, Gillen, G. & Scaffa, M.E. (Eds.), *Willard and Spackman's occupational therapy* (12th Ed., pp266-280). Philadelphia: Lippencott, Williams & Wilkins
- Chisholm, D. & Boyt-Schell, B.A. & Scaffa, M.E. (2014). Glossary. In B.A. Boyt-Schell, Gillen, G. & Scaffa, M.E. (Eds.), *Willard and Spackman's occupational therapy* (12th Ed., pp1229 -1243) Philadelphia: Lippencott, Williams & Wilkins
- Downing, R., Kowal, E., & Paradies, Y. (2011). Indigenous cultural training for health workers in Australia. *International Journal for Quality in Health Care*. 23 (3), 247-257
- Doran, G. T. (1981). There's a S.M.A.R.T. Way to Write Management's Goals and Objectives. *Management Review*, 70, 11, pp. 35-36.
- Fisher, A.G. (2013). Occupation-centred, occupation-based, occupation-focused: Same, same or different? *Scandinavian Journal of Occupational Therapy*. 20, 162- 173
- Hocking, C. (2001). Implementing occupation-based assessment. *American Journal of Occupational Therapy*. 55, 4, 463-469
- Hoffman, T. Bennett, S., & Del Mar, C. (2013). Introduction to evidence-based practice. In T. Hoffman, S. Bennett, & C. Del Mar, *Evidence-based practice across the health professions* (2nd Ed). Sydney, Australia: Elsevier Australia.
- Polatajko, H. J., & Mandich, A. (2004). Enabling occupation in children: The cognitive orientation to daily occupational performance (CO-OP) approach (p. 190). Ottawa: CAOT Publications ACE.
- Straus, S., Richardson, W., Glassziou, P. et al. (2011). *Evidence-based practice: How to practice and teach EBM*. (4th Ed). Edinburgh: Churchill Livingstone.
- Zimmerman, B. J., & Cleary, T. J. (2006). Adolescents' development of personal agency: The role of self-efficacy beliefs and self-regulatory skill. *Self-efficacy beliefs of adolescents*, 5, 45-69.



www.otaus.com.au

info@otaus.com.au

National Office

Ph (61) 3 9415 2900
Fax (61) 3 9416 1421

6/340 Gore Street
Fitzroy, Victoria 3065
Australia