What's the impact?

Heather McFarlane and **Dr Shelley Crawford** look at the impact of a new OT service in a regional hospital for adults with learning disabilities.

The closure of long stay hospitals and their replacement by community homes has undoubtedly been the most significant policy change for adults with a learning disability in the UK (Mansell and Ericsson 1996).

This shift away from a hospital treatment model towards a supporting people model is welcomed for Northern Ireland (Slevin *et al* 2011) and is consistent with policy such as Equal Lives, Transforming Your Care, and ministerial directives stating that no-one with a learning disability should live in a hospital by March 2015.

Two OT clinical lead posts commenced in November/December 2012, to assist with the resettlement process. One post was to focus on postural management and wheelchairs and the other for bespoke environmental design and housing solutions.

Prior to these posts, there had not been an OT service at Muckamore Abbey Hospital, in Northern Ireland, for more than 25 years. These posts, therefore, were a significant and innovative way to add value to the resettlement process. Both OT posts are funded only until March 2015.

We recognised the importance of a collaborative approach to occupational therapy interventions and worked closely with nursing, medical and AHP staff to share knowledge and explain our role within the multidisciplinary team.

We involved service users in the design of information leaflets and self-help programmes, as we were keen to ensure that our approaches were client centred and enabled greater autonomy for this population. We also utilised standardised assessments that had robust outcome measures to more easily demonstrate the impact of occupational therapy to service users and staff alike.

As the importance of occupational therapy was realised, not only the resettlement of patients, but also as an enabler in the acute admission and forensic wards, through the addition of Katie Carson, OT, we decided to design an evaluation of the service with the assistance of Belfast Health and Social Care Trust (BHSCT) audit department.

Heather McFarlane (left) and Dr Shelley Crawford

Staff and service user questionnaires

A staff questionnaire was circulated to nursing staff on resettlement wards and other professionals that OT worked closely with as part of the resettlement process, *eg* planning and performance, care managers, senior managers and service managers.

A total of 23 out of 39 questionnaires were returned, giving a response rate of 59 per cent. The questionnaire was circulated by Fintan McErlean, in the clinical audit department, and responses were returned to this department in an attempt to minimise bias.

An accessible questionnaire was also sent to seven service users who had recently been assessed and completed an OT independent living programme. The service users completed the questionnaires with their advocates. The response rate was 100 per cent.

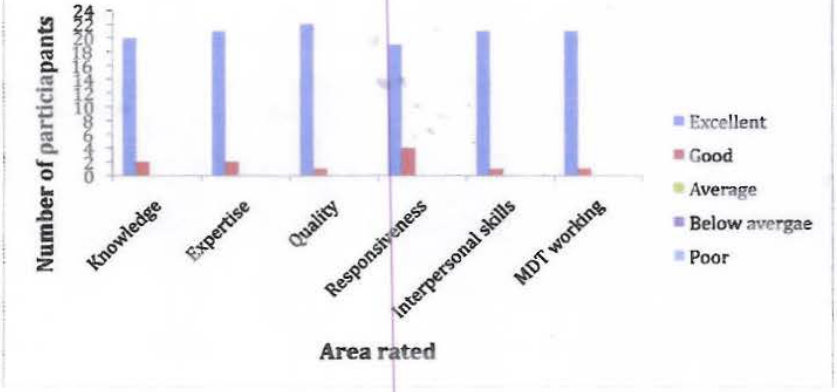
The staff questionnaire indicated that there was an overwhelming positive response to the key areas of the occupational therapy service, as the majority of staff rated the OTs as 'excellent' in all aspects, with no ratings in the 'average', 'below average' or 'poor' category (see graph opposite).

Staff were also asked three open ended questions in relation to the occupational therapy contribution to resettlement, how the OT service could be improved, and any additional comments.

It was noteworthy that most participants took time to write comments, all of which were very positive. The following are a few comments to summarise the staff feedback in the OT service:

'Ensured a holistic approach is taken to the patient care... very useful and in-depth assessment on posture/positioning. Have provided detailed reviews of functioning of the patients, which has helped with identifying the most appropriate placement option for the patient. Advised on how to modify placements to meet the needs of the patients and most importantly worked

Figure 1: How staff rated key areas of the OT service



pro-actively to find solutions. Provided much needed sensory assessments, which have helped with patients' ability to cope with change.'

'The OTs have worked very well as part of the multidisciplinary team and their expertise has led to greater, more rigorous assessments and plans which have ensured patients' individual needs are met.'

'OT involvement in the design and development of new supported housing tenancies has been crucial to the success of these schemes, providing assurance that new housing ops have been designed and built with the service user need at the centre…'

'This is a first class service. Sometimes in the world of resettlement (community integration) there are unresolved issues and uncertainties. Shelley and Heather have sought to cut through this and have acted to clarify and help, and succeeded.'

'…flexible and responsive to the needs of the patients…'

'This resource needs [to be] continued post March 2015…'

The service user feedback also highlighted the positive impact of occupational therapy and generated some narrative rich data in support of this: 'I feel more confident in making smaller meals'; '[It has] helped me to be more independent'; 'To get me ready for my new home and give me ideas'; 'I like food and cooking.'

Every one of the service users reported that the occupational therapy service had helped them to get ready for resettlement.

The activities they enjoyed most were choosing their own food ingredients and having the opportunity to prepare meals of their own choice with minimal support. Service users reported that occupational therapy could also have offered more support and intervention in relation to community living skills, such as budgeting.

A positive impact

In line with Transforming Your Care, other regional and national policies, as well as ministerial directives, the occupational therapy service has been designed and evaluated to meet the needs of the service users with learning disabilities being resettled back into the community.

The service was evaluated after 19 months and the results have shown that the occupational therapy service has had a positive and significant impact, not only on service users, but also on staff within Muckamore Abbey Hospital.

The unique role of OT around standardised functional assessments, comprehensive and rigorous assessments regarding all aspects of activities of daily living, postural management, wheelchairs and positioning, falls prevention, sensory integration, environmental design and modification for those with challenging behaviour and independent and community living skills has been widely recognised and valued by the multidisciplinary team and service users alike.

The collaborative working with service users, staff and the clinical audit department enabled us to register an evaluation and disseminate results highlighting the importance of sustaining this newly established occupational therapy service within this regional hospital past 2015.

We are indebted to the staff and service users at Muckamore Abbey Hospital for their input into the design and evaluation of the occupational therapy service.

We extend our thanks to Rhonda Scott, Aisling Curran, Esther Rafferty, Margaret Cameron and Barry Mills for their continued support and encouragement. We also thank Fintan McErlean from the clinical audit department for his assistance with this service evaluation.

Full details of the service evaluation is available from the authors.

References

DHSSPS (2005) *Equal Lives: review of policy and services for people with a learning disability in Northern Ireland*. Northern Ireland: DHSSPS.

DHSSPS (2011) *Transforming your care: a review of health and social care in Northern Ireland*. Northern Ireland: DHSSPS.

Mansell J and Ericsson K (1996) *Deinstitutionalisation and community living Intellectual services in Britain, Scandinavia and the USA*. Chatman and Hall: London

Slevin E, Taggart L, McConkey R, Cousins W, Truesdale-Kennedy M and Dowling L (2011) *A rapid review of literature relating to support for people with intellectual disabilities and their family carers when the person has: behaviours that challenge and/or mental health problems; or they are advancing in age*, Belfast, Northern Ireland: University of Ulster

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hcpc health & care professions council

Standards of proficiency

Occupational therapists

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Foreword

We are pleased to present the Health and Care Professions Council's standards of proficiency for occupational therapists.

We first published standards of proficiency for occupational therapists when our Register opened in July 2003. We published revised standards in 2007. We review the standards regularly to look at how they are working and to check whether they continue to reflect current practice in the professions we regulate.

These new revised standards are a result of our most recent review of the standards of proficiency. As a result of the first stage of the review, and the results of a public consultation, we have revised our generic standards which apply to all the professions we regulate. The revised standards are now based around 15 generic statements. This new structure means that we can retain the standards which are shared across all the professions we regulate, whilst allowing us more flexibility in describing the detailed standards which are specific to individual professions.

The profession-specific standards for occupational therapists included in this document were developed with the input of the relevant professional bodies and the views of all stakeholders during a further public consultation. The review process and consultation produced valuable feedback and we are grateful to all those who gave their time to help us in shaping the new standards.

We have made a small number of changes to the standards overall, mainly to reflect developments in education and practice, to clarify our intentions and to correct any errors or omissions. We have also made some minor changes to the introduction, in particular, to explain the language we use in the standards.

We are confident that the standards are fit for purpose and reflect safe and effective professional practice in occupational therapy.

These standards are effective from 1 March 2013.

2 Standards of proficiency – Occupational therapists

Introduction

This document sets out the standards of proficiency. These standards set out safe and effective practice in the professions we regulate. They are the threshold standards we consider necessary to protect members of the public. They set out what a student must know, understand and be able to do by the time they have completed their training, so that they are able to apply to register with us. Once on our Register you must meet those standards of proficiency which relate to the areas in which you work.

We also expect you to keep to our standards of conduct, performance and ethics and standards for continuing professional development. We publish these in separate documents, which you can find on our website.

The standards of proficiency in this document include both generic elements, which apply to all our registrants, and profession-specific elements which are relevant to registrants belonging to one of the professions we currently regulate. The generic standards are written in **bold**, and the profession-specific standards are written in plain text.

We have numbered the standards so that you can refer to them more easily. The standards are not hierarchical and are all equally important for practice.

A note about our expectations of you

You must meet all the standards of proficiency to register with us and meet the standards relevant to your scope of practice to stay registered with us.

It is important that you read and understand this document. If your practice is called into question we will consider these standards (and our standards of conduct, performance and ethics) in deciding what action, if any, we need to take.

The standards set out in this document complement information and guidance issued by other organisations, such as your professional body or your employer. We recognise the valuable role played by professional bodies in providing guidance and advice about good practice which can help you to meet the standards in this document.

Your scope of practice

Your scope of practice is the area or areas of your profession in which you have the knowledge, skills and experience to practise lawfully, safely and effectively, in a way that meets our standards and does not pose any danger to the public or to yourself.

We recognise that a registrant's scope of practice will change over time and that the practice of experienced registrants often becomes more focused and specialised than that of newly registered colleagues. This might be because of specialisation in a certain area or with a particular client group, or a movement into roles in management, education or research. Every time you renew your registration, you will be asked to sign a declaration that you continue to meet the standards of proficiency that apply to your scope of practice.

Your particular scope of practice may mean that you are unable to continue to demonstrate that you meet all of the standards that apply for the whole of your profession. As long as you make sure that you are practising safely and effectively within your given scope of practice and do not practise in the areas where you are not proficient to do so, this will not be a problem. If you want to move outside of your scope of practice, you should be certain that you are capable of working lawfully, safely and effectively. This means that you need to exercise personal judgement by undertaking any necessary training or gaining experience, before moving into a new area of practice.

Meeting the standards

It is important that you meet our standards and are able to practise lawfully, safely and effectively. However, we do not dictate how you should meet our standards. There is normally more than one way in which each standard can be met and the way in which you meet our standards might change over time because of improvements in technology or changes in your practice.

We often receive questions from registrants who are concerned that something they have been asked to do, a policy, or the way in which they work might mean they cannot meet our standards. They are often worried that this might have an effect on their registration.

As an autonomous professional, you need to make informed, reasoned decisions about your practice to ensure that you meet the standards that apply to you. This includes seeking advice and support from education providers, employers, colleagues, professional bodies, unions and others to ensure that the wellbeing of service users is safeguarded at all times. So long as you do this and can justify your decisions if asked to, it is very unlikely that you will not meet our standards.

Language

We recognise that our registrants work in a range of different settings, which include direct practice, management, education, research and roles in industry. We also recognise that the use of terminology can be an emotive issue.

Our registrants work with very different people and use different terms to describe the groups that use, or are affected by, their services. Some of our registrants work with patients, others with clients and others with service users. The terms that you use will depend on how and where you work. We have used terms in these standards which we believe best reflect the groups that you work with.

In the standards of proficiency, we use phrases such as ‘understand’, ‘know’, and ‘be able to’. This is so the standards remain applicable to current registrants in maintaining their fitness to practise, as well as prospective registrants who have not yet started practising and are applying for registration for the first time.

These standards may change in the future

We have produced these standards after speaking to our stakeholders and holding a formal public consultation.

We will continue to listen to our stakeholders and will keep our standards under continual review. Therefore, we may make further changes in the future to take into account changes in practice.

We will always publicise any changes to the standards that we make by, for instance, publishing notices on our website and informing professional bodies.

Standards of proficiency

Registrant occupational therapists must:

1 be able to practise safely and effectively within their scope of practice

1.1 know the limits of their practice and when to seek advice or refer to another professional

1.2 recognise the need to manage their own workload and resources effectively and be able to practise accordingly

2 be able to practise within the legal and ethical boundaries of their profession

2.1 understand the need to act in the best interests of service users at all times

2.2 understand what is required of them by the Health and Care Professions Council

2.3 understand the need to respect and uphold, the rights, dignity, values, and autonomy of service users including their role in the diagnostic and therapeutic process and in maintaining health and wellbeing

2.4 recognise that relationships with service users should be based on mutual respect and trust, and be able to maintain high standards of care even in situations of personal incompatibility

2.5 know about current legislation applicable to the work of their profession

2.6 understand the effect of legislation on the delivery of care

2.7 understand the importance of and be able to obtain informed consent

2.8 be able to exercise a professional duty of care

3 be able to maintain fitness to practise

3.1 understand the need to maintain high standards of personal and professional conduct

3.2 understand the importance of maintaining their own health

3.3 understand both the need to keep skills and knowledge up to date and the importance of career-long learning

4 be able to practise as an autonomous professional, exercising their own professional judgement

4.1 be able to assess a professional situation, determine the nature and severity of the problem and call upon the required knowledge and experience to deal with the problem

4.2 be able to make reasoned decisions to initiate, continue, modify or cease treatment or the use of techniques or procedures, and record the decisions and reasoning appropriately

4.3 be able to initiate resolution of problems and be able to exercise personal initiative

4.4 recognise that they are personally responsible for and must be able to justify their decisions

4.5 be able to make and receive appropriate referrals

4.6 understand the importance of participation in training, supervision and mentoring

5 be aware of the impact of culture, equality and diversity on practice

5.1 understand the requirement to adapt practice to meet the needs of different groups and individuals

5.2 understand the specific local context of practice, including the socio-cultural diversity of the community

5.3 recognise the socio-cultural environmental issues that influence the context within which people live and work

5.4 recognise the effect of inequality, poverty, exclusion, identity, social difference and diversity on occupational performance

6 be able to practise in a non-discriminatory manner

7 understand the importance of and be able to maintain confidentiality

7.1 be aware of the limits of the concept of confidentiality

7.2 understand the principles of information governance and be aware of the safe and effective use of health and social care information

7.3 be able to recognise and respond appropriately to situations where it is necessary to share information to safeguard service users or the wider public

8 be able to communicate effectively

8.1 be able to demonstrate effective and appropriate verbal and non-verbal skills in communicating information, advice, instruction and professional opinion to service users, carers, colleagues and others

8.2 be able to communicate in English to the standard equivalent to level 7 of the International English Language Testing System, with no element below 6.5[1]

8.3 understand how communication skills affect assessment and engagement of service users and how the means of communication should be modified to address and take account of factors such as age, capacity, learning ability and physical ability

8.4 be able to select, move between and use appropriate forms of verbal and non-verbal communication with service users, carers and others

8.5 be aware of the characteristics and consequences of verbal and non-verbal communication and how this can be affected by factors such as age, culture, ethnicity, gender, socio-economic status and spiritual or religious beliefs

[1] The International English Language Testing System (IELTS) tests competence in the English language. Applicants who have qualified outside of the UK, whose first language is not English and who are not nationals of a country within the European Economic Area (EEA) or Switzerland, must provide evidence that they have reached the necessary standard. Please visit our website for more information.

8.6 understand the need to provide service users or people acting on their behalf with the information necessary to enable them to make informed decisions

8.7 understand the need to assist the communication needs of service users such as through the use of an appropriate interpreter, wherever possible

8.8 recognise the need to use interpersonal skills to encourage the active participation of service users

8.9 be able to listen to a service user's occupational narrative and analyse the content in order to plan for the future

8.10 be able, through interview and personal discussion, to understand the values, beliefs and interests of service users, their families and carers

9 be able to work appropriately with others

9.1 be able to work, where appropriate, in partnership with service users, other professionals, support staff and others

9.2 understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team

9.3 understand the need to engage service users and carers in planning and evaluating diagnostics, treatments and interventions to meet their needs and goals

9.4 be able to contribute effectively to work undertaken as part of a multi-disciplinary team

9.5 understand the need to work with those who provide services in and across different sectors

9.6 understand the need to adopt an approach which centres on the service user and establish appropriate professional relationships in order to motivate and involve the service user in meaningful occupation

9.7 understand the value of enabling and empowering service users with the aim of enhancing their access to all services and opportunities which are available to them

9.8 understand group dynamics and roles, and be able to facilitate group work, in order to maximise support, learning and change within groups and communities

9.9 understand the need to capitalise, where appropriate, on the dynamics within groups and communities in order to harness the motivation and active involvement of participants

9.10 be able to work in appropriate partnership with service users in order to evaluate the effectiveness of occupational therapy intervention

10 be able to maintain records appropriately

10.1 be able to keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols and guidelines

10.2 recognise the need to manage records and all other information in accordance with applicable legislation, protocols and guidelines

11 be able to reflect on and review practice

11.1 understand the value of reflection on practice and the need to record the outcome of such reflection

11.2 recognise the value of case conferences, supervision and other methods of reflecting on and reviewing practice

11.3 be able to recognise the potential of occupational therapy in new and emerging areas of practice

12 be able to assure the quality of their practice

12.1 be able to engage in evidence-based practice, evaluate practice systematically and participate in audit procedures

12.2 be able to gather information, including qualitative and quantitative data, that helps to evaluate the responses of service users to their care

12.3 be aware of the role of audit and review in quality management, including quality control, quality assurance and the use of appropriate outcome measures

12.4 be able to maintain an effective audit trail and work towards continual improvement

12.5 be aware of, and be able to participate in, quality assurance programmes, where appropriate

12.6 be able to evaluate intervention plans using recognised outcome measures and revise the plans as necessary in conjunction with the service user

12.7 recognise the need to monitor and evaluate the quality of practice and the value of contributing to the generation of data for quality assurance and improvement programmess

13 understand the key concepts of the knowledge base relevant to their profession

13.1 understand and be able to apply the theoretical concepts underpinning occupational therapy, specifically the occupational nature of human beings and how they function in everyday activities

13.2 understand the effect of occupational dysfunction and deprivation on individuals, families, groups and communities and recognise the importance of restoring and facilitating opportunities with the aim of achieving occupational wellness

13.3 be able to understand and analyse activity and occupation and their relation to and effect on, health, wellbeing and function

13.4 understand the theoretical basis of, and the variety of approaches to, assessment and intervention

13.5 understand the need to identify and assess occupational, physical, psychological, cultural and environmental needs and problems of service users, their families and carers

13.6 be aware of social, environmental and work-related policies and services and their effect on human needs within a diverse society

13.7 be aware of the principles and applications of scientific enquiry, including the evaluation of treatment efficacy and the research process

13.8 recognise the value of the diversity and complexity of human behaviour through the exploration of different physical, psychological, environmental, social, emotional and spiritual perspectives

13.9 be aware of the origins and development of occupational therapy, including the evolution of the profession towards the current emphasis on autonomy and empowerment of individuals, groups and communities

13.10 understand the use of the current philosophical framework for occupational therapy that focuses on service users and the bio-psychosocial model

13.11 understand the structure and function of the human body, together with knowledge of health, disease, disorder and dysfunction relevant to their profession

13.12 understand the concept of leadership and its application to practice

13.13 recognise the role of other professions in health and social care

13.14 understand the structure and function of health and social care services in the UK

14 be able to draw on appropriate knowledge and skills to inform practice

14.1 be able to change their practice as needed to take account of new developments or changing contexts

14.2 be able to conduct appropriate diagnostic or monitoring procedures, treatment, therapy or other actions safely and effectively

14.3 be able to undertake and record a thorough, sensitive and detailed assessment, using appropriate techniques and equipment

14.4 be able to gather and use appropriate information

14.5 be able to undertake or arrange investigations as appropriate

14.6 be able to select and use appropriate assessment techniques

14.7 understand the need to consider the assessment of the health, social care, employment and learning needs of service users

14.8 be able to select and use relevant assessment tools to identify occupational performance needs

14.9 be able to select and use standardised and non-standardised assessments appropriately to gather information about the service user's occupational performance, taking account of the environmental context

14.10 be able to use observation to gather information about the functional abilities of service users

14.11 be able to analyse and critically evaluate the information collected

14.12 be able to demonstrate a logical and systematic approach to problem solving

14.13 be able to use research, reasoning and problem solving skills to determine appropriate actions

14.14 be able to formulate specific and appropriate care or case management plans including the setting of timescales

14.15 understand the need to agree the goals and priorities of intervention in relation to occupational needs in partnership with service users, basing such decisions on assessment results

14.16 be able to select as appropriate, the specific occupations and activities for use as therapeutic media, taking into account the particular therapeutic needs of service users

14.17 be able to understand and use the relevant sciences and established theories, frameworks and concepts of occupational therapy

14.18 be aware of the full range of occupations and activities used in intervention and how these should reflect the individual's occupational needs

14.19 be able to analyse, develop or modify therapeutic media and environments to service users, to build on their abilities and enhance their occupational performance

14.20 know how to meet the social, psychological and physical health-based occupational needs of service users across a range of practice areas

14.21 be able to use information and communication technologies appropriate to their practice

14.22 recognise the value of research to the critical evaluation of practice

14.23 be aware of a range of research methodologies

14.24 be able to evaluate research and other evidence to inform their own practice

15 understand the need to establish and maintain a safe practice environment

15.1 understand the need to maintain the safety of both service users and those involved in their care

15.2 be aware of applicable health and safety legislation, and any relevant safety policies and procedures in force at the workplace, such as incident reporting and be able to act in accordance with these

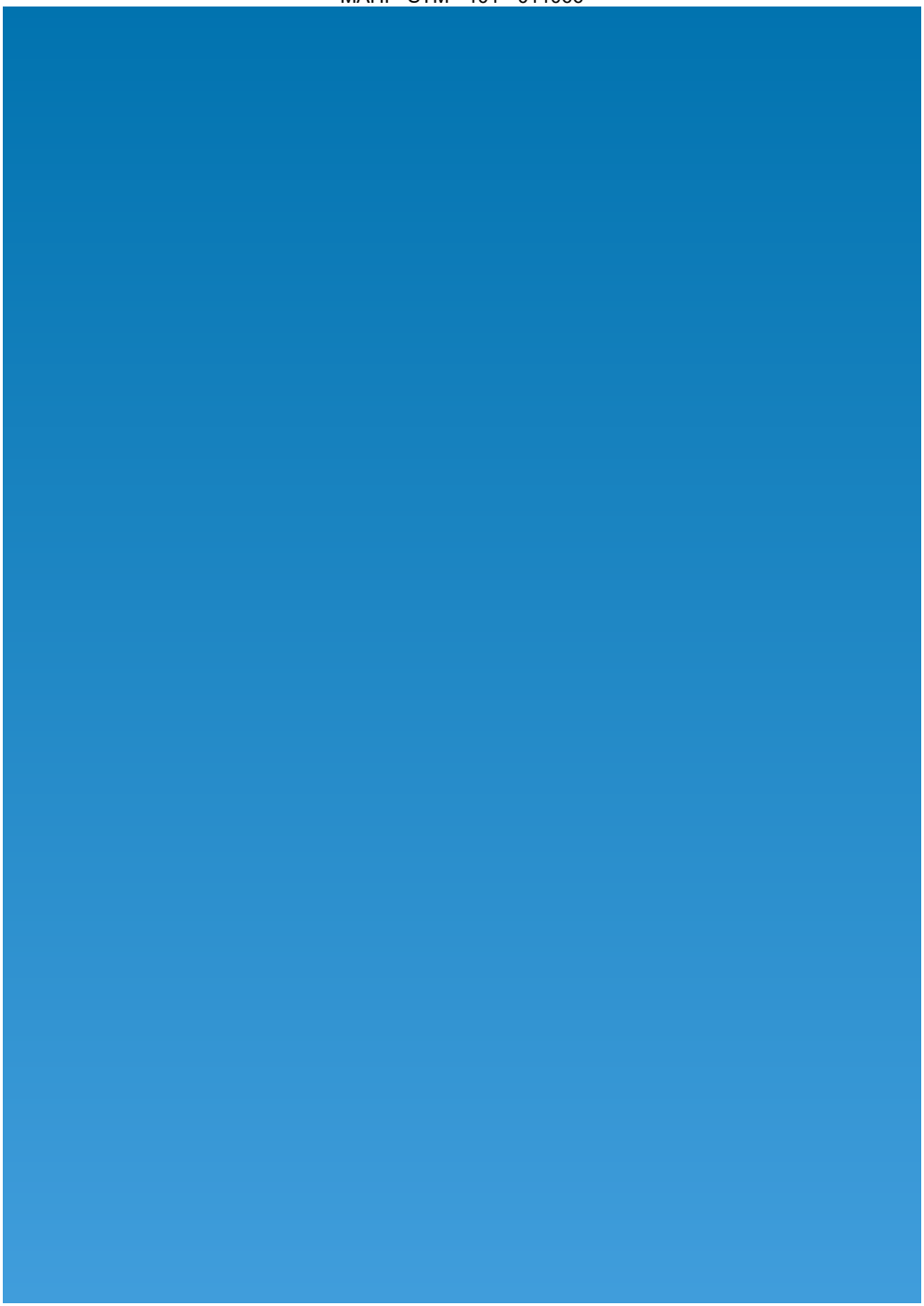
15.3 be able to work safely, including being able to select appropriate hazard control and risk management, reduction or elimination techniques in a safe manner, and in accordance with health and safety legislation

15.4 be able to select appropriate personal protective equipment and use it correctly

15.5 be able to establish safe environments for practice, which minimise risks to service users, those treating them, and others, including the use of hazard control and particularly infection control

15.6 know and be able to apply appropriate moving and handling techniques

16 Standards of proficiency – Occupational therapists



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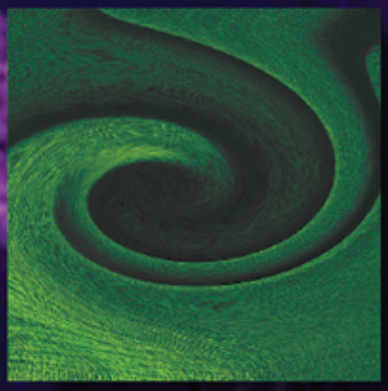

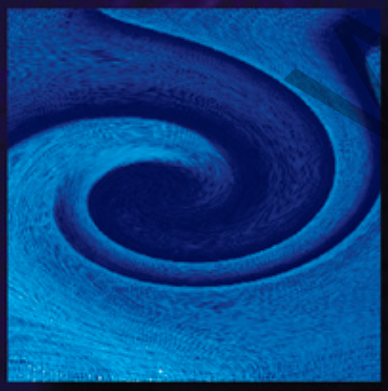

Code of Ethics and Professional Conduct

College of Occupational Therapists

Revised 2005

College of Occupational Therapists

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5/09

COLLEGE OF OCCUPATIONAL THERAPISTS' CODE OF ETHICS AND PROFESSIONAL CONDUCT

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Preface

i. The College of Occupational Therapists' Code of Ethics and Professional Conduct (hereinafter referred to as 'the Code') is produced by the College of Occupational Therapists, (hereinafter referred to as 'the College') for and on behalf of the British Association of Occupational Therapists, the central organisation for occupational therapists throughout the United Kingdom. The College of Occupational Therapists is the subsidiary organisation with delegated responsibility for the promotion of good practice and the prevention of malpractice.

ii. The title 'occupational therapist' is protected by law and can only be used by persons who have successfully completed an approved course leading to a diploma or degree in occupational therapy and who are eligible for registration with the Health Professions Council (HPC). All occupational therapists practising in the UK shall be registered with the Health Professions Council.

iii. This Code shall be used in conjunction with the HPC's current *Standards of Conduct, Performance and Ethics* and the College's latest standards for professional practice in occupational therapy.

iv Occupational therapy personnel* shall also comply with current laws and legislation, best practice standards as well as employers' reasonable policies and procedures.

**NOTE:*
Occupational therapy personnel refers to occupational therapists, occupational therapy students and occupational therapy support workers. It also includes managers, educators and researchers who are occupational therapists.

SECTION ONE

Introduction

1.1 The purpose of the Code is to provide a set of principles that apply to all occupational therapy personnel working in a variety of settings. It is a public statement of the values and principles used in promoting and maintaining high standards of professional behaviour in occupational therapy.

1.2 Any action that is in breach of the purpose and intent of this Code shall be considered unethical. Moreover, this Code may be used evidentially and is intended to apply to all persons professionally engaged in occupational therapy practice and education in the United Kingdom. The Code provides directions for all occupational therapy personnel and may be used by others to determine the standards of professional conduct expected by the College. It is recommended that employers refer to the Code in contracts of employment.

1.3 The College strongly encourages recognition of the Code by all other individuals, organisations and institutions involved with the profession.

1.4 The College is strongly committed to client-centred practice and the involvement of the client as a partner in all stages of the therapeutic process.

1.5 The needs of the carer shall also be taken into account when planning intervention.

1.6 The Code requires that all occupational therapy personnel discharge their duties and responsibilities in a professional and ethical manner.

1.7 The compilation, revision and updating of the Code are the delegated responsibility of the Ethics Committee of the College of Occupational Therapists. It is revised every five years.

1.8 If there is uncertainty or dispute as to the interpretation or application of the Code, enquiries shall be referred in the first instance to the Group Head (Practice), Education and Practice Department, College of Occupational Therapists, who may then seek further clarification from the Ethics Committee.

This version of the Code supersedes all previous editions.

SECTION TWO

Client Autonomy and Welfare

Respecting the autonomy of the client

2.1 Occupational therapy personnel shall at all times recognise, respect and uphold the autonomy of clients, and advocate client choice and partnership working in the therapeutic process. Occupational therapy personnel shall promote the dignity, privacy and safety of all clients with whom they have contact.

2.1.1 Each client is unique and therefore brings an individual perspective to the occupational therapy process. Clients have a right* to make choices and decisions about their own healthcare and independence. Such choices shall be respected, even when in conflict with professional opinion.

2.1.2 Clients shall be given sufficient information to enable them to give informed consent* about their health and social care.

2.1.3 Information shall be provided in a form and language that can be understood by the client.

2.1.4 Reasonable steps* shall be taken to ensure that the client understands the nature, purpose and likely effect of the proposed intervention(s).

2.1.5 Clients shall be given the opportunities to exercise a right of refusal, which, if so exercised, shall be respected.

**NOTE:*
Exceptional circumstances may, however, prevail, e.g. (i) where the client is deemed to lack competence in relation to consent to treatment (mental health legislation, mental capacity legislation and current case law); and (ii) rights of access to information may be curtailed in certain circumstances, such as the Data Protection Act 1998 and Children Act 1989, where local procedures shall be referred to.

Duty of Care to the Client

2.2 Occupational therapy personnel have a duty to undertake reasonable care of clients.

Confidentiality

2.3 Occupational therapy personnel are ethically and legally obliged to safeguard confidential information relating to clients.

2.3.1 The disclosure of confidential information is only permissible in occupational therapy where: the client gives consent (expressed or implied); there is legal justification (by statute or court order); it is considered to be in the public interest in order to prevent serious harm, injury or damage to the client or to any other person.

2.3.2 Disclosure to third parties (which may include relatives, police, lawyers and the media) regarding the client's diagnosis, treatment, prognosis or future requirements shall only be made where there is valid consent or legal justification to do so. Reference shall be made to local procedures.

2.3.3 All records shall be kept securely and made available only to those who have a legitimate right or need to see them.

2.3.4 Local and national policies regarding confidentiality in the storage and electronic transfer of information (including records, faxes and emails) shall be adhered to at all times.

2.3.5 Access to records by clients shall be granted in accordance with current statutory requirements. Reference shall be made to current guidance (both local and national) on access to personal health and social care information.

2.3.6 Prior to producing visual, oral or written material relating to clients, issues of confidentiality shall be addressed.

2.3.7 Discussions concerning a client shall be held in a location and manner appropriate to the protection of the client's right to confidentiality and privacy.

Protecting clients

2.4 Occupational therapy personnel shall not engage in or condone behaviour that causes unnecessary mental or physical distress. Such behaviour includes neglect, intentional acts, indifference to pain or misery and other malpractice.

2.4.1 Any intervention that is likely to cause pain or distress shall first be explained to the client. Every effort shall be made to ensure that the client understands the nature, purpose and likely effect of the intervention before it is undertaken.

2.4.2 Occupational therapy personnel shall make every effort not to leave a client in pain or distress after intervention. Reasonable professional judgement shall be used to assess the level of pain, distress and risk, and take appropriate action.

2.4.3 Occupational therapy personnel who witness or have reason to believe that the client has been the victim of dangerous, abusive, discriminatory or exploitative behaviour or practice shall use local policies to notify a line manager or other appropriate person as soon as reasonably possible.

SECTION THREE

Services to Clients

Referral of clients

3.1 Occupational therapy personnel shall have and abide by clearly documented procedures and criteria for referral to their service.

3.1.1 Occupational therapy personnel shall obtain relevant information to enable them to determine the appropriateness of the referral.

3.1.2 Occupational therapy personnel shall work to a documented system for prioritising referrals which recognises levels and degrees of need and optimises the use of resources.

Provision of services to clients

3.2 Occupational therapists shall provide services to all clients in a fair and just manner. When relevant and appropriate, occupational therapy personnel shall negotiate and act on behalf of the clients in relation to upholding and promoting the autonomy of the individual or group. Such negotiation shall be aimed at maximising the benefit for the clients and take into account resource considerations.

3.2.1 Occupational therapy personnel shall be aware of and sensitive to cultural and lifestyle diversity. They shall provide services that reflect and value these societal characteristics. Occupational therapy personnel shall not discriminate unlawfully and unjustifiably against clients or colleagues.

3.2.2 In establishing priorities and providing services the needs, wishes, feelings and choices of clients shall be taken into account wherever possible. Priorities shall always be founded on sound ethical principles and evidence-based or current best practice.

3.2.3 Services shall be client-centred and needs-led.

3.2.4 Recorded assessment of need shall clearly state those objectives that have to be achieved in order to maintain a minimum level of satisfactory and safe occupational therapy service to clients. Occupational therapists shall record unmet needs.

3.2.5 If occupational therapists feel unable to reach the minimum standards determined in 3.2.4, the appropriate manager shall be notified in writing with a copy to the client and referrer, if applicable.

3.2.6 Occupational therapists shall state and substantiate their views to their manager about resource and service deficiencies that may have implications for clients and carers.

3.2.7 The occupational therapy manager has a duty to take appropriate action upon notification of resource and service deficiencies.

Record keeping

3.3 Occupational therapists shall accurately record all information related to their involvement with the client, either as an occupational therapy record, part of a multi-disciplinary record or as a client-held record. This responsibility shall extend to other occupational therapy personnel in accordance with local guidelines.

3.3.1 Every client shall have a clearly recorded assessment of need and objectives of intervention.

3.3.2 Consent to occupational therapy shall be obtained from the client, recorded in client notes and regularly confirmed in line with local policy.

3.3.3 Consent that is refused or withdrawn shall also be recorded.

3.3.4 The prime purpose of records is to facilitate the assessment, treatment and support of a client. It is essential to provide and maintain a written record of advice given, all interventions and decisions that affect the client.

3.3.5 Accurate, legible, factual, contemporaneous and attributed records and reports of occupational therapy intervention shall be kept in order to provide information for colleagues and for legal purposes such as client access and court reports.

3.3.6 Subjective opinion shall always be identified as such and shall be relevant to the client.

SECTION FOUR

Personal/Professional Integrity

Personal and professional integrity

4.1 The highest standards of personal integrity are expected of occupational therapy personnel. They shall not engage in any criminal, unprofessional or other unlawful activity or behaviour.

4.1.1 Occupational therapy personnel shall adhere to statutory and local policies with regard to discrimination, bullying and harassment.

4.1.2 Occupational therapy personnel shall not enter into relationships that exploit clients sexually, physically, emotionally, financially, socially or in any other manner. It is unethical for occupational therapy personnel to indulge in relationships that may impair their judgment and objectivity and/or may give rise to the advantageous or disadvantageous treatment of the client.

4.1.3 Occupational therapists shall take responsibility for assessing and managing the risks involved in providing a service.

4.1.4 Any reference to the quality of service rendered by, or the integrity of, a professional colleague shall be expressed with due care to protect the reputation of that person. Care shall be taken, when giving a second opinion, to confine it to the issue and not the competence of the first professional.

4.1.4.1 Loyalty within any profession may be outweighed by public interest considerations in relation to the moral and legal obligations imposed by society generally.

4.1.4.2 Under no circumstances shall any occupational therapy personnel who witness malpractice, criminal conduct or unprofessional activity, whether by occupational therapy personnel or other staff, remain silent about it.

4.1.4.3 Occupational therapy personnel who have reasonable grounds to believe that the behaviour or professional performance of a colleague may be wanting in standards of professional competence shall notify the line manager or other appropriate person in confidence. This shall be done in accordance with the procedures laid down on whistle blowing as a consequence of the Public Interest Disclosure Act (1998).

Professional demeanour

4.2 Occupational therapy personnel shall conduct themselves in a professional manner appropriate to the setting.

4.2.1 Occupational therapy personnel shall act and dress appropriately to the setting and in accordance with health and safety requirements.

Fitness to practise

4.3 Occupational therapy personnel shall inform their employer or appropriate authority about any health or personal issues that affect their ability to do their job competently and safely.

Substance misuse

4.4 Occupational therapy personnel shall not undertake any professional activities whatsoever when under the influence of alcohol, drugs or other toxic substances. Reference shall be made to local policies where available.

4.4.1 The use of illicit substances constitutes a major infringement of the Code.

4.4.2 Occupational therapy personnel shall not encourage other people in the misuse of alcohol, drugs or other toxic substances.

Personal profit or gain

4.5 Occupational therapy personnel shall not accept tokens such as favours, gifts or hospitality from clients, their families or commercial organisations when this might be construed as seeking to obtain preferential treatment.

4.5.1 Occupational therapy personnel have a prime duty to the client and shall not let this duty be influenced by any commercial or other interest that conflicts with this duty, for example, in arrangements with commercial providers that may influence contracting for the provision of equipment.

4.5.2 If a client or their family makes a bequest to an occupational therapist, this shall be declared according to local guidelines.

4.5.3 Local policy shall always be observed in the case of gifts.

NOTE:
In certain cases, the property and affairs of a client may be subject to the authority of the Court of Protection.

Advertising

4.6 Advertising, in respect of professional activities, shall be accurate. It shall not be misleading, unfair or sensational.

4.6.1 Explicit claims shall not be made in respect of superiority of personal skills, equipment or facilities.

4.6.2 The College of Occupational Therapists' logo is copyright and can only be used when endorsed by the organisation. Permission for its use has to be obtained in writing from the Group Head of Membership and External Affairs at the College of Occupational Therapists.

Information and representation

4.7 Occupational therapy personnel shall accurately represent their qualifications, education, experience, training, competence and the services they provide.

4.7.1 Occupational therapy personnel who have reasonable grounds to believe that third party misrepresentation has occurred shall bring this to the attention of the appropriate person or authority for action to be taken.

SECTION FIVE

Professional Competence and Standards

Professional competence

5.1 Occupational therapy personnel shall only provide services and use techniques for which they are qualified by education, training and/or experience. These shall be within their professional competence, relevant to the setting and relate to their terms of employment.

5.1.1 Occupational therapy personnel shall achieve and continuously maintain high standards of competence in their knowledge, skills and behaviour.

5.1.2 Each member of the occupational therapy profession has a duty to maintain their level of professional competence and to work to current legislation, guidance and standards relevant to their practice. This includes compliance with the HPC's current *Standards of Proficiency – Occupational Therapists*.

5.1.3 All occupational therapy personnel have a duty to comply with the current professional standards for occupational therapy practice and other guidance provided by the College.

5.1.4 Occupational therapy personnel shall not be expected to act up or cover for an absent colleague if they believe the work to be outside the scope of their competence or workload capacity. Such duties shall only be undertaken with additional planning, support, supervision and/or training.

5.1.5 Occupational therapy personnel seeking to work in areas with which they are unfamiliar or in which their experience has not been recent, shall ensure that adequate self-directed learning takes place as well as other relevant training and supervision.

Delegation

5.2 Occupational therapists who delegate interventions or other procedures shall be satisfied that the person to whom they delegate is competent to carry them out. Such persons may include students, support workers or volunteers. In these circumstances, the occupational therapist shall retain ultimate responsibility for the client.

5.2.1 Occupational therapists shall provide supervision appropriate to the level of competence of the individuals for whom they have responsibility.

Collaborative working

5.3 Occupational therapy personnel shall respect the responsibilities, practices and roles of other professions, institutions and statutory and voluntary agencies that contribute to their work.

5.3.1 Occupational therapy personnel shall recognise the need for multi-professional and multi-agency collaboration to ensure that well co-ordinated services are delivered in the most effective way.

5.3.2 Occupational therapy personnel shall promote understanding of the profession.

5.3.3 Occupational therapists shall refer clients to, or consult with, other service providers when additional knowledge, expertise and support are required.

5.3.4 Occupational therapists shall identify their core skills and roles and ensure that they are not undertaking work that is deemed to be outside the scope of occupational therapy practice or their competence.

5.3.5 It is not considered to be in the interests of good client care that there be more than one occupational therapist taking overall responsibility for the assessment and treatment of a client for any one presenting problem.

5.3.6 Where more than one occupational therapist is involved in the treatment of the same client, they shall liaise with each other and agree areas of responsibility. This shall be communicated to the client and all relevant parties.

Lifelong Learning

5.4 Occupational therapy personnel shall be personally responsible for actively maintaining and developing their personal development and professional competence.

5.4.1 Adherence to professional standards is a requirement of continued practice.

5.4.2 All occupational therapy personnel shall be responsible for maintaining evidence of their continuing professional development.

5.4.3 Occupational therapy personnel shall be accountable for the quality of their work and base this on current guidance, research, reasoning and the best available evidence.

5.4.4 Occupational therapy personnel shall be supported in their practice and development through regular professional supervision within an agreed structure or model.

Occupational therapy student education

5.5 All occupational therapists have a professional responsibility to provide practice education opportunities for occupational therapy students and to promote a learning culture within the workplace.

5.5.1 Occupational therapists shall recognise the need for individual education and training to fulfil the role of the practice placement educator. They shall undertake and maintain accreditation through programmes of study provided by higher education institutions that are approved and accredited by the College of Occupational Therapists to deliver pre-registration courses in occupational therapy.

5.5.2 Occupational therapists who undertake the role of practice placement educator shall provide a learning experience for students that complies with the College of Occupational Therapists' professional standards and is compatible with the stage of the student's education or training.

5.5.3 Occupational therapists accepting students for practice placement education shall have a clear understanding of the roles and responsibilities of the student, the educational institution and the practice placement educator.

Research and service development

5.6 Occupational therapists shall contribute to the development of occupational therapy practice through research activity.

5.6.1 Occupational therapists have a responsibility to contribute to the continuing development of the profession by utilising critical evaluation, and participating in audit and research.

5.6.2 Occupational therapy personnel undertaking any form of research activity shall always address the ethical implications and adhere to research governance.

5.6.3 Occupational therapy personnel undertaking any form of research activity have an obligation to share their findings in order to inform or change practice, e.g. through publication or presentation.

KEYNOTE DOCUMENTS

College of Occupational Therapists Publications

College of Occupational Therapists (2004) *Curriculum framework for pre-registration education*. London: COT.

College of Occupational Therapists (2003) *Professional standards for occupational therapy practice*. London: COT.

College of Occupational Therapists (2003) *Standards for education: pre-registration education standards*. London: COT.

College of Occupational Therapists (2004) College of Occupational Therapists: Strategic vision and action plan for lifelong learning. *British Journal of Occupational Therapy*, 67 (1), 20-28.

College of Occupational Therapists (2003) *Research Ethics Guidelines*. London: COT.

Creek J (2003) *Occupational therapy defined as a complex intervention*. London: COT.

Other Publications

Health Professions Council (2003) *Standards of conduct, performance and ethics – your duties as a registrant*. London: HPC.

Health Professions Council (2003) *Standards of proficiency – occupational therapists*. London: HPC.

World Federation of Occupational Therapists (2004) *Code of ethics for occupational therapists*. Available: at www.wfot.org. Accessed 13th August 2004.

This version of the College of Occupational Therapists Code of Ethics and Professional Conduct (2005) is available to download in English and Welsh from the College of Occupational Therapists website: www.cot.org.uk.

Mae'r côd hwn ar gael i'w lawrlwytho yn y Gymraeg a'r Saesneg o wefan y Coleg Therapi Galwedigaethol: www.cot.org.uk.

About the publisher

The College of Occupational Therapists is a wholly owned subsidiary of the British Association of Occupational Therapists (BAOT) and operates as a registered charity. It represents the profession nationally and internationally, and contributes widely to policy consultations throughout the UK. The College sets the professional and educational standards for occupational therapy, providing leadership, guidance and information relating to research and development, education, practice and lifelong learning. In addition, 11 accredited specialist sections support expert clinical practice.

College of Occupational Therapists

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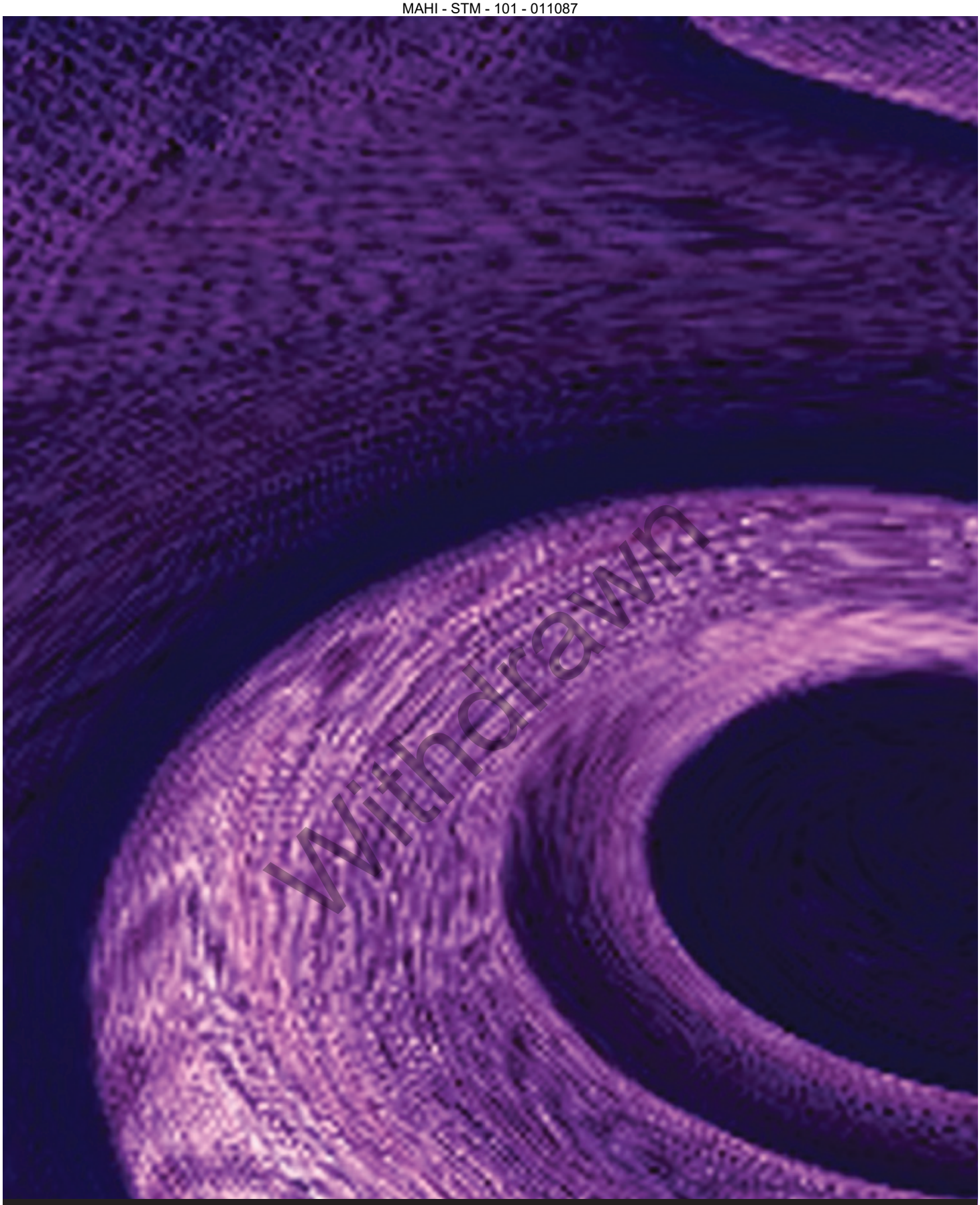

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Explanatory note to 2007 revision

Since their publication in 2003, the *Professional standards for occupational therapy practice* have proved themselves to be a convenient and effective means for those in the profession who wish to improve and maintain the quality of their practice and the services that they provide.

The College of Occupational Therapists aims to continually improve the material that it provides to its members and others. Therefore this opportunity has been taken to revise the *Professional standards for occupational therapy practice*. This revision has been minimal. It explains more fully how the standards may be used, but is otherwise limited to any updates, amendments and corrections that are required. A full, comprehensive revision is planned for 2011, taking into consideration all the feedback gathered from members and also moving to make the standards available as downloads from the College web site.

The revision of the standards will be accompanied by the development of a summary document that contains the standard statements only. This can be used as a quick reference, and as a way to explain or promote the work of the profession to others. The summary document will be disseminated free to all members and will be made available from the College web site.

These professional standards should continue to be a cornerstone for occupational therapists. The College invites any comments, feedback or suggestions that readers would like to give. The responses will inform the revision of this document in 2011. Please send your comments to:

Professional Standards for Occupational Therapy Practice
Professional Practice Group
College of Occupational Therapists
106 –114 Borough High Street
London SE1 1LB

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INTRODUCTION

A key function of the College of Occupational Therapists is to support members of the profession in their practice. By providing guidance material, information and advice, its objective is to raise the quality, safety and effectiveness of occupational therapy service provision across the United Kingdom.

These *Professional standards for occupational therapy practice* (2007) provide a single source by which all occupational therapy staff may monitor and improve their practice. They also inform others outside the profession what they may expect from occupational therapy services in terms of best practice. They stand alongside the *College of Occupational Therapists code of ethics and professional conduct* (2005), which provides a set of values and principles to promote and maintain high standards of professional behaviour in occupational therapy.

The context of the standards

The *Professional standards for occupational therapy practice* are those expected by the professional body. They have been written to be attainable, with practice improvements if necessary. They are not considered to be minimum standards, but neither are they purely aspirational.

The Health Professions Council is responsible for ensuring that all relevant health professionals meet certain given standards in order to be registered to practice in the United Kingdom. Their *Standards of conduct, performance and ethics* explain these requirements (Health Professions Council 2003b). If a formal complaint is brought against an occupational therapist, the Health Professions Council will judge the practice of the individual against their standards of conduct, performance and ethics (HPC 2003b) and their relevant standards of proficiency (HPC 2003a). The professional standards may be used as subsidiary evidence.

Many of the professional standards are based upon legal requirements, or the guidance and requirements of regulatory or monitoring bodies. Much of the material within the standards will be compatible, if not the same, as is included in local policy. However, in some circumstances, local organisations or services may have their own specific requirements to ensure the quality of service provision. In such a case, occupational therapists must, first and foremost, follow local policy. Where this differs significantly from these standards, the occupational therapist or occupational therapy service should attempt to uphold the principles of the particular professional standard and should seek advice.

Legal application of the standards

In any civil or criminal proceedings these standards will be admissible as evidence. They may be used as a measure of reasonable and/or acceptable practice. For instance, it may be more difficult to put up a defence against allegations of negligence if these standards have not been followed. Similarly, it would be difficult to substantiate a claim of unfair dismissal before an employment tribunal if an employer could establish a persistent failure to meet these standards.

In some instances these standards simply reiterate present legal requirements. If legal proceedings concern a breach of those requirements, then these standards could be used to support the contention that the individual was aware of the requirement and lack of knowledge would not be a valid defence.

How to use the standards

The *Professional standards for occupational therapy practice* have been broadly structured to reflect the general occupational therapy process. In certain circumstances more than one standard section will be relevant to one stage of practice. For example, there is a standard statement concerning assessment prior to discharge/closure or transfer, but the standard on general assessment is also pertinent to this activity, as is record keeping.

The *Professional standards for occupational therapy practice* are designed to enable individuals and services to build and strengthen their quality and effectiveness. Each standard has a compatible monitoring form. The standards and the monitoring forms are not worded or structured for use in a formal audit process, but as a tool to highlight areas of excellence and aspects of the service where improvements can be made. Repeated use will also identify change over time as improvements are made. The service monitoring forms may be photocopied for this purpose.

It is suggested that the standards are used a section at a time to review a service. The choice of which section may be guided by a recognised area of need within the service, or as part of a rolling service development programme. The standards and requirements should be applicable in almost all settings, although it is recognised that in some particular areas there may be phrases or other elements that will need adapting. The service monitoring forms ask the reader whether they and/or their service meet the requirements under each standard statement, with a simple yes/no response. There is space for comments or action to be taken, which may then be used to develop a programme of improvements.

Individuals may use the standards and requirements as a reference for guidance or as confirmation of good practice. They may also be used as a structure for dialogue between two or more people who wish to reflect on their practice. They might be useful in identifying areas for personal development between an occupational therapist and their supervisor or manager.

The *Professional standards for occupational therapy practice* can also be used as a way of informing others outside the profession what may be expected in terms of service processes and quality. The assurance of quality can be a good promotional tool when occupational therapy services have to raise their profile, or put forward a case for service change. From 2007 a short summary of the standard statements will be available for use as a quick reference, or to provide information to others in a more manageable format.

REFERRAL

Accurate, sensitive and timely referral to occupational therapy is a crucial element in a service user's pathway of care, enabling them to benefit from the most appropriate intervention at an optimal time.

Referral standard statement 1
Occupational therapists should have and abide by clearly documented procedures and criteria for referral to their service.

Occupational therapists/ occupational therapy services are required to:
- have a clearly documented procedure for referral to the service
- have clearly documented criteria for referral to the service
- obtain adequate information on which to base a decision about the appropriateness of the referral
- decline the referral if the information gathered indicates that the needs of the individual cannot be met by the occupational therapy service
- inform the referring agency if the referral is declined and on what basis
- inform both the service user and the referring agency if an individual has to be placed on a waiting list and advise them of the likely waiting time
- record or maintain the referral details in the occupational therapy records, including the source and date of referral
- work with those who have identifiable needs and would benefit from intervention where there is an open referral system.

Referral standard statement 2
Occupational therapists should respond to referrals within a stated time frame, based upon local need, resources and policy.

Occupational therapists/ occupational therapy services are required to:
- have a clearly documented policy stating a time frame for responding to referrals
- have a clearly documented system for prioritising referrals that recognises levels and degrees of need and optimises the use of resources.

Referral standard statement 3
Where the referral is inappropriate or the service user's needs cannot be met, occupational therapists should either transfer it to an alternative service, or provide information about other services.

Occupational therapists/ occupational therapy services are required to:
- gain and record informed consent before a service user is referred to another service
- inform the original referral source
- ensure that the referral is made to a service/ individual that can best meet the requirements of the individual being referred.

Service Monitoring Forms

REFERRAL

Referral standard statement 1
Occupational therapists have and abide by clearly documented procedures and criteria for referral to their service.

Do you/ does your service:	Yes	No	Comment and action required
▪ have a clearly documented procedure for referral to the service			
▪ have clearly documented criteria for referral to the service			
▪ obtain adequate information on which to base a decision about the appropriateness of the referral			
▪ decline the referral if the information gathered indicates that the needs of the individual cannot be met by the occupational therapy service			
▪ inform the referring agency if the referral is declined and on what basis			
▪ inform both the service user and the referring agency if an individual has to be placed on a waiting list and advise them of the likely waiting time			
▪ record or maintain the referral details in the occupational therapy records, including the source and date of referral			
▪ work with those who have identifiable needs and would benefit from intervention where there is an open referral system.			

Service Monitoring Forms

REFERRAL

Referral standard statement 2 **Occupational therapists should respond to referrals within a stated time frame, based upon local need, resources and policy.**			
Do you/ does your service:	**Yes**	**No**	**Comment and action required**
▪ have a clearly documented policy stating a time frame for responding to referrals			
▪ have a clearly documented system for prioritising referrals that recognises levels and degrees of need and optimises the use of resources.			

Referral standard statement 3 **Where the referral is inappropriate or the service user's needs cannot be met, occupational therapists should either transfer it to an alternative service, or provide information about other services.**			
Do you/ does your service:	**Yes**	**No**	**Comment and action required**
▪ gain and record informed consent before a service user is referred to another service			
▪ inform the original referral source			
▪ ensure that the referral is made to a service/ individual that can best meet the requirements of the individual being referred.			

CONSENT

"It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical investigation, or providing personal care, for a patient. This principle reflects the right of patients to determine what happens to their own bodies, and is a fundamental part of good practice. A health professional who does not respect this principle may be liable both to legal action by the patient and action by their professional body. Employing bodies may also be liable for the actions of their staff."

(Department of Health 2001d, p2)

Consent standard statement 1
Consent to occupational therapy should be obtained from the service user, recorded and regularly confirmed.

Occupational therapists/ occupational therapy services are required to:

- ensure that the staff member who obtains consent has sufficient knowledge of the proposed intervention and any possible risks involved, that they are able to fully inform the service user
- explain to the service user, and document, the proposed course of action before obtaining consent
- provide ongoing information and re-confirm consent on a regular basis throughout the intervention
- record the nature of consent given, whether by:
  - word of mouth
  - in writing
  - through guardian/ advocate
  - other means
- gain written consent to the proposed intervention when substantial risk is identified, documenting what points were discussed before written consent was given
- consider the interests of carers and/ or other family members when discussing and obtaining consent
- be assured of the mental capacity of the service user to give consent
- fully explain and gain written consent before audio-recording, photographing or videoing an individual for information purposes, research, training or publication
- keep all written consent forms in the service user's records
- gain consent before a student observes or provides intervention and ensure the consent and its nature are documented in the service user's record.

(College of Occupational Therapists 2003a)

Consent standard statement 2
Occupational therapists should ensure that the service user is fully informed about the nature of occupational therapy generally and the specific nature of the interventions relevant to them. This means that their decisions on consent will be informed.

Occupational therapists/ occupational therapy services are required to:

- have personal identification available when discussing consent
- inform the service user referred to occupational therapy about assessment and intervention – providing details about its purpose, nature, consequences, risks and possible alternatives

- provide information, in appropriate languages and modalities, which explains the nature and purpose of occupational therapy and sets out clearly the client's rights in consenting to occupational therapy.

(College of Occupational Therapists 2003a)

Consent standard statement 3
Occupational therapists should accept the service user's decision to refuse or withdraw consent at any time, unless the individual lacks the requisite capacity to make valid decisions.

Occupational therapists/ occupational therapy services are required to:
- inform the service user that, once consent is given, it can be withdrawn at any time without jeopardising any care they may receive in the future
- document a service user's refusal to consent and the reasons given.

(College of Occupational Therapists 2003a)

Consent standard statement 4
Occupational therapy staff have a professional and legal obligation to respect the duty of confidentiality, subject to statutory and common law exceptions to this duty.

Occupational therapists/ occupational therapy services are required to:
- have a policy statement on confidentiality, provided to service users on referral or prominently displayed
- only give information to other professionals directly involved in the service user's care, unless there are specific circumstances where the law requires it to be disclosed to others
- obtain written consent if information is to be disclosed to a third party not directly involved in the individual's care, except where law requires the disclosure
- keep all written consent forms in the service user's records
- document the legal justification for the disclosure and details of the person to whom it has been made.

(College of Occupational Therapists 2003a)

Consent standard statement 5
Occupational therapy staff should be aware of the correct legal approach to take when obtaining consent is difficult or impossible.

a) Adults with impaired capacity
Incapacity is not automatically to be implied simply by reason of the client's mental disorder/ learning disability or because the client is subject to a section of the Mental Health Act 1983 (Great Britain, Parliament 1983). Occupational therapists in mental health services must make themselves aware of current mental health legislation and amendments when they occur.

While no one can give consent on behalf of a mentally incapacitated adult, in common law occupational therapists and other health professionals have a duty to act in the service user's best interests. Such action may include substantial treatment to preserve the life and health of the individual, but may also include routine matters to preserve their general well-being.

Occupational therapists/ occupational therapy services are required to:

- always offer people the opportunity to make decisions about their care, and give consent
- establish whether the service user has the capacity to consent to the intervention
- record the details of the assessment of capacity and the outcomes in the care records
- document if consent is freely given
- document the legal status of the service user, for example whether they are detained under the Mental Health Act 1983 or any later amendments (Great Britain, Parliament 1983)
- act in the best interests of the service user where the person lacks the requisite capacity to make valid decisions
- inform themselves of and abide by the legal requirements relating to consent to treatment under the Mental Health Act 1983 or any later amendments (Great Britain, Parliament 1983).

b) People under the age of 16

People aged 16 or 17 are entitled to consent to their own intervention (Family Law Reform Act 1969), but as with adults, this is only valid if it given voluntarily by an informed individual who is capable of understanding the implications of the intervention and of providing consent.

For those under 16, the courts have said that children who have sufficient ability or competence to understand what is fully involved in a proposed intervention, also have the capacity to consent to that intervention. The level of understanding required and the level of a child's competence may vary, so careful consideration is required in each situation. Where a child lacks capacity, consent may only be given by a person with parental responsibility who has capacity, or by the court.

Where a child has refused intervention, this refusal can be over-ruled by a person with parental responsibility or the courts. In such circumstances, the best interests of the child must be considered, in terms of physical and psychological well-being.

Occupational therapists/ occupational therapy services are required to:

- ensure that the child, or person under the age of 16, is fully informed and has a clear understanding of what is involved in treatment
- ensure that any consent given by the child is voluntarily given
- discuss with the child the advantages and advisability of having a parent/ guardian present
- obtain parental/ guardian consent if the child does not have sufficient understanding of what is involved in treatment.

They are also required to document discussions relating to consent in the child's records, in particular:

- the nature of the consent given by the child
- the consent when given by a parent/ guardian
- the occupational therapist's reasons for believing that the child understands enough to give consent
- the reasons why a child is believed not to have sufficient understanding or ability to give consent

- discussions with the child about the advisability of having a parent/ guardian present
- the reasons behind any decision not to have a parent/ guardian present or involved.

Occupational therapists should seek legal advice if they are concerned that disclosing a child's records to a parent/ guardian or other person may act against the interests of the child. They should also seek advice if they are concerned that a parent/guardian's wish to over-rule a child's refusal to intervention is not in the child's best interest.

In some cases a child will require emergency treatment, but will be judged not to have the requisite mental capacity to give consent, and there will be insufficient time to gain parental/ guardian consent. In such cases, the occupational therapist should document:
- the treatment given in an emergency
- the reasons for the treatment being given in an emergency.

c) obstacles to language, communication or providing written consent
If a service user has capacity, but there are language, communication or physical difficulties, the occupational therapists needs to facilitate the consent process in any way possible.

Occupational therapists/ occupational therapy services are required to:
- obtain the services of an interpreter when there are obstacles to language
- record the identified need and subsequent use of an interpreter in the service user's record
- obtain communication aids or assistive devices where there are obstacles to communication
- document the identified means of communication in the service user's records
- document if the service user wishes to give consent but is physically unable to sign or mark a form
- ensure that there is a procedure in place to obtain a signing interpreter, communication aids or assistive devices.

(College of Occupational Therapists 2003a)

Addendum - Consent standard statement 5
Occupational Therapy staff should be aware of the correct legal approach to take when obtaining consent is difficult or impossible.

Occupational therapists need to be aware that under the Mental Capacity Act 2005, which will be fully implemented in October 2007, there are certain circumstances under which a person may give consent on behalf of a mentally incapacitated adult.

The Act makes it clear who can take decisions, in which situations, and how they should go about this. It sets out a single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time. Everything that is done for or on behalf of a person who lacks capacity must be in that person's best interests. The Act provides a checklist of factors that decision-makers must work through in deciding what is in a person's best interests.

Where a person is providing care or treatment for someone who lacks capacity, whether due to mental or physical ill-health, then the person can provide the care without incurring legal liability, providing they have completed and recorded the proper assessment of capacity and best interest. Occupational therapists who work with people in any setting who may lose their capacity to give consent should be fully aware of the requirements of the Mental Capacity Act 2005.

Service Monitoring Forms

CONSENT

Consent standard statement 1
Consent to occupational therapy should be obtained from the service user, recorded and regularly confirmed.

Do you/ does your service:	Yes	No	Comment and action required
▪ ensure that the staff member who obtains consent has sufficient knowledge of the proposed intervention and any possible risks involved, that they are able to fully inform the service user			
▪ explain to the service user, and document, the proposed course of action before obtaining consent			
▪ provide ongoing information and re-confirm consent on a regular basis throughout the intervention			
▪ record the nature of consent given, whether by: - word of mouth - in writing - through guardian/ advocate - other means			
▪ gain written consent to the proposed intervention when substantial risk is identified, documenting what points were discussed before written consent was given			
▪ consider the interests of carers and/ or other family members when discussing and obtaining consent			
▪ be assured of the mental capacity of the service user to give consent			
▪ fully explain and gain written consent before audio-recording, photographing or videoing an individual for information purposes, research, training or publication			
▪ keep all written consent forms in the service user's records			
▪ gain consent before a student observes or provides intervention and ensure the consent and its nature are documented in the service user's record.			

Consent standard statement 2 **Occupational therapists should ensure that the service user is fully informed about the nature of occupational therapy generally and the specific nature of the interventions relevant to them. This means that their decisions on consent will be informed.**			
Do you/ does your service:	**Yes**	**No**	**Comment and action required**
▪ have personal identification available when discussing consent			
▪ inform the service user referred to occupational therapy about assessment and intervention – providing details about its purpose, nature, consequences, risks and possible alternatives			
▪ provide information, in appropriate languages and modalities, which explains the nature and purpose of occupational therapy and sets out clearly the client's rights in consenting to occupational therapy.			

Consent standard statement 3 **Occupational therapists should accept the service user's decision to refuse or withdraw consent at any time, unless the individual lacks the requisite capacity to make valid decisions.**			
Do you/ does your service:	**Yes**	**No**	**Comment and action required**
▪ inform the service user that, once consent is given, it can be withdrawn at any time without jeopardising any care they may receive in the future			
▪ document a service user's refusal to consent and the reasons given.			

Consent standard statement 4 **Occupational therapy staff have a professional and legal obligation to respect the duty of confidentiality, subject to statutory and common law exceptions to this duty.**			
Do you/ does your service:	**Yes**	**No**	**Comment and action required**
▪ have a policy statement on confidentiality, provided to service users on referral or prominently displayed			
▪ only give information to other professionals directly involved in the service user's care, unless there are specific circumstances where the law requires it to be disclosed to others			
▪ obtain written consent if information is to be disclosed to a third party not directly involved in the individual's care, except where law requires the disclosure			
▪ keep all written consent forms in the service user's records			
▪ document the legal justification for the disclosure and details of the person to whom it has been made.			

Consent standard statement 5
Occupational therapy staff should be aware of the correct legal approach to take when obtaining consent is difficult or impossible.

a) Adults with impaired capacity

Do you/ does your service:	Yes	No	Comment and action required
▪ always offer people the opportunity to make decisions about their care, and give consent			
▪ establish whether the service user has the capacity to consent to the intervention			
▪ record the details of the assessment of capacity and the outcomes in the care records			
▪ document if consent is freely given			
▪ document the legal status of the service user, for example whether they are detained under the Mental Health Act 1983 or any later amendments (Great Britain, Parliament 1983)			
▪ act in the best interests of the service user where the person lacks the requisite capacity to make valid decisions			
▪ inform themselves of and abide by the legal requirements relating to consent to treatment under the Mental Health Act 1983 or any later amendments (Great Britain, Parliament 1983).			

Service Monitoring Forms

CONSENT

Consent standard statement 5
Occupational therapy staff should be aware of the correct legal approach to take when obtaining consent is difficult or impossible.

b) People under the age of 16

Do you/ does your service:	Yes	No	Comment and action required
▪ ensure that the child, or person under the age of 16, has a clear understanding of what is involved in treatment			
▪ ensure that any consent given by the child is voluntarily given			
▪ discuss with the child the advantages and advisability of having a parent/ guardian present			
▪ obtain parental/ guardian consent if the child does not have sufficient understanding of what is involved in treatment.			
▪ document discussions relating to consent in the child's records, in particular: - the nature of the consent given by the child - the consent when given by a parent/ guardian - the occupational therapist's reasons for believing that the child understands enough to give consent - the reasons why a child is believed not to have sufficient understanding to give consent - discussions with the child about the advisability of having a parent/ guardian present - the reasons behind any decision not to have a parent/ guardian present or involved.			
▪ document the treatment given in an emergency			
▪ document the reasons for the treatment given in an emergency			

Consent standard statement 5
Occupational therapy staff should be aware of the correct legal approach to take when obtaining consent is difficult or impossible.

c) obstacles to language, communication or providing written consent

Do you/ does your service:	Yes	No	Comment and action required
▪ obtain the services of an interpreter when there are obstacles to language			
▪ record the identified need and subsequent use of an interpreter in the service user's record			
▪ obtain communication aids or assistive devices where there are obstacles to communication			
▪ document the identified means of communication in the service user's records			
▪ document if the service user wishes to give consent but is physically unable to sign or mark a form			
▪ ensure that there is a procedure in place to obtain a signing interpreter, communication aids or assistive devices.			

ASSESSMENT AND GOAL SETTING

"Assessment provides the foundation for effective treatment and it is critical to undertake a thorough and reliable assessment at several stages during the occupational therapy process, because without thorough and accurate assessment the intervention selected may prove inappropriate and/ or ineffective."

(Laver Fawcett 2002, p107)

Assessment and goal setting standard statement 1

Occupational therapists should prepare for an assessment by ensuring that it is appropriate and safe, and that the person being assessed has given their consent.

Occupational therapists/ occupational therapy services are required to:

- identify the need for an assessment, based on information provided upon referral or screening and in line with local policy guidance
- assess and document the service user's physical, environmental and personal safety before or in the early stages of an occupational therapy assessment
- explain the nature and purpose of the assessment to the service user and/ or their carers to facilitate their involvement
- gain and document consent before the assessment commences.

Assessment and goal setting standard statement 2

A decision not to carry out, or to discontinue, assessment should be based on identifiable and justifiable reasons.

Occupational therapists/ occupational therapy services are required to:

- only assess when it is in the remit of the service, in the scope of their competence and when it does not pose a risk to the safety of the service user or therapist
- document any decision not to assess and the reasons behind it
- inform the referral source when an assessment is not carried out following a referral
- document any decision to discontinue an assessment and the reasons behind it – for example, sudden illness, distress, consent not given, participation refused, risk to the service user or therapist.

Assessment and goal setting standard statement 3

The assessment tool should be fit for purpose, and should be used appropriately by the occupational therapy service and its staff.

Occupational therapists/ occupational therapy services are required to:

- utilise standardised assessments, or assessments derived from recognised models of occupational therapy, where available
- contribute to a shared or single assessment process where one is established

- ensure that the staff member who carries out the assessment has the knowledge and skills required
- fully document the details of the assessment, including the date, time, location, those present and the outcomes
- take all possible measures to ensure the service user's safety during the assessment, in terms of mobility, the environment and equipment used.

Assessment and goal setting standard statement 4

The assessment should be carried out under conditions that recognise and value the needs of the service user and their main carer/s.

Occupational therapists/ occupational therapy services are required to:

- ensure assessments are centred on the service user, taking into account their occupation, role, environment and lifestyle
- ensure the assessment accepts and values the background and culture of the service user
- ensure the assessment is undertaken in the service user's preferred language
- ensure privacy and confidentiality by undertaking the assessment in a suitable environment
- make the outcome of the assessment available to the service user and/ or their carers (with the individual's consent)
- provide an opportunity for the service user and/ or their carer to comment upon the assessment
- recognise the rights of the service user's main carer/s to an assessment of their own needs and make appropriate referrals if required
- document the carer's needs and abilities and any referrals made on behalf of the carer.

Assessment and goal setting standard statement 5

The goals for intervention should be agreed in discussion with the service user and/ or their carer, based on their priorities and the needs as indicated by the assessment.

Occupational therapists/ occupational therapy services are required to:

- record clearly the service user's assessed needs and the goals and objectives of intervention
- agree priority areas for intervention with the service user
- record clearly the service user's priorities and choices
- work in partnership with the service user and their carer/s when identifying the goals for intervention
- set realistic and achievable goals
- communicate the outcome of the assessment and the identified intervention goals with other core members of the health and social care team.

Service Monitoring Forms **ASSESSMENT AND GOAL SETTING**

Assessment and goal setting standard statement 1 **Occupational therapists should prepare for an assessment by ensuring that it is appropriate and safe, and that the person being assessed has given their consent.**			
Do you/ does your service:	**Yes**	**No**	**Comment and action required**
n identify the need for an assessment, based on information provided upon referral or screening and in line with local policy guidance			
n assess and document the service user's physical, environmental and personal safety before or in the early stages of an occupational therapy assessment			
n explain the nature and purpose of the assessment to the service user and/or their carers to facilitate their involvement			
n gain and document consent before the assessment commences.			

Assessment and goal setting standard statement 2 **A decision not to carry out, or to discontinue, assessment should be based on identifiable and justifiable reasons.**			
Do you/ does your service:	**Yes**	**No**	**Comment and action required**
n only assess when it is in the remit of the service, in the scope of your competence and when it does not pose a risk to the safety of the service user or therapist			
n document any decision not to assess and the reasons behind it			
n inform the referral source when an assessment is not carried out following a referral			
n document any decision to discontinue an assessment and the reasons behind it – for example, sudden illness, distress, consent not given, participation refused, risk to the service user or therapist.			

Service Monitoring Forms **ASSESSMENT AND GOAL SETTING**

Assessment and goal setting standard statement 3 **The assessment tool should be fit for purpose, and should be used appropriately by the occupational therapy service and its staff.**			
Do you/ does your service:	**Yes**	**No**	**Comment and action required**
n utilise standardised assessments, or assessments derived from recognised models of occupational therapy, where available			
n contribute to a shared or single assessment process where one is established			
n ensure that the staff member who carries out the assessment has the knowledge and skills required			
n fully document the details of the assessment, including the date, time, location, those present and the outcomes			
n take all possible measures to ensure the service user's safety during the assessment, in terms of mobility, the environment and equipment used.			

Service Monitoring Forms

ASSESSMENT AND GOAL SETTING

Assessment and goal setting standard statement 4
The assessment should be carried out under conditions that recognise and value the needs of the service user and their main carer/s.

Do you/does your service:	Yes	No	Comment and action required
▪ ensure assessments are centred on the service user, taking into account their occupation, role, environment and lifestyle			
▪ ensure the assessment accepts and values the background and culture of the service user			
▪ ensure the assessment is undertaken in the service user's preferred language			
▪ ensure privacy and confidentiality by undertaking the assessment in a suitable environment			
▪ make the outcome of the assessment available to the service user and/or their carers (with the individual's consent)			
▪ provide an opportunity for the service user and/or their carer to comment upon the assessment			
▪ recognise the rights of the service user's main carer/s to an assessment of their own needs and make appropriate referrals if required			

n document the carers' needs and abilities and any referrals made on behalf of the carer.			

Assessment and goal setting standard statement 5 **The goals for intervention should be agreed in discussion with the service user and/ or their carer, based on their priorities and the needs as indicated by the assessment.**			
Do you/ does your service:	**Yes**	**No**	**Comment and action required**
n record clearly the service user's assessed needs and the goals and objectives of intervention			
n agree priority areas for intervention with the service user			
n record clearly the service user's priorities and choices			
n work in partnership with the service user and their carer/s when identifying the goals for intervention			
n set realistic and achievable goals			
n communicate the outcome of the assessment and the identified intervention goals with other core members of the health and social care team.			

INTERVENTION AND EVALUATION

Intervention has been defined as "The purposeful and skilled interaction of the physical therapist with the patient/ client, and when appropriate, with other individuals involved in care using various methods and techniques to produce changes in the condition."
(Jacobs and Jacobs 2001, p94)

In broader terms this may be interpreted as the process of carrying out an activity with, or on behalf of, a service user, in order to move them towards their stated goals.

"Evaluation is carried out both formally and informally. The measurement of outcomes is an integral part of quality assurance. Whalley Hammell (1994) defines outcomes measures in occupational therapy as referring to 'an end product in terms of health, performance and satisfaction'." (Hagedorn 1995, p184)

Intervention and evaluation standard statement 1
Intervention should be based upon the goals and objectives that have been identified and negotiated with the service user.

Occupational therapists/ occupational therapy services are required to:
- select the media or activities on the basis of which offer the best options for achieving the agreed therapeutic goals and have most meaning for the service user
- carry out the intervention in a suitable environment
- make the best use of existing resources
- work in collaboration with other professionals to fit in with the overall programme of intervention the service user is receiving
- engage the service user in activities which have been selected, adapted, graded and sequenced according to their needs
- manage and document any decisions or actions taken where there is an element of risk in planning and/ or respecting the service user's choices
- document and explain any unmet needs
- respect the choice of the service user, if at any time they wish to discontinue intervention.

Intervention and evaluation standard statement 2
Intervention should be in accordance with the best or evidence-based practice.

Occupational therapists/ occupational therapy services are required to:
- develop an information and evidence resource to support clinical practice
- seek evidence or descriptions of best practice to justify interventions or approaches
- evaluate this evidence and incorporate findings within intervention

Intervention and evaluation standard statement 3
Intervention should only be provided by a member of staff or person in a care role if they are deemed competent.

Occupational therapists/ occupational therapy services are required to:
- only provide services and use techniques for which they are qualified by education, training and/ or experience (College of Occupational Therapists 2005, p14)

- only provide services and use techniques that are within their professional competence, relevant to the setting and relate to their terms of employment (College of Occupational Therapists 2005, p14)
- ensure that any person to whom tasks or actions are delegated – such as students, support workers and volunteers – is competent to carry them out
- provide adequate information, supervision and teaching to other members of staff, family members and carers if they are to provide intervention

Intervention and evaluation standard statement 4
The occupational therapist should monitor and review the effectiveness of an activity or intervention, revising it as necessary to ensure progress.

Occupational therapists/ occupational therapy services are required to:
- identify a baseline from which to measure any change in the service user's well-being, function and/or mental state and thereby to evaluate treatment
- use assessment tools incorporating outcome measures, where formal evaluation is required
- understand the purpose and accuracy of the outcome measure being used, so that the results can be interpreted correctly
- document the process and results of intervention, using the records and outcome measures to ensure that progress is being made towards the agreed goals and objectives.

Service Monitoring Forms

INTERVENTION AND EVALUATION

Intervention and evaluation standard statement 1
Intervention should be based upon the goals and objectives that have been identified and negotiated with the service user.

Do you/ does your service:	Yes	No	Comment and action required
▪ select the media or activities on the basis of which offer the best options for achieving the agreed therapeutic goals and have most meaning for the service user			
▪ carry out the intervention in a suitable environment			
▪ make the best use of existing resources			
▪ work in collaboration with other professionals to fit in with the overall programme of intervention the service user is receiving			
▪ engage the service user in activities which have been selected, adapted, graded and sequenced according to their needs			
▪ manage and document any decisions or actions taken where there is an element of risk in planning and/ or respecting the service user's choices			
▪ document and explain any unmet needs			
▪ respect the choice of the service user, if at any time they wish to discontinue intervention.			

Service Monitoring Forms **INTERVENTION AND EVALUATION**

Intervention and evaluation standard statement 2 **Intervention should be in accordance with the best or evidence-based practice.**			
Do you/ does your service:	**Yes**	**No**	**Comment and action required**
▪ develop an information and evidence resource to support clinical practice			
▪ seek evidence or descriptions of best practice to justify interventions or approaches			
▪ evaluate this evidence and incorporate findings within intervention.			

Intervention and evaluation standard statement 3 **Intervention should only be provided by a member of staff or person in a care role if they are deemed competent.**			
Do you/ does your service:	**Yes**	**No**	**Comment and action required**
▪ only provide services and use techniques for which they are qualified by education, training and/ or experience			
▪ only provide services and use techniques that are within their professional competence, relevant to the setting and relate to their terms of employment			
▪ ensure that any person to whom tasks or actions are delegated – such as students, support workers and volunteers – is competent to carry them out			
▪ provide adequate information, supervision and teaching to other members of staff, family members and carers if they are to provide intervention			

Service Monitoring Forms **INTERVENTION AND EVALUATION**

Intervention and evaluation standard statement 4 **The occupational therapist should monitor and review the effectiveness of an activity or intervention, revising it as necessary to ensure progress.**			
Do you/ does your service:	**Yes**	**No**	**Comment and action required**
▪ identify a baseline from which to measure any change in the service user's well-being, function and/or mental state and thereby to evaluate treatment			
▪ use assessment tools incorporating outcome measures, where formal evaluation is required			
▪ understand the purpose and accuracy of the outcome measure being used, so that the results can be interpreted correctly			
▪ document the process and results of intervention, using the records and outcome measures to ensure that progress is being made towards the agreed goals and objectives.			

DISCHARGE, CLOSURE OR TRANSFER OF CARE

"The process of discontinuing interventions included in a single episode of care".
(Jacobs and Jacobs 2001, p53)

Discharge, closure or transfer standard statement 1
Occupational therapists should assess the service user in preparation for discharge, closure or transfer, considering their ability to manage in their future environment, and at all times taking into account the service user's priorities and choices.

Occupational therapists/ occupational therapy services are required to:
- assess the service user's progress against their pre-set goals
- document the amount of assistance needed for occupational performance areas
- make recommendations for any ongoing intervention or support required
- make recommendations for any assistive equipment and/ or environmental modifications required
- make recommendations for any further follow-up, intervention or re-assessment required.

Discharge, closure or transfer standard statement 2
Occupational therapy should only be discontinued when the person being treated has achieved their pre-set goals, has moved outside the criteria of the service, or withdraws their consent.

Occupational therapists/ occupational therapy services are required to:
- include discharge, closure or transfer of care as part of the intervention plan
- prepare and implement a discharge, closure or transfer plan that is consistent with the goals of the service user and the intervention plan
- prepare and implement a discharge, closure or transfer plan that takes into consideration the needs and considerations of the family or carer, and the community or other support resources
- allow sufficient time for the co-ordination and implementation of a discharge, closure or transfer plan
- liaise with members of the service user's care team about the discharge, closure or transfer plan, keeping them informed about how it will be implemented and followed up.

n document the carers' needs and abilities and any referrals made on behalf of the carer.			

Assessment and goal setting standard statement 5 **The goals for intervention should be agreed in discussion with the service user and/ or their carer, based on their priorities and the needs as indicated by the assessment.**			
Do you/ does your service:	**Yes**	**No**	**Comment and action required**
n record clearly the service user's assessed needs and the goals and objectives of intervention			
n agree priority areas for intervention with the service user			
n record clearly the service user's priorities and choices			
n work in partnership with the service user and their carer/s when identifying the goals for intervention			
n set realistic and achievable goals			
n communicate the outcome of the assessment and the identified intervention goals with other core members of the health and social care team.			

Service Monitoring Forms **DISCHARGE, CLOSURE OR TRANSFER OF CARE**

Discharge, closure or transfer standard statement 1
Occupational therapists should assess the service user in preparation for discharge, closure or transfer, considering their ability to manage in their future environment, and at all times taking into account the service user's priorities and choices.

Do you/ does your service:	Yes	No	Comment and action required
n assess the service user's progress against their pre-set goals			
n document the amount of assistance needed for occupational performance areas			
n make recommendations for any ongoing intervention or support required			
n make recommendations for any assistive equipment and/or environmental modifications required			
n make recommendations for any further follow-up, intervention or re-assessment required.			

Discharge, closure or transfer standard statement 2
Occupational therapy should only be discontinued when the person being treated has achieved their pre-set goals, has moved outside the criteria of the service, or withdraws their consent.

Do you/ does your service:	Yes	No	Comment and action required
n include discharge, closure or transfer of care as part of the intervention plan			
n prepare and implement a discharge, closure or transfer plan that is consistent with the goals of the service user and the intervention plan			
n prepare and implement a discharge, closure or transfer plan that takes into consideration the needs and considerations of the family or carer, and the community or other support resources			
n allow sufficient time for the co-ordination and implementation of a discharge, closure or transfer plan			
n liaise with members of the service user's care team about the discharge, closure or transfer plan, keeping them informed about how it will be implemented and followed up.			

RECORD KEEPING

Record keeping – as either an occupational therapy record or part of a multidisciplinary record – is an essential and integral part of care. The purpose of the records is to give a comprehensive, accurate and justifiable account of the care, treatment and support provided or planned for a service user. The information also supports the use of audit, evidence based practice and improvements in clinical effectiveness through research.

For further information on record keeping requirements please see *Record Keeping. College of Occupational Therapists Guidance 2*. (2005).

Record keeping standard statement 1
A record should be kept of all occupational therapy activity and intervention made with, or on behalf of, the service user.

Occupational therapists/ occupational therapy services are required to:

- clearly identify the service user by name, address and date of birth and/or any system of identification number on all records kept
- document details of all key people involved in the service user's care, both professionals and family/ carers
- document all referral details, including date and source of referral and reason for referral when given
- document any relevant social, medical or rehabilitative history
- document, date and time all assessments made, methods used and resulting outcomes, including risk assessments
- document and date the views and wishes of the service user about goals or treatment plans, and any timeframes suggested
- document the consent and nature of consent given to intervention
- document, date and time all interventions planned and carried out in connection with the service user, and the resulting outcomes
- document and date all reviews, and alterations to goals, treatment plans or timeframes
- document all interventions or decisions made by members of the multidisciplinary team when it impacts upon the occupational therapy care given, including decisions taken in clinical supervision
- incorporate in the records all correspondence, emails, telephone conversations and reports related to the service user's care
- document and date interventions or contact with family and carers, and any outcomes
- document all information and advice provided to the service user and their family/ carers
- document all discharge, closure or transfer details
- document the destination of onward referrals or care transfers and any information that needs to be considered in handover (with the knowledge and consent of the service user).

(College of Occupational Therapists 2000c)

Record keeping standard statement 2
Occupational therapy records should be well organised, well managed and clear, to ensure that they are accessible to those who may need to refer to them.

Occupational therapists/ occupational therapy services are required to:
- maintain and organise records systematically, ensuring that they are easy to find and in good order
- ensure that records are chronological and contemporaneous
- ensure the records are complete, factual, objective and concise
- ensure the records are legible and do not use slang or unexplained abbreviations and acronyms
- amend written records by scoring out with a single line, so that the original text is still legible
- provide a clear signature, designation and date with all entries, additions or amendments
- meet local or regulatory body requirements for countersigning student or support staff entries in the records. (Health Professions Council 2003b)
- ensure that electronic records clearly identify the member of staff making the record, in the absence of a signature and meet the same standards as written records
- ensure electronic records are completed to the same standard as written records.

(College of Occupational Therapists 2000c)

Record keeping standard statement 3
Occupational therapy staff should be aware of, and abide by, legal requirements for the confidentiality, storage and disposal of records, and a service user's right to access their own records. They should also be guided by local policy on these matters.

Occupational therapists/ occupational therapy services are required to:
- inform themselves of, and abide by, the key principles of the Data Protection Act 1998 and local policy, in relation to a service user's right of access to their records (Great Britain, Parliament 1998a)
- inform themselves of, and abide by, the key principles of the Data Protection Act 1998 and local policy, relating to the confidentiality, storage and disposal of records (Great Britain, Parliament 1998a)
- inform themselves of, and abide by, any relevant requirements contained in the Computer Misuse Act 1990, the Freedom of Information Act 2000 and the Human Rights Act 2000.
- store records securely, with arrangements in place to protect them from use by unauthorised persons, damage or loss
- ensure the safekeeping of other records such as diaries that may be used as legal evidence
- retain and dispose of records according to legal and local guidance.

(College of Occupational Therapists 2000c)

Service Monitoring Forms

RECORD KEEPING

Record keeping standard statement 1
A record should be kept of all occupational therapy activity and intervention made with, or on behalf of, the service user.

Do you/ does your service:	Yes	No	Comment and action required
▪ clearly identify the service user by name, address and date of birth and/or any system of identification number on all records kept			
▪ document details of all key people involved in the service user's care, both professionals and family/ carers			
▪ document all referral details, including date and source of referral and reason for referral when given			
▪ document any relevant social, medical or rehabilitative history			
▪ document, date and time all assessments made, methods used and resulting outcomes, including risk assessments			
▪ document and date the views and wishes of the service user about goals or treatment plans, and any timeframes suggested			
▪ document the consent and nature of consent given to intervention			
▪ document, date and time all interventions planned and carried out in connection with the service user, and the resulting outcomes			
▪ document and date all reviews, and alterations to goals, treatment plans or timeframes			
▪ document all interventions or decisions made by members of the multidisciplinary team when it impacts upon the occupational therapy care given, including decisions taken in clinical supervision			
▪ incorporate in the records all correspondence, emails, telephone conversations and reports related to the service user's care			
▪ document and date interventions or contact with family and carers, and any outcomes			
▪ document all information and advice provided to the service user and their family/carers			

▪ document all discharge, closure or transfer details			
▪ document the destination of onward referrals or care transfers and any information that needs to be considered in handover (with the knowledge and consent of the service user).			

Service Monitoring Forms

RECORD KEEPING

Record keeping standard statement 2
Occupational therapy records should be well organised, well managed and clear, to ensure that they are accessible to those who may need to refer to them.

Do you/ does your service:	Yes	No	Comment and action required
▪ maintain and organise records systematically, ensuring that they are easy to find and in good order			
▪ ensure that records are chronological and contemporaneous			
▪ ensure the records are complete, factual, objective and concise			
▪ ensure the records are legible and do not use slang or unexplained abbreviations and acronyms			
▪ amend written records by scoring out with a single line, so that the original text is still legible			
▪ provide a clear signature, designation and date with all entries, additions or amendments			
▪ meet local or regulatory body requirements for countersigning student or support staff entries in the records. (Health Professions Council 2003b)			
▪ ensure that electronic records clearly identify the member of staff making the record, in the absence of a signature and meet the same standards as written records			
▪ ensure electronic records are completed to the same standard as written records.			

Service Monitoring Forms

RECORD KEEPING

Record keeping standard statement 3
Occupational therapy staff should be aware of, and abide by, legal requirements for the confidentiality, storage and disposal of records, and a service user's right to access their own records. They should also be guided by local policy on these matters.

Do you/ does your service:	Yes	No	Comment and action required
▪ inform themselves of, and abide by, the key principles of the Data Protection Act 1998 and local policy, in relation to a service user's right of access to their records (Great Britain, Parliament 1998a)			
▪ inform themselves of, and abide by, the key principles of the Data Protection Act 1998 and local policy, relating to the confidentiality, storage and disposal of records (Great Britain, Parliament 1998a)			
▪ inform themselves of and abide by any relevant requirements contained in the Computer Misuse Act 1990, the Freedom of Information Act 2000 and the Human Rights Act 2000			
▪ store records securely, with arrangements in place to protect them from use by unauthorised persons, damage or loss			
▪ ensure the safekeeping of other records such as diaries that may be used as legal evidence			
▪ retain and dispose of records according to legal and local guidance.			

SERVICE QUALITY AND GOVERNANCE

The principles of quality and governance apply equally to all occupational therapists, in all settings. Individual therapists and services have a duty to provide an occupational therapy service of the highest competence, safety, quality and value.

Quality has been defined as "doing the right things, to the right people, at the right time and doing things right first time" (Department of Health 1997b, p17).

Governance refers to the processes and systems put in place to ensure that quality is provided, whilst making best use of resources.

Service quality and governance standard statement 1
Occupational therapists should maintain and develop their knowledge, skills and behaviour, and therefore their competence to practise.

Occupational therapists/ occupational therapy services are required to:

- seek out and attend learning opportunities relevant to their practice and development as professionals (Ilott and White 2002)
- enable the development of their staff, by providing supervision and appraisal systems and support for learning opportunities
- be aware of developments in their area of practice and beyond, for example through reading, attending learning opportunities, membership of a specialist section or special interest group
- apply newly acquired professional knowledge, skills and behaviour in a safe and responsible manner
- share good practice with fellow professionals
- have local management structures which provide regular supervision and feedback (or equivalent support)
- reflect upon professional practice and development, maintaining a record through the use of professional development portfolios
- participate in a regular appraisal process, enabling reflection on current practice, consideration of past, current and future objectives and learning/ development needs.

Service quality and governance standard statement 2
Occupational therapists should protect and maintain the safety of those who use their service.

Occupational therapists/ occupational therapy services are required to:

- abide by national and local health and safety regulations, policies and procedures
- work only within their professional competence, in terms of education, training and/ or experience
- minimise the risk of untoward events by identifying the potential for harm and avoiding or managing these factors.This should not rule out positive risk-taking as part of therapy intervention
- recognise and learn from adverse events, identifying and addressing areas of poor practice.

Service quality and governance standard statement 3

Occupational therapists should provide a service of consistent quality, in line with local, professional and national standards.

Occupational therapists/ occupational therapy services are required to:

- monitor the performance and quality of their service against relevant local, national and professional standards and guidelines as they are published
- ensure mechanisms are in place to monitor safe, effective, ethical, equitable and anti-discriminatory practice
- be informed of the opinions of the people to whom they provide a service and their carers
- participate in the development of and co-operate with local quality and governance systems
- raise awareness of and co-operate with the local complaints procedure
- take responsibility for drawing attention to any areas of concern about the service.

Service quality and governance standard statement 4

Occupational therapists should provide a service that is of the highest quality and the best value for money.

Occupational therapists/ occupational therapy services are required to:

- monitor the use of resources and facilities, along with the outcomes of the service, to ensure their optimum efficiency and effectiveness
- recognise and take opportunities to influence health and social policy and practice to the benefit of those who use the service.

Service Monitoring Forms

SERVICE QUALITY AND GOVERNANCE

Service quality and governance standard statement 1 **Occupational therapists should maintain and develop their knowledge, skills and behaviour, and therefore their competence to practise.**			
Do you/does your service:	**Yes**	**No**	**Comment and action required**
▪ seek out and attend learning opportunities relevant to your practice and development as professionals			
▪ enable the development of staff, by providing supervision and appraisal systems and support for learning opportunities			
▪ be aware of developments in your area of practice and beyond, for example through reading, attending learning opportunities, membership of a specialist section or special interest group			
▪ apply newly acquired professional knowledge, skills and behaviour in a safe and responsible manner			
▪ share good practice with fellow professionals			
▪ have local management structures which provide regular supervision and feedback (or equivalent support)			
▪ reflect upon professional practice and development, maintaining a record through the use of professional development portfolios			
▪ participate in a regular appraisal process, enabling reflection on current practice, consideration of past, current and future objectives and learning/development needs.			

Service quality and governance standard statement 2
Occupational therapists should protect and maintain the safety of those who use their service.

Do you/ does your service:	Yes	No	Comment and action required
n abide by national and local health and safety regulations, policies and procedures			
n work only within your professional competence, in terms of education, training and/ or experience			
n minimise the risk of untoward events by identifying the potential for harm and avoiding or managing these factors. This should not rule out positive risk-taking as part of therapy intervention			
n recognise and learn from adverse events, identifying and addressing areas of poor practice.			

Service quality and governance standard statement 3
Occupational therapists should provide a service of consistent quality, in line with local, professional and national standards.

Do you/ does your service:	Yes	No	Comment and action required
n monitor the performance and quality of your service against relevant local, national and professional standards and guidelines as they are published			
n ensure mechanisms are in place to monitor safe, effective, ethical, equitable and anti-discriminatory practice			
n inform yourself of the opinions of the people to whom you provide a service and their carers			
n participate in the development of and co-operate with local quality and governance systems			
n raise awareness of and co-operate with the local complaints procedure			
n take responsibility for drawing attention to any areas of concern about the service.			

Service Monitoring Forms **SERVICE QUALITY AND GOVERNANCE**

Service quality and governance standard statement 4 **Occupational therapists should provide a service that is of the highest quality and the best value for money.**			
Do you/ does your service:	**Yes**	**No**	**Comment and action required**
n monitor the use of resources and facilities, along with the outcomes of the service, to ensure their optimum efficiency and effectiveness			
n recognise and take opportunities to influence health and social policy and practice to the benefit of those who use the service.			

PROFESSIONAL DEVELOPMENT/ LIFELONG LEARNING

Continuing personal and professional development and lifelong learning for all members ensures the competence required to provide safe, efficient and effective services in all settings.

Professional development/ lifelong learning standard statement 1
Occupational therapy staff should be supported in their practice and development through regular supervision, within an agreed structure or model.

Occupational therapists/ occupational therapy services are required to:
- participate in supervision to an agreed structure or model, such as peer group or individual supervision
- have written local guidance or protocols for supervision describing the process, structure/ model and confidentiality boundaries
- have a verbal or written agreement between the supervisor and the supervisee, detailing the frequency, duration, content, process and confidentiality boundaries
- ensure that if individual supervision is used, it is by a therapist of a more senior grade or greater experience
- ensure that supervisory staff are sufficiently trained and experienced to fulfil their role
- respect and uphold the confidentiality of the supervisory relationship
- provide a suitable location and adequate time for supervision.

Professional development/ lifelong learning standard statement 2
Supervision sessions should be recorded detailing the content of discussion and any agreed action.

Occupational therapists/ occupational therapy services are required to:
- accurately and objectively record all supervision sessions
- ensure that the record is agreed as a true account by participating individuals
- keep supervision records for a minimum of 12 months
- ensure supervision records are available for use at an annual appraisal
- ensure that the previous 12 months of supervision records and any agreed contract are available if formal or informal disciplinary action or grievance action is taken.

Professional development/ lifelong learning standard statement 3
Occupational therapy staff should participate in an annual appraisal cycle.

Occupational therapists/ occupational therapy services are required to:
- provide a suitable location and adequate time for the appraisal
- prepare adequately for the appraisal meeting, using any documentation provided, and reflecting upon performance, achievement of role and responsibilities
- review, clarify and confirm the roles and responsibilities expected of the staff member, in light of the organisational structure and objectives

- appraise the staff member fairly and objectively against past or current objectives, roles and responsibilities
- agree future objectives for the staff member, including key targets, action to be taken and timescale, considering the requirements of the individual, the post and the objectives of the organisation
- agree and document the development and learning needs of the staff member
- document accurately and objectively the content and outcomes of the appraisal, using any local or organisational documentation provided
- ensure the record is agreed as a true account by participating individuals
- ensure the appraiser is sufficiently trained and experienced to fulfil their role
- review the appraisal outcome on a regular basis and follow up any agreed actions
- provide a procedure for either party to follow should they be dissatisfied with the appraisal outcome.

Professional development/ lifelong learning standard statement 4

Occupational therapy staff should achieve and continuously maintain high standards of competence in terms of knowledge, skills and behaviour.

Occupational therapists/ occupational therapy services are required to:

- receive a minimum of one half day each month for continuing development, scholarship and/ or research
- provide continuing development opportunities to support workers who contribute to occupational therapy services
- support the training and development of colleagues from other professions, services and agencies
- participate in informal and formal learning opportunities
- have access to time, funding and developmental opportunities that enhance the contribution of occupational therapy to the employing organisation
- apply their learning to benefit service users and their carers
- ensure learning opportunities are socially and culturally inclusive and appropriate
- participate in inter-professional learning to develop team skills through better knowledge and understanding of team member roles
- document professional development activities to provide evidence of continuous learning.

Service Monitoring Forms **PROFESSIONAL DEVELOPMENT/ LIFELONG LEARNING**

Professional development/ lifelong learning standard statement 1
Occupational therapy staff should be supported in their practice and development through regular supervision, within an agreed structure or model.

Do you/ does your service:	Yes	No	Comment and action required
n participate in supervision to an agreed structure or model, such as peer group or individual supervision			
n have written local guidance or protocols for supervision describing the process, structure/ model and confidentiality boundaries			
n have a verbal or written agreement between the supervisor and the supervisee, detailing the frequency, duration, content, process and confidentiality boundaries			
n ensure that if individual supervision is used, it is by a therapist of a more senior grade or greater experience			
n ensure that supervisory staff are sufficiently trained and experienced to fulfil their role			
n respect and uphold the confidentiality of the supervisory relationship			
n provide a suitable location and adequate time for supervision.			

Service Monitoring Forms **PROFESSIONAL DEVELOPMENT/ LIFELONG LEARNING**

Professional development/ lifelong learning standard statement 2 **Supervision sessions should be recorded detailing the content of discussion and any agreed action.**			
Do you/ does your service:	**Yes**	**No**	**Comment and action required**
n accurately and objectively record all supervision sessions			
n ensure that the record is agreed as a true account by participating individuals			
n keep supervision records for a minimum of 12 months			
n ensure supervision records are available for use at an annual appraisal			
n ensure that the previous 12 months of supervision records and any agreed contract are available if formal or informal disciplinary action or grievance action is taken.			

Professional development/ lifelong learning standard statement 3
Occupational therapy staff should participate in an annual appraisal cycle.

Do you/ does your service:	**Yes**	**No**	**Comment and action required**
n provide a suitable location and adequate time for the appraisal			
n prepare adequately for the appraisal meeting, using any documentation provided, and reflecting upon performance, achievement of role and responsibilities			
n review, clarify and confirm the roles and responsibilities expected of the staff member, in light of the organisational structure and objectives			
n appraise the staff member fairly and objectively against past or current objectives, roles and responsibilities			
n agree future objectives for the staff member, including key targets, action to be taken and timescale, considering the requirements of the individual, the post and the objectives of the organisation			
n agree and document the development and learning needs of the staff member			
n document accurately and objectively the content and outcomes of the appraisal, using any local or organisational documentation provided.			

Professional development / lifelong learning standard statement 3 (continued) **Occupational therapy staff should participate in an annual appraisal cycle.**			
Do you/ does your service:	**Yes**	**No**	**Comment and action required**
n ensure the record is agreed as a true account by participating individuals			
n ensure the appraiser is sufficiently trained and experienced to fulfil their role			
n review the appraisal outcome on a regular basis and follow up any agreed actions			
n provide a procedure for either party to follow should they be dissatisfied with the appraisal outcome.			

Professional development/ lifelong learning standard statement 4
Occupational therapy staff should achieve and continuously maintain high standards of competence in terms of knowledge, skills and behaviour.

Do you/ does your service:	Yes	No	Comment and action required
n receive a minimum of one half day each month for continuing development, scholarship and/ or research			
n provide continuing development opportunities to support workers who contribute to occupational therapy services			
n support the training and development of colleagues from other professions, services and agencies			
n participate in informal and formal learning opportunities			
n have access to time, funding and developmental opportunities that enhance the contribution of occupational therapy to the employing organisation			
n apply your learning to benefit service users and their carers			
n ensure learning opportunities are socially and culturally inclusive and appropriate			
n participate in inter-professional learning to develop team skills through better knowledge and understanding of team member roles			
n document professional development activities to provide evidence of continuous learning.			

PRACTICE PLACEMENTS

Members of the profession have a responsibility to provide practice placement opportunities for occupational therapy students, to ensure a future workforce and to promote a learning culture within the workplace.

The following standards are a précis/ shortened version of the Fieldwork Education section of the College of Occupational Therapists Standards for Education:
Pre-registration Education Standards. (College of Occupational Therapists 2003b)

Practice placements standard statement 1
There should be a practice placement agreement between the Higher Education Institution (HEI) and the occupational therapy service, with appropriate policies and procedures, and sufficient facilities and resources to support practice education.

Occupational therapists/ occupational therapy services are required to:
- maintain a reciprocal relationship with the HEI which acknowledges the costs, benefits and resource requirements of providing practice education
- ensure that practice education contributes to the learning culture of their service, supporting lifelong learning, continued competence and a work-life balance
- develop a placement resource file including the operational policies and procedures that assure the quality of practice education, for example, health and safety, support available to both student and practice placement educator etc
- ensure mechanisms are in place to support students with diverse needs, to ensure compliance with the special education needs, disability and equal opportunities legislation
- provide students with preparatory information before the placement starts and a comprehensive induction programme at the beginning of the placement, orientating the student and providing practical information and advice
- ensure access to a range of resources, facilities and staff to support independent learning
- ensure the student and the educator have clear support mechanisms within the placement and from the HEI.

Practice placements standard statement 2
The practice education provided within the service should contribute to the overall aims of the education programme, by helping students become fit to practise, and fit to receive their award.

In partnership with the HEI, occupational therapists/ occupational therapy services are required to:
- ensure that the practice curriculum reflects the international and national reference standards and benchmarks
- base the practice curriculum upon a sound educational philosophy that is compatible with the values of occupational therapy
- be involved in the development of the pre-registration curriculum
- ensure that the curriculum is updated regularly to reflect contemporary practice, professional priorities for service development, research findings and policy initiatives.

Practice placements standard statement 3
There should be sufficient, properly prepared and supported practice placement educators to facilitate the achievement of students' learning outcomes, while maintaining service delivery.

Occupational therapists/ occupational therapy services are required to:
- acknowledge the responsibilities placed on practice placement educators and their need to balance pre-registration education with caseload management
- ensure that practice placement educators have sufficient time and availability to provide regular supervision and assessment (a minimum of one hour formal supervision per week)
- ensure that there are appropriate arrangements to guarantee service user safety and continuity of learning when the practice placement educator is absent
- ensure that practice placement educators are aware of their duty of care to students and service users
- recognise only people with sufficient experience and expertise as practice placement educators
- support practice placement educators with relevant professional development activities.

Practice placements standard statement 4
A range of methods designed to promote students' personal and professional development and help them achieve learning outcomes, should be employed during each placement.

Occupational therapists/ occupational therapy services are required to:
- ensure that each student has an individual learning agreement that reflects their learning needs, the module outcomes and the experience available
- ensure that the learning, teaching and supervisory strategies, promote continuing professional development towards entry-level competence and are outlined in the placement resource file
- use a range of learning methods and opportunities, including inter-professional learning, to enable the placement outcomes to be achieved
- design all learning, teaching and supervisory methods so as to: assess and manage risk, ensure the safety, consent and confidentiality of clients and their carers, and demonstrate respect for others
- use a planned approach to the amount, type and frequency of supervision, employing a model that recognises individual learning styles
- facilitate the integration of theory with practice throughout the placement by formal and informal supervision demonstrated in the student's portfolio and the practice placement report
- identify the requirements for professional conduct and the opportunities for developing professional identity in the practice placement file
- enable the student to set time aside each week for independent study.

Practice placements standard statement 5
There should be rigorous, robust and effective assessments of safety, competence and professionalism during practice education.

Occupational therapists/ occupational therapy services are required to:

- ensure that the assessment design and procedures assess fitness for award, practice and purpose
- employ assessments which measure whether learning outcomes are met and which facilitate personal and professional development
- ensure that practice placement educators are aware of assessment principles, to assure valid, reliable and fair judgements.
- ensure that key stakeholders have confidence in the integrity of placement assessments
- ensure that the assessment criteria for each placement and in the individual learning agreement specify the outcomes that need to be achieved if the award's levels of competence and conduct are to be met
- ensure practice placement educators are aware of the additional support systems available to them when supervising exceptional or failing students or those with special needs
- ensure that the assessment regulations comply with the professional and statutory body requirements.

Service Monitoring Forms

PRACTICE PLACEMENTS

Practice placements standard statement 1
There should be a practice placement agreement between the Higher Education Institution (HEI) and the occupational therapy service, with appropriate policies and procedures, and sufficient facilities and resources to support practice education.

Do you/ does your service:	Yes	No	Comment and action required
▪ maintain a reciprocal relationship with the HEI which acknowledges the costs, benefits and resource requirements of providing practice education			
▪ ensure that practice education contributes to the learning culture of their service, supporting lifelong learning, continued competence and a work-life balance			
▪ develop a placement resource file including the operational policies and procedures that assure the quality of practice education, for example, health and safety, support available to both student and practice placement educator etc			
▪ ensure mechanisms are in place to support students with diverse needs, to ensure compliance with the special education needs, disability and equal opportunities legislation			
▪ provide students with preparatory information before the placement starts and a comprehensive induction programme at the beginning of the placement, orientating the student and providing practical information and advice			
▪ ensure access to a range of resources, facilities and staff to support independent learning			
▪ ensure the student and the educator have clear support mechanisms within the placement and from the HEI.			

Practice placements standard statement 2 **The practice education provided within the service should contribute to the overall aims of the education programme, by helping students become fit to practise, and fit to receive their award.**			
In partnership with the HEI, do you/ does your service:	**Yes**	**No**	**Comment and action required**
▪ ensure that the practice curriculum reflects the international and national reference standards and benchmarks			
▪ base the practice curriculum upon a sound educational philosophy that is compatible with the values of occupational therapy			
▪ get involved in the development of the pre-registration curriculum			
▪ ensure that the curriculum is updated regularly to reflect contemporary practice, professional priorities for service development, research findings and policy initiatives.			

Service Monitoring Forms

PRACTICE PLACEMENTS

Practice placements standard statement 3
There should be sufficient, properly prepared and supported practice placement educators to facilitate the achievement of students' learning outcomes, while maintaining service delivery.

Do you/ does your service:	Yes	No	Comment and action required
▪ acknowledge the responsibilities placed on practice placement educators and their need to balance pre-registration education with caseload management			
▪ ensure that practice placement educators have sufficient time and availability to provide regular supervision and assessment (a minimum of one hour formal supervision per week)			
▪ ensure that there are appropriate arrangements to guarantee client safety and continuity of learning when the practice placement educator is absent			
▪ ensure that practice placement educators are aware of their duty of care to students and clients			
▪ recognise only people with sufficient experience and expertise as practice placement educators			
▪ support practice placement educators with relevant professional development activities.			

Practice placements standard statement 4
A range of methods designed to promote students' personal and professional development and help them achieve learning outcomes, should be employed during each placement.

Do you/ does your service:	Yes	No	Comment and action required
▪ ensure that each student has an individual learning agreement that reflects their learning needs, the module outcomes and the experience available			
▪ ensure that the learning, teaching and supervisory strategies, promote continuing professional development towards entry-level competence and are outlined in the placement resource file			
▪ use a range of learning methods and opportunities, including inter-professional learning, to enable the placement outcomes to be achieved			
▪ design all learning, teaching and supervisory methods so as to: assess and manage risk, ensure the safety, consent and confidentiality of clients and their carers, and demonstrate respect for others			
▪ use a planned approach to the amount, type and frequency of supervision, employing a model that recognises individual learning styles			
▪ facilitate the integration of theory with practice throughout the placement by formal and informal supervision demonstrated in the student's portfolio and the practice placement report			
▪ identify the requirements for professional conduct and the opportunities for developing professional identity in the practice placement file			
▪ enable the student to set time aside each week for independent study.			

Service Monitoring Forms

PRACTICE PLACEMENTS

Practice placements standard statement 5
There should be rigorous, robust and effective assessments of safety, competence and professionalism during practice education.

Do you/ does your service:	Yes	No	Comment and action required
▪ ensure that the assessment design and procedures assess fitness for award, practice and purpose			
▪ employ assessments which measure whether learning outcomes are met and which facilitate personal and professional development			
▪ ensure that practice placement educators are aware of assessment principles, to assure valid, reliable and fair judgements.			
▪ ensure that key stakeholders have confidence in the integrity of placement assessments			
▪ ensure that the assessment criteria for each placement and in the individual learning agreement specify the outcomes that need to be achieved if the award's levels of competence and conduct are to be met			
▪ ensure practice placement educators are aware of the additional support systems available to them when supervising exceptional or failing students or those with special needs			
▪ ensure that the assessment regulations comply with the professional and statutory body requirements.			

SAFE WORKING PRACTICE

Health and safety law puts a duty on employers to ensure the health, safety and welfare of their employees, so far as is reasonable. Employees have a duty to care for their own health and safety, and to care for the health and safety of those who may be affected by what they do. These duties, under the Health and Safety at Work etc Act 1974 and the Management of health and safety at work regulations (1999), also apply to lone workers.

Risk management is "having a strategy for managing potential risks and reducing the likelihood and effect of untoward incidents. This includes strategies that incorporate positive risk-taking aspects of therapy which occupational therapists frequently engage in so as to provide positive, realistic and meaningful interventions" (Clarke 2000, p529).

"Occupational therapists have both professional and legal responsibilities to ensure safe moving and handling practice" (Tipping 2002, p181). The Manual handling operations regulations (1992) specify that each employer shall, as far as is reasonably practicable, avoid the need for his employees to undertake any manual handling operations at work which involve a risk of their being injured. Where it is not practicable to avoid the need, they must make a suitable assessment of all manual handling operations, taking appropriate steps to reduce the risk of injury.

Identical duties are placed on self-employed workers in respect of their own safety.

Safe working practice standard statement 1
Occupational therapy staff should take responsibility for systematically assessing and managing the risks involved in providing a service.

Occupational therapists/ occupational therapy services are required to:

- have clear, up to date policies, programmes or systems in place aimed at identifying and managing real or potential risk
- enable positive risks to be taken safely by service users, in cases where such risks are a necessary part of intervention
- assess the likelihood of risk to the health and safety of anyone affected by their activities
- clearly document the outcome of any risk assessment
- develop and implement risk management strategies to eliminate, avoid or reduce the likelihood of unwanted risk
- participate in training to prevent and manage violence at work, including abuse and harassment, where assessment shows there to be a risk
- ensure contingency plans are in place for risks that cannot be eliminated
- clearly document any decisions based upon the risk assessment, especially where a risk is taken in assessment or intervention
- adhere to local risk management policies and incident reporting procedures including and in relation to infectious diseases
- change practice where reviews of incidents indicate this may be necessary
- establish documentation and incident reporting procedures where there are none locally
- fully co-operate with the investigation of incidents if they occur
- identify and be aware of procedures to be carried out should an incident occur.

Safe working practice standard statement 2

Occupational therapy staff who are lone workers or working alone away from their base, should take reasonable care of themselves and other people affected by their work and co-operate with their employers in meeting their legal obligations.

Occupational therapists/ occupational therapy services are required to:

- ensure that a risk assessment is made of lone working practice and that any risks or hazards are identified and documented
- be aware of and follow measures which avoid or control the risks/ hazards associated with lone working
- ensure that the lone worker can handle all equipment/ material used safely
- provide an appropriate level of supervision, based on the findings of the risk assessment
- provide a higher level of supervision for less experienced staff
- ensure that arrangements are in place for providing help when the risk assessment shows that it is not possible for the work to be done safely by a lone worker
- ensure that that there is a system for monitoring the safety and well being of the lone worker, or those working alone away from their base, such as regular telephone contact
- ensure that there is an emergency system in place should an incident occur.

Safe working practice standard statement 3

Occupational therapy staff should maintain an approach to lifting or moving people that abides by the law and should also facilitate the active rehabilitation of the people in their care, enabling them to exercise control and autonomy in their lives.

Occupational therapists/ occupational therapy services are required to:

- exercise sound professional judgement in arriving at handling regimes that are sensitive to the needs and wishes of service users and their family/ carers, and ensure that the welfare and autonomy of the person requiring lifting or moving is paramount
- acknowledge a service user's right of refusal and right of choice, placing emphasis on a working partnership that promotes dignity, privacy, safety and social inclusion
- avoid unnecessary manual handling operations which involve a risk of injury
- complete a formal risk assessment where an individual is assessed as having some dependency, to ensure that assistance is provided safely
- carry out and document appropriate actions and recommendations based upon the risk assessment
- take steps to ensure the risk of injury during those operations is as low as possible, and that others are not put at risk
- make full and proper use of any system for manual handling provided by the employer, knowing how to select and use equipment when appropriate
- inform the employer if hazardous handling activities are identified
- ensure that they are competent at handling people and up to date in techniques having attended local manual handling courses

- ensure that service staff who are untrained, unconfident or who have musculo-skeletal problems, do not perform tasks which will pose a risk to them
- ensure the service or team has an agreed protocol for manually handling patients.

Safe working practice standard statement 4

Occupational therapy services should use equipment appropriately and with regard to the safety of staff and those referred to the service.

Occupational therapists/ occupational therapy services are required to:

- select and use the most appropriate equipment for the task
- only use equipment for the purpose for which it was manufactured
- ensure the equipment is safe and hygienic for use
- provide adequate information and training to people and/ or their carers, to ensure safe use of loan equipment
- store all equipment safely and securely
- handle equipment with regard to manual handling operations
- transport equipment safely, being adequately restrained within a vehicle.

Safe working practice standard statement 1
Occupational therapy staff should take responsibility for systematically assessing and managing the risks involved in providing a service.

Do you/ does your service:	Yes	No	Comment and action required
n have clear, up to date policies, programmes or systems in place aimed at identifying and managing real or potential risk			
n enable positive risks to be taken safely by service users, in cases where such risks are a necessary part of intervention			
n assess the likelihood of risk to the health and safety of anyone affected by your activities			
n clearly document the outcome of any risk assessment			
n develop and implement risk management strategies to eliminate, avoid or reduce the likelihood of unwanted risk			
n participate in training to prevent and manage violence at work, including abuse and harassment, where assessment shows there to be a risk			
n ensure contingency plans are in place for risks that cannot be eliminated			
n clearly document any decisions based upon the risk assessment, especially where a risk is taken in assessment or intervention.			

Safe working practice standard statement 1 (continued) **Occupational therapy staff should take responsibility for systematically assessing and managing the risks involved in providing a service.**			
Do you/does your service:	**Yes**	**No**	**Comment and action required**
▪ adhere to local risk management policies and incident reporting procedures including and in relation to infectious diseases			
▪ change practice where reviews of incidents indicate this may be necessary			
▪ establish documentation and incident reporting procedures where there are none locally			
▪ fully co-operate with the investigation of incidents if they occur			
▪ identify and be aware of procedures to be carried out should an incident occur.			

Safe working practice standard statement 2
Occupational therapy staff who are lone workers should take reasonable care of themselves and other people affected by their work and co-operate with their employers in meeting their legal obligations.

Do you/ does your service:	Yes	No	Comment and action required
n ensure that a risk assessment is made of lone working practice and that any risks or hazards are identified and documented			
n make yourself aware of and follow measures which avoid or control the risks/ hazards associated with lone working			
n ensure that the lone worker can handle all equipment/ material used safely			
n provide an appropriate level of supervision, based on the findings of the risk assessment			
n provide a higher level of supervision for less experienced staff			
n ensure that arrangements are in place for providing help when the risk assessment shows that it is not possible for the work to be done safely by a lone worker			
n ensure that that there is a system for monitoring the safety and well being of the lone worker, or those working alone away from their base, such as regular telephone contact			
n ensure that there is an emergency system in place should an incident occur.			

Safe working practice standard statement 3
Occupational therapy staff should maintain an approach to lifting or moving people that abides by the law and should also facilitate the active rehabilitation of the people in their care, enabling them to exercise control and autonomy in their lives.

Do you/ does your service:	Yes	No	Comment and action required
n exercise sound professional judgement in arriving at handling regimes that are sensitive to the needs and wishes of service users and their family/ carers, and ensure that the welfare and autonomy of the person requiring lifting or moving is paramount			
n acknowledge a service user's right of refusal and right of choice, placing emphasis on a working partnership that promotes dignity, privacy, safety and social inclusion			
n avoid unnecessary manual handling operations which involve a risk of injury			
n complete a formal risk assessment where an individual is assessed as having some dependency, to ensure that assistance is provided safely			
n carry out and document appropriate actions and recommendations based upon the risk assessment			
n take steps to ensure the risk of injury during those operations is as low as possible, and that others are not put at risk.			

Safe working practice standard statement 3 (continued)
Occupational therapy staff should maintain an approach to lifting or moving people that abides by the law and should also facilitate the active rehabilitation of the people in their care, enabling them to exercise control and autonomy in their lives.

Do you/ does your service:	Yes	No	Comment and action required
n make full and proper use of any system for manual handling provided by the employer, knowing how to select and use equipment when appropriate			
n inform the employer if hazardous handling activities are identified			
n ensure that they are competent at handling people and up to date in techniques having attended local manual handling courses			
n ensure that service staff who are untrained, unconfident or who have musculo-skeletal problems, do not perform tasks which will pose a risk to them			
n ensure the service or team has an agreed protocol for manually handling patients.			

Service Monitoring Forms

SAFE WORKING PRACTICE

Safe working practice standard statement 4
Occupational therapy services should use equipment appropriately and with regard to the safety of staff and those referred to the service.

Do you/ does your service:	Yes	No	Comment and action required
n select and use the most appropriate equipment for the task			
n only use equipment for the purpose for which it was manufactured			
n ensure the equipment is safe and hygienic for use			
n provide adequate information and training to people and/ or their carers, to ensure safe use of loan equipment			
n store all equipment safely and securely			
n handle equipment with regard to manual handling operations			
n transport equipment safely, being adequately restrained within a vehicle.			

RESEARCH ETHICS

Research governance frameworks for health and social care have developed in the United Kingdom to ensure that research in these sectors is conducted to high scientific and ethical standards. The frameworks have been established with a concern to protect the rights, dignity, safety and well-being of research participants.

Occupational therapists undertaking research in health and social care settings must ensure that they comply with research governance requirements and the ethical review of research proposals.

Research ethics standard statement 1
Occupational therapy researchers should take steps to prevent or minimise harm to participants, researchers or others throughout the research.

Occupational therapy researchers are required to:
- judge whether a research method is likely to affect the well-being of participants, researchers or others
- identify and address any potential risks which might arise in the course of the research
- justify the research methods and processes used, demonstrating why alternative approaches involving less risk or intrusion cannot be used
- justify any intervention used in the course of the research
- place the welfare of participants above the needs of the research and the researchers
- ensure that appropriate support is available to both participants and researchers throughout the research and beyond
- obtain ethical approval from a recognised relevant body before beginning any research.

Research ethics standard statement 2
Occupational therapy researchers should take steps to maximise the potential benefits of research.

Occupational therapy researchers are required to:
- make explicit the intended value of the research for participants, researchers, the profession, the research community and/ or society
- identify and state clearly from the outset the potential benefits (or absence of them) of the research
- design and conduct research in a methodologically rigorous manner
- disseminate research findings in a format that would reach the proper audience.

Research ethics standard statement 3
Occupational therapy researchers should respect everyone involved in research as true partners.

Occupational therapy researchers are required to:
- respect cultural, religious, gender and other differences in a research population
- acknowledge the possibility of a power relationship between themselves and participants, and avoid exploiting that power

- identify and acknowledge any undue influences which might exist if the researchers have had a relationship of trust with the participants.

Research ethics standard statement 4
Occupational therapy researchers should create circumstances in which participants are able to act on their own, freely made decisions.

Occupational therapy researchers are required to:
- explain research procedures, including any potential benefits or harm, in a way that can be understood by each potential participant
- obtain written consent from all participants before engaging them in research
- give sufficient time for potential participants who are able to give consent to consider whether or not to participate
- ensure that potential participants who decline to participate suffer no detriment because of their decision
- allow potential participants to withdraw freely from the research at any time without giving a reason and suffer no detriment as a result
- withdraw and destroy a participant's data if he or she so requests, provided that the data can be identified
- refrain from using any coercion or inducement to persuade potential participants to participate in research
- identify and clearly state from the outset any potential risks involved in participation and discuss these with participants.

Research ethics standard statement 5
Occupational therapy researchers should act with integrity and honesty.

Occupational therapy researchers are required to:
- take steps to avoid deceiving or misleading, or withholding information from, participants and potential participants
- act with integrity and honesty in stating what they intend to do in their research and in conducting the research
- act with integrity and honesty in collecting, storing, analysing and interpreting data and in presenting their results
- take care not to raise expectations of improved service provision as a result of participation in research.

Research ethics standard statement 6
Occupational therapy researchers should act with impartiality and fairness.

Occupational therapy researchers are required to:
- have a valid reason for deciding to include or exclude any groups or individuals in the research
- attempt to validate the accuracy of information given by those advocating or interpreting for participants.

Research ethics standard statement 7
Occupational therapy researchers should establish and maintain the confidentiality and/ or anonymity of participants.

Occupational therapy researchers are required to:
- explain clearly, during the process of obtaining informed consent, any limits to confidentiality and anonymity
- obtain explicit consent from potential participants before accessing personal information about them
- design and put into place procedures to ensure the confidentiality and anonymity of participants
- store data securely and destroy them at the appropriate time.

Service Monitoring Forms

RESEARCH ETHICS

Research ethics standard statement 1
Occupational therapy researchers should take steps to prevent or minimise harm to participants, researchers or others throughout the research.

In research, do you/ does your service:	Yes	No	Comment and action required
▪ judge whether a research method is likely to affect the well-being of participants, researchers or others			
▪ identify and address any potential risks which might arise in the course of the research			
▪ justify the research methods and processes used, demonstrating why alternative approaches involving less risk or intrusion cannot be used			
▪ justify any intervention used in the course of the research			
▪ place the welfare of participants above the needs of the research and the researchers			
▪ ensure that appropriate support is available to both participants and researchers throughout the research and beyond			
▪ obtain ethical approval from a recognised relevant body before beginning any research.			

Research ethics standard statement 2 **Occupational therapy researchers should take steps to maximise the potential benefits of research.**			
In research, do you/ does your service:	**Yes**	**No**	**Comment and action required**
▪ make explicit the intended value of the research for participants, researchers, the profession, the research community and/ or society			
▪ identify and state clearly from the outset the potential benefits (or absence of them) of the research			
▪ design and conduct research in a methodologically rigorous manner			
▪ disseminate research findings in a format that would reach the proper audience.			

Research ethics standard statement 3 **Occupational therapy researchers should respect everyone involved in research as true partners.**			
In research, do you/ does your service:	**Yes**	**No**	**Comment and action required**
▪ respect cultural, religious, gender and other differences in a research population			
▪ acknowledge the possibility of a power relationship between themselves and participants, and avoid exploiting that power			
▪ identify and acknowledge any undue influences which might exist if the researchers have had a relationship of trust with the participants.			

Research ethics standard statement 4 **Occupational therapy researchers should create circumstances in which participants are able to act on their own, freely made decisions.**			
In research, do you/ does your service:	**Yes**	**No**	**Comment and action required**
▪ explain research procedures, including any potential benefits or harm, in a way that can be understood by each potential participant			
▪ obtain written consent from all participants before engaging them in research			
▪ give sufficient time for potential participants who are able to give consent to consider whether or not to participate			
▪ ensure that potential participants who decline to participate suffer no detriment because of their decision			
▪ allow potential participants to withdraw freely from the research at any time without giving a reason and suffer no detriment as a result			
▪ withdraw and destroy a participant's data if he or she so requests, provided that the data can be identified			
▪ refrain from using any coercion or inducement to persuade potential participants to participate in research			
▪ identify and clearly state from the outset any potential risks involved in participation and discuss these with participants.			

Research ethics standard statement 5 **Occupational therapy researchers should act with integrity and honesty.**			
In research, do you/ does your service:	**Yes**	**No**	**Comment and action required**
▪ take steps to avoid deceiving or misleading, or withholding information from, participants and potential participants			
▪ act with integrity and honesty in stating what they intend to do in their research and in conducting the research			
▪ act with integrity and honesty in collecting, storing, analysing and interpreting data and in presenting their results			
▪ take care not to raise expectations of improved service provision as a result of participation in research.			

Research ethics standard statement 6 **Occupational therapy researchers should act with impartiality and fairness.**			
In research, do you/ does your service:	**Yes**	**No**	**Comment and action required**
▪ have a valid reason for deciding to include or exclude any groups or individuals in the research			
▪ attempt to validate the accuracy of information given by those advocating or interpreting for participants.			

Service Monitoring Forms

RESEARCH ETHICS

Research ethics standard statement 7 **Occupational therapy researchers should establish and maintain the confidentiality and/ or anonymity of participants.**			
In research, do you/ does your service:	**Yes**	**No**	**Comment and action required**
▪ explain clearly, during the process of obtaining informed consent, any limits to confidentiality and anonymity			
▪ obtain explicit consent from potential participants before accessing personal information about them			
▪ design and put into place procedures to ensure the confidentiality and anonymity of participants			
▪ store data securely and destroy them at the appropriate time.			

GLOSSARY OF TERMS

The majority of the definitions in this glossary are taken from Creek (2003) *Occupational therapy defined as a complex intervention.* Most are distillations of various peoples' definitions and/ or general dictionaries. The original sources may be found in the above document.

Action plan (treatment plan): Specification of the approach to be used and the actions to be taken by the therapist and service user towards solving identified problems or reaching agreed goals.

Action planning (treatment planning): A collaborative endeavour between the therapist, the service user, the carer and the treatment team to devise a unique approach that meets the needs of the individual under a particular set of circumstances.

Activities of daily living: Basic activities required to maintain personal health and well-being.

Aim: A brief statement of the general purpose which treatment or intervention will be planned to achieve.

Appraisal (critical appraisal): A systematic way of considering the truthfulness of a piece of research, the results and how relevant and applicable they are, in order to make a decision about whether any flaws are important enough to raise doubts about the conclusions arising from the research

Approach: The methods by which theories are put into practice and treatment is administered.

Assessment: The process of collecting accurate and relevant information about a service user in order to set baselines and to monitor and measure the outcomes of therapy or intervention.
The art of gathering relevant information in order to define the problem to be tackled, or identify the goal to be attained, and to establish a baseline for treatment planning.

Audit: The systematic and critical analysis of the quality of clinical care including diagnostic and treatment procedures, associated use of resources, outcomes and quality of life for people seen by the service.

Autonomy: Personal freedom; freedom of the will; the capacity to make choices; the ability to govern one's own actions.

Choice: The power, right or faculty of deciding between possibilities; a scope or field of possibilities.

Clinical reasoning: The mental strategies and high level cognitive patterns and processes that underlie the process of naming, framing and solving problems and that enable the therapist to reach decisions about the best course of action. Clinical reasoning translates the knowledge, skills and values of the therapist into action and ensures that occupational therapists practise occupational therapy and not some other form of intervention.

Continuing professional development: Movement along the continuum of competence required by practitioners, educators, managers and researchers to provide services based upon evidence of effectiveness and best value. This can be achieved through informal and formal learning.

Enablement/ enabling: The process of helping the individual to achieve what is important to her/ him, to respond to her/ his circumstances, to assert her/ his individuality and establish her/ his goals.

Environment: The human and non-human surroundings of the individual, including objects, people, events, cultural influences, social norms and expectations. Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives.

Environmental adaptation: Changing the physical or social features of an environment in order to enhance performance, promote or restrict a behaviour or provide therapy.

Ethics: The formal, co-operative endeavour of a particular tradition, group or individual to define its values and moral principles.

Evaluation: The process of using clinical reasoning, problem analysis, self-appraisal and review to interpret the results of assessment in order to make judgements about the situation or needs of an individual, the success of occupational therapy or the therapist's own performance.

Evidence: Facts or testimony in support of a conclusion, statement or belief. Can include the findings from high quality, systematic research, clinical expertise, past experience, information gathered from assessment and the preferences of people seen by the service.

Evidence-based practice: The conscious, explicit and judicious use of current best available evidence in making decisions about the care of individual people. It is a way for staff to be more accountable in the interventions they provide.

Function: The ability to perform competently the roles and occupations required in the course of daily life; an action performed to fulfil an allocated task.

Functional assessment (functional analysis): Part of the assessment process that looks at the roles and occupations performed by the individual in her/ his daily life, including self-care, productivity and leisure, and at her/ his capabilities and problem areas. Functional assessment allows the occupational therapist to identify areas of difficulty, determine level of independence, make recommendations about care needs, find out what meaning the individual places on different aspects of life, identify areas needing further assessment and set the main goals of intervention.

Goal: A concise statement of a desired outcome or specific result to be attained at a particular stage in an intervention.

Governance:	The processes and systems in place to ensure that quality is provided, whilst making best use of resources.
Independence:	The position of not being dependent on authority; not relying on others for one's opinions or behaviours; being able to do things for oneself; having choice, control and participation in society.
Intervention:	Occupational therapy intervention (Intervention): Actions taken by the therapist, on behalf of the service user and in collaboration with the service user and/ or carer, to assist them to acquire, maintain or regain the adaptive skills required to support her/ his life roles and occupations.
Lone workers:	Those who work by themselves without close or direct supervision, including mobile professionals working away from their fixed bases.
Manual handling:	"Any transporting or supporting of a load (including the lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or bodily force". (Great Britain, Parliament 1992, Regulation 2)
Model for practice:	A simplified representation of the structure and content of a phenomenon or system that describes or explains certain data or relationships and integrates elements of theory and practice.
Occupation:	The highest level of complexity of human function, which provides longitudinal organisation of time and effort in a person's life. Occupation defines and organises a sphere of action over a period of time and is perceived by the individual as part of her/ his personal and social identity.
Occupational therapy researcher:	Any occupational therapy personnel involved in any part of the research process, other than as participants.
Outcome measurement:	Evaluation of the nature and degree of change brought about by intervention, or the extent to which a goal has been reached or an outcome has been achieved.
Outcome:	An agreed, clearly defined, expected or desired result of intervention (predetermined outcome); the result of therapeutic processes, which may be different from the initial objectives of therapy (actual results of therapy).
Person-centred practice:	A partnership between the therapist and service user in which the service user's occupational goals are given priority during assessment and treatment. The therapist listens to and respects the service user's standards and adapts the intervention to meet their needs. The service user actively participates in negotiating goals for intervention and making decisions.
Policy/ local policy:	A principle or guideline that governs an activity and that employees or members of an institution or organisation are expected to follow.

Problem solving:	A set of cognitive strategies used to resolve difficulties; the analytical process whereby a course of action is decided upon, or one or more solutions to a problem are found and tried out until one is found to be effective.
Professional competence:	The combination of knowledge, skills and behaviour required to perform the role of an occupational therapist.
Professional experience:	The aptitudes, skills, knowledge and judgement acquired from having been occupied for a period of time in any branch or branches of occupational therapy practice.
Professional responsibility:	Being accountable for carrying out the duties required of an occupational therapist and for one's actions.
Professional role:	The responsibilities and functions expected of someone in a particular job or position.
Record keeping:	Systems for collecting, collating and storing information about people.
Records:	Detailed accounts, kept by professionals, of people from the time they enter the care of a health or social care facility until the intervention ends or they are discharged. Records include the actions of the professional.
Referral:	The process by which an occupational therapist comes into contact with a person with occupational therapy needs or puts the person in contact with another, appropriately qualified professional or with another agency.
Reflection:	Self-monitoring of thoughts and feelings, and self-regulation of actions, leading to more effective practice, increased insight, new knowledge and improved skills. Reflection in action involves thinking about oneself during the therapy process and acting on feedback. Reflection after the event involves returning to, recalling and re-evaluating the experience.
Rehabilitation:	The process through which a service user is helped to adjust to the limitations of her/ his disability by developing residual capacities and regaining maximum competence commensurate with individual limitations.
Research:	A search or investigation undertaken to discover facts and reach new conclusions by the critical study of a subject or by a course of scientific enquiry.
Resources:	Includes equipment (such as standardised assessments) IT equipment, office space, staffing etc.
Risk assessment:	The systematic evaluation of local risk factors, carried out to determine the degree to which risk is present and to develop a risk management strategy.
Risk management:	Weighing up the potential benefits and risks of an activity in order to allow positive risk taking to take place; having a strategy for dealing with potential risks in order to reduce the likelihood and effect of harm.

Risk:	Exposure to the possibility of loss, injury or other adverse circumstance.
Skill:	A specific ability or integrated set of abilities (e.g. motor, sensory, cognitive or perceptual) which evolve with practice. Skills have to be learnt or practised to a standard that will enable the effective performance of a task or subsection of a task.
Supervision:	A relationship in which one person oversees and/ or directs the work of, and shares knowledge and skills with, a less experienced or less skilled person, as in the fieldwork educator/ student relationship.
Task:	A self-contained stage in an activity; a definable piece of performance with a completed purpose or product; a constituent part of an activity.
Treatment plan/ treatment planning:	See Action plan/ action planning

REFERENCES

Audit Commission (2001) *Hidden talents: education, training and development for healthcare staff in NHS trusts.* Yorkshire: Audit Commission.

Clarke C (2000) Risk management: an information guide for occupational therapists. *British Journal of Occupational Therapy, 63(11),* 529-31.

College of Occupational Therapists (1995) *Violence at work. (Information Guide).* London: COT.

College of Occupational Therapists (1998) *Curriculum framework document for occupational therapy education leading to eligibility for state registration.* London: COT.

College of Occupational Therapists (2000b) *Production of college documents: position statements, standards for practice and clinical guidelines. (Information Guide).* London: COT.

College of Occupational Therapists (2000c) *Occupational therapy record keeping*. (*Standards for Practice*). London: COT.

College of Occupational Therapists (2002) *The implementation of manual handling operations (MHO) regulations: witness statement from College of Occupational Therapists for the Disability Rights Commission.* London: COT.

College of Occupational Therapists (2003a) *Consent.* (*Standards for Practice*). London: COT.

College of Occupational Therapists (2004 Revised) *Pre-registration education standards*. *(Standards for Education).* London: COT.

College of Occupational Therapists (2004) *Strategic vision and action plan for lifelong learning.* London: COT.

College of Occupational Therapists (2005) *College of Occupational Therapists code of ethics and professional conduct.* London: COT.

College of Occupational Therapists (2006*) Manual Handling. College of Occupational Therapists Guidance 3*. London: COT.

College of Occupational Therapists (2006) *Record Keeping. College of Occupational Therapists Guidance 2*. London: COT.

College of Occupational Therapists (2006*) Risk Management. College of Occupational Therapists Guidance 1*. London: COT.

Confidentiality and Security Advisory Group for Scotland (2002) *Protecting patient confidentiality: final report.* Available at: Scottish Health on the web. http://www.show.scot.nhs.uk/ Accessed on 1st May 2003.

Council of Europe Steering Committee on Bioethics (2001) *Draft additional protocol to the Convention on Human Rights and Biomedicine, on biomedical research. [Consultation text]*. London: Department of Health.

Creek J (2003) *Occupational therapy defined as a complex intervention.* London: College of Occupational Therapists.

Department of Health (1997b) *The new NHS: modern dependable.* (Command Paper 3807). London: Stationery Office.

Department of Health (1999c) *For the record: managing records in NHS trusts and health authorities. Appendix B: For the record - NHS retention and disposal schedule.* (HSC 1999/053). London: DH.

Department of Health (2000a*) Data Protection Act 1998: guidance to social services.* London: DH.

Department of Health (2000b) *Data Protection Act 1998: protection and use of patient information.* London: DH.

Department of Health (2001a) *The essence of care: patient-focused benchmarking for health care practitioners*. London: DH.

Department of Health (2001b) *Good practice in consent implementation guide: consent for examination or treatment.* London: DH.

Department of Health (2001c) *National service framework for older people.* London: DH.

Department of Health (2001d) *Reference guide to consent for examination or treatment.* London: DH.

Department of Health (2001e) *Research governance framework for health and social care.* London: DH.

Department of Health (2002a) *Independent health care national minimum standards regulations*. London: Stationery Office.

Department of Health (2002b) *Seeking consent: working with people in prison*. London: DH.

Department of Health, Home Office (2000) *Reforming the Mental Health Act.* London: Stationery Office.

Department of Health Social Services and Public Safety (2002) *Research governance framework for health and social care.* Belfast: DHSSPS.

Gillick v West Norfolk and Wisbech AHA (1986) AC 112.

Great Britain, Parliament (1960) *The Professions Supplementary to Medicine Act 1960*. London: HMSO.

Great Britain, Parliament (1974) *Health and Safety at Work Act 1974.* London: HMSO.

Great Britain, Parliament (1983) *Mental Health Act 1983: chapter 20*. London: HMSO.

Great Britain, Parliament (1984) *Mental Health (Scotland) Act 1984: chapter 36*. London: HMSO.

Great Britain, Parliament (1989) *Children Act 1989: chapter 41*. London: HMSO.

Great Britain, Parliament (1992) *The manual handling operations regulations 1992.* (SI 1992/2793). London: HMSO.

Great Britain, Parliament (1998a) *Data Protection Act 1998: chapter 29*. London: Stationery Office.

Great Britain, Parliament (1998b) *Human Rights Act 1998: chapter 42*. London: Stationery Office.

Great Britain, Parliament (1999) *Management of health and safety at work regulations 1999.* (SI 1999/3242). London: Stationery Office.

Great Britain, Parliament (2001) *The Special Educational Needs and Disability Act 2001*. London: Stationery Office.

Hagedorn R (1995) *Occupational therapy: perspectives and processes*. Edinburgh: Churchill Livingstone.

Health Professions Council (2003a) *Standards of proficiency – occupational therapists.* London: HPC.

Health Professions Council (2003b) *Standards of conduct, performance and ethics. Your duties as a registrant: 2003.* London: HPC.

Heinemann Educational Books (1979) *Heinemann English dictionary*. London: HEB.

Hocking C, Ness NE (2002) *Revised minimum standards for the education of occupational therapists.* Perth, Au: WFOT.

Howard RS, Lancée J (2000) *Occupational therapy education in Europe: curriculum guidelines*. Amsterdam: European Network of Occupational Therapy in Higher Education.

Ilott I, White E (2001) College of Occupational Therapists research and development strategic vision and action plan. *British Journal of Occupational Therapy, 64(6),* 270-77.

Ilott I, White E (2002) College of Occupational Therapists: Position statement on lifelong learning. *British Journal of Occupational Therapy, 65(5),* 198-200.

Information Commissioner (1998) *Legal guidance on the Data Protection Act 1998*. Wilmslow: IC.

Jacobs K, Jacobs L eds (2001) *Quick reference dictionary for occupational therapy.* 3rd ed. Thorofare NJ: Slack.

Laver Fawcett A (2002) Assessment. In: Turner A, Foster M, Johnson SE *Occupational therapy and physical dysfunction: principles, skills and practice. 5th ed.* Edinburgh: Churchill Livingstone. 107-144.

Quality Assurance Agency for Higher Education (2000) *Benchmarking academic standards.* Gloucester: QAA.

Quality Assurance Agency for Higher Education (2001a) *Code of practice for the assurance of academic quality and standards in higher education: students with disabilities.* Gloucester: QAA.

Quality Assurance Agency for Higher Education (2001b) *Code of practice for the assurance of academic quality and standards in higher education: placement learning.* Gloucester: QAA.

Quality Assurance Agency for Higher Education (2001c) *Subject benchmark statements: health care programmes, occupational therapy.* Gloucester: QAA.

Quality Assurance Agency for Higher Education (2001d) *The framework for higher education qualifications in England, Wales and Northern Ireland.* Gloucester: QAA.

Sealey C (1999) Clinical governance: an information guide for occupational therapists. *British Journal of Occupational Therapy, 62(6),* 263-68.

Scottish Executive, Health Department (2001) *Research governance framework for health and community care.* Edinburgh: Scottish Executive.

Scottish Intercollegiate Guidelines Network (2002) *Continuing professional development: a manual for SIGN guideline developers.* Edinburgh: SIGN.

Tipping E (2002) Tools for living. In: Turner A, Foster M, Johnson SE *Occupational therapy and physical dysfunction: principles, skills and practice.* 5th ed. Edinburgh: Churchill Livingstone. 165-209.

BIBLIOGRAPHY

Bond Solon Training (2003) *The occupational therapist and the court.* London: COT.

Clarke C, Sealey-Lapeš C, Kotsch L (2001) *Outcome measures: information pack for occupational therapy.* London: College of Occupational Therapists.

College of Occupational Therapists (2003) *Providing a safe service to people with infectious diseases.* London: COT.

Department of Health (1994) *Patient's charter.* 2nd ed. London: DH.

Department of Health (1997) *The Caldicott Committee report on the review of patient-identifiable information.* London: DH.

Department of Health (1998) *A first class service: quality in the new NHS*. London: DH.

Department of Health (1999) *Doubly disabled: equality for disabled people in the new NHS*. (HSC1999/093). London: DH.

Department of Health (1999) *Implementing section 21 of the Disability Discrimination Act 1995 across the NHS*. (HSC1999/156). London: DH.

Department of Health (1999) *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children.* London: Stationery Office.

Department of Health, Welsh Office (1999) *Code of practice: Mental Health Act*. London: Stationery Office.

Great Britain, Parliament (1969) Family Law Reform Act 1969. London: HMSO.

Great Britain, Parliament (1975) *The Sex Discrimination Act 1975.* London: HMSO.

Great Britain, Parliament (1976) *The Race Relations Act 1976.* London: HMSO.

Great Britain, Parliament (1995) *Children (Scotland) Act 1995: chapter 36.* London: HMSO.

Great Britain, Parliament (1995) *Disability Discrimination Act 1995: chapter 50.* London: HMSO.

Great Britain, Parliament (2000) *Adults with Incapacity (Scotland) Act 2000.* London: Stationery Office.

Great Britain, Parliament (2000) *Data Protection (Subject Access Modification) (Health) Order 2000*. (SI 2000/413). London: Stationery Office.

Great Britain, Parliament (2001) *Learning from Bristol: The Department of Health's response to the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995.* London: Stationery Office.

Great Britain, Parliament, House of Commons (2001) *The Royal Liverpool children's inquiry: report*. London: Stationery Office.

NHS Executive (1999) *The NHS performance assessment framework.* London: Department of Health.

Re F (*mental health patient: sterilisation*) [1990] 2 AC 1, sub nom F v West Berkshire Health Authority [1989] 2 All ER 545, HL.

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Preface

i. The *Code of ethics and professional conduct* (hereafter referred to as 'the Code') is produced by the College of Occupational Therapists, for and on behalf of the British Association of Occupational Therapists (BAOT), the national professional body and trade union for occupational therapists throughout the United Kingdom (UK). The College of Occupational Therapists (COT) is the subsidiary organisation, with delegated responsibility for the promotion of good practice.

ii. The College of Occupational Therapists is committed to client-centred practice and the involvement of the service user as a partner in all stages of the therapeutic process.

iii. The completion, revision and updating of the Code are the delegated responsibility of the Professional Practice Board of the College of Occupational Therapists. It is revised every five years.

iv. Under the *Health Act 1999* (Great Britain. Parliament) the title 'occupational therapist' is protected by law and can only be used by persons who are registered with the Health Professions Council (HPC). This means that they will have successfully completed an approved course leading to a diploma or degree in occupational therapy and must be meeting the

current HPC standards for continued registration. All occupational therapists practising in the UK must be registered with the HPC.

v. Membership of the British Association of Occupational Therapists is voluntary. It is not a requirement for practice, but provides benefits to support practice. Members of BAOT sign up to abide by this Code, but its content should be relevant and useful to all occupational therapy personnel across the United Kingdom, whether they be members of BAOT or not. It is a public document, so also available to service users and their carers, other professions and employing organisations.

vi. The term 'occupational therapy personnel' includes occupational therapists, occupational therapists working in generic roles, occupational therapy students and support workers. It is also pertinent to occupational therapists who are managers, educators and researchers. At times this document uses the term 'practitioner'. This refers to anyone from the above groups who is working within an occupational therapy context.

vii. Where occupational therapy personnel are working in an integrated setting, or in less clearly defined occupational therapy roles, this Code will still apply in principle and should be used to ensure good and ethical practice.

viii. This Code should be used in conjunction with the current versions of the Health Professions Council's *Standards of conduct, performance and ethics; Guidance on conduct and ethics for students;* and *Standards of proficiency – occupational therapists,* along with the College of Occupational Therapists' current *Professional*

standards for occupational therapy practice. The appendices to this document must be read in conjunction with local policy.

ix. Occupational therapy personnel must respect the rights of all people under the *Human Rights Act 1998* (Great Britain. Parliament 1998b). They must also comply with any current UK and devolved legislation and policies, best practice standards, and employers' policies and procedures that are relevant to their area of practice.

This version of the Code supersedes all previous editions.

September 2010

Key terms

Assessment	*A process of collecting and interpreting information about people's functions and environments, using observation, testing and measurement, in order to inform decision-making and to monitor change.* (Consensus definition from European Network of Occupational Therapy in Higher Education (ENOTHE) 2004)
Autonomy	*The freedom to make choices based on consideration of internal and external circumstances and to act on those choices.* (Consensus definition from ENOTHE 2004)
Capacity	For the purpose of the *Mental Capacity Act 2005*: *a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.*

	It does not matter whether the impairment or disturbance is permanent or temporary. (Great Britain. Parliament 2005, part 1, section 2)
Carer	Someone who provides (or intends to provide), paid or unpaid, a substantial amount of care on a regular basis for someone of any age who is unwell, or who, for whatever reason, cannot care for themselves independently. (Adapted from Great Britain. Parliament 1995)
Competency	*Competence is the acquisition of knowledge, skills and abilities at a level of expertise sufficient to be able to perform in an appropriate work setting.* (*www.qualityresearchinternational.com/glossary/competence.htm* Accessed on 25.01.10.)
Continuing professional development (CPD)	*A range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice.* (Health Professions Council 2009c, p1)

Key terms

Cost effectiveness	The extent to which an intervention can be regarded as providing value for money. (Adapted from Phillips and Thompson 2009)
Delegate	To give an assignment to another person, or to assign a task to another person to carry out on one's behalf, whilst maintaining control and responsibility.
Duty of care	A responsibility to act in a way which ensures that injury, loss or damage will not be carelessly or intentionally inflicted upon the individual or body to whom/which the duty is owed, as a result of the performance of those actions. A duty of care arises: ■ when there is a sufficiently close relationship between two parties, (e.g. two individuals, or an individual and an organisation). Such a relationship exists between a service user and the member of occupational therapy personnel to whom he or she has been referred, whilst the episode of care is ongoing; ■ where it is foreseeable that the actions of one party may cause harm to the other; and/or ■ where it is fair, just and reasonable in all the

	circumstances to impose such a duty. (See Caparo Industries Plc v Dickman 1990)
Ethics	A code of behaviour for personal or professional practice.
Governance	[The systems by] *which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.* (*www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/index.htm* Accessed on 25.01.10.)
Handover	To give away or entrust the total care and responsibility for an individual to another. The handover action is complete when the receiving person acknowledges and accepts control and responsibility. This is not to be confused with the role of occupational therapy personnel in a ward handover, where he or she may report information to ward staff, but still retains responsibility for the occupational therapy provided to the service user.
Informed consent	Informed consent is an ongoing agreement by a person to receive treatment, undergo procedures or participate in research, after risks, benefits and alternatives have been

	adequately explained to them. Informed consent is a continuing requirement. Therefore occupational therapy personnel must ensure that service users continue to understand the information that they have been provided with, and any changes to that information, thereby continuing to consent to the intervention or research in which they are participating. In order for informed consent to be considered valid, the service user must have the capacity* to give consent and the consent must be given voluntarily and be free from undue influence. * see Appendix 1 for further information on capacity.
Must	Where there is an overriding principle or duty.
Occupation	*A group of activities that has personal and sociocultural meaning, is named within a culture and supports participation in society. Occupations can be categorised as self-care, productivity and/or leisure.* (Consensus definition from ENOTHE 2004)

Occupational alienation	*A sense that one's occupations are meaningless and unfulfilling, typically associated with feelings of powerlessness to alter the situation.* (Hagedorn 2001, cited in ENOTHE 2004)
Occupational deprivation	*A state of prolonged preclusion from engagement in occupations of necessity or meaning due to factors outside the control of an individual, such as through geographic isolation, incarceration or disability.* (Christiansen and Townsend 2004, cited in ENOTHE 2004)
Occupational science	*Academic discipline of the social sciences aimed at producing a body of knowledge on occupation through theory generation, and systematic, disciplined methods of inquiry.* (Crepeau, Cohn and Schell 2003, cited in ENOTHE 2004)
Occupational therapy personnel	For the purpose of this document, this term includes occupational therapists, occupational therapists working in generic roles, occupational therapy students and support workers working with or for occupational therapists. It is also pertinent to occupational therapists who are managers, educators and researchers.

Practice placement educator	*This is the person who is qualified to supervise students while they are on a practice placement. The professional practice educator normally will have undergone a practice educators' course (preferably the COT APPLE scheme or its equivalent) and will be familiar with the assessment regulations and processes in operation at the student's university.* (COT 2009e)
Reasonable	An objective standard. Something (e.g. an act or decision) is reasonable if the act or decision is one that a well-informed observer would also do or make.
Service user	In this Code the term 'service user' refers to any individual in direct receipt of any services/interventions provided by a member of occupational therapy personnel.
Should	Where the principle or duty may not apply in all circumstances, by contrast with a 'must' obligation.
Sustainable	*Sustainable health care combines three key factors: quality patient care, fiscally responsible budgeting and minimizing environmental impact.* (Jameton and McGuire 2002)

Section One: Introduction

The purpose of the Code

1.1 To be deemed as 'competent' you need a combination of knowledge, skills, and behaviours. You may learn knowledge and skills through professional training and/or experience and continuing professional development, but these elements alone are not necessarily what make you a good or safe practitioner. You must also demonstrate behaviours that promote and protect the wellbeing of service users and their carers, the wider public, and the reputation of employers and the profession. This *Code of ethics and professional conduct* describes a set of professional behaviours and values that the British Association of Occupational Therapists expects its members to abide by, and believe all occupational therapy personnel should follow.

1.1.1 The Health Professions Council (HPC) has overall responsibility for ensuring that all relevant health professionals meet certain given standards in order to be registered to practise in the United Kingdom. Their current *Standards of conduct, performance and ethics* and current *Standards of proficiency – occupational therapists* explain these requirements. If a formal complaint is made about an occupational therapist, the Health Professions Council will take account of whether their own standards have been met,

and will also take account of any guidance or codes of practice produced by professional membership bodies (HPC 2008, p15).

1.1.2 You have a responsibility to act in a professional and ethical manner at all times. The Code provides a set of behaviours and values that are relevant to you, irrespective of where you work or your level of experience. The Code, along with the College of Occupational Therapists' current professional standards and the HPC's current standards, provides you with a framework for promoting and maintaining good and safe professional behaviour and practice in occupational therapy.

1.1.3 You should be familiar with the content of the Code and should apply it in your workplace. As a practical document, it should be the first point of reference for you if you have a dilemma related to professional or ethical conduct.

1.1.4 Higher Education Institutions will use the Code early in students' education, to inform them of the required standards of ethics and conduct that occupational therapy personnel are expected to uphold during their academic and professional lives, emphasising its application from point of entry to the programme to the end of their professional career.

1.1.5 The Code may also be used by others outside the profession to determine the measure of ethical and professional conduct expected of you. The College encourages recognition of

the Code by other individuals, organisations and institutions who are involved with the profession, including employers and commissioners.

1.1.6 The Code is a broad document and cannot provide detailed answers to all the specific professional or ethical dilemmas that you might face in your work. If there is uncertainty or dispute as to the interpretation or application of the Code, enquiries shall be referred in the first instance to the Head of Professional Practice at the College of Occupational Therapists, who may then pass it on to the College's Professional Practice Board.

Defining occupational therapy, its values and beliefs

1.2 Occupational therapy has a unique approach to service users. Its beliefs and values have been drawn together and incorporated into the *College of Occupational Therapists' curriculum guidance for pre-registration education* (COT 2009d):

> *Occupational therapists view people as occupational beings. People are intrinsically active and creative, needing to engage in a balanced range of activities in their daily lives in order to maintain health and wellbeing. People shape, and are shaped by, their experiences and interactions with their environments. They create identity and meaning through what they do and have the capacity to transform themselves through premeditated and autonomous action.*

> *The purpose of occupational therapy is to enable people to fulfil, or to work towards fulfilling, their potential as occupational beings. Occupational therapists promote function, quality of life and the realisation of potential in people who are experiencing occupational deprivation, imbalance or alienation. They believe that activity can be an effective medium for remediating dysfunction, facilitating adaptation and recreating identity.*
>
> (COT 2009d, p1)

A shorter definition for occupational therapy was adopted by the College of Occupational Therapists' Council in January 2004. Listed as the current BAOT/UK definition on the World Federation of Occupational Therapists website, it reads:

> *Occupational therapy enables people to achieve health, well being and life satisfaction through participation in occupation.*
>
> (COT 2004)

Further descriptions of occupational therapy and its values and beliefs are available from the COT/BAOT Briefing *Definitions and core skills for occupational therapy* (COT 2009b), *Occupational therapy defined as a complex intervention* (Creek 2003), *The value of occupational therapy and its contribution to adult social service users and their carers* (COT et al 2008) and *From interface to integration: a strategy for modernising occupational therapy services in local health and social care communities. A consultation.* (COT 2002).

Section Two: Service user welfare and autonomy

Duty of care

2.1 A duty of care arises where there is a sufficiently close relationship between two parties, as with a member of occupational therapy personnel and a service user, and where it is reasonably foreseeable that the actions of one party could, if carelessly performed, cause harm or loss to the other party. Discharging the duty of care requires you to perform your occupational duties to the standard of a reasonably skilled and careful practitioner.

2.1.1 Discharging the duty of care

In practice a duty of care arises when a referral has been received by an occupational therapy service or practitioner. The duty of care would require you to assess the suitability of the potential service user for occupational therapy with reasonable care and skill, following usual and approved occupational therapy practice.

If, as a result of the initial assessment, the individual is not suitable for the receipt of occupational therapy services, then no further duty of care arises other than to inform the referrer of the decision that has been made.

2.1.2 You are required to ensure that all reasonable steps are taken to ensure the health, safety and welfare of any person involved in any activity for which you are responsible. This might be a service user, a carer, another member of staff or a member of the public (Great Britain. Parliament 1974).

2.1.3 Breach of duty of care

You may be in breach of your duties to take care if it can be shown that you have failed to perform your professional duties to the standard expected of a reasonably skilled occupational therapy practitioner.

2.1.4 Defences

If it is asserted that you have, in the performance of your duties, breached your duty of care to a service user, it is a good defence to show that a responsible body of like practitioners would have acted in the same way: the 'Bolam Principle'. The Bolam Principle will only be a good defence however if it can be shown that the body of opinion relied on has a logical basis and is respectable, responsible and reasonable in its own right: the 'Bolitho Principle'.

Welfare

2.2 You must always recognise the human rights of service users and act in their best interests.

2.2.1 You should enable individuals to preserve their individuality, self-respect, dignity, privacy, autonomy and integrity.

2.2.2 You must not engage in, or support, any behaviour that causes any unnecessary mental or physical distress. Such behaviour includes neglect and indifference to pain.

2.2.3 You must protect and safeguard the interests of vulnerable people in your care or with whom you have contact in the course of your professional duties. Your duty of care extends to raising concerns, with your manager or an appropriate alternative person, about any service user or carer who may be at risk in any way. Local policy should be followed.

2.2.4 You must always provide adequate information to a service user in order for them to provide informed consent. This is particularly important where any intervention may cause pain or distress. Every effort should be made to ensure that the service user understands the nature, purpose and likely effect of the intervention before it is undertaken (see section 2.3 on mental capacity and informed consent, and also Appendix 2 on informed consent).

2.2.5 You must make every effort not to leave a service user in pain or distress following intervention. Professional judgement and experience should be used to assess the level of pain, distress or risk and appropriate action

should be taken if necessary. Advice should be sought when required.

2.2.6 You should communicate honestly, openly and in a professional manner with service users, their families and carers, addressing concerns co-operatively should they arise and receiving feedback. Advice should be sought when required and local policy followed.

2.2.7 You must take appropriate precautions to protect service users, their carers and their families, and yourself from infection in relation to personal, equipment and environmental cleanliness. Local infection control guidance and policy should be followed.

2.2.8 Everyone has a responsibility to safeguard children, young people and vulnerable adults. Should you witness, or have reason to believe that a service user has been the victim of, dangerous, abusive, discriminatory or exploitative behaviour or practice, you must notify a line manager or other prescribed person, seeking the service user's consent where possible, and using local procedures where available.

2.2.9 If you witness, or have reason to believe, that a service user has been the victim of abuse in your workplace, you may notify your line manager or other prescribed person. The *Public Interest Disclosure Act (PIDA) 1998* (Great Britain. Parliament 1998c) places no obligation on you to make a disclosure, or 'whistle-blow'. However, such a disclosure

would be a 'protected disclosure', so you would not suffer detriment as a result of making the disclosure.

2.2.10 If you are an employer or supplier of personnel, you must report to the Independent Safeguarding Authority any person who has been removed from work because of their behaviour, where that behaviour may meet any of the criteria for the individual to be barred from working with children or vulnerable adults (Great Britain. Parliament 2006, section 36).

See also standards 1, 7 and 11 of the HPC (2008) *Standards of conduct, performance and ethics.*

Mental capacity and informed consent

2.3 You have a continuing duty to respect and uphold the autonomy of service users, encouraging and enabling choice and partnership-working in the occupational therapy process.

The law on mental capacity is set out in the *Mental Capacity Act 2005* (Great Britain. Parliament 2005) and the associated *Mental Capacity Act 2005 code of practice* (Department for Constitutional Affairs 2007). Those acting in a professional capacity for, or in relation to, a person who lacks capacity are legally required to have regard to the relevant sections of the *code of practice*. You should, therefore, be familiar with the Act and the *code of practice* (see Appendix 2). Practitioners in devolved countries

should be aware of their country equivalent legislation and its implications for their practice.

You must assess service users' mental capacity to make decisions in relation to occupational therapy provision, in accordance with the provisions of the *Mental Capacity Act* 2005 (Great Britain. Parliament 2005). If the service user does have capacity, you must seek the service user's informed consent to treatment (see Appendix 2). If the service user does not have capacity, you must consider whether the proposed treatment is in the service user's best interests, having taken into account the factors and consultation requirements of the Act, before commencing treatment.

2.3.1 Where service users have mental capacity, they have a right to make informed choices and decisions about their future and the care and intervention that they receive. If possible, such choices should be respected, even when in conflict with professional opinion.

2.3.2 For consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question (DH 2009, chapter 1, section 1). The gaining of consent, whether verbal or written, must be recorded.

2.3.3 Service users with capacity should be given sufficient information, in an appropriate manner, to enable them to give consent to any proposed intervention(s) concerning them. They should be able to understand the nature and purpose of the proposed intervention(s), including any possible risks involved.

2.3.4 Where possible the need, or a reasonable request, to be treated, seen or visited by a practitioner with specific characteristics should be met, for example by a professional and not a student, by a male or female practitioner, or by a particular language speaker.

2.3.5 Where a service user's capacity to give informed consent is restricted or absent, you should, as far as possible, ascertain and respect their preferences and wishes, at all times seeking to act in their best interests. All decisions and actions taken must be documented (see Appendix 2).

2.3.6 Most service users have the right to refuse any intervention at any time in the occupational therapy process. This must be respected and recorded in the care record. You must not coerce or put undue pressure on a service user to accept intervention, but must inform them of any possible risk or consequence of refusing treatment. For service users without capacity, a 'best interests' decision is required.

See Appendices 1 and 2 for further guidance on mental capacity and informed consent.

See also standard 9 of the HPC (2008) *Standards of conduct, performance and ethics.*

Confidentiality

2.4 You are obliged to safeguard confidential information relating to service users at all times. This includes when communicating with others via any

medium. It is also established law that confidential personal information must be protected and a failure to do so can lead to a fine, or give the service user a cause of action for breach of confidence.

2.4.1 You must make yourself aware of your legal responsibilities under the *Data Protection Act 1998,* the *Human Rights Act 1998* and the *Mental Capacity Act 2005* (Great Britain. Parliament 1998a, 1998b, 2005) (see Appendix 3).

2.4.2 You must keep all records securely, making them available only to those who have a legitimate right or need to see them.

2.4.3 The disclosure of confidential information regarding the service user's diagnosis, treatment, prognosis or future requirements is only possible where: the service user gives consent (expressed or implied); there is legal justification (by statute or court order); or it is considered to be in the public interest in order to prevent serious harm, injury or damage to the service user or to any other person. Local procedures should be followed.

2.4.4 You must adhere to local and national policies regarding confidentiality in the storage and electronic transfer of information (including records, faxes and e-mails) at all times.

2.4.5 You must grant access to records by service users in accordance with the *Data Protection Act 1998*, the *Access to Health Records Act 1990* and the *Freedom of Information Act 2000* (Great Britain. Parliament 1998a, 1990,

2000) (or relevant/equivalent country regulations or orders). Reference should be made to current guidance (both local and national) on access to personal health and social care information.

2.4.6 You must obtain and record consent prior to using visual, oral or written material relating to service users outside of their care situation, e.g. for learning/teaching purposes. Service user confidentiality and choice must be observed in this circumstance.

2.4.7 Discussions with or concerning a service user should be held in a location and manner appropriate to the protection of the service user's right to confidentiality and privacy.

More information on confidentiality is available in Appendix 3 and from the College of Occupational Therapists' guidance *Record Keeping* (COT 2010).

See also standard 2 of the HPC (2008) *Standards of conduct, performance and ethics.*

Section Three: Service provision

Equality

3.1 You must care for all service users in a fair and just manner, always acting in accordance with human rights, legislation and in the service user's best interests.

3.1.1 You must offer equal access to services without bias or prejudice on the basis of age, gender, race, nationality, colour, faith, sexual orientation, level of ability or position in society. Practice should at all times be centred on the service user (HPC 2008, standard 1).

3.1.2 You should be aware of and sensitive to how the above factors affect service users' cultural and lifestyle choices, incorporating this into any service planning, individual assessment and/or intervention where possible.

3.1.3 You must report in writing to your employing authority, at the earliest date in your employment, any religious and/or cultural beliefs that would influence how you carry out your duties. You should explore ways in which you can avoid placing an unreasonable burden on colleagues because of this. This does not affect your duties, as set out in sections 3.1.1

and 3.1.2, and you must always provide service users with full, unbiased information.

Resources

3.2 Occupational therapy services should be centred on the service user and their carer(s), but local, national and environmental resources for care are not infinite. At times priorities will have to be identified and choices will have to be made, whilst complying with legal requirements, and national and/or local policy.

3.2.1 In establishing priorities and providing services, service user and carer choice should be taken into account, and implemented wherever reasonably possible. If the service user lacks the mental capacity to identify his or her preferences, occupational therapy personnel must act in the service user's best interests (see Appendix 1 for more information on mental capacity).

3.2.2 You should work as cost-effectively and efficiently as possible in order to sustain resources.

3.2.3 You have a duty to report and provide evidence on resource and service deficiencies that may endanger the health and safety of service users and carers to the relevant service manager (Great Britain. Parliament 1998c, section 43B, point (1)d). Local policy should be followed. Service managers should then take appropriate action.

3.2.4 Where the service user's or their carer's choice cannot be met by the occupational therapy service, you should explain this to the service user/carer. You may provide information as to different service providers, sources of funding etc. Provided that you have referred the service user to another agency if appropriate; complied with all the necessary procedures; and ensured that a follow up is not reasonably required, you will have no further responsibility or liability.

The occupational therapy process

3.3 You must have and abide by clearly documented procedures and criteria for your service(s).

3.3.1 You should be aware of the standards and requirements of the professional body and the registration body, abiding by them as required by registration and/or membership.

3.3.2 You should work in partnership with the service user and their carer(s), throughout the care process, respecting their choices and wishes and acting in the service user's best interests at all times.

3.3.3 Following receipt of a referral for occupational therapy, the legal responsibility and liability for any assessment and possible intervention provided by occupational therapy lies with the occupational therapy service to which the case is allocated, even if that assessment or possible intervention has been requested by another professional (see section 2.1.1).

3.3.4 You have the right to refuse to provide any intervention that you believe would be harmful to a service user, or that would not be clinically justified, even if requested by another professional. The guidance given by the Court of Appeal in the case of R (Burke) v. General Medical Council (Official Solicitor and others intervening) (2005), is that if a form of treatment is not clinically indicated, a practitioner is under no legal obligation to provide it although he or she should seek a second opinion. Similarly, a doctor who is responsible for a service user may instruct a therapist not to carry out certain forms of treatment if he or she believes them to be harmful to the service user (Department of Health 1977).

3.3.5 Any advice or intervention provided should be based upon the most recent evidence available, best practice, or local/national guidelines and protocols.

3.3.6 A service user can decide not to follow all or part of the practitioner's recommendations, seeking intervention, equipment or advice elsewhere. This must be recorded in the care record, together with your assessment that the service user has the capacity to make such a decision (see Appendix 2 and also point 2.3.6). Provided that you have referred the service user to another agency if appropriate, complied with all the necessary procedures, and ensured that a follow-up is not reasonably required, you will have no further responsibility or liability.

Risk management

3.6 Risk management is an intrinsic part of governance and the provision of a quality service. Risk management is a process of identifying and adequately reducing the likelihood and impact of any kind of incident occurring that might cause harm. The principles remain the same whether the potential harm is to people, organisations or the environment. The process also enables positive risks to be taken with service users in a safe and appropriate way.

3.6.1 You must familiarise yourself with the risk management legislation that is relevant to your practice, and with your own local risk management procedures.

3.6.2 You are responsible for assessing and managing the identified risks involved in providing care to your service users.

3.6.3 You are expected to co-operate with your employers in meeting the requirements of legislation and local policy. You must also take reasonable care for your own health and safety and that of others who may be affected by what you do, or do not do (Great Britain. Parliament 1974, section 7).

3.6.4 You must ensure that you remain up to date in all your statutory training related to risk management, health and safety, and moving and handling.

More information is available from the College of Occupational Therapists current guidance on risk management.

Record keeping

3.7 Record keeping is core to the provision of good quality and safe care. The key purpose of records is to facilitate the care and support of a service user. It is essential to provide and maintain a written record of all that has been done for/with or in relation to a service user, including the clinical reasoning behind the care planning and provision.

3.7.1 You must accurately, legibly and contemporaneously record all information related to your involvement with the service user, in line with the standards of the Health Professions Council, the College of Occupational Therapists and local policy. Any record must be clearly dated and attributable to the person making the entry (HPC 2008, standard 10).

3.7.2 You must ensure that you meet any legal requirements regarding confidentiality in record keeping (see section 2.4).

More information is available from the current College of Occupational Therapists' *Professional standards for occupational therapy practice* and guidance on *Record keeping* (COT 2010).

Section Four: Personal/ professional integrity

Personal integrity

4.1 The highest standards of personal integrity are expected of occupational therapy personnel. You must not engage in any criminal or otherwise unlawful, or unprofessional behaviour that would bring the profession into disrepute (HPC 2008, standard 3).

4.1.1 You must always conduct and present yourself in a professional manner whilst in your work role. You should act and dress appropriately to the setting, conforming to local policy and in accordance with health and safety requirements.

4.1.2 You should adhere to statutory and local policies at all times.

4.1.3 You must inform the regulatory body and/or their employers if you are convicted of a criminal offence, receive a conditional discharge for an offence, or if you accept a police caution (HPC 2008, standard 4).

4.1.4 You must inform the regulatory body if you are disciplined, suspended or placed under a practice restriction by an employer because of

concerns about your conduct or competence (HPC 2008, standard 4).

4.1.5 You should co-operate with any investigation or formal enquiry into your own professional conduct, the conduct of another worker or the treatment of a service user, where appropriate.

More information on informing the regulatory body is available from *Guidance on health and character: a guide for applicants and registrants on how we consider information they declare* (HPC 2009b).

Relationships with service users

4.2 You should foster appropriate therapeutic relationships with your service users in a transparent, ethical and impartial way, centred on the needs and choices of the service user and their family/carers.

4.2.1 It is unethical for you to enter into relationships that would impair your judgement and objectivity and/or which would give rise to the advantageous or disadvantageous treatment of a service user.

4.2.2 You must not enter into relationships that exploit service users sexually, physically, emotionally, financially, socially or in any other manner.

4.2.3 You must not exploit any professional relationship for any form of personal gain or benefit.

4.2.4 You should avoid entering into a close personal relationship with a current service user. You are responsible for maintaining an appropriate professional relationship. If there is a risk that the professional boundary may be broken, this should be disclosed and discussed with your service manager. You should hand over therapy care for the service user to an appropriate professional colleague.

4.2.5 In the case of relationships, sexual or otherwise, regardless of when the professional relationship may have started or ended, or however consensual it may have been, it will always be your responsibility to prove that you have not exploited the vulnerability of the service user and/or his or her carer, should concerns be raised.

4.2.6 As far as is reasonably practical, you should not enter into a professional relationship with someone with whom you already have, or have had, a close personal relationship. This includes family members and friends. Where there is no reasonable alternative, you must make every effort to remain professional and objective whilst working with the individual you know or have known.

4.2.7 In such circumstances this should be disclosed and discussed with the service manager and a note should be made in care records. This is for your protection as much as for the service user.

More information is available concerning sexual relationships and boundaries from the COT/BAOT

Briefing *Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professionals* (COT 2009a).

Professional integrity

4.3 You must act with honesty and integrity at all times. You must not get involved in any behaviour or activity that is likely to damage the public's confidence in you or your profession.

(HPC 2008, standard 13)

4.3.1 You must adhere to statutory and local policies with regard to discrimination, bullying and harassment.

4.3.2 Any reference to the quality of work, or the integrity of a professional colleague should be expressed with due care to protect the reputation of that person. Any opinion must be evidence-based and given through appropriate channels. When providing a second opinion to a service user and/or their carer, it must be confined to the case in question and not extend to the general competence of the first practitioner.

4.3.3 Should you have reasonable grounds to believe that the behaviour or professional performance of a colleague may be deficient in standards of professional competence, you should notify the line manager or other appropriate person in strictest confidence. This includes (but is not limited to) when a colleague's performance is seriously deficient, when he or she has a health problem which is

impairing his or her competence to practise, or when he or she is practising in a manner which places service users or colleagues at risk.

4.3.4 In reporting any concerns to a line manager or other appropriate person, the information must be objective, relevant and limited to the matter of concern.

4.3.5 Under no circumstances should you remain silent about any malpractice, criminal conduct or unprofessional activity that you witness, whether by occupational therapy personnel or other staff.

4.3.6 You may give evidence in court concerning any alleged negligence of a colleague. Such evidence must be objective and capable of substantiation.

Fitness to practise

4.4 You must inform your employer/appropriate authority and the Health Professions Council about any health or personal conditions that may affect your ability to perform your job competently and safely.

4.4.1 You should limit or stop working if your performance or judgement is affected by your health (HPC 2008, standard 12).

Substance misuse

4.5 You must not undertake any professional activities whatsoever when under the influence of alcohol, drugs or other intoxicating substances.

4.5.1 You must not promote and/or use illegal substances in the workplace.

Personal profit or gain

4.6 You should not accept tokens such as favours, gifts or hospitality from service users, their families or commercial organisations when this might be construed as seeking to obtain preferential treatment (Great Britain. Parliament 1889,1906,1916). In respect of private practice this principle still prevails in terms of personal gain.

4.6.1 Local policy should always be observed in the case of gifts.

4.6.2 If a service user or their family makes a bequest to a practitioner or a service, this should be declared according to local guidelines.

4.6.3 You must put the interests of the service user first and should not let this duty be influenced by any commercial or other interest that conflicts with this duty, for example in arrangements with commercial providers that may influence contracting for the provision of equipment.

Information and representation

4.7 Information and/or advertising, in respect of professional activities or work, must be accurate. It should not be misleading, unfair or sensational (HPC 2008, standard 14).

4.7.1 You should accurately represent your qualifications, education, experience, training, competence and the services you provide. Explicit claims should not be made in respect of superiority of personal skills, equipment or facilities.

4.7.2 You should not claim another person's work or achievements as your own unless the claim can be fully justified. You should respect the intellectual property rights of others at all times.

4.7.3 You may only advertise, promote or recommend a product or service in an accurate and objective way. You may not support or make unjustifiable statements about a product or service.

4.7.4 If you are aware that possible misrepresentation of the protected title 'occupational therapist' has occurred, you must contact the Health Professions Council.

Section Five: Professional competence and lifelong learning

Professional competence

5.1 You must only provide services and use techniques for which you are qualified by education, training and/or experience. These must be within your professional competence, appropriate to the needs of the service user and relate to your terms of employment.

5.1.1 You should achieve and continuously maintain high standards in your professional knowledge, skills and behaviour.

5.1.2 You should be aware of and abide by the current legislation, guidance and standards that are relevant to your practice.

5.1.3 If you are asked to act up or cover for an absent colleague, such duties should only be undertaken with additional planning, support, supervision and/or training. You should be able to refuse such a request, without reprisal, if you believe the work to be outside the scope of your competence or workload capacity.

5.1.4 If you are seeking to work in areas with which you are unfamiliar or in which your experience has not been recent, you should ensure that adequate self-directed learning takes place as well as other relevant training and supervision.

5.1.5 If you extend your role beyond the scope of occupational therapy practice, or if you take on a new role, you must ensure that additional skills are acquired and maintained for safe and competent practice, for example in prescribing (COT 2009c).

See also standards 5 and 6 of the HPC (2008) *Standards of conduct, performance and ethics.*

Delegation

5.2 If you delegate interventions or other procedures you should be satisfied that the person to whom you are delegating is competent to carry them out. In these circumstances, you, as the delegating occupational therapist, retain responsibility for the occupational therapy care provided to the service user (HPC 2008, standard 8).

5.2.1 You should provide appropriate supervision for the individual to whom you have delegated the responsibility.

Collaborative working

5.3 You should respect the responsibilities, practices and roles of other people with whom you work.

5.3.1 You should be able to articulate the purpose of occupational therapy and the reason for any intervention being undertaken, so promoting the understanding of the profession.

5.3.2 You should recognise the need for multiprofessional and multi-agency collaboration to ensure that well co-ordinated services are delivered in the most effective way.

5.3.3 You have a duty to refer the care of a service user to another appropriate colleague if it becomes clear that the task is beyond your scope of practice. You should consult with other service providers when additional knowledge, expertise and/or support are required (HPC 2008, standard 6).

5.3.4 If you and another practitioner are involved in the treatment of the same service user, you should work co-operatively, liaising with each other and agreeing areas of responsibility. This should be communicated to the service user and all relevant parties.

Continuing professional development

5.4 You are personally responsible for actively maintaining and continuing your professional development and competence, and for participating in learning opportunities over and above those which are legally required for your work. You must maintain your continuing professional development (CPD) to

meet the standards of proficiency for registration with the Health Professions Council.

5.4.1 You are responsible for maintaining a record of your CPD.

5.4.2 You should aim for your CPD to improve the quality of your work and to be of benefit to your service users.

5.4.3 Employing organisations and service managers are encouraged to recognise the value of continuing professional development to individual practitioners, the service and service users.

5.4.4 You should maintain an awareness of current policy, guidelines, research and best available evidence, and should incorporate this into your work where appropriate.

5.4.5 You should be supported in your practice and development through regular professional supervision within an agreed structure or model. Sole practitioners should seek out professional support and advice for themselves.

5.4.6 If you have expert or high-level knowledge, skills and experience, you have a responsibility to share these with your colleagues through supervision, mentoring, preceptorship and teaching opportunities.

More information is available from the *Joint position statement on continuing professional development for health and social care practitioners* (Royal College

of Nursing et al 2007) and *Your guide to our standards for continuing professional development* (HPC 2009c).

Occupational therapy practice education

5.5 You have a professional responsibility to provide regular practice education opportunities for occupational therapy students where possible, and to promote a learning culture within the workplace.

5.5.1 You should recognise the need for individual education and training to fulfil the role of the practice placement educator. You should, where possible, undertake and maintain accreditation through programmes of study provided by higher education institutions that are recognised by the College of Occupational Therapists.

5.5.2 If you undertake the role of Practice Placement Educator, you should provide a learning experience for students that complies with the *College of Occupational Therapists pre-registration education standards* (COT 2009e) and the College's current professional standards, and is compatible with the stage of the student's education or training.

5.5.3 If you accept a student for practice education, you should have a clear understanding of the role and responsibilities of the student, the educational institution and the practice educator.

More information is available from the *College of occupational therapists' curriculum guidance for pre-registration education* (COT 2009d) and the *College of Occupational Therapists pre-registration education standards* (COT 2009e).

Section Six: Developing and using the profession's evidence base

6.1 As research consumers, you must be aware of the value and importance of research as the basis of the profession's evidence base.

6.1.1 You should be able to access, understand and critically evaluate research and its outcomes, incorporating it into your practice where appropriate.

6.1.2 You should audit the services that you provide against appropriate available standards.

6.1.3 When undertaking any form of research activity, you must understand the principles of ethical research, address the ethical implications and adhere to national and local research governance and ethics requirements.

6.1.4 When undertaking any form of research activity, you must protect the interests of service users, fellow researchers and others.

6.1.5 When undertaking any form of research activity, you must protect the confidentiality of participants throughout and after the research process.

6.1.6 When undertaking any form of research activity, you should abide by local, professional and national ethical guidelines and approval processes.

6.1.7 You should disseminate the findings of your research activity through appropriate publication methods in order to benefit the profession and service users, and to contribute to the body of evidence that supports occupational therapy service delivery.

Appendix 1: Mental capacity

The following is a summary of some of the key, relevant provisions of the *Mental Capacity Act 2005* (Great Britain. Parliament), with references to the *Mental Capacity Act 2005 code of practice* (Department for Constitutional Affairs (DCA) 2007) where appropriate. It is intended to guide you to the relevant parts of the documents, and is not a full statement of the applicable law.

Mental Capacity Act 2005

Section 1 of the *Mental Capacity Act* (Great Britain. Parliament, Chapter 9) sets out the following principles to be observed when dealing with service users who may lack capacity:

- A person must be assumed to have capacity unless it is established that he (or she) lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

- Before the act is done, or the decision is made, consideration must be given as to whether the desired outcome can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Section 2 of the Act defines the circumstances in which a person may be said to lack capacity. A person lacks capacity in relation to a situation if, at the particular time, he is unable to make a decision for himself in relation to the situation because of an impairment of, or a disturbance in the functioning of, the mind or brain. Section 2 identifies some factors to be considered when assessing capacity:

- It does not matter whether the impairment or disturbance is permanent or temporary.
- A lack of capacity cannot be established merely by reference to:
  - **(a)** a person's age or appearance; or
  - **(b)** a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.

Section 3 sets out the test for determining whether an individual is unable to make decisions for himself. The *Mental Capacity Act 2005 code of practice* (DCA 2007) states that the assessment of capacity should be undertaken by the person who is directly concerned with the individual at the time the decision needs to be made. That person must assess a service user's capacity to make decisions about his treatment, and may only proceed in the absence of informed consent if they 'reasonably believe' that the individual lacks capacity.

1 For the purposes of Section 2, a person is unable to make a decision for himself if he is unable:

   (a) to understand the information relevant to the decision;

   (b) to retain that information;

   (c) to use or weigh that information as part of the process of making the decision; or

   (d) to communicate his decision (whether by talking, using sign language or any other means).

2 A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).

3 The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

4 The information relevant to a decision includes information about the reasonably foreseeable consequences of:

   (a) deciding one way or another; or

   (b) failing to make the decision.

If an individual is assessed as lacking capacity, it will be necessary to determine what treatment is in his best interests. There is extensive guidance on this point, but the central points are set out in Section 4 of Chapter 9 of the Act.

Section 5 offers some protection from liability to those involved in the care or treatment of those lacking in capacity. Please refer to the act for further information.

The Social Care Institute for Excellence (SCIE) has developed a web-based *Mental Capacity Act* (Great Britain. Parliament 2005) resource which can be found at:

http://www.scie.org.uk/publications/mca/index.asp Accessed on 08.03.10.

The Office of the Public Guardian has developed a number of guidance booklets which can be found at:

http://www.publicguardian.gov.uk/mca/mca.htm Accessed on 08.03.10.

The *Mental Capacity Act 2005 code of practice* (DCA 2007) is also available from this website.

Practitioners in devolved countries should be aware of their country equivalent legislation and its implications for their practice.

Appendix 2: Informed consent

Anyone over 16 has capacity to consent to treatment and anyone over 18 years has capacity to refuse it. It is to be presumed that a service user has capacity to give informed consent to treatment unless he meets the criteria as set out in Section 2 of the *Mental Capacity Act 2005* (Great Britain. Parliament 2005) (see Appendix 1).

Informed consent is an ongoing agreement by a person to receive treatment, undergo procedures or participate in research, after risks, benefits and alternatives have been adequately explained to them. Informed consent is a continuing requirement. Therefore occupational therapy personnel must ensure that service users continue to understand the information that they have been provided with, and any changes to that information, thereby continuing to consent to the intervention or research in which they are partipating.

If a person cannot communicate their consent, due to disability or injury, it may be possible to infer implied consent if:

- the service user can reasonably be expected to understand the nature or character of the treatment or procedure; and

- the benefits to the service user outweigh the risks; and
- the service user is given a clear and practical procedure for withholding consent but does not do so.

A service user can only give informed consent if he has the mental capacity to do so. A mentally incapacitated service user cannot validly consent to or refuse treatment, nor can his relatives/carers consent on his behalf. Where a service user lacks the capacity to decide, then under Section 5 of the Act, any treatment is justified if the provider reasonably believes that by giving it, the provider is acting in the best interests of the service user. A number of safeguards apply:

- The practitioner must try to encourage the service user to participate in the decision (Section 4.4).
- The practitioner must consider the service user's past wishes, beliefs and values (prior to the loss of capacity), if these can be ascertained (Section 4.5).
- The practitioner must consider the views of those caring for the service user and anyone else interested in his welfare (Section 4.6).
- The treatment proposed by the practitioner must be proportionate (Section 6.4).

The *Mental Capacity Act 2005* also enables the court to make a decision on behalf of the service user, or appoint a deputy to do so in place of the court (Great Britain. Parliament, Section 16.1(a) and Section 17.1(d)).

Informed refusal

Informed refusal is a decision not to accept or undergo intervention or participate in research after the risks, benefits and alternatives have been adequately explained.

It is the overriding right of any individual to decide for himself whether or not to accept intervention. Unless a practitioner can rely on the terms of the *Mental Health Act 1983* and the *Mental Capacity Act 2005* (Great Britain. Parliament), they will have committed a trespass to the person if they enforce such intervention, and will be liable to be sued for damages.

The Department of Health has produced numerous guides on consent. These are available at:

http://www.dh.gov.uk/en/Publichealth/Scientificdevelopmentgeneticsandbioethics/Consent/Consentgeneralinformation/DH_119
Accessed on 08.03.10.

Advice relevant to Scotland is available from *A good practice guide on consent for health professionals in the NHSScotland* (Scottish Executive Health Department 2006).

Practitioners in devolved countries should be aware of their country equivalent legislation and its implications for their practice.

Appendix 3: Information governance

The Data Protection Act 1998

The *Data Protection Act 1998* (Great Britain. Parliament 1998a) gives individuals the right to know what information is held about them. It provides a framework to ensure that personal information is handled properly.

The Act works in two ways. Firstly, it states that anyone who processes personal information must comply with eight principles, which make sure that personal information is:

- fairly and lawfully processed;
- processed for limited purposes;
- adequate, relevant and not excessive;
- accurate and up to date;
- not kept for longer than is necessary;
- processed in line with peoples' rights;
- secure; and
- not transferred to other jurisdictions without adequate protection.

The second area covered by the Act provides individuals with important rights, including the right

to find out what personal information is held about them on computer and most paper records.

The *Data Protection Act 1998* (Great Britain. Parliament 1998a) doesn't guarantee personal privacy at all costs, but aims to strike a balance between the rights of individuals and the sometimes competing interests of those with legitimate reasons for using personal information. It applies to paper records as well as computer records.

Compliance

The following questions should be considered when dealing with information subject to the *Data Protection Act 1998* (Great Britain. Parliament 1998a). Being able to answer 'yes' to each one does not guarantee compliance and further guidance may be needed, however, answering yes to these questions indicates that compliance with the Act is more likely than not:

- Do I really need this information about an individual? Do I know what I'm going to use it for?
- Do the people whose information I hold know that I've got it, and are they likely to understand what it will be used for?
- If I'm asked to pass on personal information, would the people about whom I hold information expect me to do this?
- Am I satisfied the information is being held securely, whether it's on paper or on computer? And what about my website? Is it secure?
- Is access to personal information limited to those with a strict need to know?

- Am I sure the personal information is accurate and up to date?
- Do I delete or destroy personal information as soon as I have no more need for it?
- Have I trained my staff (or have I been trained) in the duties and responsibilities under the *Data Protection Act 1998* (Great Britain. Parliament 1998a)?
- Do I need to notify the Information Commissioner and if so is my notification up to date?

Breach of the *Data Protection Act 1998* (Great Britain. Parliament 1998a), or the misuse of information which is subject to the Act, can lead to prosecution and, if convicted of an offence, a fine against a practitioner personally, or his or her employer.

The Human Rights Act 1998

Article 8 of The European Convention on Human Rights, as incorporated into UK law by the *Human Rights Act 1998* (Council of Europe 1953, Great Britain. Parliament 1998b), provides for the right to respect for private life. Therefore unauthorised disclosure or misuse of personal data will be a breach of an individual's human rights under the Act.

The duty to maintain confidential information ceases in the following circumstances:

- if the service user gives permission for the information to be disclosed;
- if the information becomes public by some other means – perhaps the service user publicises it himself; and/or

- if the disclosure of information is 'protected'. This situation would arise if the information disclosed was released as part of a public interest disclosure.

Practitioners in devolved countries should be aware of their country equivalent legislation and its implications for their practice.

References

R (Burke) v. General Medical Council (*Official Solicitor and others intervening*) [2005] EWCA Civ 1003, [2006] QB 273. Available at: *http://www.familylawweek.co.uk/site.aspx?i=ed409* (paragraph 50) Accessed on 26.01.10.

Caparo Industries Plc v Dickman [1990] 2 AC 605 (HL).

Christiansen CH, Townsend EA (2004) *Introduction to occupation: the art and science of living.* Upper Saddle River, NJ: Prentice Hall.

College of Occupational Therapists (2002) *From interface to integration: a strategy for modernising occupational therapy services in local health and social care communities. A consultation.* London: COT.

College of Occupational Therapists (2004) *Definition of occupational therapy from member countries, draft 8.* London: COT. Available at: *http://www.wfot.org/office_files/DEFINITIONS%20-%20DRAFT8%20 2007%282%29.pdf* Accessed on 02.12.09.

College of Occupational Therapists (2006) *Risk management.* London: COT.

College of Occupational Therapists (2007) *Professional standards for occupational therapy practice.* 2nd ed. London: COT.

College of Occupational Therapists (2009a) *Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professionals.* (COT/BAOT Briefings No. 118). London: COT.

College of Occupational Therapists (2009b) *Definitions and core skills for occupational therapy*. (COT/BAOT Briefings No. 23). London: COT.

College of Occupational Therapists (2009c) *Extended scope practice.* (COT/BAOT Briefings No. 14). London: COT.

College of Occupational Therapists (2009d) *The College of Occupational Therapists' curriculum guidance for pre-registration education*. London: COT.

College of Occupational Therapists (2009e) *College of Occupational Therapists pre-registration education standards*. 3rd ed. London: COT.

College of Occupational Therapists (2010) *Record keeping*. 2nd ed. London: COT.

College of Occupational Therapists; Directors of Adult Social Services; Association of Directors of Social Work; Association of Directors for Social Services Cymru (2008) *The value of occupational therapy and its contribution to adult social service users and their carers*. London: COT. Available at: *http://www.cot.org.uk/MainWebSite/Resources/Document/The%20value%20of%20OT%20and%20its%20contribution.pdf* Accessed on 23.11.09.

Council of Europe (1953) *Convention for the protection of human rights and fundamental freedoms (European convention on human rights) as amended by Protocol No. 11.* Rome: Council of Europe. Available at: *http://conventions.coe.int/treaty/en/Treaties/Html/005.htm* Accessed on 09.03.10.

Creek J (2003) *Occupational therapy defined as a complex intervention*. London: College of Occupational Therapists.

Crepeau EB, Cohn ES, Schell BAB eds (2003) *Willard & Spackman's occupational therapy*. 10th ed. Philadelphia: Lippincott Williams & Wilkins.

Department for Constitutional Affairs (2007) *Mental Capacity Act 2005 code of practice.* London: Stationery Office.

Department of Health (1977) *Relationships between medical and remedial professions.* (HC (77) 33). London: DH.

Department of Health (2009) *Reference guide to consent for examination or treatment*. 2nd ed. London: DH.

Department of Health [ca. 2010a] *Clinical governance*. London: DH. Available at: *www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/index.htm* Accessed on 25.01.10.

Department of Health [ca. 2010b] *Consent key documents*. London: DH. Available at: *http://www.dh.gov.uk/en/Publichealth/Scientificdevelopmentgeneticsandbioethics/Consent/Consentgeneralinformation/DH_119* Accessed on 08.03.10.

European Network of Occupational Therapy in Higher Education Terminology Project Group (2004) *Occupational therapy terminology database.* Amsterdam: ENOTHE. Available at: *http://pedit.hio.no/~brian/enothe/terminology/* Accessed on 25.11.09.

Great Britain. Parliament (1889, 1906, 1916) *Prevention of Corruption Acts 1889 to 1916*. London: HMSO.

Great Britain. Parliament (1974) *Health and Safety at Work Act 1974*. London: HMSO.

Great Britain. Parliament (1983) *Mental Health Act 1983.* London: HMSO.

Great Britain. Parliament (1990) *Access to Health Records Act 1990*. London: HMSO.

Great Britain. Parliament (1995) *Carers (Recognition & Services) Act 1995*. London: HMSO.

Great Britain. Parliament (1998a) *Data Protection Act 1998*. London: Stationery Office.

Great Britain. Parliament (1998b) *Human Rights Act 1998*. London: Stationery Office.

Great Britain. Parliament (1998c) *Public Interest Disclosure Act (PIDA) 1998.* London: Stationery Office.

Great Britain. Parliament (1999) *Health Act 1999.* London: Stationery Office.

Great Britain. Parliament (2000) *Freedom of Information Act 2000.* London: Stationery Office.

Great Britain. Parliament (2005) *Mental Capacity Act 2005.* London. Stationery Office.

Great Britain. Parliament (2006) *Safeguarding Vulnerable Groups Act 2006.* London: Stationery Office.

Hagedorn R (2001) *Foundations for practice in occupational therapy.* 3rd ed. Edinburgh: Churchill Livingstone.

Harvey L (2009) Analytic quality glossary. [s.l]: Quality Research International. Available at: *www.qualityresearchinternational.com/glossary/competence*.htm Accessed on 25.01.10.

Health Professions Council (2007) *Standards of proficiency: occupational therapists*. London: HPC.

Health Professions Council (2008) *Standards of conduct, performance and ethics*. London: HPC.

Health Professions Council (2009a) *Continuing professional development and your registration.* 2nd ed. London: HPC.

Health Professions Council (2009b) *Guidance on health and character: a guide for applicants and registrants on how we consider information they declare*. London: HPC.

Health Professions Council (2009c) *Your guide to our standards for continuing professional development*. London: HPC.

Health Professions Council (2010) *Guidance on conduct and ethics for students*. London: HPC.

Jameton A, McGuire C (2002) Toward sustainable health-care services: principles, challenges, and a process. *International Journal of Sustainability in Higher Education*. *3(2),*113–127.

Office of the Public Guardian [ca.2010] *[Mental Capacity Act] Forms and Booklets*. Birmingham: OPG. Available at: *http://www.scie.org.uk/publications/mca/index.asp* Accessed on 08.03.10.

Phillips C, Thompson G (2009) *What is cost effectiveness?* 2nd ed. London: Hayward Medical Communications.

Royal College of Nursing, College of Occupational Therapists, Institute of Biomedical Science (2007) *A joint statement on continuing professional development for health and social care practitioners*. London: RCN.

Scotland: Scottish Executive Health Department (2006) *A good practice guide on consent for health professionals in the NHSScotland*. Edinburgh: Stationery Office.

Social Care Institute for Excellence [ca.2010] *Mental Capacity Act (MCA) resource*. London: SCIE. Available at: *http://www.publicguardian.gov.uk/mca/mca.htm* Accessed on 08.03.10.

Bibliography

Bolitho v City and Hackney Health Authority [1998] AC 232 (HL).

British Association of Social Workers (2002) *The code of ethics for social workers.* Birmingham: BASW.

British Dietetic Association (2008) *Code of professional conduct*. Birmingham: BDA.

Chartered Society of Physiotherapy (2002) *Rules of professional conduct.* London: CSP.

College of Occupational Therapists (2003) *Research ethics guidelines*. London: COT.

College of Occupational Therapists of Ontario (2009) *Standards for professional boundaries.* Toronto, ON: COTO.

Department of Health (2009) *The NHS constitution: the NHS belongs to us all.* London: DH.

Donoghue v Stevenson [1932] AC 562 (HL).

Great Britain. Parliament (1993*) The Access to Health Records (Northern Ireland) Order 1993*. (SI 1250) (NI 4). London: HMSO.

Great Britain. Parliament (2004) *Children Act 2004*. London: Stationery Office.

Professional Foundation of Occupational Therapy in Denmark (2008) *A collection of documents concerning mission, visions, values, professional*

ethics, cooperation. Copenhagen, Denmark: Danish Association of Occupational Therapists. Available at: *http://viewer.zmags.com/publication/2639d8ad#/2639d8ad/1* Accessed on 06.10.09.

Scotland. Scottish Executive (2000) *Adults with Incapacity (Scotland) Act 2000*. Edinburgh: Stationery Office.

Scotland. Scottish Executive (2002) *Freedom of Information (Scotland) Act 2002.* Edinburgh: Stationery Office.

Society and College of Radiographers (2008) *Code of conduct and ethics*. London: SCoR.

Volunteer Development Agency (2009) *DIY committee guide common law duty of care help! sheet*. London: Volunteer Development Agency. Available at: *http://www.diycommitteeguide.org/article/common-law-duty-care-help-sheet* Accessed on 09.02.10.

World Federation of Occupational Therapists (2005) *Code of ethics.* Forrestfield, AU: WFOT.

Code of Ethics and Professional Conduct

This *Code of ethics and professional conduct* describes a set of professional behaviours and values that the British Association of Occupational Therapists expects its members to abide by, and believes all occupational therapy personnel should follow.

Occupational therapists must demonstrate behaviours that promote and protect the wellbeing of service users and their carers, the wider public, and the reputation of employers and the profession. To be deemed as 'competent' occupational therapists need a combination of knowledge, skills and behaviours. They may learn knowledge and skills through professional training and/or experience and continuing professional development, but these elements alone are not necessarily what make a good or safe practitioner.

Reviewed every five years, the Code is an essential, practical and user-friendly guide for all members of the occupational therapy profession. Equally, it provides a useful resource for members of the public, employing organisations and other professions who need to be aware of the Code, its requirements and the expectations of the professional body in terms of ethics and professional conduct.

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The Royal College of Occupational Therapists is a wholly owned subsidiary of the British Association of Occupational Therapists (BAOT) and operates as a registered charity. It represents the profession nationally and internationally, and contributes widely to policy consultations throughout the UK. The College sets the professional and educational standards for occupational therapy, providing leadership, guidance and information relating to research and development, education, practice and lifelong learning. In addition, 10 accredited specialist sections support expert clinical practice.

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Preface

i. The *Code of ethics and professional conduct* (hereafter referred to as 'the Code') is produced by the College of Occupational Therapists, for and on behalf of the British Association of Occupational Therapists (BAOT), the national professional body and trade union for occupational therapists throughout the United Kingdom (UK). The College of Occupational Therapists (COT or College) is the subsidiary organisation, with delegated responsibility for the promotion of good practice.

ii. The College is committed to person-centred practice and the involvement of the service user as a partner in all stages of the therapeutic process.

iii. The completion, revision and updating of the Code is the delegated responsibility of the Professional Practice Department of the College. It is revised every five years.

iv. Under the *Health Act 1999* (Great Britain. Parliament) the title 'occupational therapist' is protected by law and can only be used by persons who are registered as such with the regulatory body, the Health and Care Professions Council (HCPC). This means that they will have successfully completed an approved course leading to a diploma or degree in occupational therapy and must be meeting the current HCPC

standards and requirements for continued registration. All occupational therapists practising in the UK must be registered with the HCPC.

v. Membership of the British Association of Occupational Therapists is voluntary. It is not a requirement for practice and, although it cannot be a criterion for employment, it provides benefits to support ethical and safe working practice (Great Britain. Parliament 1992). Members of BAOT sign up to abide by this Code, but its content will be relevant and useful to all occupational therapy personnel across the United Kingdom, whether they be members of BAOT or not. It is a public document, so also available to service users and their carers, other professions and employing organisations.

vi. The term 'occupational therapy personnel' includes occupational therapists, occupational therapy students and support workers. It is also pertinent to occupational therapists who are managers, educators and researchers. At times this document also uses the term 'practitioner' in reference to the same range of people.

vii. Where occupational therapy personnel are working in less clearly defined occupational therapy roles or more diverse roles, this code will still apply and should be used to ensure ethical and safe working practice.

viii. This Code should be used in conjunction with the current versions of the HCPC's standards and guidance, along with the College of Occupational Therapists' current professional standards for occupational therapy practice, and local policy.

ix. This Code does not identify every piece of relevant legislation, recognising that some may differ across the four UK nations. Occupational therapy personnel must be aware of and comply with any current European, UK or national legislation and policies, best practice standards, and employers' policies and procedures that are relevant to their area of practice. The relevant areas of legislation are listed in Appendix 1.

This version of the Code supersedes all previous editions (June 2015).

Key terms

Assessment	*A process of collecting and interpreting information about people's functions and environments, using observation, testing and measurement, in order to inform decision-making and to monitor change.* (Consensus definition from European Network of Occupational Therapy in Higher Education (ENOTHE) 2004)
Autonomy	*The freedom to make choices based on consideration of internal and external circumstances and to act on those choices.* (Consensus definition from ENOTHE 2004)
Best interests	As well as recognising the use of best interests decisions under the *Mental Capacity Act 2005* (Great Britain. Parliament 2005), the approach is extended within the Code to all service users. *The best interests approach asks whether any proposed course of action is the best one for the patient all things considered.* (UK Clinic Ethics Network n.d.)

Candour	*Candour is the quality of being open and honest.* (Department of Health 2014, p29)
Capacity (lacking)	For the purpose of the *Mental Capacity Act 2005:* *a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.* *It does not matter whether the impairment or disturbance is permanent or temporary.* (Great Britain. Parliament 2005, part 1, section 2)
Carer	Someone who provides (or intends to provide), paid or unpaid, a substantial amount of care on a regular basis for someone of any age who is unwell, or who, for whatever reason, cannot care for themselves independently. (Adapted from Great Britain. Parliament 1995) This is sometimes divided into formal carers (care workers) who are paid to give care, and informal carers (often family) who are not paid to provide care.

Key terms

Competency	*Competence is the acquisition of knowledge, skills and abilities at a level of expertise sufficient to be able to perform in an appropriate work setting.* (Harvey 2014)
Continuing professional development (CPD)	*A range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice.* (Health and Care Professions Council 2012, p1)
Cost effectiveness	The extent to which an intervention can be regarded as providing value for money. (Adapted from Phillips and Thompson 2009)
Delegate	To give an assignment to another person, or to assign a task to another person, to carry out on one's behalf, while maintaining control and responsibility.
Duty of care	A responsibility to act in a way which ensures that injury, loss or damage will not be carelessly or intentionally inflicted upon the individual or body to whom/which the duty is owed, as a result of the performance of those actions.

	A duty of care arises: ■ When there is a sufficiently close relationship between two parties (e.g. two individuals, or an individual and an organisation). Such a relationship exists between a service user and the member of occupational therapy personnel to whom s/he has been referred, while the episode of care is ongoing. ■ Where it is foreseeable that the actions of one party may cause harm to the other. ■ Where it is fair, just and reasonable in all the circumstances to impose such a duty. (See Caparo Industries Plc v Dickman 1990)
Ethics	A code of behaviour for personal or professional practice.
Governance	[The systems by which] *organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.* (Adapted from Department of Health 1998, chapter 3)

Key terms

Handover	To give away or entrust the total care and responsibility for an individual to another. The handover action is complete when the receiving person acknowledges and accepts control and responsibility. This is not to be confused with the role of occupational therapy personnel in a ward handover, where he or she may report information to ward staff, but still retains responsibility for the occupational therapy provided to the service user.
Informed consent	Informed consent is an ongoing agreement by a person to receive treatment, undergo procedures or participate in research, after risks, benefits and alternatives have been adequately explained to them. Informed consent is a continuing requirement. Therefore, occupational therapy personnel must ensure that service users continue to understand the information with which they have been provided, and any changes to that information, thereby continuing to consent to the intervention or research in which they are participating. In order for informed consent to be considered valid, the service user must have the capacity to give consent and the consent must be given voluntarily and be free from undue influence.

Must	Where there is an overriding principle or duty.
Occupation	*A group of activities that has personal and sociocultural meaning, is named within a culture and supports participation in society. Occupations can be categorised as self-care, productivity and/or leisure.* (Consensus definition from ENOTHE 2004)
Occupational alienation	*A sense that one's occupations are meaningless and unfulfilling, typically associated with feelings of powerlessness to alter the situation.* (Hagedorn 2001, cited in ENOTHE 2004)
Occupation-centred	*A professional stance to advance 'occupation as the centre of occupational therapy research, education and practice'.* (Nielson 1998, cited in Fisher 2013)
Occupational deprivation	*A state of prolonged preclusion from engagement in occupations of necessity or meaning due to factors outside the control of an individual, such as through geographic isolation, incarceration or disability.* (Christiansen and Townsend 2004, cited in ENOTHE 2004)

Key terms

Occupational science	*Academic discipline of the social sciences aimed at producing a body of knowledge on occupation through theory generation, and systematic, disciplined methods of inquiry.* (Crepeau et al 2003, cited in ENOTHE 2004)
Occupational therapy personnel	For the purpose of this document, this term includes occupational therapists, occupational therapists working in generic or diverse roles, occupational therapy students and support workers working with or for occupational therapists. It is also pertinent to occupational therapists who are managers, educators and researchers.
Practice placement educator	The occupational therapist who supervises students while they are on a practice placement.
Reasonable	An objective standard. Something (e.g. an act or decision) is reasonable if the act or decision is one which a well-informed observer would also do or make.
Service	Within the context of this document the term 'service' usually refers to the occupational therapy service you provide as an individual or group, rather than referring to the occupational therapy department or facility.

Service user	In this Code the term 'service user' refers to any person in direct receipt of any services/interventions provided by a member of occupational therapy personnel in all sectors and all settings.
Should	Where the principle or duty may not apply in all circumstances, in contrast with a 'must' obligation. You should have a justifiable reason for not meeting this requirement.
Sustainable	*Sustainable health care combines three key factors: quality patient care, fiscally responsible budgeting and minimizing environmental impact.* (Jameton and McGuire 2002)

Section One: Introduction

Defining occupational therapy, its values and beliefs

1.1 Occupational therapy has a unique approach to service users. Its beliefs and values have been drawn together and incorporated into the *College of Occupational Therapists' learning and development standards for pre-registration education* (College of Occupational Therapists 2014b).

> *Occupational therapists view people as occupational beings. As occupational beings, people are intrinsically active and creative, needing to engage in a balanced range of activities in their daily lives in order to sustain health and wellbeing. People shape, and are shaped by, their experiences and interactions with their environments. They create identity, purpose and meaning through what they do and have the capacity to transform themselves through conscious and autonomous action.*
>
> *The purpose of occupational therapy is to enable people to fulfil, or to work towards fulfilling, their potential as occupational beings. Occupational therapists promote activity, quality of life and the realisation of potential in people who are experiencing occupational disruption, deprivation, imbalance or isolation. We believe that activity can be an effective medium for*

> *remediation, facilitating adaptation and re-creating identity.*
>
> (COT 2014b, p2)

The statement on occupational therapy from the World Federation of Occupational Therapists (WFOT) states:

> *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 2010)

A shorter definition was adopted by BAOT/COT Council in 2004 and published by WFOT in their *Definitions of occupational therapy from member organisations*:

> *Occupational therapy enables people to achieve health, well being and life satisfaction through participation in occupation.*
>
> (WFOT 2013, p48)

The purpose of the Code

1.2 To be deemed as 'competent' you need to demonstrate a combination of knowledge, skills, and behaviours. You may learn knowledge and skills through professional training and/or experience and continuing professional development, but these elements alone are not necessarily what make you a good or safe practitioner. You must also demonstrate behaviours that promote and protect the wellbeing of service users and their carers, the wider public, and the reputation of your employers and your profession. This *Code of ethics and professional conduct* describes a set of professional behaviours and values that the British Association of Occupational Therapists expects its members to abide by, and believe all occupational therapy personnel should follow.

1.2.1 The Health and Care Professions Council (HCPC) has overall responsibility for ensuring that all relevant health professionals meet certain given standards in order to be registered to practise in the United Kingdom. If a formal complaint is made about an occupational therapist, the HCPC will take into account whether their standards have been met. You must know and abide by the requirements of the HCPC.

1.2.2 You have a responsibility to act in a professional and ethical manner at all times. The Code provides a set of values and behaviours that are relevant to you, irrespective of where you work or your level of experience. These values and ensuing attitudes, behaviours and capabilities support

and enable professionalism in occupational therapy practice. The Code, along with the College of Occupational Therapists' current professional standards for occupational therapy practice and the HCPC's standards, provide you with a framework for promoting and maintaining good, safe and ethical professional behaviour and practice in occupational therapy.

1.2.3 You should be familiar with the content of the Code. As a practical document, you need to understand its content and how to apply it in your workplace. It should be the first point of reference for you if you have a dilemma related to professional or ethical conduct. Local policy and/or standards should also be adhered to.

1.2.4 Higher education institutions will use the Code throughout students' education to inform them of the required standards of ethics and conduct that occupational therapy personnel are expected to uphold during their academic and professional lives, emphasising its application from point of entry to the programme to the end of their professional career. Higher education institutions are required to ensure that the Code is observed in order to maintain their pre-registration occupational therapy programme's accredited status.

1.2.5 The Code may also be used by others outside the profession to determine the measure of ethical and professional conduct expected of you. The College encourages recognition of

the Code by other individuals, organisations and institutions who are involved with the profession, including employers and commissioners.

1.2.6 The Code is a broad document and cannot provide detailed answers to all the specific professional or ethical dilemmas that you might face in your work. If there is uncertainty or dispute as to the interpretation or application of the Code, advice should be sought from the College of Occupational Therapists' Professional Practice Enquiry Service, which may seek an expert opinion if considered necessary.

Section Two: Service provision

Focusing on occupation

2.1 Your practice should be focused on enabling individuals, groups and communities 'to change aspects of their person, the occupation, or the environment, or some combination of these to enhance occupational participation'.

(Adapted from World Federation of Occupational Therapists 2010)

2.1.1 Access to occupational therapy should be based on the occupational needs of the individual, group or community.

2.1.2 Assessment, interventions, outcomes and documentation should be centred on occupational performance, engagement and participation in life roles.

2.1.3 The professional rationale for your intervention or activity should be the enhancement of health and wellbeing through the promotion of occupational performance and engagement.

2.1.4 In this way service users should be empowered to maintain their own health and wellbeing wherever possible.

The occupational therapy process

2.2 You must have and abide by clearly documented procedures and criteria for your service/s.

2.2.1 You should be aware of the standards and requirements of the professional body and the regulatory body, abiding by them as required by registration and/or membership.

2.2.2 You should work in partnership with the service user and their carer/s throughout the care process, respecting their choices and wishes and acting in the service user's best interests at all times.

2.2.3 Following receipt of a referral for occupational therapy, the legal responsibility and liability for any assessment and possible intervention provided by occupational therapy lies with the occupational therapy service to which the case is allocated (see section 3.1.1).

2.2.4 You have the right to refuse to provide any intervention that you believe would be harmful to a service user, or that would not be clinically justified, even if requested by another professional. The guidance given by the Court of Appeal in the case of *R (Burke) v. General Medical Council (Official Solicitor and others intervening)* (2005), is that if a form of treatment is not clinically indicated, a practitioner is under no legal obligation to provide it, although s/he should seek a second opinion. Similarly, a doctor who is responsible for a service user may instruct a therapist not to carry out certain forms of treatment if s/he

believes them to be harmful to the service user (Department of Health 1977).

2.2.5 You should maintain an awareness of current policy, guidelines, research and best available evidence, and should incorporate this into your work where appropriate.

2.2.6 A service user can decide not to follow all or part of your recommendations, seeking intervention, equipment or advice elsewhere. This must be recorded in the care record, together with your assessment that the service user has the capacity to make such a decision (see points 3.3.4 and 3.3.5). Provided that you have referred the service user to another agency if appropriate, complied with all the necessary procedures, taken reasonable action to ensure the service user's safety, and ensured that a follow-up is not reasonably required, you will have no further responsibility or liability.

Equality

2.3 You must care for all service users in a fair and just manner, always acting in accordance with human rights, legislation and in the service user's best interests.

2.3.1 You must offer equal access to services without bias or prejudice on the basis of age, gender, race, nationality, colour, faith, sexual orientation, level of ability or position in society. Practice should at all times be based

upon the occupational needs and choices of the service user.

2.3.2 You should be aware of and sensitive to how the above factors affect service users' cultural and lifestyle choices, incorporating this into any service planning, individual assessment and/or intervention where possible.

2.3.3 Where possible, the need, or a reasonable request, to be treated, seen or visited by a practitioner with specific characteristics should be met; for example, by a professional and not a student, by a male or female practitioner, or by a particular language speaker.

2.3.4 You must report in writing to your employing authority, at the earliest date in your employment, any religious and/or cultural beliefs that would influence how you carry out your duties. You should explore ways in which you can avoid placing an unreasonable burden on colleagues because of this. This does not affect your duties, as set out in sections 2.3.1 and 2.3.2, and you must always provide service users with full, unbiased information.

2.3.5 It is important to recognise the significance of spiritual, religious and cultural beliefs. If a service user or colleague asks for support, you must ensure that you follow local policy and obtain consent before you seek to meet their spiritual needs. You can offer to find alternative support if you don't feel comfortable in this situation. You must not impose your own faith or belief system onto any situation or person at work.

Resources and sustainability

2.4 Your service and your practice should be centred on the occupational needs of the service user and their carer/s, but local, national and environmental resources for care are not infinite. At times, priorities will have to be identified and choices will have to be made, while complying with legal requirements, and national and/or local policy.

2.4.1 In establishing priorities and providing services, service user and carer choice should be taken into account, and implemented wherever reasonably possible. If the service user lacks the mental capacity to identify his or her preferences, occupational therapy personnel must act in the service user's best interests.

2.4.2 You should work as cost-effectively and efficiently as possible in order to sustain resources. Practitioners are encouraged 'to re-evaluate practice models and expand clinical reasoning about occupational performance to include sustainable practice' (WFOT 2012); for example, considering the health and wellbeing co-benefits of a low carbon lifestyle (Sustainable Development Unit 2014).

2.4.3 You have a duty to report and provide evidence on resource and service deficiencies that may endanger the health and safety of service users and carers to the relevant manager, who should then take appropriate action (Great Britain. Parliament 1998a,

section 43B, point (1)d). Local policy should be followed.

2.4.4 Where the service user's or their carer's choice cannot be met, you should explain this to the service user/carer. If you cannot offer, or they will not accept, an alternative, you may provide information as to different service providers, sources of funding, etc. Provided that you have referred the service user to another agency, if appropriate; complied with all the necessary procedures; taken reasonable action to ensure the service user's safety and ensured that a follow up is not reasonably required, you will have no further responsibility or liability.

Risk management

2.5 Risk management is an intrinsic part of governance and the provision of a quality service. Risk management is a process of identifying and adequately reducing the likelihood and impact of any kind of incident occurring that might cause harm. The principles remain the same whether the potential harm is to people, organisations or the environment. The process also enables positive risks to be taken with service users in a safe and appropriate way.

2.5.1 You must familiarise yourself with the risk management legislation that is relevant to your practice, and with your own local risk management procedures.

2.5.2 You are responsible for assessing and managing the identified risks involved in providing care to your service users.

2.5.3 Where care for the service user is shared with or transferred to another practitioner or service, you must co-operate with them to ensure the health, safety and welfare of service users (Great Britain. Parliament 2014 Section 12 (2)(i)).

2.5.4 You are expected to co-operate with your employers in meeting the requirements of legislation and local policy. You must also take reasonable care for your own health and safety and that of others who may be affected by what you do, or do not do (Great Britain. Parliament 1974, section 7).

2.5.5 You must ensure that you remain up to date in all your statutory training related to risk management, health and safety, and moving and handling.

More information is available from the College of Occupational Therapists' current guidance on risk management.

Record keeping

2.6 Record keeping is core to the provision of good quality and safe care. The key purpose of records is to facilitate the care and support of a service user. It is essential to provide and maintain a written or electronic record of all that has been done for/with or in relation to a service user, including any risk

assessment and the clinical reasoning behind the care planning and provision. Your records also demonstrate how you meet your duty of care and that your practice is appropriate.

2.6.1 You must accurately and legibly record all information related to your involvement with the service user, as soon as practically possible after the activity, in line with the standards of the Health and Care Professions Council, the College of Occupational Therapists and local policy. Any record must be clearly dated, timed and attributable to the person making the entry.

2.6.2 You must ensure that you meet any legal requirements regarding appropriate data sharing and data confidentiality in record keeping (see section 3.4).

More information is available from the current College of Occupational Therapists' professional standards for occupational therapy practice and guidance on record keeping.

Section Three: Service user welfare and autonomy

Duty of care

3.1 A duty of care arises where there is a sufficiently close relationship between two parties, as with a member of occupational therapy personnel and a service user, and where it is reasonably foreseeable that the actions of one party could, if carelessly performed, cause harm or loss to the other party. Discharging the duty of care requires you to perform your occupational duties to the standard of a reasonably skilled and careful practitioner.

3.1.1 Fulfilling your duty of care

In practice, a duty of care arises when a referral has been received by an occupational therapy service or practitioner. The duty of care would require you to assess the suitability of the potential service user for occupational therapy with reasonable care and skill, following usual and approved occupational therapy practice.

If, as a result of the initial assessment, the individual is not suitable for the receipt of occupational therapy services, then no further

duty of care arises other than to inform the referrer of the decision that has been made.

3.1.2 You are required to ensure that all reasonable steps are taken to ensure the health, safety and welfare of any person involved in any activity for which you are responsible. This might be a service user, a carer, another member of staff or a member of the public (Great Britain. Parliament 1974).

3.1.3 Your duty of care would not necessarily stop at the point when a person is discharged from your service or chooses to discharge themselves. Only when you have referred the service user to another agency, if appropriate; complied with all the necessary procedures; taken reasonable action to ensure the service user's safety; and ensured that a follow up is not reasonably required, then you will have no further responsibility or liability.

3.1.4 Breach of duty of care

You may be in breach of your duties to take care if it can be shown that you have failed to perform your professional duties to the standard expected of a reasonably skilled occupational therapy practitioner.

3.1.5 Defences

If it is claimed that you have, in the performance of your duties, breached your duty of care to a service user, it is a good defence to show that a responsible body of like practitioners would have acted in the

same way - the Bolam Principle. The Bolam Principle will only be a good defence, however, if it can be shown that the body of opinion relied on has a logical basis and is respectable, responsible and reasonable in its own right. This is the Bolitho Principle (Bolitho v City and Hackney Health Authority 1998).

Welfare

3.2 You must always recognise the human rights of service users and act in their best interests.

3.2.1 You should enable individuals to preserve their individuality, self-respect, dignity, privacy, autonomy and integrity.

3.2.2 You must not engage in, or support, any behaviour that causes any unnecessary mental or physical distress. Such behaviour includes neglect and indifference to pain.

3.2.3 You must protect and safeguard the interests of vulnerable people in your care or with whom you have contact in the course of your professional duties. Vulnerable people should be treated with dignity and respect as equal members of society, entitled to enjoy the same rights and privileges as any one of us would expect. Your duty of care extends to raising concerns, with your manager or an appropriate alternative person, about any service user or carer who may be at risk in any way. Local policy should be followed.

3.2.4 You must always provide adequate information to a service user in order for them to provide informed consent. Every effort should be made to ensure that the service user understands the nature, purpose and likely effect of the intervention before it is undertaken (see section 3.3 on informed consent and mental capacity). This is particularly relevant where there is any element of risk, or where any intervention may cause pain or distress.

3.2.5 You must make every effort not to leave a service user in pain or distress following intervention. Professional judgement and experience should be used to assess the level of pain, distress or risk and appropriate action should be taken if necessary. Advice should be sought when required.

3.2.6 You must support service users and carers if they want to raise a concern or a complaint about the care or service they have received. You should communicate honestly, openly and in a professional manner, receiving feedback and addressing concerns co-operatively should they arise. Advice should be sought when required and local policy followed.

3.2.7 You have a professional duty of candour. You must be open and honest with service users when you become aware that something has gone wrong or someone has suffered harm as a result of your actions or omissions. You should immediately take steps to put matters right and apologise to service users and carers if appropriate to do so.

You must inform your manager/employer and follow local policy.

You must not knowingly obstruct another practitioner in the performance of their duty of candour. You must not provide information, or make dishonest statements about an incident, with the intent to mislead.

3.2.8 If you witness, or have reason to believe, that a service user has been the victim of mistreatment, abuse or neglect in your workplace, you must raise your concerns with your line manager or other prescribed person in order to maintain service user safety.

3.2.9 Everyone has a responsibility to safeguard children, young people and adults at risk. Should you witness, or have reason to believe, that a service user has been the victim of dangerous, abusive, discriminatory or exploitative behaviour or neglect in any setting, you must notify a line manager or other prescribed person, seeking the service user's consent where possible, and using local procedures where available.

3.2.10 If you are an employer or supplier of personnel, you must report to the relevant national disclosure and barring service any person who has been removed from work because of their behaviour, where that behaviour may meet any of the criteria for the individual to be barred from working with children or adults at risk.

3.2.11 You must take appropriate precautions to protect service users, their carers and families, and yourself from infection in relation to personal, equipment and environmental cleanliness. Local infection control guidance and policy should be followed.

Informed consent and mental capacity

3.3 You have a continuing duty to respect and uphold the autonomy of service users, encouraging and enabling choice and partnership working in the occupational therapy process.

Informed consent is an ongoing agreement by a person to receive treatment, undergo procedures or participate in research after risks, benefits and alternatives have been adequately explained to them. Informed consent is a continuing requirement. Unless restricted by mental health and/or mental capacity legislation, it is the overriding right of any individual to decide for himself (herself) whether or not to accept intervention.

A service user can only give informed consent if he or she has the mental capacity to do so. A mentally incapacitated service user cannot validly consent to or refuse treatment, nor can his relatives/carers consent on his behalf.

3.3.1 Where service users have mental capacity, they have a right to make informed choices and decisions about their future and the care and intervention that they receive. Where possible,

such choices should be respected, even when in conflict with professional opinion.

3.3.2 Service users with capacity should be given sufficient information, in an appropriate manner, to enable them to give consent to any proposed intervention/s concerning them. They should be able to understand the nature and purpose of the proposed intervention/s, including any possible risks involved.

3.3.3 For consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question. The giving of consent, whether verbal or written, must be recorded.

3.3.4 You should, as far as possible, support people in making their own choices. Where a service user's capacity to give informed consent is restricted or absent, you should try to ascertain and respect their preferences and wishes, at all times seeking to act in their best interests. All decisions and actions taken must be documented. You must attempt to provide alternative ways for a service user to give or withhold consent if speech is not possible.

3.3.5 You must assess service users' mental capacity to make decisions in relation to occupational therapy provision, in accordance with current legislation. If the service user does not have capacity, you must consider whether the proposed treatment is in the service user's best interests, having regard to the factors and consultation requirements of the legislation

and codes of practice, before commencing treatment.

3.3.6 Most service users have the right to refuse any intervention at any time in the occupational therapy process. This must be respected and recorded in the care record. You must not coerce or put undue pressure on a service user to accept intervention, but must inform them of any possible risk or consequence of refusing treatment. For service users without capacity, a 'best interests' decision is required.

3.3.7 Practitioners should be aware of current legislation, codes of practice and relevant guidance in relation to mental capacity and consent.

Further advice is available from the Department of Health; the Department of Health, Social Services and Public Safety for Northern Ireland; the Scottish Executive; and the Welsh Assembly Government.

Confidentiality

3.4 You are obliged to safeguard confidential information relating to service users at all times. It is established law that confidential personal information must be protected and a failure to do so can lead to a fine, or give the service user a cause of action for breach of confidence. The same rights and restrictions apply to material stored or transferred electronically and when communicating with others via any medium, including virtual/online communities and networks.

3.4.1 You must make yourself aware of your legal responsibilities under the *Data Protection Act 1998,* the *Human Rights Act 1998* (Great Britain. Parliament 1998b, 1998c) and mental health/capacity legislation.

3.4.2 You must keep all records, in any format, securely, making them available only to those who have a legitimate right or need to see them.

3.4.3 The disclosure of confidential information regarding the service user's diagnosis, treatment, prognosis or future requirements is only possible where: the service user gives consent (expressed or implied); there is legal justification (by statute or court order); or it is considered to be in the public interest in order to prevent serious harm, injury or damage to the service user or to any other person. Local procedures should be followed.

3.4.4 For the purposes of direct care, relevant personal confidential data should be shared among registered and regulated health and social care professionals who have a legitimate relationship with the service user, following guidance on implied consent (DH 2013, p14).

3.4.5 You must adhere to local and national policies regarding confidentiality in the storage, movement and transfer of information at all times, including via electronic/digital means.

3.4.6 You must grant service users access to their own records in accordance with relevant legislation. Reference should be made to

current guidance/policy (both local and national) on access to personal health and social care information.

3.4.7 You must obtain and record consent prior to using visual, oral, written or electronic/digital material relating to service users outside of their care situation, e.g. for learning/teaching purposes. Service user confidentiality and choice must be observed in this circumstance.

3.4.8 Discussions with or concerning a service user should be held in a location and manner appropriate to the protection of the service user's right to confidentiality and privacy.

See also section 6.1.8 in relation to confidentiality in research.

More information on confidentiality is available from the current version of the College of Occupational Therapists' guidance on record keeping.

Section Four: Professionalism

Professional conduct

4.1 As practitioners you are not just accountable for your competence, but also for your actions and behaviours, both inside and external to the workplace.

4.1.1 You must be aware of and take responsibility for the impression and impact you make on others, conducting and presenting yourself in a professional manner while in your work role.

4.1.2 You must be aware of and take responsibility for your conduct outside of your work role, in situations where your behaviour and actions may be witnessed by your colleagues, your employer, your service users and/or the public.

4.1.3 You must be aware of and take responsibility for your conduct when using any form of social media. See section 4.1.2. The content of this Code should be applied to social media use, whether for work or personal purposes.

4.1.4 You should adhere to statutory and local policies at all times.

Professional and personal integrity

4.2 You must act with honesty and integrity at all times. You must not engage in any criminal or otherwise unlawful or unprofessional behaviour or activity which is likely to damage the public's confidence in you or your profession.

4.2.1 You must not undertake any professional activities when under the influence of alcohol, drugs or other intoxicating substances.

4.2.2 You must not promote and/or use illegal substances in the workplace.

4.2.3 You must inform your employers and the regulatory body if you are convicted of a criminal offence, receive a conditional discharge for an offence, or if you accept a police caution.

4.2.4 You must inform the regulatory body if you have had any restriction placed upon your practice, been suspended or dismissed by an employer, or similar organisation, because of concerns about your conduct or competence.

4.2.5 You should co-operate with any investigation or formal enquiry into your own professional conduct, the conduct of another worker or the treatment of a service user, where appropriate.

The professionalism of colleagues

4.3 Any reference to the quality of work, or the integrity of a professional colleague should be expressed with due care to protect the reputation of that person. Any concern must be objective, evidence-based where possible and raised through appropriate channels.

4.3.1 Should you have reasonable grounds to believe that the behaviour or professional performance of a colleague may be deficient in standards of professional competence, you should notify the line manager or other appropriate person in strictest confidence. This includes (but is not limited to) when a colleague's performance is seriously deficient, when he or she has a health problem which is impairing his or her competence to practise, or when he or she is practising in a manner which places service users or colleagues at risk.

4.3.2 If you become aware that something has gone wrong or someone has suffered harm as a result of your colleagues' actions or omissions, you should raise your concerns with a line manager or other appropriate person and follow local policy.

4.3.3 If you become aware of any intentional malpractice, criminal conduct or unprofessional activity, whether by occupational therapy personnel or other staff, you should raise your concerns with a line manager or other appropriate person and follow local policy.

4.3.4 In reporting any concerns to a line manager or other appropriate person, the information must be objective, relevant and limited to the matter of concern.

4.3.5 If you are aware of discrimination, bullying and harassment in the workplace, you must adhere to statutory and local policies with regard to reporting it.

4.3.6 You may give evidence in court concerning any alleged negligence of a colleague. Such evidence must be objective and capable of substantiation.

4.3.7 When providing a second opinion to a service user and/or their carer, it must be confined to the case in question and not extend to the general competence of the first practitioner.

Personal profit or gain

4.4 You should not accept tokens such as favours, gifts or hospitality from service users, their families or commercial organisations when this might be construed as seeking to obtain preferential treatment (Great Britain. Parliament 1889, 1906, 1916). In respect of private practice this principle still prevails in terms of personal gain.

4.4.1 Local policy should always be observed in the case of gifts.

4.4.2 If a service user or their family makes a bequest to a practitioner or a service, this

should be declared according to local guidelines.

4.4.3 You must put the interests of the service user first and should not let this duty be influenced by any commercial or other interest that conflicts with this duty; for example, in arrangements with commercial providers that may influence contracting for the provision of equipment.

Information and representation

4.5 Information and/or advertising, in respect of professional activities or work, must be accurate. It should not be misleading, unfair or sensational.

4.5.1 You should accurately represent your qualifications, education, experience, training, competence and the services you provide. Explicit claims should not be made in respect of superiority of personal skills, equipment or facilities.

4.5.2 You should not claim another person's work or achievements as your own unless the claim can be fully justified. You should respect the intellectual property rights of others at all times.

4.5.3 You may only advertise, promote or recommend a product or service in an accurate and objective way. You may not support or make unjustifiable statements about a product or service.

4.5.4 If you are aware that possible misrepresentation of the protected title 'occupational therapist' has occurred, you must contact the Health and Care Professions Council.

Relationships with service users

4.6 You should foster appropriate therapeutic relationships with your service users in a transparent, ethical and impartial way, centred on the needs and choices of the service user and their family/carers.

4.6.1 It is unethical for you to enter into relationships that would impair your judgement and objectivity and/or which would give rise to the advantageous or disadvantageous treatment of a service user.

4.6.2 You must not enter into relationships that exploit service users sexually, physically, emotionally, financially, socially or in any other manner.

4.6.3 You must not exploit any professional relationship for any form of personal gain or benefit.

4.6.4 You should avoid entering into a close personal relationship with a current service user. You are responsible for maintaining an appropriate professional relationship. If there is a risk that the professional boundary may be broken, this should be disclosed and discussed with your manager. You should hand over

therapy care for the service user to an appropriate professional colleague.

4.6.5 In the case of relationships, sexual or otherwise, regardless of when the professional relationship may have started or ended, or however consensual it may have been, it will always be your responsibility to prove that you have not exploited the vulnerability of the service user and/or his or her carer, should concerns be raised.

4.6.6 As far as is reasonably practical, you should not enter into a professional relationship with someone with whom you already have, or have had, a close personal relationship. This includes family members and friends. Where there is no reasonable alternative you must make every effort to remain professional and objective while working with the individual you know or have known. In such circumstances this should be disclosed and discussed with the service manager and a note should be made in care records. This is for your protection as much as for the service user.

Fitness to practise

4.7 You must inform your employer/appropriate authority and the Health and Care Professions Council about any health or personal conditions that may affect your ability to perform your job competently and safely.

4.7.1 You should limit or stop working if your performance or judgement is affected by your health.

More information on informing the regulatory body is available from *Guidance on health and character* (HCPC 2014).

Section Five: Professional competence and lifelong learning

Professional competence

5.1 You must only provide services and use techniques for which you are qualified by education, training and/or experience. These must be within your professional competence, appropriate to the needs of the service user and relate to your terms of employment.

5.1.1 You should achieve and continuously maintain high standards in your professional knowledge, skills and behaviour.

5.1.2 You should be aware of and abide by the current legislation, guidance and standards that are relevant to your practice, remaining up to date with relevant training where necessary.

5.1.3 You should understand the scope and benefits of emerging information and communication technologies to ensure that you can make best use of what is available in your own practice, or through referral to other agencies.

5.1.4 If you are asked to act up or cover for an absent colleague, or if you are asked to take

on additional tasks, such duties should only be undertaken after discussion, considering additional planning, support, supervision and/or training.

5.1.5 Adequate training and support should be provided to enable you to be competent to carry out any additional tasks or responsibilities asked of you.

5.1.6 You should be given the opportunity to raise any concerns and be provided with the rationale behind the original request. If you find that you cannot agree to such a request you should contact your local union representative for advice and support.

5.1.7 If you are seeking to work in areas with which you are unfamiliar or in which your experience has not been recent, or if you take on a more diverse role, you must ensure that you have adequate skills and knowledge for safe and competent practice and that you have access to appropriate support.

Delegation

5.2 If you delegate interventions or other procedures you should be satisfied that the person to whom you are delegating is competent to carry them out. In these circumstances, you, as the delegating practitioner, retain responsibility for the occupational therapy care provided to the service user.

5.2.1 You should provide appropriate supervision for the individual to whom you have delegated the responsibility.

Continuing professional development

5.3 You must undertake continuing professional development (CPD) through a range of learning activities to ensure that your practice is safe, legal and effective, according to the requirements of the Health and Care Professions Council. You must maintain a continuous, up-to-date and accurate record of your CPD activities (HCPC 2012, p6).

See the College of Occupational Therapists' *Code of continuing professional development* (COT 2014a) in Appendix 1.

5.3.1 Employing organisations and managers are encouraged to recognise the value of continuing professional development to individual practitioners, the service and service users.

5.3.2 You should be supported in your practice and development through regular professional supervision, whether provided locally or via long-arm support.

5.3.3 If you have expert or high-level knowledge, skills and experience, you have a responsibility to share these with your colleagues through supervision, mentoring, preceptorship and teaching opportunities.

More information is available from the *Joint position statement on continuing professional development for health and social care practitioners* (Royal College of Nursing et al 2007), the current version of the COT supervision guidance and HCPC guidance on supervision.

Collaborative working

5.4 You should respect the responsibilities, practices and roles of other people with whom you work.

5.4.1 You should be able to articulate the purpose of occupational therapy and the reason for any intervention being undertaken, so promoting the understanding of the profession.

5.4.2 You should recognise the need for multiprofessional and multiagency collaboration to ensure that well co-ordinated services are delivered in the most effective way.

5.4.3 You have a duty to refer the care of a service user to another appropriate colleague if it becomes clear that the task is beyond your scope of practice. You should consult with other service providers when additional knowledge, expertise and support are required.

5.4.4 If you and another practitioner are involved in the treatment of the same service user, you should work co-operatively, liaising with each other and agreeing areas of responsibility. This

should be communicated to the service user and all relevant parties. Consent must be sought before sharing information.

Occupational therapy practice education

5.5 You have a professional responsibility to provide regular practice education opportunities for occupational therapy students where possible, and to promote a learning culture within the workplace.

5.5.1 You should recognise the need for individual education and training to fulfil the role of the practice placement educator and, where possible, undertake programmes of study.

5.5.2 If you undertake the role of practice placement educator, you should provide a learning experience for students that complies with the *College of Occupational Therapists' learning and development standards for pre-registration education* (COT 2014b) and current professional standards, and is compatible with the stage of the student's education or training.

5.5.3 If you accept a student for practice education, you should have a clear understanding of the role and responsibilities of the student, the educational institution and the practice educator.

More information is available from the *College of occupational therapists' learning and development standards for pre-registration education* (COT 2014b).

Section Six: Developing and using the profession's evidence base

6.1 As research consumers, you must be aware of the value and importance of research as the basis of the profession's evidence base.

6.1.1 You should be able to access, understand and critically evaluate research and its outcomes, incorporating it into your practice where appropriate.

6.1.2 You should evaluate the effectiveness and efficiency of the services that you provide, and undertake audits against appropriate available standards.

6.1.3 You should incorporate evidence-based outcome measures into your practice and research activity to demonstrate effectiveness of intervention and services.

6.1.4 When undertaking any form of research activity, you must understand the principles of ethical research and adhere to national and local research governance requirements.

6.1.5 When undertaking any form of research activity, you should abide by national, professional and local ethics approval and permission processes.

6.1.6 When undertaking any form of research activity, you must protect the interests of service users, fellow researchers and others.

6.1.7 When undertaking any form of research activity you must establish and follow appropriate procedures for obtaining informed consent, including regard to the needs and capacity of participants.

6.1.8 When undertaking any form of research activity, you must protect the confidentiality of participants throughout and after the research process.

6.1.9 You should disseminate the findings of your research activity through appropriate publication methods in order to benefit the profession and service users, and to contribute to the body of evidence that supports occupational therapy service delivery.

Appendix 1: Legislation

You are expected to be familiar and comply with any current European, UK or national legislation and policies, best practice standards, and employers' policies and procedures that are relevant to your area of practice. The *Code of ethics and professional conduct* does not identify every piece of relevant legislation, recognising that many differ across the four UK nations. Areas of legislation and guidance that are relevant to this document include:

Candour

Clinical governance

Confidentiality – data protection and sharing, access to records/freedom of information

Consent

Equality

Health and safety/safe working practice

Health and social care

Human rights

Mental health and mental capacity

Record keeping

Reporting and disclosure

Risk assessment and management

Safeguarding

Sexual offending

Appendix 2: College of Occupational Therapists code of continuing professional development

The purpose

The College of Occupational Therapists (COT) has devised this *Code of continuing professional development* (COT 2014a) to support the occupational therapy workforce by setting out clear expectations for all BAOT (British Association of Occupational Therapists) members' professional development.

It is aligned with, and complementary to, Health and Care Professions Council (HCPC) requirements for registrants, and does not replace the regulatory requirements of HCPC for professional development and adherence to their standards for continuing professional development (HCPC 2012).

This code places responsibility upon all occupational therapy personnel to extend their professional development beyond regulatory requirements in order to ensure a fulfilling career journey that sustains the profession in changing contexts and provides the best outcomes for service users.

This code should be interpreted by individual members to reflect their specific practice environment and level of expertise.

The code of continuing professional development

i. You are personally responsible for ensuring that you continue to learn, develop and enhance your professional skills and practice abilities as an occupational therapy professional and embed them in your practice.

ii. Development activities will ensure that, at a minimum, you are able to practise in a safe and reliable manner, centred around your service user/s and their occupational engagement.

iii. Your critical reflective thinking and development will take account of:

   a. Your personal values beliefs and attitudes.
   b. Your professional capability.
   c. Your practice context.
   d. Relevant current and future policy.

iv. Learning and development opportunities occur in both professional and personal areas of life and may be formal or informal. These experiences can support and evidence professional development if considered through a critically reflective approach and applied to occupational therapy practice. You will be able to demonstrate how you turn every suitable experience into a learning opportunity.

v. Critical reflective thinking underpins the bringing together of different ideas and application of all professional development activities to the benefit of your service user/s, your service and yourself. You will be able to demonstrate how you have developed your critically reflective thinking skills throughout your professional journey.

vi. You will undertake systematic formal reflection; for example, through annual appraisal and regular supervision, on your:

   a. Current professional skills and practice abilities as an occupational therapy professional.
   b. Current context of practice and service needs.
   c. Personal beliefs and values as they relate to your professional life.

   This appraisal (or systematic formal reflection) will be informed, where possible, by service user and colleague feedback and should form the baseline for your professional development strategy and plan.

vii. You will establish, maintain and actively pursue a professional development strategy that considers your current role, supports your future career path and gives direction to your learning. A plan to fulfil this strategy will be identified to ensure all the development opportunities that you undertake have purpose and meaning to you.

viii. As applicable to your professional role you will be able to demonstrate how your professional development plan positively impacts on:

   a. The experience of service users.
   b. The quality of services provided now and in the future.
   c. Your professional identity as an occupational therapy practitioner.

ix. Your professional development activities will work to support organisational needs and be shared with relevant others, including fellow occupational therapists, associate members and other professionals.

References

Bolitho v City and Hackney Health Authority [1998] AC 232 (HL).

R (Burke) v. General Medical Council (Official Solicitor and others intervening) [2005] EWCA Civ 1003, [2006] QB 273. Available at: *http://www.familylawweek.co.uk/site.aspx?i=ed409* (paragraph 50) Accessed on 12.01.15.

Caparo Industries Plc v Dickman [1990] 2 AC 605 (HL).

Christiansen CH, Townsend EA (2004) *Introduction to occupation: the art and science of living*. Upper Saddle River, NJ: Prentice Hall.

College of Occupational Therapists (2014a) *Code of continuing professional development*. London: COT.

College of Occupational Therapists (2014b) *College of Occupational Therapists' learning and development standards for pre-registration education.* London: COT.

Crepeau EB, Cohn ES, Schell BAB eds (2003) *Willard and Spackman's occupational therapy*. 10th ed. Philadelphia: Lippincott Williams & Wilkins.

Department of Health (2014) *Requirements for registration with the Care Quality Commission: response to consultations on fundamental standards, the Duty of Candour and the fit and proper persons requirement for directors.* London: DH. Available at: *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/327561/Consultation_response.pdf* Accessed on 12.01.15.

References

Department of Health (2013) *Information: to share or not to share: government response to the Caldicott review.* London: DH. Available at: *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251750/9731-2901141-TSO-Caldicott-Government_Response_ACCESSIBLE.PDF* Accessed on 12.01.15.

Department of Health (1998) *A first class service: quality in the new NHS*. London: DH. Available at: *http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4006902* Accessed on 27.01.15.

Department of Health (1977) *Relationships between medical and remedial professions*. (HC (77) 33). London: DH.

European Network of Occupational Therapy in Higher Education Terminology Project Group (2004) *Occupational therapy terminology database*. Amsterdam: ENOTHE. Available at: *http://pedit.hio.no/~brian/enothe/terminology/* Accessed on 12.01.15.

Fisher A (2013) Occupation-centred, occupation-based, occupation-focused: same, same or different? *Scandinavian Journal of Occupational Therapy, 20(3),* 162–173.

Great Britain. Parliament (2014) *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.* (SI 2936). London: Stationery Office. Available at: *http://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents* Accessed on 12.01.15.

Great Britain. Parliament (2005) *Mental Capacity Act 2005.* London: Stationery Office. Available at: *http://www.legislation.gov.uk/ukpga/2005/9/contents* Accessed on 13.01.15.

Great Britain. Parliament (1999) *Health Act 1999.* London: Stationery Office. Available at: *http://www.legislation.gov.uk/ukpga/1999/8/contents* Accessed on 13.01.15.

Great Britain. Parliament (1998a) *Public Interest Disclosure Act 1998*. London: Stationery Office. Available at: *http://www.legislation.gov.uk/ukpga/1998/23/contents* Accessed on 13.01.15.

Great Britain. Parliament (1998b) *Data Protection Act 1998*. London: Stationery Office. Available at: *http://www.legislation.gov.uk/ukpga/1998/29/contents* Accessed on 13.01.15.

Great Britain. Parliament (1998c) *Human Rights Act 1998*. London: Stationery Office. Available at: *http://www.legislation.gov.uk/ukpga/1998/42/contents* Accessed on 13.01.15.

Great Britain. Parliament (1995) *Carers (Recognition and Services) Act 1995*. London: HMSO. Available at: *http://www.legislation.gov.uk/ukpga/1995/12/contents* Accessed on 13.01.15.

Great Britain. Parliament (1992) *Trade Union and Labour Relations (Consolidation) Act* 1992. London: HMSO. Available at: *http://www.legislation.gov.uk/ukpga/1992/52/contents* Accessed on 13.01.15.

Great Britain. Parliament (1974) *Health and Safety at Work Act 1974*. London. HMSO. Available at: *http://www.legislation.gov.uk/ukpga/1974/37* Accessed on 13.01.15.

Great Britain. Parliament (1889, 1906, 1916) *Prevention of Corruption Acts 1889 to 1916*. London: HMSO.

References

Hagedorn R (2001) *Foundations for practice in occupational therapy.* 3rd ed. Edinburgh: Churchill Livingstone.

Harvey L (2014) *Analytic quality glossary.* [s.l]: Quality Research International. Available at: *http://www.qualityresearchinternational.com/glossary/competence.htm* Accessed on 27.01.15.

Health and Care Professions Council (2014) *Guidance on health and character.* London: HCPC. Available at: *http://www.hpc-uk.org/publications/* Accessed on 12.01.15.

Health and Care Professions Council (2012) *Continuing professional development and your registration*. London: HCPC. Available at: *http://www.hpc-uk.org/publications/* Accessed on 12.01.15.

Jameton A, McGuire C (2002) Toward sustainable health-care services: principles, challenges, and a process. *International Journal of Sustainability in Higher Education, 3(2),* 113–127.

Neilson C (1998) The issue is how can academic culture move towards occupation-centered education? *American Journal of Occupational Therapy, 52(5),* 386–387.

Phillips C, Thompson G (2009) *What is cost effectiveness*? 2nd ed. London: Hayward Medical Communications.

Royal College of Nursing, Institute of Biomedical Science, Unison, British Academy of Audiology, Royal College of Midwives, British Association of Art Therapists . . . Chartered Society of Physiotherapy (2007) *A joint statement on continuing professional development for health and social care practitioners*. London: RCN.

Sustainable Development Unit (2014) *Sustainable, resilient, healthy people & places: a sustainable development strategy for the NHS, public health and social care system*. Cambridge: SDU. Available at: *http://www.sduhealth.org.uk/documents/publications/2014%20strategy%20and%20modulesNewFolder/Strategy_FINAL_Jan2014.pdf* Accessed on 08.03.15.

UK Clinic Ethics Network (undated) *Mental Capacity Act: determining best interests*. (Educational Resources). Available at: *http://www.ukcen.net/index.php/education_resources/mental_capacity/determining_best_interests* Accessed on 25.01.15.

World Federation of Occupational Therapists (2013) *Definitions of occupational therapy from member organisations*. Forrestfield, AU: WFOT. (This document can be accessed from the Resource Centre, filter resources by category: 'General'). Available at: *http://www.wfot.org/resourcecentre.aspx* Accessed on 14.01.15.

World Federation of Occupational Therapists (2012) *Environmental sustainability, sustainable practice within occupational therapy*. (Position Statement). Forrestfield, AU: WFOT. (Position statements can be accessed from the Resource Centre, filter resources by category: 'Position Statements'). Available at: *http://www.wfot.org/resourcecentre.aspx* Accessed on 14.01.15.

World Federation of Occupational Therapists (2010) *Statement on occupational therapy*. Forrestfield, AU: WFOT. (Position statements can be accessed from the Resource Centre, filter resources by category: 'Position Statements'). Available at: *http://www.wfot.org/resourcecentre.aspx* Accessed on 14.01.15.

Bibliography

For the most recent versions of College of Occupational Therapists' publications please visit www.cot.org.uk/publications

College of Occupational Therapists (2015) *Supervision*. London: COT.

College of Occupational Therapists (2011) *Professional standards for occupational therapy practice.* London: COT. Available at: *http://www.cot.co.uk/standards-ethics/professional-standards-occupational-therapy-practice* Accessed on 12.01.15.

College of Occupational Therapists (2010) *Risk management.* 2nd ed. London: COT.

College of Occupational Therapists (2010) *Record keeping*. 2nd ed. London: COT.

College of Occupational Therapists (2010) *Code of ethics and professional conduct*. London: COT.

Department for Constitutional Affairs (2007) *Mental Capacity Act 2005 code of practice.* London: Stationery Office. Available at: *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224660/Mental_Capacity_Act_code_of_practice.pdf* Accessed on 12.01.15.

Department of Health (2009) *Reference guide to consent for examination or treatment*. 2nd ed. London: DH.

Great Britain. Parliament (2006) *Safeguarding Vulnerable Groups Act 2006*. London: Stationery Office. Available at: *http://www.legislation.gov.uk/ukpga/2006/47/contents* Accessed on 14.01.15.

Great Britain. Parliament (2000) *Freedom of Information Act 2000.* London: Stationery Office. Available at: *http://www.legislation.gov.uk/ukpga/2000/36/contents* Accessed on 13.01.15.

Great Britain. Parliament (1983) *Mental Health Act 1983*. London: HMSO. Available at: *http://www.legislation.gov.uk/ukpga/1983/20/contents* Accessed on 14.01.15.

Health and Care Professions Council (2013) *Standards of proficiency: occupational therapists*. London: HCPC. Available at: *http://www.hpc-uk.org/publications/* Accessed on 12.01.15.

Health and Care Professions Council (2012) *Standards of conduct, performance and ethics*. London: HCPC. Available at: *http://www.hpc-uk.org/publications/* Accessed on 12.01.15.

Health and Care Professions Council (2012) *Your guide to our standards of continuing professional development*. London: HCPC. Available at: *http://www.hpc-uk.org/publications/* Accessed on 12.01.15.

Health and Care Professions Council (2010) *Guidance on conduct and ethics for students*. London: HCPC. Available at: *http://www.hpc-uk.org/publications/* Accessed on 12.01.15.

Royal College of Nursing (2011) *Spirituality in nursing care: a pocket guide*. London: RCN. Available at: *http://www.rcn.org.uk/__data/assets/pdf_file/0008/372995/003887.pdf* Accessed on 02.02.15.

World Federation of Occupational Therapists (2005) *Code of ethics*. Forrestfield, AU: WFOT.

Code of Ethics and Professional Conduct

This *Code of ethics and professional conduct* describes a set of professional behaviours and values that the British Association of Occupational Therapists expects its members to abide by, and believes all occupational therapy personnel should follow.

Occupational therapists must demonstrate behaviours that promote and protect the wellbeing of service users and their carers, the wider public, and the reputation of employers and the profession. To be deemed as 'competent', occupational therapists need a combination of knowledge, skills and behaviours. They may learn knowledge and skills through professional training and/or experience and continuing professional development, but these elements alone are not necessarily what make a good or safe practitioner.

Reviewed every five years, the Code is an essential, practical and user-friendly guide for all members of the occupational therapy profession. Equally, it provides a useful resource for members of the public, employing organisations and other professions who need to be aware of the Code, its requirements and the expectations of the professional body in terms of ethics and professional conduct.

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Royal College of Occupational Therapists

Professional Standards for Occupational Therapy Practice

College of Occupational Therapists

Royal College of Occupational Therapists

The *Professional standards for occupational therapy practice 2017* should be read alongside the College of Occupational Therapists' *Code of ethics and professional conduct* (COT 2015a). Together they describe the level and nature of professional practice that the College expects its members to abide by, and believes all occupational therapy practitioners should follow.

The *Code of ethics and professional conduct* (COT 2015a) is available to download at: **www.rcot.co.uk/standards-ethics/standards-ethics**

Enquiries related to these two documents should be directed to:
Royal College of Occupational Therapists' Professional Practice Enquiry Service
Telephone: 020 7450 2330 Email: professional.enquiries@rcot.co.uk

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The Royal College of Occupational Therapists is a wholly owned subsidiary of the British Association of Occupational Therapists (BAOT) and operates as a registered charity. It represents the profession nationally and internationally, and contributes widely to policy consultations throughout the UK. The College sets the professional and educational standards for occupational therapy, providing leadership, guidance and information relating to research and development, education, practice and lifelong learning. In addition, 10 accredited specialist sections support expert clinical practice.

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College of Occupational Therapists

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Key terms

The College has selected or developed these definitions and explanations to help with the understanding of this document. If you are a member of the public and you need help understanding any element of this document, please ask your local occupational therapist.

Assessment	*A process of collecting and interpreting information about people's functions and environments, using observation, testing and measurement, in order to inform decision-making and to monitor change.* (Consensus definition from European Network of Occupational Therapy in Higher Education (ENOTHE) 2004)
Asset	*An 'asset' is defined as any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses.* (Hudson 2010)

Asset-based approach	An approach that values, utilises and builds upon the abilities, skills, knowledge and other resources of individuals, families, groups and communities. It aims to promote and strengthen the factors that support good health and wellbeing, enabling those individuals, groups and communities to gain more control over their lives and circumstances.
Autonomy	*The freedom to make choices based on consideration of internal and external circumstances and to act on those choices.* (Consensus definition from ENOTHE 2004)
Best interests	The best interests approach asks whether any proposed course of action is the best one for the service user, all things considered. As well as recognising the use of best interests decisions under the *Mental Capacity Act 2005* (Great Britain. Parliament 2005), the approach is extended within these standards to all service users. (Adapted from UKCEN (UK Clinical Ethics Network) 2011))
Care	'Care' is used in various ways in this document, talking about the care

Key terms

	team, care documentation, etc. It is also used to encompass more than intervention, to capture the responsibility or attitudinal element, where the approach to our service users is one of care rather than neglect, as used in having a 'duty of care' or 'shared care' with another organisation. It also fits with the provision of both health and social care.
Carer	Someone who provides (or intends to provide), paid or unpaid, a substantial amount of care on a regular basis for someone of any age who is unwell or who, for whatever reason, cannot care for themselves independently. (Adapted from Great Britain. Parliament 1995) This is sometimes divided into formal carers (care workers) who are paid to give care, and informal carers (often family) who are not paid to provide care.
Competence/ competency	*Competence is the acquisition of knowledge, skills and abilities at a level of expertise sufficient to be able to perform in an appropriate work setting.* (Harvey 2014)

Continuing professional development (CPD)	*CPD is a combination of approaches, ideas and techniques that will help you manage your own learning and growth.* (CIPD (Chartered Institute of Personnel and Development) 2016) *A range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice.* (Health and Care Professions Council (HCPC) 2012, p1)
Diverse settings	Working in settings or roles where occupational therapists traditionally have not worked.
Duty of care	A responsibility to act in a way that ensures that injury, loss or damage will not be carelessly or intentionally inflicted upon the individual or body to whom/which the duty is owed, as a result of the performance of those actions. A duty of care arises: ■ When there is a sufficiently close relationship between two parties (e.g. two individuals, or an individual and an organisation). Such a relationship exists

	between a service user and the member of occupational therapy personnel to whom s/he has been referred, while the episode of care is ongoing. ■ Where it is foreseeable that the actions of one party may cause harm to the other. ■ Where it is fair, just and reasonable in all the circumstances to impose such a duty. (See Caparo Industries plc v Dickman 1990)
Enablement	[The process of creating opportunities] *to participate in life's tasks and occupations irrespective of physical or mental impairment or environmental challenges.* (Christiansen and Townsend 2004, p276)
Generic role	A generic role may involve or practice combining tasks previously undertaken by different professions. This might be a part or all of a role. For example, providing management support across a range of professional groups, or carrying out a range of health checks within the community.

Healthy occupations	Activities that encourage and develop health and wellbeing, or decrease the risk of injury or disease.
Intervention	*The process and skilled actions taken by occupational therapy practitioners ... to facilitate engagement in occupation.* (O'Brian et al 2012, p180)
Must	Where there is a legal requirement, an overriding principle or duty to act.
Occupation	*In occupational therapy, 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 (WFOT) 2016)
Occupational performance	A person's ability to carry out the activities and roles that they need, or want, or are expected to do in their daily life.
Occupational therapy personnel	For the purpose of this document, this term includes occupational therapists, occupational therapists

Key terms

	working in diverse settings or generic roles, occupational therapy students and support workers working with or for occupational therapists. It is also pertinent to occupational therapists who are managers, educators and researchers.
Outcome measure	*Outcome measurement can demonstrate the effectiveness of intervention for individual service users or population groups, guiding further decision-making and/or intervention. The use of outcome measures, especially standardised measures, allows occupational therapists to build up and use a body of evidence for occupational therapy.* (COT 2015b, p2)
Participation	*Participation is involvement in a life situation.* (World Health Organisation 2002, p10) *Participation can take on both objective (for example frequency) and subjective dimensions involving experiences of meaning, belonging, choice, control, and the feeling of participation.* (Eriksson et al 2007; Hemmingsson and Jonsson 2005 in Bonnard and Anaby 2016, p188)

Positive risk	Recognising and accepting, but managing, risk when there is a positive objective or outcome.
Practitioner	For the purposes of this document, see 'occupational therapy personnel'.
Reasonable	An objective standard. Something (e.g. an act or decision) is reasonable if the act or decision is one which a well-informed observer would also do or make.
Service user	For the purposes of this document the term 'service user' has a wide interpretation; relating to not just those in receipt of health and social care services but also to the population with whom you are working.
Should	Where the principle or duty may not apply in all circumstances, by contrast with a 'must' obligation.
Sustain/ sustainable	*Sustainable health care combines three key factors: quality patient care, fiscally responsible budgeting and minimizing environmental impact.* (Jameton and McGuire 2002)

Section One: Essential reading

1.1 Occupational therapy practitioners

> *Occupational therapy enables people to achieve health, wellbeing and life satisfaction through participation in occupation.*
>
> (College of Occupational Therapists 2004 definition, in World Federation of Occupational Therapists 2013, p48)

Occupational therapy practitioners are a highly skilled workforce operating across a wide range of settings, including health, social care, housing, education, research, employment, prisons and the third sector.

As an occupational therapist or a support worker, you are aware of your legal and professional obligations and how they impact upon your work. You always work within your competence and the remit of your job description and within the terms of your employment.

As an occupational therapist you are a qualified and competent professional. You are an autonomous practitioner and are personally accountable for what you do. You have a reasonable and demonstrable rationale for your practice (HCPC 2013, p5). You meet the

requirements of the Health and Care Professions Council (HCPC) and are registered with them when practising within the United Kingdom.

1.2 The importance of occupation

Underpinning your practice is the belief that occupation and activity are fundamental to a person's health and wellbeing, within the context of their various environments. A person's ability to carry out the activities and roles that they need, want, or are expected to do in their daily life is seen as their occupational performance.

You understand how a person's health and wellbeing affects, and is affected by, their occupational performance and participation. Your professional practice is concerned with developing, maximising and/or maintaining service users' ability to engage in a range of occupations.

You enable a person, group or community to achieve their chosen goals through the modification of their desired or required occupations, learning new skills and approaches, adaptation of their environments, or a combination of these. You see activity in itself as an effective medium for remediation or an agent of change.

You take an asset-based approach, analysing and utilising the strengths of the individual, the environment, and the community in which a person lives and functions. You work with the person, their family and/or carers and their

communities where appropriate, to identify solutions and enhance their ability to engage in the occupations they want, need, or are expected to do.

1.3 The role of the Health and Care Professions Council and the College of Occupational Therapists

The primary role of the Health and Care Professions Council (HCPC), as the regulating body, is the protection of the public. As an occupational therapist, you must be registered with the HCPC in order to practise within the United Kingdom and your professional practice must be carried out in accordance with their standards. If a formal complaint is made, or a concern is raised about a registrant's fitness to practise, the HCPC will take account of whether their own standards have been met (HCPC 2013, 2016).

The College of Occupational Therapists (COT) is the professional body and voluntary membership organisation for occupational therapists throughout the United Kingdom. It is a subsidiary of and trading name for the British Association of Occupational Therapists (BAOT), which also acts as a trade union. The College sets the professional and educational standards for the occupational therapy profession and represents the profession at national and international levels. A key function of the College is to support you, as members, informing

and supporting you in your practice. It is not the role of the College to judge a practitioner's fitness to practise.

1.4 The professional standards

The *Professional standards for occupational therapy practice* are produced by the College, in consultation and collaboration with its members. They are developed in line with the Health and Care Professions Council (HCPC) standards in order to support you in meeting their requirements.

These standards should be read in conjunction with the *Code of ethics and professional conduct* (COT 2015a). Together they describe a level of practice and a set of professional values and behaviours that the College expects its members to abide by, and believes all occupational therapy practitioners should follow.

They are universal and applicable, with some interpretation, to all practitioners, irrespective of role or location. Whether an assistant, a new graduate or highly experienced; whether in a diverse setting or a generic role, you should be able to apply the underpinning principles of these standards to the work that you do.

In your practice you will need to use the knowledge and skills you have learned through education, experience and continuing professional development. You will also need to demonstrate behaviours that promote and protect the wellbeing of service users and their

carers, the wider public, and the reputation of your employers and the profession. You also need to use national guidelines, research and evidence to underpin and inform your practice. Maintaining these standards will help you to:

- be a safe and effective practitioner
- provide a high-quality service
- provide value for money
- explain and promote the work that you do in the language of occupation
- meet the registration requirements of the HCPC.

The *Professional standards* are very succinct in terms of describing what is expected of you. You are advised to read relevant COT guidance documents for further detail and explanation.

For students and educators these standards also complement the *College of Occupational Therapists' learning and development standards for pre-registration education* (COT 2014a) and *Entry level occupational therapy core knowledge and practice skills* (COT 2016), which describe the expected profile of an occupational therapy graduate. Both may be used to guide, develop and monitor the progress of students, graduates and returners to the profession.

These standards are an information resource to direct you and a means by which you can examine your practice. They may also be used as an aid to discussions in the workplace, whether with your colleagues, your manager or those

you supervise. They may help to guide strategic decisions relating to occupational therapy and be used as a basis for dialogue and negotiation with commissioners, purchasers of services and in other business settings. You can use the standards to demonstrate the value and uniqueness of your professional contribution.

In any civil or criminal proceedings these standards may be admissible as evidence. They may be used as a measure of reasonable and/or acceptable practice in support of the complaint or the defence.

1.5 Terminology in these standards

Throughout these standards the term 'practitioner' has been used to identify you as the active individual, wherever you work and whatever your role. The term 'service user' has been used for those to whom you provide education, support, intervention or a service. This may sometimes be a group or a community. Although not always specified in the standards, the service user's carers and/or family should be actively involved where appropriate and with the agreement of the service user. The work that you do for and with service users has been termed 'care' and/or 'intervention'.

1.6 Monitoring and developing your practice and service

The Health and Care Professions Council (HCPC) requires you to 'be able to assure the quality of

[your] practice' recognising 'the need to monitor and evaluate the quality of practice and the value of contributing to the generation of data for quality assurance and improvement programmes' (HCPC 2013, section 12). You also have a responsibility to ensure that your service is optimised to meet identified need. Using these standards as a benchmark against which to scrutinise your practice and/or your service is one means of doing this. There are audit resources available on the College website to help you with this (www.cot.co.uk).

The results of monitoring and improving your practice should be included in your continuing professional development (CPD) portfolio, along with your other evidence of learning and development.

1.7 When local policy says different

You may find that occasionally local circumstances prevent you from meeting some part of the standards. In such a case, you need to be sure that you are meeting your legal responsibilities, your duty of care to service users and all HCPC requirements. If you are concerned that your local policy is causing you to fall short of your legal and professional duties, or that it puts the welfare of service users, yourself or your colleagues at risk, you must raise this with your employer. Keep a record of your concerns. You are advised to contact your local union representative and the College's Professional Practice Enquiries Service in such situations, as each may be able to advise you.

Section Two: Standard statements

- **These standards should be read in conjunction with the *Code of ethics and professional conduct*** (COT 2015a).
- Together they describe a level of practice and a set of professional values and behaviours that the College expects its members to abide by, and believes all occupational therapy practitioners should follow. They are applicable, with some interpretation, to all practitioners, irrespective of role or location.
- Although not always specified in the standards, the service user's carers and/or family should be actively involved where appropriate and with the agreement of the service user.

1. Underpinning your occupational therapy practice is an understanding of the relationship between occupation and health and wellbeing.

1.1 You understand how occupational performance and participation affects, and is affected by, a person's health and wellbeing.

1.2 You understand the relationship between the person, their environment and their occupational performance and wellbeing.

1.3 You are able to explain and record your professional reasoning for anything you do for/with or in relation to service users.

1.4 Your practice is shaped or structured according to recognised theories, frameworks and concepts of occupational therapy.

1.5 You use national guidelines, research and other evidence to underpin and inform your practice.

1.6 In diverse settings or generic roles your practice still has an occupation focus.

2. Service users are at the centre of your practice.

2.1 You work in partnership with service users, being led and guided by their needs, choices and aspirations.

2.2 With the service user's agreement, you actively involve their carers and/or family in your practice as appropriate.

2.3 You seek to act in the best interests of service users to ensure their optimum health, wellbeing and safety.

2.4 You use the service user's preferred means of communication where possible, optimising their abilities to participate by any suitable means.

2.5 You uphold the service user's right to make choices over the care that they receive and the plans that they wish to make.

2.6 If a service user declines intervention or chooses to follow an alternative course of

action, you do all you reasonably can to maintain his or her safety and wellbeing.

2.7 You assess and meet the needs of the carers where appropriate.

2.8 You work towards the inclusion and involvement of the service user in their own communities.

3. Through review of documents, discussion and/or interview, you screen/triage the service user's occupational needs.

3.1 You consider the occupational needs of the service user and the potential benefit of occupational therapy within the context of your service provision.

3.2 Where occupational needs are not present or could best be met through other service provision, you direct service users to alternative services, information and advice.

4. Through interview, observation and/or specific assessment, you identify and evaluate the service user's occupational performance and participation needs.

4.1 You use assessment techniques, tools and/or equipment that are relevant to occupation and appropriate to the service users and their circumstances.

4.2 Your analysis of the assessment outcomes shows how the service user's current situation or conditions affect their occupational performance and ability to participate.

4.3 If further assessments or investigations are indicated, you instigate these or refer to other services.

5. You develop appropriate intervention plans, or recommendations, based upon the occupational performance needs, choices and aspirations of service users, as identified through your assessments.

5.1 You work with service users in the planning process, agreeing their objectives and priorities for intervention.

5.2 You promote wellbeing, encourage healthy occupations and participation in life roles.

5.3 You act to reduce, delay or prevent future needs where possible.

5.4 You consider how the assets of the individual, their carers/family and their communities can be used to maximise their occupational performance.

5.5 You consider the impact of your intervention on the person, occupation and environment and how occupational performance and participation is affected.

5.6 You work with service users and relevant others to develop skills to manage their own occupational needs.

5.7 You agree and record timescales and/or review dates in your plans.

5.8 You review, amend and document your plans and interventions regularly in partnership with service users.

5.9 You work in collaboration with relevant others to inform your intervention.

6. You evaluate the impact of the intervention that you have provided in terms of the service user's response and occupational outcomes.

6.1 You use outcome measures to monitor and review the ongoing effectiveness of your intervention.

6.2 You include the views and experience of service users when evaluating the effectiveness of occupational therapy intervention.

6.3 You take account of information gathered from relevant others.

6.4 Where necessary you modify and revise your plans and intervention in partnership with the service users.

6.5 Any decision to cease intervention is based upon your evaluation and is taken in consultation with the service users.

6.6 Your outcomes demonstrate the value and benefit of your input to the individual and/or community.

7. You keep care records that are fit for purpose and process them according to legislation.

7.1 You provide a comprehensive, accurate and justifiable account of all that you plan or provide for service users.

7.2 You record the evidence and rationale for all that you do.

7.3 Your care records are written promptly, as soon as practically possible after the activity occurred.

7.4 You are aware of and meet all requirements in relation to record keeping, whether in legislation, guidance or policies.

7.5 You comply with any legal and professional requirements and local policies in relation to confidentiality, the sharing of information and service user access.

7.6 You keep your records securely, retain and dispose of them according to legal requirements and local policy.

➤ You are advised to read the College of Occupational Therapists' current guidance on *Record keeping* (COT 2010a) for further information. A third edition is due for publication in 2017.

8. You seek to demonstrate and enhance the quality, value and effectiveness of the service/s that you provide.

8.1 You collect and collate outcome data to evidence the effectiveness of your interventions.

8.2 You collect and collate outcome data to meet the requirements of commissioners/funders of services.

8.3 You seek to measure the impact of your input on the occupational performance, participation and wellbeing of service users.

8.4 Where possible you collect and use data to demonstrate the value for money of the service/s that you provide.

8.5 You use the information that you collect, with other national, local and professional resources, to improve the quality, value and effectiveness of the service/s that you provide.

9. You are qualified by education, training and/or experience to practise capably and safely in your chosen role.

9.1 You have sufficient knowledge and skills to make reliable professional judgements suitable to your level of responsibility.

9.2 You only work within your professional competence, seeking advice or referring to another professional when required.

9.3 You continually maintain your knowledge and skills in order to meet the needs of service users safely and effectively.

9.4 You maintain your awareness and skills in digital technology in order to meet the requirements of your role.

9.5 You participate in any statutory and mandatory training required for your work.

9.6 You seek out and engage with continuing professional development opportunities relevant to your learning and development needs, to encompass practice skills, research skills, teaching others and leadership.

9.7 You receive the equivalent of a minimum of one half day each month for agreed continuing professional development activity, scholarship and/or research (RCN et al 2007), over and above statutory and mandatory training.

9.8 As a practitioner, you receive regular professional supervision and appraisal, where you use critical reflection to review your practice.

- As part of your CPD, you are advised to read the College of Occupational Therapists' *Managing information: a 10-year strategic vision for occupational therapy informatics* (2014b) and the accompanying *Managing information: implementation plan 2015–2025* (COT 2015c).
- You are also advised to read the College's current guide on *Supervision* (COT 2015d) and the *College of Occupational Therapists code of continuing professional development* (COT 2015a, appendix 2) for further information.
- Further additional reading includes the College's *Entry level occupational therapy core knowledge and practice skills* (COT 2016) and the forthcoming publication (in development at the time of press, due late 2017) *The career development framework: guiding principles for occupational therapy* (COT in press).

10. You work collaboratively with your colleagues to maximise the outcomes of intervention.

10.1 You actively seek to build and sustain positive professional relationships.

10.2 You work and communicate with colleagues and representatives of other organisations to ensure the safety and wellbeing of service users.

10.3 You work with others within your area of expertise to promote knowledge, skills and good practice.

10.4 You refer to other colleagues or services where appropriate, utilising their skills to the benefit of the service user.

11. Your communication style and manner is always professional.

11.1 Your language and communication style demonstrates respect to those with whom you are working.

11.2 You always maintain professional communication towards your colleagues and/or service users.

11.3 You communicate with service users clearly, openly, sensitively and effectively.

11.4 Discussions related to service users are held in a way that maintains their dignity and privacy.

11.5 You confidently participate in formal and informal reporting.

11.6 You communicate effectively within your line management structure.

11.7 You document your comments where a written record is needed.

12. You support the training and development of colleagues and those you supervise.

12.1 You provide regular supervision and annual appraisals to those you line/professionally manage.

12.2 Where appropriate you provide regular practice education opportunities for occupational therapy students, in accordance with relevant standards.

12.3 You support the learning and development of colleagues from other professions, services and agencies in relation to occupational therapy.

13. You monitor, make best use of and sustain your personal and service resources.

13.1 You recognise the limits of your own capacity and do not extend your workload or remit to the detriment of the quality or safety of your service.

13.2 You seek to work as effectively and efficiently as possible to make best use of environmental, physical, financial, human and personal resources.

13.3 You ensure that your service meets the ongoing needs of the service user population.

13.4 As a practitioner you report and document where resource and service deficiencies may endanger the health and safety of service users, carers, yourself and your colleagues.

13.5 As a manager, clinical or professional leader, you act on any reports concerning resources and service deficiencies.

14. You take reasonable care of your own health and safety and that of others who may be affected by what you do, or do not do.

14.1 You abide by national and local health and safety regulations, policies and procedures.

14.2 You abide by national and local risk management regulations, policies and procedures.

14.3 You enable positive risks to be taken safely by service users, in cases where such risks are a necessary part of intervention.

14.4 You establish and maintain a safe practice environment, including when travelling or in the community.

14.5 You abide by legislation and guidance concerning moving and handling, while enabling service users to gain optimal occupational performance and autonomy in their lives.

14.6 You ensure that you, and those for whom you are responsible, are trained and competent in moving and handling techniques, including the selection and use of equipment.

➤ You are advised to read the College's current guidance on *Risk management* (COT 2010b) for further information. A new edition is due to be published in late 2017.

References

Bonnard M, Anaby D (2016) Enabling participation of students through school-based occupational therapy services: towards a broader scope of practice. *British Journal of Occupational Therapy, 79(3),*188–192. Available at: *http://bjo.sagepub.com/content/79/3/188.full.pdf+html*

Caparo Industries plc v Dickman [1990] 2 AC 605 (HL).

Christiansen CH, Townsend EA eds (2004) *Introduction to occupation: the art and science of living*. Upper Saddle River, NJ: Prentice Hall.

CIPD (Chartered Institute of Personnel and Development) (2016) *What is CPD?* London: CIPD. Available at: *https://www.cipd.co.uk/cpd/about.aspx*

College of Occupational Therapists (in press) *The career framework: guiding principles for occupational therapy.* London: COT.

College of Occupational Therapists (2016) *Entry level occupational therapy core knowledge and practice skills.* London: COT.

College of Occupational Therapists (2015a) *Code of ethics and professional conduct*. London: COT. Available at: *https://www.cot.co.uk/sites/default/files/publications/public/CODE-OF-ETHICS-2015.pdf*

College of Occupational Therapists (2015b) *Measuring outcomes.* (Research Briefing). London: COT. Available at: *https://www.cot.co.uk/briefings/measuring-outcomes-2015*

References

College of Occupational Therapists (2015c) *Managing information: implementation plan 2015–2025.* London: COT. Available at: *https://www.cot.co.uk/publication/z-listing/managing-information-implementation-plan-2015-2025*

College of Occupational Therapists (2015d) *Supervision*. London: COT. Available at: *https://www.cot.co.uk/publication/z-listing/supervision*

College of Occupational Therapists (2014a) *College of Occupational Therapists' learning and development standards for pre-registration education*. London: COT.

College of Occupational Therapists (2014b) *Managing information: a 10-year strategic vision for occupational therapy informatics*. London: COT. Available at: *https://www.cot.co.uk/publication/cot-publications/managing-information*

College of Occupational Therapists (2011) *Professional standards for occupational therapy practice.* London: COT.

College of Occupational Therapists (2010a) *Record keeping*. 2nd ed. London: COT. Available at: *https://www.cot.co.uk/publication/books-guidance/record-keeping*

College of Occupational Therapists (2010b) *Risk management*. 2nd ed. London: COT. Available at: *https://www.cot.co.uk/publication/books-z-listing/risk-management*

Eriksson L, Welander J, Granlund M (2007) Participation in everyday school activities for children with and without disabilities. *Journal of Developmental and Physical Disabilities, 19(5)*, 485–502.

European Network of Occupational Therapy in Higher Education Terminology Project Group (2004) *Occupational therapy terminology database.* Amsterdam: ENOTHE. Available at: *http://pedit.hio.no/~brian/enothe/terminology/*

Great Britain. Parliament (2005) *Mental Capacity Act 2005.* London: Stationery Office. Available at: *http://www.legislation.gov.uk/ukpga/2005/9/contents*

Great Britain. Parliament (1995) *Carers (Recognition & Services) Act 1995*. London: HMSO. Available at: http://www.legislation.gov.uk/ukpga/1995/12/contents

Harvey L (2014) *Analytic quality glossary*. [s.l.]: Quality Research International. Available at: *http://www.qualityresearchinternational.com/glossary/#c*

Health and Care Professions Council (2016) *Standards of conduct, performance and ethics*. London: HCPC.

Health and Care Professions Council (2013) *Standards of proficiency: occupational therapists*. London: HCPC.

Health and Care Professions Council (2012) *Your guide to our standards for continuing professional development*. London: HCPC.

Hemmingsson H, Jonsson H (2005) An occupational perspective on the concept of participation in the international classification of functioning, disability and health – some critical remarks. *American Journal of Occupational Therapy, 59(5),* 569–576.

Hudson B (2010) *An asset-based approach to community building.* Surrey: Community Care. Available at: *http://www.communitycare.co.uk/2010/06/11/an-asset-based-approach-to-community-building/*

References

Jameton A, McGuire C (2002) Towards sustainable health-care services: principles, challenges, and a process. *International Journal of Sustainability in Higher Education, 3(2),* 113–127.

O'Brian JC, Hussay SM, Sabonis-Chaffee B (2012) *Introduction to occupational therapy*. 4th ed. Missouri: Elsevier Mosby.

Royal College of Nursing, College of Occupational Therapists, Institute of Biomedical Science (2007) *A joint statement on continuing professional development for health and social care practitioners*. London: RCN.

UKCEN Clinical Ethics Network (2011) *Mental Capacity Act: determining best interests*. Warwick: UKCEN. Available at: *http://www.ukcen.net/index.php/education_resources/mental_capacity/determining_best_interests*

World Federation of Occupational Therapists (2016) Definition "occupation". Forrestfield, AU: WFOT. Available at: *http://www.wfot.org/AboutUs/AboutOccupationalTherapy/DefinitionofOccupationalTherapy.aspx*

World Federation of Occupational Therapists (2013) *Definitions of occupational therapy from member organisations*. Forrestfield, AU: WFOT. Available at: *http://www.wfot.org/ResourceCentre.aspx*

World Health Organisation (2002) *Towards a common language for functioning, disability and health ICF.* Geneva: WHO. Available at: *http://www.who.int/classifications/icf/en/*

All websites accessed on 28.07.16.

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Professional Standards for Occupational Therapy Practice

The *Professional standards for occupational therapy practice* are produced by the College in consultation and collaboration with its members. They are developed in line with the Health and Care Professions Council (HCPC) standards, in order to support members in meeting their requirements.

Reviewed every five years, the standards are an essential and practical guide for all members of the occupational therapy profession. They should be read alongside the *Code of ethics and professional conduct* (COT 2015). Together they describe a level of practice and a set of professional values and behaviours that the College expects its members to abide by, and believes all occupational therapy practitioners should follow. Equally, they provide a useful reference point for members of the public, employing organisations and others who need to be aware of the expectations of the professional body.

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Royal College of Occupational Therapists

Professional standards for occupational therapy practice, conduct and ethics

Royal College of Occupational Therapists

About the publisher

The Royal College of Occupational Therapists (RCOT) is a wholly owned subsidiary of the British Association of Occupational Therapists (BAOT) and operates as a registered charity. It represents the profession nationally and internationally, and contributes widely to policy consultations throughout the UK. RCOT sets the professional and educational standards for occupational therapy, providing leadership, guidance and information relating to research and development, education, practice and lifelong learning. In addition, 10 accredited specialist sections support expert clinical practice.

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Professional standards for occupational therapy practice, conduct and ethics

Royal College of Occupational Therapists

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Terminology and language

A list of key terms can be found in Section 7. Considering the breadth of the profession, we recognise that some of the terminology used in this document may need a degree of interpretation when applying the Standards to your individual scope of practice or work setting. Each statement is written as a description of the expected action/behaviour. If you don't do it, you are not meeting the standard, although you may have a justifiable reason. Throughout these Standards:

- The term 'practitioner' has been used to identify you as the active individual, wherever you work and whatever your scope and level of practice. It includes occupational therapists, support workers and occupational therapy learners, both students and apprentices. It is applicable to practitioners in all roles, including those who are in management and leadership, education, research, consultancy and advisory roles, and working in industry.
- The term 'occupational therapy workforce' has been used as a collective term for all practitioners as defined in the paragraph above.
- The work you do for and with individuals/groups has been termed 'intervention', which includes providing services such as care and support, information, assessment, recommendations or advice, direction, supervision and education.
- The term 'people (or those) who access the service' has been used for those to whom you provide intervention. These may be individuals, families and carers, groups or communities.
- Within the context of this document, the term 'service' usually refers to the overall occupational therapy input that you provide, rather than referring to an occupational therapy department or facility.
- Although not specified in the individual standards, the person's carers and/or family are actively involved where appropriate and with the individual's agreement.

Section 1

Introduction

This section describes the context and status of these professional standards.

1.1 The professional standards for occupational therapy practice, conduct and ethics

1.1.1 The Royal College of Occupational Therapists, as the sole professional body for the profession in the United Kingdom (UK), supports, develops and protects the UK domain knowledge. These *Professional standards for occupational therapy practice, conduct and ethics* are an element of that knowledge and define an agreed set of professional standards that guide the work of the occupational therapy workforce. These standards are reflected in the skills, ways of thinking, behaviours, practice and experiences of RCOT members, and in published literature.

1.1.2 The Royal College of Occupational Therapists (hereafter referred to as 'RCOT') is committed to valuing diversity within the profession, its membership, those who access occupational therapy services, its staff and the wider working environment. We understand that each individual is unique and should be treated with fairness, consistency and transparency, and without discrimination.

1.1.3 For the first time, the *Professional standards for occupational therapy practice* and the *Code of ethics and professional conduct* have been merged into one document, organised as a combination of ethical principles and standard statements. Together they underpin and define the requirements for professional practice and conduct. **This document describes a level of practice and a way of thinking that RCOT expects its members to abide by and believes all members of the occupational therapy workforce should adopt.**

1.1.4 **These Standards are universal and applicable, with some interpretation, to all practitioners. Wherever you work and whatever your scope and level of practice, you should be able to apply the underpinning principles of these Standards to the work you do.**

1.1.5 RCOT sets the professional and educational standards for the occupational therapy profession in the UK. These *Professional standards for occupational therapy practice, conduct* and ethics (herein referred to as the 'Standards') are produced in consultation and collaboration with RCOT members. The completion, revision and updating of the Standards is the delegated responsibility of the RCOT Professional Practice Department. They are revised every five years, or earlier if necessary.

1.1.6 This is a public document, so may be used by others outside the profession to determine the measure of professional practice and conduct expected of members of the occupational therapy workforce. RCOT encourages recognition of these Standards by other individuals, organisations and institutions who/which are involved with the profession, including employers, commissioners and those who access occupational therapy services.

1.1.7 Membership of RCOT provides benefits to support safe, effective and ethical working practice and continuing professional development. It is advantageous to both practitioners and employers, but it is voluntary and cannot be a

requirement for practice or a criterion for employment (Great Britain. Parliament 1992). RCOT members sign up to abide by these Standards, but they will be relevant and useful to all within the occupational therapy workforce across the UK, whether they are members of the organisation or not.

1.2 Occupational therapy in practice

1.2.1 Underpinning occupational therapy practice is the belief that participation in meaningful occupations ('all the things we need, want or have to do' (Wilcock 2006, p14)) is fundamental to the facilitation and maintenance of health and wellbeing. A person's ability to carry out their activities and roles in daily life is understood as their occupational performance. This ability to perform and participate in occupations can affect and be affected by their experiences or circumstances.

1.2.2 As an occupational therapist, or occupational therapy learner, you hold a unique view of the people and communities with whom/which you work. You have, or are developing, a degree-level (College of Occupational Therapists 1992) knowledge of how people perform physically, mentally, sensorially, cognitively, psychologically and socially. This enables you to deliver occupation-focused, person-centred intervention in all settings.

1.2.3 As an occupational therapy practitioner, you may intervene within the dimensions of the person, their environment and in the occupation itself. A person's environment might be physical, social, societal, cultural, economic and/or attitudinal. You enable the people with whom you work to bring about change in order to achieve their chosen occupational goals. This may be through the modification of their desired or required occupations, learning new skills and approaches, alteration of their environment/s, or a combination of these. You also understand activity in itself to be of therapeutic benefit.

1.2.4 As a support worker, you have an approach to your work that is based on an understanding of the connection between the person, their environment and occupation. You will understand that the purpose of the intervention you provide is to maximise an individual's occupational performance and participation.

1.2.5 To be considered as a competent or capable occupational therapy practitioner, you need to demonstrate a combination of recognised knowledge and skills, along with behaviours that reflect a professional way of thinking across the four Pillars of Practice (RCOT 2021). You learn knowledge and skills through your professional education and/or experience and continuing professional development, but these elements alone are not necessarily what make you a safe, effective and ethical practitioner. Your conduct must also promote and protect the wellbeing of people who access your service, the wider public, and the reputation of your employers and your profession. You are an autonomous practitioner and are personally responsible for what you do. You can ensure your own capability in practice through your knowledge, understanding and application of these principles and standards.

1.3 Legislation, guidance, policy and procedures

1.3.1 This document does not identify every piece of relevant legislation, recognising that there are differences across the four UK nations and that legislation changes periodically. You must be attentive to and comply with any current legislation, statutory guidance, best practice standards, and policies and procedures that are relevant to your location, scope and level of practice. The key broad areas of legislation related to this publication are listed in Section 8.

1.3.2 This version of the *Professional standards for occupational therapy practice, conduct and ethics* (2021) supersedes all previous editions of the *Code of ethics and professional conduct* and the *Professional standards for occupational therapy practice*.

Section 2

The uses and purposes of this document

This section describes how these Standards can be useful and beneficial to you.

2.1 Informing your practice

2.1.1 This is a practical document. You need to understand its content and how to apply it to your work. It is an information resource to direct you and a means by which you can examine your practice. It may also be used as an aid to discussions in the workplace, whether with your work colleagues or with those who access the service. These Standards may help to guide strategic decisions relating to occupational therapy. They can be used as a basis for dialogue and negotiation with commissioners, funders, purchasers of services and in other business settings. You can use the Standards to demonstrate the value and uniqueness of your professional contribution.

2.1.2 These Standards describe the essential practice, behaviours and values that you have a responsibility to abide by at all times. They may be taken as appropriate standards of reasonable care, as defined by the professional body, which may be referred to by the Health and Care Professions Council (HCPC), your regulatory body.

RCOT expects its members to work to high standards of performance, to continually improve and to seek out opportunities to lead and excel.

2.1.3 Maintaining these standards will help you to:

- be a safe, effective and ethical practitioner;
- provide a high-quality, evidence-informed and inclusive service;
- provide a person-centred or personalised service;
- explain and promote the work you do in the language of occupation;
- make best use of and sustain all resources, including financial, human and environmental; and
- meet the registration requirements of the HCPC.

2.1.4 This document should be your first point of reference if you have a query related to professional practice, conduct or ethics. You should also refer and adhere to local policy and/or standards. You may find that occasionally local circumstances prevent you from meeting some part of these Standards. In such circumstances, you need to be sure that you are meeting your legal responsibilities, your duty of care to those who access the service, and all HCPC requirements. If you are concerned that your local policy causes you to fall short of your legal and professional duties, or puts the welfare of those who access your service/s, yourself or your colleagues at risk, you must raise this with your employer. You should keep a record of your concerns and actions.

2.1.5 If you have a concern, or if there is uncertainty or dispute as to the interpretation or application of the Standards, you are advised to contact RCOT's Professional Practice Enquiries Service, and possibly your local union representative, for advice.

2.1.6 In any civil or criminal proceedings, these Standards may be admissible as evidence. They can be used as a measure of reasonable and/or acceptable practice in support of the complaint or the defence.

2.2 Informing educators and pre-registration learners in higher education

2.2.1 Education providers will use this document throughout a pre-registration learner's education to inform them of the required standards of practice, conduct and ethics that occupational therapists are expected to uphold during their academic and professional lives. These Standards will support the learning received by all future graduates, and are applicable from point of entry to the pre-registration programme to the end of their professional career.

2.2.2 Education providers are required to ensure that the Standards are observed in order to maintain their occupational therapy pre-registration programme's accredited status with RCOT.

For learners and educators, these Standards also complement the current version of RCOT's *Learning and development standards for pre-registration education* (RCOT 2019a).

2.3 Monitoring and developing your practice and service

2.3.1 The primary role of the HCPC is the protection of the public. It has overall responsibility for ensuring that all relevant health professionals meet certain given standards in order to be registered to practise in the UK. Anyone using the title or practising as an 'occupational therapist' in the UK must be registered with the HCPC. If a formal complaint is made about an occupational therapist, the HCPC will consider whether its own standards have been met. You must know and abide by the requirements of the HCPC.

2.3.2 A key function of RCOT is to inform, support and encourage you as members of the profession. It is not RCOT's role to judge a practitioner's fitness to practise. The *Professional standards for occupational therapy practice, conduct and ethics* are developed in line with the HCPC standards (HCPC 2013, 2016). If you use the RCOT professional standards as an informative and convenient way to monitor and maintain your professional practice, they will help you to meet the HCPC requirements. There are resources available on the RCOT website to help you with this.

2.3.3 The results of monitoring and improving your practice can be included in your continuing professional development (CPD) portfolio, along with your other evidence of learning and development.

2.3.4 Using these Standards as a benchmark against which to scrutinise your service also enables you to gather data for yourself and others who have an interest or investment in your service.

Section 3

Principles and standards – welfare and autonomy

This section relates to the ethics and values underpinning your conduct and practice.

3.1 Duty of care

Your duty of care is your responsibility to act in a way that ensures that injury, loss or damage will not be carelessly or intentionally inflicted on the individual or group to whom/which the duty is owed as a result of your actions.

There is a general duty of care to one another, but as part of the occupational therapy workforce you carry a specific duty of care to those who access the service, including their families and carers, even if you are not directly responsible for their care.

In determining whether the duty of care was discharged, the standard against which your work will be assessed is:

the standard of the ordinary skilled person exercising and professing to have that specialist skill. A [person] need not possess the highest expert skill; it is well established law that it is sufficient if [the person] exercises the ordinary skill of the ordinary competent [person] exercising that particular art.
(Bolam v Friern Hospital Management Committee 1957 in Unison 2003)

In other words, you do not need to be the best there is, but you must be practising at the standard of a reasonably competent practitioner. The standards to be expected are not generally affected by any personal attributes, such as level of experience.

3.1.1 The duty of care exists from the moment:

- you/the service receive a referral or request for assistance; and/or
- the individual is accepted for occupational therapy or they agree and begin to receive a service.

3.1.2 You discharge your duty of care by performing your professional duties to the standard of a reasonably competent practitioner, in terms of your knowledge, skills and abilities.

3.1.3 You may be in breach of your duty of care if it can be shown that you have failed to perform your professional duties to the standard expected of a reasonably competent occupational therapy practitioner.

3.1.4 If it is claimed that you have, in the performance of your duties, breached your duty of care to the person who accesses the service, it is a good defence to show that a responsible body of like practitioners would have acted in the same way. This is the Bolam Principle (Bolam v Friern Hospital Management Committee 1957).

3.1.5 The Bolam Principle will only be a good defence, however, if it can be shown that the body of opinion relied on has a logical basis and is respectable, responsible and reasonable in its own right. This is the Bolitho Principle (Bolitho v City and Hackney Health Authority 1998).

3.1.6 Your responsibilities under your duty of care

3.1.6.1 You keep your knowledge, skills and abilities up to date.

3.1.6.2 You provide a service that is within your professional competence, appropriate to the needs of those who access the service, and within the range of activities defined by your professional role.

3.1.6.3 You maintain an accurate record of the intervention you provide as part of your duty of care.

3.1.6.4 You have and record a demonstrable professional rationale for the decisions you make and occupational therapy intervention you provide.

3.1.6.5 You protect confidential information, except where there is justifiable reason for disclosure.

3.1.6.6 You ensure that all reasonable steps are taken to ensure the health, safety and welfare of any person involved in any activity for which you are responsible. This might be a person accessing the service, a carer, another member of staff, a learner or a member of the public (Great Britain. Parliament 1974).

3.1.6.7 You ensure that anyone to whom you delegate work is competent to carry it out in a safe and appropriately skilled manner (see Section 6, point 6.5).

3.1.6.8 When you consider that wellbeing, safety and care standards are not being met, you raise your concerns with an appropriate person.

3.1.6.9 **When a person with mental capacity is discharged or discharges themselves from your service, or chooses not to follow your recommendations, your duty of care does not finish immediately.**
You must:

- ensure that they are aware of any possible risks arising from their choice;
- take reasonable action to ensure their safety;
- refer the individual to or provide information about an alternative agency, if appropriate;
- inform relevant others, with consent if possible, especially if there is an element of risk remaining;
- arrange for a follow-up, if required and consented to;
- comply with all necessary local discharge procedures;
- record this in the relevant documentation, together with any assessment of mental capacity if required.

You will then have fulfilled your duty of care.

3.2 Welfare

3.2.1 Under the *Universal Declaration of Human Rights* (United Nations General Assembly 1948) everyone has economic, social and cultural rights. These include the right to social protection, an adequate standard of living, and physical and mental wellbeing.

You seek to act in the best interests of all those who access the service and those with whom you work, at all times, to ensure their welfare, optimising their health, wellbeing and safety.

3.2.1.1 You always recognise a person's human rights and act in their best interests, without discrimination of any kind.

3.2.1.2 You enable individuals to preserve their individuality, self-respect, dignity, privacy, security, autonomy and integrity.

3.2.1.3 You take appropriate actions to promote positive health and welfare in the workplace (including physical and mental health), safe working practices and a safe environment.

3.2.1.4 You do not engage in or support behaviour that causes any unnecessary mental or physical distress. Such behaviour includes neglect and indifference to pain.

3.2.1.5 You make every effort not to leave an individual in unnecessary pain, discomfort or distress following intervention. Professional judgement and experience are used to assess the level of pain, distress or risk, and appropriate action is taken if necessary. Advice is sought when required.

3.2.1.6 You support those who access the service if they want to raise a concern or a complaint about the care or service they have received. You communicate honestly, openly and in a professional manner, receiving feedback and addressing concerns co-operatively should they arise. Advice is sought when required and local policy followed.

3.2.1.7 You have a professional duty of candour. When something goes wrong as a result of your actions or omissions, you immediately take steps to put matters right, and you apologise to those affected if appropriate to do so. You inform your manager/ employer and follow local policy.

3.2.1.8 You do not knowingly obstruct another practitioner in the performance of their duty of candour. You do not provide information, or make dishonest statements about an incident, with the intent to mislead.

3.2.1.9 You know, and act on, your responsibility to protect and safeguard the interests of vulnerable people with whom you have contact in your work role.

3.2.1.10 If you witness, or have reason to believe that an individual has experienced, dangerous, abusive, discriminatory or exploitative behaviour or neglect in your workplace or any other setting, you raise your concerns. You notify a line manager or other designated person, seeking the individual's consent where possible, and using local procedures where available.

3.2.1.11 If you are an employer or supplier of personnel, you report to the relevant national disclosure and barring service any person who has been removed from work because of their behaviour, where that behaviour may meet any of the criteria for the individual to be barred from working with at-risk children or adults.

3.2.1.12 You raise a concern with the relevant registration body if the practice, behaviour or health of a practitioner appears to be a risk to the safety of those who access the service, colleagues or the public.

3.2.1.13 Where learners (students or apprentices) are involved, you also report to the relevant education provider.

3.3 Diversity, equality and sensitivity

3.3.1 Your approach is always to protect the rights of individuals and to advance equality of opportunity for all. You work in a way that is equally fair and just, inclusive and without discrimination of any kind. You always act in accordance with human rights, legislation and in the individual's best interests.

3.3.1.1 You offer equal access to the service and fulfil your role without bias or prejudice.

3.3.1.2 You treat all people, irrespective of their needs, with dignity and respect as equal members of society, entitled to enjoy the same choices, rights, privileges and access to services.

3.3.1.3 You reflect on and are sensitive to how diversity affects people's needs and choices, incorporating this into any service planning, individual assessment and/or intervention where possible.

3.3.1.4 You recognise that each person has their own philosophy of life, and the potential significance of personal, spiritual, religious and cultural beliefs.

3.3.1.5 You are attentive to and seek to meet personal, spiritual, religious and cultural needs or choices within the intervention that you provide, following local policy.

3.3.1.6 Where possible, a reasonable request to be treated or seen by a practitioner with specific characteristics is met; for example, by a professional and not a learner, by a male or female practitioner or by a particular language speaker.

3.3.1.7 You do not impose your own faith or belief system on any situation or person at work.

3.3.1.8 You report in writing to your employer, at the earliest date in your employment, any personal circumstances, religious and/or cultural beliefs that would influence how you carry out your duties. You explore ways in which you can avoid placing an unreasonable burden on colleagues in these circumstances. This does not affect your general duties as set out in law or these Standards.

3.4 The importance of choice and personalised care

3.4.1 **You have a continuing duty to respect and uphold the autonomy of those who access the service.** You encourage and enable choice, shared decision making and partnership working in the occupational therapy process, if wanted by the individual (see Section 3, point 3.5 on informed consent and mental capacity and Section 4, point 4.5.6 on carer/family involvement).

3.4.1.1 Your practice is shaped by and focused on the occupational needs, aspirations, values and choices of those who access the service.

3.4.1.2 You uphold the right of individuals and groups to make choices over the plans that they wish to make and the intervention that you provide.

3.4.1.3 Where possible, you use the individual's preferred means of communication, optimising their ability to participate in planning and decision making by any suitable means.

3.4.1.4 You seek to act in the best interests of people to ensure their optimum health, wellbeing and safety. If the choices of an individual with mental capacity are considered unwise, they are still accepted as the individual's choice.

3.4.1.5 If an individual with mental capacity declines intervention, decides not to follow all or part of your recommendations or chooses to follow an alternative course of action, you fulfil your duty of care as defined in Section 3, point 3.1.

3.5 Informed consent and mental capacity

3.5.1 **Before any person is provided with any intervention or treatment, or undergoes any investigation, it is necessary to obtain that person's informed consent. The fact that a person has given their consent is not sufficient**. Consent is only valid if it is properly 'informed', meaning that all relevant information has been given to the person in a way that they understand. The process of providing information will depend, in each case, on an assessment of the information relevant to that particular person's decision at that point in time. Obtaining informed consent is a continuing requirement and may need repetition if there is repeated intervention or any change in the intervention offered; it is not a one-off event. Unless restricted by mental health and/or mental capacity legislation, it is the overriding right of any individual to decide for themselves whether or not to accept occupational therapy.

3.5.2 This principle reflects the right of individuals to make decisions over their own body, health and wellbeing, and is a fundamental part of good practice. A practitioner who does not respect this principle may be liable to both legal action by the individual and action by their regulatory body.

3.5.3 For consent to be valid, it must be given voluntarily by the individual. They must be provided with all the information that is relevant to their decision and must have the mental capacity to understand and consent to the particular intervention or decision.

3.5.3.1 You attend to current legislation, guidance and codes of practice in relation to mental capacity and consent.

3.5.3.2 You give sufficient information, in an appropriate manner, to enable people to give informed consent to any proposed action or intervention concerning them.

3.5.3.3 All means necessary are utilised to enable individuals to understand the nature and purpose of the proposed action or intervention, including any possible risks involved.

3.5.3.4 As far as possible, you enable individuals to make their own choices. Where their ability to give informed consent is restricted or absent, you try to ascertain and respect the individual's preferences and wishes, at all times seeking to act in their best interests. All decisions and actions taken are documented.

3.5.3.5 People have the right to refuse or withdraw consent for any intervention at any time in the occupational therapy process. You respect a person's choices where possible, even when they conflict with professional opinion (see Section 3, point 3.4).

3.5.3.6 You respect the choices of a child under the age of 16 who is of sufficient maturity to be capable of making up their own mind on the matter requiring decision (Gillick competence).

3.5.3.7 You record when and how consent is given, refused or withdrawn, whether verbal, indicated or written.

3.5.3.8 When a person's mental capacity is in doubt, you must assess their ability to make decisions in relation to the proposed occupational therapy provision, in accordance with current legislation and guidance. This requires that you assess their capacity in a four-stage process:

- Does the person understand what information you are giving them?
- Can they retain the information so as to form an opinion?
- Can they weigh up the information and reach an informed decision?
- Can they communicate that decision to you?

If you have any doubt about a person's capacity to make a decision, you record your decision together with the reasons for your conclusions. You should not provide intervention unless someone with mental capacity has given informed consent for you to do so.

3.5.3.9 If the person does not have the mental capacity to give consent, you cannot provide intervention unless:

- you have consent from someone who is legally authorised to decide that the intervention is in the best interests of the person (such as a health and welfare deputy);
- there is an Advance Decision or a court order permitting treatment;
- or, rarely, where it is not possible to obtain informed consent, but the intervention is urgent and you believe should be given in the person's best interests even though no one has provided consent for the intervention.

3.5.3.10 You do not coerce or put pressure on a person to accept intervention, but inform them of any possible risk or consequence of refusing treatment. For those without mental capacity, a 'best interests' decision is required.

3.6 Engaging with risk

3.6.1 *As a practitioner, it is your role, as far as possible, to enable people to overcome the barriers that prevent them from doing the activities that matter to them, to take opportunities and not to see risk as another barrier.*

(RCOT 2018a, Section 1.2, p2)

3.6.1.1 **You embrace and engage with risk, assessing and managing it in partnership with those who access the service**.

3.6.1.2 You enable people to take the risks that they choose and to achieve their chosen goals, as safely as reasonably possible.

3.6.1.3 You co-operate with your employers in meeting the requirements of legislation and local policy, whilst enabling people who access the service to gain optimal occupational performance and autonomy in their lives. These requirements include health and safety, risk management, moving and handling and digital risk management.

3.6.1.4 You take reasonable care of your own health and safety and that of others who may be affected by what you do, or do not do (Great Britain. Parliament 1974, section 7). The principles remain the same whether the potential harm is to people, organisations or the environment.

3.6.1.5 As much as is within your control, you:

- establish and maintain a safe practice environment, including when travelling or in the community;
- establish and maintain safe working practices; and
- establish and maintain secure digital systems, including when travelling or in the community.

3.6.1.6 You notify a line manager, or other designated person, when you identify a risk that is not within your control.

3.6.1.7 You monitor, review and, where necessary, revise any situation that entails risk.

3.6.1.8 When a person lacks the mental capacity to make certain choices, risk does not necessarily limit best interests decisions, especially when these take into account the individual's stated preferences and wishes. A risk assessment and a 'best interests' decision are both required.

3.6.1.9 Where care for the person is shared with or transferred to another practitioner or service, you co-operate with them to ensure the health, safety and welfare of the individual (Great Britain. Parliament 2014. Regulation 12 (2)(i)).

3.6.1.10 You ensure that you remain up to date in all your statutory training to ensure safe practice, including risk management, health and safety, safeguarding, moving and handling techniques and data protection.

3.6.1.11 Where appropriate, you ensure that you and those for whom you are responsible are trained, competent and safe in the selection and use of relevant equipment, being attentive to local procedures.

You are advised to read RCOT's current guidance on risk management (RCOT 2018a).

Section 4

Principles and standards – service provision

This section relates to the ways of thinking and actions that form your practice.

4.1 Focusing on occupation

4.1.1 Underpinning your practice is the belief that engagement in occupation ('all the things we need, want or have to do' (Wilcock 2006, p14)) is fundamental to a person's health and wellbeing.

4.1.1.1 **The ultimate professional rationale for your intervention or activity, including in diverse settings or generic roles, is the enhancement of health and wellbeing through the promotion of occupational performance, engagement and participation in life roles** (RCOT 2019b).

4.1.1.2 You understand the relationship between the person, the occupation and the environment and how one may affect, or be affected by, the other.

4.1.1.3 You enable individuals, groups and communities to change aspects of their person, the occupation or the environment, or some combination of these, to enhance occupational performance, engagement and participation in life roles.

4.1.1.4 Assessment, interventions, outcomes and documentation should be centred on occupational performance, engagement and participation in life roles.

4.2 Your professional rationale

4.2.1 Your actions are based on a set of logical professional reasons, which are themselves informed by professional knowledge, skills and experience, and published resources.

4.2.1.1 You are able to explain, and you record, your professional rationale for anything you do for/with or in relation to those who access the service.

4.2.1.2 You use national guidelines, current policy, research and best available evidence to underpin and inform your reasoning, rationale and practice.

4.2.1.3 Your practice is shaped or structured according to recognised theories, frameworks and concepts that are applicable to occupational therapy.

4.3 Access to occupational therapy

4.3.1 Access to occupational therapy is based on the occupational needs or aspirations of the individual, group or community.

4.3.2 **Access is offered equally without bias or prejudice, in keeping with clearly documented procedures and criteria for your service/s (see Section 3, point 3.3).**

4.3.3 You consider the possible occupational needs of those who access the service and the potential benefit of occupational therapy, within the remit and context of your particular service provision and your level and scope of practice.

4.3.4 Where occupational needs are not present, or where there are needs that cannot be met by you/your service, you refer or direct individuals to alternative services, information and advice, where available.

4.3.5 There are certain circumstances where you can refuse to provide, or choose to withdraw, intervention. These include where there is fear of violence; where there is harassment; where there is a lack of appropriate and safe equipment; where you do not have the knowledge and skills; where there is a conscientious objection; where you know the person accessing the service personally; where you are asked to do something illegal; where you believe the intervention would be harmful to the person; where it is not clinically justified; or where you consider there has been a change in circumstances such that the intervention is no longer covered by valid and informed consent.

4.3.6 You have the right to refuse to provide any intervention that you believe would be harmful to a person accessing the service or that would not be clinically justified, even if requested by another professional. The guidance given by the Court of Appeal in the case of *R (Burke) v. General Medical Council Official Solicitor and others intervening* (2005) is that if a form of treatment is not clinically indicated, a practitioner is under no legal obligation to provide it, although they should seek a second opinion. Similarly, a doctor who is responsible for a service user may instruct a therapist not to carry out certain forms of treatment if they believe them to be harmful to the service user (Department of Health 1977).

4.4 Referral/request for assistance and assessment

4.4.1 Following receipt and/or acceptance of a referral or a request for assistance, the service to which the case is allocated takes the legal responsibility and liability for any assessment and possible intervention provided (see also Section 3, point 3.1).

4.4.2 If you have accepted someone onto a waiting list, you have a degree of responsibility. If your service carries a waiting list or another reason causes a significant delay before you take any action, you contact the individual and the referrer, informing them of the situation.

4.4.3 Through interview, observation and/or specific assessment, you identify and evaluate the occupational performance and participation needs of those who access the service.

4.4.4 You use assessment techniques, tools and/or equipment that are relevant and appropriate to those who access the service, their occupational needs and their circumstances.

4.4.5 Your analysis of the assessment outcomes shows how the current situation or conditions of those who access the service affect their occupational performance and ability to participate.

4.4.6 If, as a result of assessment, occupational therapy is considered inappropriate for the person, you inform the individual and the referrer, giving your decision and your rationale.

4.4.7 If further assessments or investigations are indicated, you initiate these or refer to other services.

4.5 Intervention or recommendations

4.5.1 You work in partnership with those who access the service, agreeing their objectives, priorities and timescales for intervention.

4.5.2 You develop personalised intervention plans, or recommendations, based on the occupational performance needs, choices and aspirations of those who access the service, as identified through your assessments.

4.5.3 You intervene as early as possible, to optimise outcomes and to reduce, delay or prevent future needs where possible.

4.5.4 You promote wellbeing, encouraging healthy occupations and participation in life roles.

4.5.5 You empower people to maintain their own health and wellbeing and to manage their own occupational needs, wherever possible.

4.5.6 With the individual's agreement, you actively involve their carers and/or family, keeping them informed and included in decision making, as appropriate.

4.5.7 In order to enable carers and/or family to be involved, their requirements and needs are incorporated into the interventions/recommendations, where necessary.

4.5.8 If indicated and with consent, you refer any carer for an assessment of their own needs.

4.5.9 You consider how the assets and strengths of the individual, their carers/family and their communities can be used to maximise their occupational performance and participation.

4.5.10 You review and modify your plans and interventions regularly in partnership with those who access the service.

4.5.11 Any decision to cease intervention is informed by your evaluation and the choices of the person who is accessing your service (see Section 3, point 3.1.6).

4.6 Outcomes – quality, value and effectiveness

4.6.1 You evaluate the value and benefit of your intervention for those who access the service in terms of their occupational performance, participation and wellbeing.

4.6.2 You use outcome measures to monitor, review and demonstrate the ongoing effectiveness of your intervention.

4.6.3 You include the views and experiences of individuals or communities when evaluating your practice.

4.6.4 Your evaluation takes account of information gathered from other relevant sources, such as carers and/or family, or other professionals.

4.6.5 You undertake audits against appropriate available standards to facilitate service improvement.

4.6.6 You collect and collate outcome data to meet the requirements of commissioners/funders of services.

4.6.7 Where possible, you collect and use data to demonstrate the value for money of the service/s you provide.

4.6.8 You use the information you collect, with other national, local and professional guidance and research evidence, to improve the quality, value and effectiveness of the service/s you provide.

4.7 Developing and using the profession's evidence base

4.7.1 You take every opportunity to engage with research, proportionate to your scope and level of practice.

4.7.2 You reflect on the value and importance of research as the foundation of the profession's evidence base.

4.7.3 You access, understand and critically evaluate research and its outcomes, incorporating it into your practice where appropriate to provide evidence-informed interventions.

4.7.4 You incorporate evidence-based outcome measures and research activity into your practice, to demonstrate the effectiveness of intervention and services.

4.7.5 When undertaking any form of research activity:

- You understand the principles of ethical research and adhere to national and local research governance requirements.
- You follow professional, national and local ethics approval and permission processes.
- You make every effort to work collaboratively with people who access services during all stages of the research process.
- You protect the interests of participants, fellow researchers and others.
- You establish and follow appropriate procedures for obtaining informed consent, with due regard to the needs and capacity of participants.
- You protect the confidentiality of participants throughout and after the research process and adhere to UK data protection laws.
- You disseminate your research findings using appropriate local, national and international methods.

This benefits those who access occupational therapy services, contributes to the body of evidence that supports occupational therapy, and assists with the translation of evidence into practice.

4.8 Keeping records

4.8.1 Good practice in keeping records protects the welfare of those who access the service. As such, it forms part of your duty of care. Your records are also your evidence that you have fulfilled your duty of care in your practice.

4.8.1.1 You create and maintain a comprehensive written or digital record of all that has been done for/with, on behalf of, or in relation to those who access the service.

4.8.1.2 Your records are comprehensive and accurate.

4.8.1.3 Your records are completed promptly, as soon as practically possible after the activity occurs.

4.8.1.4 All records, whether written or digital, are legible, understandable, clearly dated, timed, kept chronologically and attributable to the person making the entry.

4.8.1.5 You demonstrate that your practice is appropriate by recording your clinical/professional rationale.

4.8.1.6 You identify the evidence that informs your practice, where available.

4.8.1.7 You include all your risk assessments, actions taken to manage the risk and any outcomes.

4.8.1.8 Your records demonstrate how you meet your duty of care.

4.8.1.9 Your records demonstrate that your practice is effective.

4.8.1.10 You process your records according to current legislation, guidance and local policy.

4.8.1.11 You explain your reason for recording and processing information to those who access the service.

4.8.1.12 You comply with any legal requirements and local policy in relation to confidentiality, the sharing of information and any individual's request to access their own records.

4.8.1.13 You keep your records securely, retaining and disposing of them according to legal requirements and local policy.

You are advised to read RCOT's current guidance on keeping records (RCOT 2018b) for further information.

4.9 Confidentiality and sharing information

4.9.1 Confidentiality is an important legal and ethical duty, but it is not absolute. There is a balance between the professional and legal responsibility to respect and protect the confidentiality of those who access the service, and sharing information for the wellbeing and protection of the individual or the wider public.

The same protections and restrictions apply to information/data stored and transferred via hard copy or digitally and when communicating with others via any medium, including virtual/online communities and networks.

You abide by the current versions of the *UK General Data Protection Regulation* (UK GDPR) *and the Data Protection Act 2018* (Great Britain. Parliament 2018) in all your information/data processing.

4.9.1.1 You familiarise yourself with your duties under legislation, regulations and local policy.

4.9.1.2 You safeguard verbal, written or digital confidential information (data) relating to those who access the service, at all times.

4.9.1.3 Discussions with or concerning an individual should be held in a location and manner appropriate to the protection of their right to confidentiality and privacy.

4.9.1.4 You must have a valid, lawful basis for sharing or using a person's information. This must be recorded (Information Commissioner's Office 2019, p51).

4.9.1.5 You explain the reason and seek consent for sharing any relevant information.

4.9.1.6 Members of a team should share confidential information when it is needed for the safe and effective care of the person accessing the service (Health and Social Care Information Centre 2013, p13).

4.9.1.7 You share information in the best interests of those who access the service within the framework of the *Caldicott Principles 2013* (Department of Health 2013), i.e. the information necessary for the purpose with those who have a clear 'need to know'.

4.9.1.8 You share relevant confidential information where there is legal justification (by statute or court order) or where it is considered to be in the individual's or public interest in order to prevent serious harm, injury or damage. You follow local policy and inform the individual where possible.

4.9.1.9 When an individual has objected to specific information being shared, this is respected unless there is a legal requirement to share (Health and Social Care Information Centre 2013, p25).

4.9.1.10 You adhere to local and national policy regarding confidentiality and security in the storage, movement and transfer of information, in all formats and media, at all times, making them available only to those who have a legitimate right or need to see them.

4.9.1.11 You grant individuals access to their own records in accordance with relevant legislation and current guidance/policy (both local and national) (Information Commissioner's Office 2019, p101).

4.9.1.12 You obtain and record consent prior to using visual, oral, written or digital material relating to individuals for wider purposes (such as teaching). The person's confidentiality and choice must be observed in these circumstances.

See also Section 4, point 4.7.5 in relation to confidentiality in research.

4.10 Resources and sustainability

4.10.1 It is a universal responsibility to work as effectively and efficiently as possible to make best use of and sustain environmental, physical, financial, human and personal resources, whilst seeking to meet the needs of those who access the service. This means using resources to deliver services in a way that does not compromise the health of present or future generations (Stancliffe 2014).

4.10.1.1 You seek to ensure that your service meets the needs of those who access it, now and in the future.

4.10.1.2 You seek to gain and provide value for money when acquiring or providing goods and services.

4.10.1.3 You seek 'to re-evaluate practice models and expand clinical reasoning about occupational performance to include sustainable practice' (World Federation of Occupational Therapists 2012).

4.10.1.4 Where service resources are limited, any priorities that are identified and choices made are compliant with legal requirements, and national and/or local policy.

4.10.1.5 In establishing priorities and providing services, the choices of those who access the service are taken into account and implemented wherever reasonably possible.

4.10.1.6 Where a person's first choice cannot be met, you explain this and offer an alternative where available. If this is not possible, or is unacceptable:

- you refer individuals to or provide information on different service providers, sources of funding, etc.
- you ensure you meet your duty of care, as detailed in Section 3, point 3.1.

4.10.1.7 If the person lacks the mental capacity to identify their preferences, you should not provide any intervention unless:

- you have obtained consent from someone who is legally authorised to decide that the intervention is in the best interests of the person or the court;
- an Advance Decision exists covering the treatment; or
- the treatment is required urgently and you believe treatment should be provided in their best interests, according to legislation, guidance and policy.

4.10.1.8 You recognise the limits of your own capacity and do not extend your workload or remit to the detriment of the quality or safety of your practice or service.

4.10.1.9 You document, report and provide evidence (to the relevant manager) on resource and service deficiencies that may endanger the health and safety of those who access the service, carers, yourself or your colleagues (Great Britain. Parliament 1998, section 43B, point (1)d). Local policy should be followed.

4.10.1.10 As a manager or leader, you act on any reports concerning resources and service deficiencies, seeking to ensure the health and safety of all those affected by your service.

You are advised to read the World Federation of Occupational Therapists' *Sustainability matters: guiding principles for sustainability in occupational therapy practice, education and scholarship* for further information (Shann et al 2018).

Section 5

Principles and standards – professionalism

This section relates to the conduct and attitude expected of you.

5.1 Professionalism

Professionalism goes beyond being a capable practitioner. It concerns how a practitioner represents themselves, their employer and their profession to others. It is the way of thinking, values and motivations that underpin the behaviours and interactions seen.

Your behaviour may be deemed unacceptable when it does not have the wellbeing of those who access the service at its core, or when it undermines confidence in the service, organisation or profession. This may be whilst in your work role, or outside of your work role.

5.2 Equality and inclusion

5.2.1 You must comply with the law and the requirements set out in *The Equality Act 2010* (Great Britain. Parliament 2010), and not discriminate against the following protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

5.2.2 You embrace and value the diversity of everyone equally, across all aspects of life, and this is reflected in your practice.

5.2.3 You recognise your own internal biases and the role you play in addressing continued systemic discrimination within your own practice and wider systems.

5.3 Professional conduct

5.3.1 **You are accountable for your actions and behaviours, both inside and away from the workplace.**

5.3.2 You maintain professional boundaries at all times.

5.3.3 You reflect on and take responsibility for:

- the impression and impact you make on others, conducting and presenting yourself in a professional manner whilst in your work or study role;
- your conduct outside of your work or study role, in situations where your behaviour and actions may be witnessed by, or have an impact on, your colleagues, your employer, those who access the service and/or the public.

5.3.4 You adhere to statutory and local policy at all times.

5.4 Professional conduct on digital platforms, including social media

5.4.1 You reflect on and take responsibility for the way you use digital platforms.

5.4.2 Your conduct and content on digital platforms and social media do nothing to undermine confidence in your professional practice or rationale, your employer or your profession.

5.4.3 When using digital platforms and social media, you recognise that you are presenting yourself, through words and images, to a wide group of people.

5.4.4 You consider the outcome that, if you are known to be or identified as a practitioner or an employee, your words and images may be seen as representative of or applicable to your profession and/or your employer.

5.5 Professional and personal integrity

5.5.1 You act with honesty and integrity at all times.

5.5.2 You do not engage in any criminal or otherwise unlawful or unprofessional behaviour or activity, which is likely to damage the public's confidence in you or your profession.

5.5.3 You do not undertake any professional activities when under the influence of alcohol, drugs or other intoxicating substances.

5.5.4 **You inform HCPC and/or your employers if you are convicted of a criminal offence, receive a conditional discharge for an offence or if you accept a police caution.**

5.5.5 **If a registered occupational therapist, you inform HCPC if you have had any restriction placed on your practice, or have been suspended or dismissed by an employer or similar organisation, because of concerns about your conduct or competence.**

5.5.6 You co-operate with any investigation or formal inquiry into your own professional conduct, the conduct of another worker or the treatment of a person who accesses the service, where appropriate.

5.6 Communication

5.6.1 Your language and communication style and manner are always professional, whether towards your colleagues or those who access the service.

5.6.2 You are able to articulate the purpose of occupational therapy and the reason for any intervention being undertaken, so enabling fully informed consent and promoting understanding of the profession.

5.6.3 You communicate clearly, openly and effectively.

5.6.4 You reflect on the potential significance and impact of verbal and non-verbal communication, remaining sensitive to the diversity of backgrounds, experiences and needs of your listeners.

5.6.5 Where possible and appropriate, you facilitate communication in the individual's preferred or first language.

5.6.6 Discussions related to those who access the service are held in a way that maintains their dignity and privacy.

5.6.7 You clearly and accurately participate in formal and informal reporting.

5.6.8 You communicate effectively within your line management structure.

5.6.9 You document your communication where a record is needed.

5.7 Collaborative working

5.7.1 You actively seek to build and sustain positive professional relationships.

5.7.2 You respect the responsibilities, practices and roles of other people with whom you work.

5.7.3 You respect and value the diversity of your colleagues, recognising the unique assets they bring to the workplace.

5.7.4 You act with integrity towards your colleagues at all times, treating them fairly and equally, without discrimination, bullying or harassment. Bullying and discriminatory behaviour are unacceptable and unprofessional.

5.7.5 If you experience or witness bullying and/or discriminatory behaviour, you raise your concerns with a line manager or other appropriate person and follow statutory and local policy.

5.7.6 You work with others within your area of expertise to promote knowledge, skills, and safe and effective practice.

5.7.7 You work collaboratively with or refer to your colleagues, utilising their skills to maximise the outcomes of intervention when appropriate.

5.7.8 You consult with other service providers when additional knowledge, expertise and/or support are required.

5.7.9 You refer a person who accesses the service to another appropriate colleague if the task is outside of your level or scope of practice (see Section 6, point 6.2).

5.7.10 You recognise the need for interprofessional and multiagency collaboration to ensure that well-co-ordinated, person-centred services are delivered in the most effective ways.

5.7.11 You work and communicate with colleagues and representatives of other organisations to ensure the safety and wellbeing of people accessing services.

5.7.12 When you and another occupational therapy practitioner are working with the same person, you work co-operatively, liaising with each other and agreeing areas of responsibility. This is communicated to the person and all relevant parties.

5.7.13 You seek consent from those who access the service for their personal information to be shared with colleagues or other services where necessary.

5.8 Professional and personal relationships

5.8.1 It is your responsibility to ensure that you maintain a professional relationship with those who access the service and that you always act in their best interests.

If concerns are raised about any relationship, sexual or otherwise, it will always be your responsibility to demonstrate that you have not exploited the vulnerability of an individual, regardless of when the relationship may have started or ended, or however consensual it may have been.

5.8.1.1 You foster appropriate therapeutic relationships with those who access the service in a transparent, ethical and impartial way.

5.8.1.2 You maintain a professional relationship and high standards of care in situations where there is tension or discord.

5.8.1.3 You do not enter into relationships that would impair your judgement and objectivity and/or that would give rise to the advantageous or disadvantageous treatment of any individual or group.

5.8.1.4 You do not enter into relationships that exploit individuals sexually, physically, emotionally, financially, socially or in any other manner.

5.8.1.5 You do not exploit any professional relationship for any form of personal gain or benefit.

5.8.1.6 You avoid entering into a close personal relationship with an individual whilst you are responsible for providing occupational therapy, but instead maintain an appropriate professional relationship.

5.8.1.7 If there is a risk that any professional boundary may be broken, you disclose and discuss this with your manager. In these circumstances, you hand over therapy care for the individual to an appropriate professional colleague.

5.8.1.8 **As far as is reasonably practical, you do not enter into a professional relationship with someone with whom you already have or have had a close personal relationship. This includes family members, neighbours, partners and friends.**

5.8.1.9 Where there is no reasonable alternative, you make every effort to remain professional and objective whilst working with an individual you know or have known.

5.8.1.10 In these circumstances, this is disclosed and discussed with your manager and a note made in relevant records. This is for your protection as much as for the person accessing the service.

5.9 The professionalism of colleagues

5.9.1 Any reference you make to the quality of work or the integrity of a professional colleague is expressed with due care.

5.9.2 You raise your concerns with a line manager or other appropriate person and follow statutory and local policy if:

- you become aware that something has gone wrong or someone has suffered harm as a result of a colleague's actions or omissions;
- you become aware of any intentional malpractice, criminal conduct or unprofessional activity, whether by occupational therapy personnel or other staff; or
- you are aware of any kind of discrimination, bullying and/or harassment in the workplace, whether towards colleagues or those who access the service.

5.9.3 The information you provide is objective, relevant, evidence based where possible and limited to the matter of concern.

5.9.4 If giving evidence in an inquiry or court case concerning any alleged negligence or misconduct of a colleague, the evidence you provide is objective and substantiated.

5.10 Personal profit or gain

5.10.1 You do not accept tokens such as favours, gifts or hospitality from those who access the service, their families or commercial organisations when this might be construed as seeking to obtain preferential treatment (Great Britain. Parliament 1889, 1906, 1916). In respect of private practice, this principle still prevails in terms of personal gain.

5.10.2 Local policy is always observed in the case of gifts.

5.10.3 If an individual or their family makes a bequest to a practitioner or a service, it is declared according to local policy.

5.10.4 You put the interests of those who access the service first and do not let this duty be influenced by any commercial or other interest that conflicts with this duty: for example, in arrangements with commercial providers that may influence contracting for the provision of equipment, or care and support.

5.11 Information and representation

5.11.1 Information and/or advertising (in any format or on any platform) in respect of professional activities or work is accurate. It is not misleading, unfair or sensational and complies with any relevant legislation.

5.11.2 You accurately represent your qualifications, education, experience, training, capability and the services you provide. Explicit claims are not made in respect of superiority of personal skills, equipment or facilities.

5.11.3 You respect the intellectual property rights of others at all times. You do not claim another person's work or achievements as your own unless the claim can be fully justified.

5.11.4 You only advertise, promote or recommend a product or service in an accurate and objective way. You do not provide preferential or unjustifiable information about a product or service.

5.11.5 If you are aware that possible misrepresentation of the protected title 'occupational therapist' has occurred, you raise a concern with the HCPC.

Section 6

Principles and standards – capability and fitness to practise

This section relates to your ability to meet the demands of your role safely and effectively.

6.1 Fitness to practise

The HCPC refer to a practitioner's 'fitness to practise', which means you have the skills, knowledge, experience, character and health to practise safely and effectively (HCPC 2017b, p4). In order to remain competent, you need to keep your skills and knowledge up to date and relevant to your level and scope of practice. You also need to be attentive to and look after your own physical and mental health and wellbeing.

6.2 Your professional competence

6.2.1 **You only provide services and use techniques for which you are qualified by your professional education, ongoing learning and/or experience. These must be within your professional competence, appropriate to the needs of those who access the service, and relate to your terms of employment.**

6.2.2 You have sufficient knowledge, skills and experience to make reliable professional judgements, suitable to your level of responsibility and scope of practice.

6.2.3 You seek advice or refer to another professional when you do not have sufficient knowledge and/or skills.

6.2.4 You are attentive to and abide by the current legislation, guidance and standards that are relevant to your level and scope of practice and place of work.

6.2.5 You make yourself aware of developments within the profession and current research, relevant to your level and scope of practice, applying these where appropriate and possible.

6.3 Maintaining and expanding your capability

6.3.1 You continuously maintain high standards in your professional knowledge, skills and conduct across the four Pillars of Practice: Professional Practice; Facilitation of Learning; Leadership; and Evidence, Research and Development (RCOT 2021).

6.3.2 You reflect on and apply the *Principles for continuing professional development and lifelong learning in health and social care* (Interprofessional CPD and Lifelong Learning UK Working Group 2019). The five principles state that continuing professional development (CPD) and lifelong learning should:

1: *be each person's responsibility and be made possible and supported by your employer;*

2: *benefit service users;*

3: *improve the quality of service delivery;*

4: *be balanced and relevant to each person's area of practice or employment; and*

5: *be recorded and show the effect on each person's area of practice. (Interprofessional CPD and Lifelong Learning UK Working Group 2019, p6)*

6.3.3 You remain up to date with any changes to legislation, guidance and standards, both general and specific to your level and scope of practice.

6.3.4 You remain up to date with professional developments, guidance and research, both general and specific to your level and scope of practice.

6.3.5 You participate in any statutory and mandatory training required for your work.

6.3.6 You seek to extend your capabilities, across all four Pillars of Practice, through post-graduate study, which may or may not be award bearing.

6.3.7 **You maintain a continuous, up-to-date and accurate record of your CPD activities, according to the requirements of the Health and Care Professions Council (HCPC 2017a, p5).**

6.3.8 As a practitioner, you receive and/or provide regular professional supervision and appraisal, where critical reflection is used to review practice. This may be provided locally or via long-arm support.

6.3.9 You support the learning and development of colleagues and the profession by sharing your knowledge, skills and experience.

6.3.10 You keep up to date with digital skills, understanding the scope, benefits and potential impact of emerging digital technologies to ensure that you can make best use of what is available.

For further information about continuing professional development, please refer to the Interprofessional CPD and Lifelong Learning UK Working Group (2019) *Principles for continuing professional development and lifelong learning in health and social care.*

6.4 Changing roles and responsibilities

6.4.1 If you seek or are asked to work in areas within which you have less experience, you ensure that you have adequate skills and knowledge for safe and effective practice and that you have access to appropriate supervision and support (see Section 6, point 6.2).

6.4.2 You assess any possible risks in taking on a different role or responsibilities, to ensure that you provide a safe service.

6.4.3 If you are asked to act up or cover for an absent colleague, or if you are asked to take on additional tasks, such duties are only undertaken after discussion, considering additional planning, support, supervision, and/or learning and development requirements.*

* Circumstances may require you to be flexible in what you do. You need to use your professional judgement to remain safe in your practice and always work in the best interests of those who access the service. It is the responsibility of the organisations in which you work to ensure you are supported to do this (NHS England et al 2020)

6.4.4 You ensure that adequate support and learning opportunities are provided to enable you to carry out any additional tasks or responsibilities safely and effectively.

6.4.5 You formally raise any concerns you may have about your capability to carry out any additional tasks or responsibilities.

6.4.6 If you find that you cannot agree to such a request, you contact your local union representative for advice and support where necessary.

6.5 Delegation

6.5.1 When you delegate interventions or other procedures, you ensure that the person to whom you are delegating is competent to carry them out.

6.5.2 You provide appropriate supervision and support for the individual to whom you have delegated the task/s.

6.5.3 Although all registered practitioners are autonomous professionals, responsible for their own practice and professional judgement, you, as delegating practitioner, retain ultimate accountability for any actions taken.

6.6 The capability of colleagues

6.6.1 Should you have reasonable grounds to believe that the conduct or professional performance of a colleague may be deficient in standards of professional capability, you notify their line manager or other appropriate person in strictest confidence. This includes (but is not limited to) when:

- a colleague's performance is seriously deficient;
- they have a health problem that is impairing their competence to practise; or
- they are practising in a manner that places those who access the service or colleagues at risk.

6.6.2 In reporting any concerns to a line manager or other appropriate person, the information is objective, relevant, substantiated where possible and limited to the matter of concern.

6.6.3 If asked for a second opinion by a person who accesses the service and/or their carer, it is confined to the case in question and not extended to the general capability of any other practitioner.

6.7 Occupational therapy pre-registration practice-based learning

6.7.1 **You take professional responsibility for providing regular practice-based learning opportunities for pre-registration occupational therapy learners where possible and for promoting a learning culture within the workplace.**

6.7.2 You recognise the need for personal development and learning to fulfil the role of the practice educator and, where possible, undertake appropriate study.

6.7.3 As practice educator, you provide an experience of practice for learners that complies with the current version of the RCOT *Learning and development standards for pre-registration education* (RCOT 2019a) and current professional standards, and is compatible with the stage of the learner's education or training.

6.7.4 As practice educator, you have a clear understanding of the role and responsibilities for yourself, the learner and the education provider.

More information is available from the current versions of the RCOT *Learning and development standards for pre-registration education* (RCOT 2019a) and the *Career development framework* (RCOT 2021).

6.8 Your health and fitness to practise

6.8.1 You monitor and proactively look after your own physical and mental health and wellbeing.

6.8.2 You seek help or advice at the earliest opportunity should your physical or mental health become a concern.

6.8.3 You make changes to how you practise, or you stop practising, if your health may affect your ability to perform your job capably and safely.

6.8.4 You inform your employer/appropriate authority and the HCPC about any health or personal condition that you believe may affect your ability to practise safely and effectively, if you are unable to adapt your work or if you need to stop practising (HCPC 2017b, p6).

More information on informing the regulatory body is available from *Guidance on health and character* (HCPC 2017b).

Section 7

Key terms

RCOT has selected or developed these definitions and explanations to help with the understanding of this document.

Autonomous practice	A fundamental element of the Health and Care Professions Council *Standards of proficiency for occupational therapists* (HCPC 2013), this is the ability to assess a professional situation and address it appropriately, with the relevant occupational therapy knowledge and experience. It is also inclusive of the ability to make reasoned decisions, to be able to justify these decisions and accept personal responsibility for all actions.
Best interests	The best interests approach asks whether any proposed course of action is the best one for the individual, taking into account their: • past and present wishes and feelings; • beliefs and values that may have influenced the decision being made, had the person had capacity; and • other factors that the individual would be likely to consider if they had capacity.
Candour (duty of)	'Telling patients openly and honestly that something has gone wrong with their care is an essential part of a healthcare professional's practice. The obligation to do so is known as the professional duty of candour.' (Professional Standards Authority for Health and Social Care 2019, Section 1.1)
Capability	The ability to do something. 'A step beyond competence; capable practitioners can handle change and devise solutions in complex situations.' (McGee and Inman 2019, p14)
Carer	Someone who provides (or intends to provide), paid or unpaid, a substantial amount of care on a regular basis for someone of any age who is unwell, or who, for whatever reason, cannot care for themselves independently. (Based on Great Britain. Parliament 1995) This is sometimes divided into formal carers (care workers), who are paid to give care, and informal carers (often family), who are not paid to provide care.

Competence/ Competency	'Competence is the acquisition of knowledge, skills and abilities at a level of expertise sufficient to be able to perform in an appropriate work setting.' (Harvey 2020)
Confidentiality	Confidentiality means protecting personal information. There is an ethical and legal duty to protect people's personal information from improper disclosure. Appropriate information-sharing is an essential part of the provision of safe and effective care. (Adapted from General Medical Council 2017, p10)
Continuing professional development (CPD)	The way in which an individual continues to learn and develop throughout their career, including during their pre-registration programme. CPD is essential and evolves skills, knowledge, professional identity and professional conduct so that individuals stay up to date and practise safely and effectively. (Adapted from Interprofessional CPD and Lifelong Learning UK Working Group 2019)
Data protection	'Data protection is the fair and proper use of information about people. It's part of the fundamental right to privacy – but on a more practical level, it's really about building trust between people and organisations.' (Information Commissioner's Office 2019)
Delegate	To give an assignment to another person, or to assign a task to another person, to carry out on one's behalf, whilst maintaining control and responsibility.
Digital technology	'Digital technologies are electronic tools, systems, devices and resources that generate, store or process data.' (Victoria State Government – Education and Training 2019)

Discrimination	Treating a person, or particular group of people, less favourably than another is, has been or would be treated in a comparable situation, based on an identifiable characteristic. (Adapted from European Union Agency for Fundamental Rights, Council of Europe 2011, p22) *The Equality Act 2010* identifies the following protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. (Great Britain. Parliament 2010, chapter 1)
Diverse settings	Settings or roles in which occupational therapists traditionally have not worked.
Diversity	'The fact of many different types of things or people being included in something; a range of different things or people.' (Cambridge University Press 2020) 'The concept of diversity encompasses acceptance and respect. It means understanding that each individual is unique, and recognizing our individual differences.' (Queensborough Community College 2018)
Duty of care	A responsibility to act in a way that ensures that injury, loss or damage will not be carelessly or intentionally inflicted on the individual or body to whom/which the duty is owed, as a result of the performance of those actions. A duty of care arises: • When there is a sufficiently close relationship between two parties (e.g. two individuals, or an individual and an organisation). Such a relationship exists between a person who accesses the service and the member of the occupational therapy workforce to whom they have been referred, whilst the episode of care is ongoing. • Where it is foreseeable that the actions of one party may cause harm to the other. • Where it is fair, just and reasonable in all the circumstances to impose such a duty. (Caparo Industries Plc v Dickman 1990)

Environment	The circumstances, objects or conditions that make up a person's surroundings, in which they live and that they experience. This might include physical, social, societal, cultural or economic environments.
Equality	'Equality is about ensuring that every individual has an equal opportunity to make the most of their lives and talents. 'It is also the belief that no one should have poorer life chances because of the way they were born, where they come from, what they believe, or whether they have a disability. 'Equality recognises that historically certain groups of people with protected characteristics such as race, disability, sex and sexual orientation have experienced discrimination.' (Equality and Human Rights Commission 2018)
Ethical	A quality or status that describes the reasoning, actions and behaviours of a person, group (or organisation) as right in the moral sense.
Ethics	Principles and values that govern the reasoning, actions and behaviours of a person or group, in this case within a profession. These often relate to beliefs about what is morally right and wrong.
Generic role or practice	A generic role may involve combining tasks previously undertaken by different professions. This might be a part or all of a role. For example, providing management support across a range of professional groups or carrying out a range of health checks within the community.
Gillick competency	As a result of the Gillick case, in England today, except in situations that are regulated otherwise by law, the legal right to make a decision on any particular matter concerning the child shifts from the parent to the child when the child reaches sufficient maturity to be capable of making up his or her own mind on the matter requiring decision. (Gillick v West Norfolk and Wisbech Area Health Authority 1985) Separate legislation applies in Scotland and Northern Ireland.

Governance	'Governance encompasses the system by which an organisation is controlled and operates, and the mechanisms by which it, and its people, are held to account. Ethics, risk management, compliance and administration are all elements of governance.' (Governance Institute of Australia 2020)
Hand over	To give away or entrust the responsibility for an individual to another. The handover action is complete when the receiving person acknowledges and accepts management and responsibility. This is not to be confused with the role of the practitioner in a ward/ case handover, where they may report information to other staff but still retain responsibility for the occupational therapy provided to the individual.
Healthy occupations	Activities that encourage and develop health and wellbeing, or decrease the risk of injury or disease.
Human rights	'Human rights are the basic rights and freedoms that belong to every person in the world, from birth until death. They apply regardless of where you are from, what you believe or how you choose to live your life. They can never be taken away, although they can sometimes be restricted – for example if a person breaks the law, or in the interests of national security. 'These basic rights are based on shared values like dignity, fairness, equality, respect and independence. These values are defined and protected by law. 'In Britain our human rights are protected by the *Human Rights Act 1998*.' (Equality and Human Rights Commission 2019)
Inclusion	Inclusion is a universal human right. The aim of inclusion is to embrace and value the diversity of everyone equally, across all aspects of life. It is about giving equal access and opportunities, and removing barriers. It is also about giving respect, and getting rid of discrimination and intolerance.

Informed consent	Informed consent is an ongoing agreement by a person to receive treatment, undergo procedures or participate in research, after the risks, benefits and alternatives have been adequately explained to them. Informed consent is a continuing requirement. Therefore, occupational therapy personnel must ensure that those who access the service continue to understand the information with which they have been provided, and any changes to that information, thereby continuing to consent to the intervention or research in which they are participating. In order for informed consent to be considered valid, the individual who accesses the service must have the capacity to understand the information and use it to make an informed decision. The consent must be given voluntarily and be free from undue influence. Alternatively the consent may be given by a health and welfare deputy or by a court.
Intervention	The work you do for and with individuals/groups, which might include providing services such as care and support, information, recommendations or advice, direction, supervision and education. 'The process and skilled actions taken by occupational therapy practitioners … to facilitate engagement in occupation.' (O'Brien et al 2012, p180)
Learner	'An individual enrolled in an occupational therapy pre-registration programme, regardless of which entry route into the profession the learner is enrolled in. Learners may also be known as "students" or, in the case of apprenticeship pre-registration programmes, "apprentices".' (Royal College of Occupational Therapists 2019a, p12)
Lifelong learning	'Formal and informal learning opportunities that allow an individual to continuously develop and improve the knowledge and skills they need for employment and personal fulfilment.' (Interprofessional CPD and Lifelong Learning UK Working Group 2019)

Mental capacity (lacking)	'"Mental capacity" means being able to make your own decisions. 'Someone lacking capacity – because of an illness or disability such as a mental health problem, dementia or a learning disability – cannot do one or more of the following four things: • Understand information given to them about a particular decision • Retain that information long enough to be able to make the decision • Weigh up the information available to make the decision • Communicate their decision.' (Mental Health Foundation 2019) Mental capacity, or a lack thereof, may be time-limited and context-specific. Consider that it may be possible to explain risks and benefits by an alternative means or with the assistance of family members who have experience of communicating with the individual concerned.
Occupation	'In occupational therapy, 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.' (World Federation of Occupational Therapists (WFOT) 2019) 'Occupation includes the things we need, want or have to do.' (Wilcock 2006, p14)
Occupation-centered	Occupation-centred describes an approach where occupation is at the core. It is made up of occupation-focused and occupation-based practice.
Occupation-focused	Occupation-focused describes practice where information about the person, environment and occupation relates closely with occupational performance. (Fisher 2013)
Occupational performance	A person's ability to carry out the activities and roles that they need, want, or are expected to do in their daily life.

Occupational therapy workforce	For the purposes of this document, this is a collective term that includes occupational therapists, support workers and occupational therapy learners, including students and apprentices. It is applicable to practitioners in all roles, including those who are in management and leadership, education, research, consultancy and advisory roles, and working in industry.
Outcome measure	'An outcome measure is a standardised instrument used by therapists to establish whether their desired therapeutic outcomes have been achieved.' (Laver Fawcett 2007, p12)
Participation	'Participation is involvement in a life situation.' (World Health Organization 2002, p10) 'Participation can take on both objective (for example, frequency) and subjective dimensions involving experiences of meaning, belonging, choice, control, and the feeling of participation.' (Eriksson et al 2007; Hemmingsson and Jonsson 2005 in Bonnard and Anaby 2016, p188)
People who access the service	The term 'people (or those) who access the service' has been used for those to whom you provide intervention. This may be an individual, families and carers, a group or a community.
Personal relationship	A relationship that exists for social or emotional reasons. This may be with a colleague or may develop with a person who accesses the service.
Personalised care	A personalised approach to health and care ensures that people are in control of and are given choices in the way their needs are addressed, planned and delivered. This approach is based on people's strengths and what matters to them. It ensures that individuals are active participants, not just passive recipients, of the support they receive.
Practice educator	'An occupational therapist who supervises, facilitates learning, assesses and supports a pre-registration learner during the required 1000 hours of successfully completed practice-based learning.' (RCOT 2019a, p13)

Practice-based learning	'Occupational therapy education delivered in a variety of settings that allows learners to apply and practise their newly acquired knowledge and skills in a safe environment. Practice-based learning has traditionally occurred in role-established settings, such as hospitals and community health services; however, alternative and non-traditional settings are also integral to pre-registration programmes. The inclusion of practice-based learning settings in which there is no existing occupational therapy role is important to develop learners with leadership skills who are capable of working in diverse settings.' (RCOT 2019a, p13)
Practitioner	For the purposes of this document, the term 'practitioner' has been used to identify you as the active individual, wherever you work and whatever your scope and level of practice within the occupational therapy workforce.
Professional boundary	A professional boundary is the line between acceptable and unacceptable behaviour for a practitioner who is part of or represents a profession. (Adapted from General Social Care Council 2009, p5)
Professional (clinical) reasoning	'The process used by practitioners to plan, direct, perform and reflect on client care.' (Schell et al 2014)
Professional rationale	The basis for your course of action, based on your professional reasoning.
Professional relationship	A formal relationship that exists for the purpose of carrying out your role, with boundaries governed by policies, procedures and agreed ways of working.
Reasonable	An objective standard. Something (e.g. an act or decision) is reasonable if the act or decision is one that a well-informed observer would also do or make.

Scope of practice	This is the area or areas of your profession in which you have chosen to practise, with the knowledge, skills and experience to practise lawfully, safely and effectively. (Adapted from HCPC 2013, p4)
Service	Within the context of this document, the term 'service' usually refers to the occupational therapy that you provide as an individual or group, rather than referring to the occupational therapy department or facility.
Supervision	'A professional relationship and activity which ensures good standards of practice and encourages development.' (COT 2015, p1)
Sustain/ Sustainable	'Sustainable health care combines three key factors: quality patient care, fiscally responsible budgeting and minimizing environmental impact.' (Jameton and McGuire 2002)
Way of thinking	A mental attitude or approach that predetermines your interpretation of information and situations, your response to them and your behaviour or conduct.
Welfare	'The availability of resources and presence of conditions required for reasonably comfortable, healthy and secure living.' (National Examination Board in Occupational Safety and Health 2016, p7)

Section 8

Legislation, policies and standards – key topics

You are expected to be familiar with and comply with any current legislation and policies, best practice standards, and employers' policies and procedures that are relevant to your scope, level and location of practice. This document does not identify every piece of relevant legislation, recognising that many differ across the four UK nations. Areas of legislation and guidance that are relevant to this document include:

Bullying

Candour

Clinical governance

Confidentiality – data protection and sharing, access to records/freedom of information

Consent

Consent for a child under 16 years (Gillick competence)

Discrimination

Duty of care

Equality

Health and safety/safe working practice

Health care

Human rights

Keeping records

Mental health and mental capacity

Negligence (Bolam test)

Reporting and disclosure

Risk

Safeguarding vulnerable people

Sexual offending

Social care

References

All websites accessed on 29.04.20.

Bolam v Friern Hospital Management Committee [1957] 1 WLR 582.

Bolitho v City and Hackney Health Authority [1998] AC 232 (HL).

Bonnard M, Anaby D (2016) Enabling participation of students through school-based occupational therapy services: towards a broader scope of practice. [Online]. *British Journal of Occupational Therapy, 79(3)*,188–192. doi:10.1177/0308022615612807

Cambridge University Press (2020) *Cambridge English Dictionary*. [s.l.]: [s.n.]. Available at: *https://dictionary.cambridge.org/dictionary/english/*

Caparo Industries Plc v Dickman [1990] 2 AC 605 (HL).

College of Occupational Therapists (2015) *Supervision: guidance for occupational therapists and their managers*. London: COT. Available at: *https://www.rcot.co.uk/sites/default/files/Supervision.pdf*

College of Occupational Therapists (1992) *College of Occupational Therapists Diploma: the degree-equivalent value of the Diploma of the College of Occupational Therapists (DipCOT) is recognised by universities and higher education institutions.* London: COT. Available at: *https://www.rcot.co.uk/about-us/our-history/rcot-diploma*

Department of Health (2013) *Information: to share or not to share: the information governance review*. London: DH. Available at: *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf*

Department of Health (1977) *Relationships between medical and remedial professions*. (HC (77) 33). London: DH.

Equality and Human Rights Commission (2019) *What are human rights?* London: Equality and Human Rights Commission. Available at: *https://www.equalityhumanrights.com/en/human-rights/what-are-human-rights*

Equality and Human Rights Commission (2018) *Understanding equality. What is equality?* London: Equality and Human Rights Commission. *Available at: https://www.equalityhumanrights.com/en/secondary-education-resources/useful-information/understanding-equality*

Eriksson L, Welander J, Granlund M (2007) Participation in everyday school activities for children with and without disabilities. *Journal of Developmental and Physical Disabilities, 19*(5), 485–502.

European Union Agency for Fundamental Rights, Council of Europe (2011) *Handbook on European non-discrimination law*. Luxembourg: Europe Publications Office of the European Union. Available at: *https://fra.europa.eu/sites/default/files/fra_uploads/1510-fra-case-law-handbook_en.pdf*

Fisher AG (2013) Occupation-centred, occupation-based, occupation-focused: same, same or different? *Scandinavian Journal of Occupational Therapy, 20(3)*, 162–173.

General Medical Council (2017) *Confidentiality: good practice in handling patient information*. Manchester: GMC. Available at: *https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality*

General Social Care Council (2009) *Professional boundaries: guidance for social workers*. London: GSCC. Available at: *https://www.basw.co.uk/resources/professional-boundaries-guidance-social-workers*

Gillick v West Norfolk and Wisbech Area Health Authority [1985] AC 112 (HL).

Governance Institute of Australia (2020) *What is governance?* Sydney: Governance Institute of Australia. Available at: *https://www.governanceinstitute.com.au/resources/what-is-governance/*

Great Britain. Parliament (2018) *Data Protection Act 2018*. London: Stationery Office. Available at: *http://www.legislation.gov.uk/ukpga/2018/12/contents/enacted*

Great Britain. Parliament (2014) *The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*. (SI 2936). London: Stationery Office. Available at: *http://www.legislation.gov.uk/uksi/2014/2936/pdfs/uksi_20142936_en.pdf*

Great Britain. Parliament (2010) *Equality Act 2010*. London: Stationery Office. Available at: *https://www.legislation.gov.uk/ukpga/2010/15/contents*

Great Britain. Parliament (1998) *Public Interest Disclosure Act 1998*. London: Stationery Office. Available at: *http://www.legislation.gov.uk/ukpga/1998/23/section/1*

Great Britain. Parliament (1995) *Carers (Recognition and Services) Act 1995*. London: HMSO. Available at: *http://www.legislation.gov.uk/ukpga/1995/12/enacted*

Great Britain. Parliament (1992) *Trade Union and Labour Relations (Consolidation) Act 1992*. London: HMSO. Available at: *https://www.legislation.gov.uk/ukpga/1992/52/contents*

Great Britain. Parliament (1974) *Health and Safety at Work Act 1974*. London: HMSO. Available at: *https://www.legislation.gov.uk/ukpga/1974/37/part/I/crossheading/general-duties*

Great Britain. Parliament (1889, 1906, 1916) *Prevention of Corruption Acts 1889 to 1916*. London: HMSO.

Harvey L (2020) Analytic quality glossary. [s.l]: Quality Research International. Available at: *http://www.qualityresearchinternational.com/glossary/index.htm#c*

Health and Care Professions Council (2017a) *Continuing professional development and your registration*. London: HCPC. Available at: *https://www.hcpc-uk.org/globalassets/resources/guidance/continuing-professional-development-and-your-registration.pdf*

Health and Care Professions Council (2017b) *Guidance on health and character*. London: HCPC. Available at: *https://www.hcpc-uk.org/globalassets/resources/guidance/guidance-on-health-and-character.pdf*

Health and Care Professions Council (2016) *Standards of conduct, performance and ethics*. London: HCPC.

Health and Care Professions Council (2013) *Standards of proficiency: occupational therapists*. London: HCPC.

Health and Social Care information Centre (2013) *A guide to confidentiality in health and social care. Treating confidential information with respect*. Version 1.1. London: HSCIC.

Hemmingsson H, Jonsson H (2005) An occupational perspective on the concept of participation in the International Classification of Functioning, Disability and Health – some critical remarks. *American Journal of Occupational Therapy*, 59(5), 569–576.

Information Commissioner's Office (2019) *Guide to the General Data Protection Regulation*. Wilmslow: ICO. Available at: *https://ico.org.uk/media/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr-1-0.pdf*

Interprofessional CPD and Lifelong Learning UK Working Group (2019) *Principles for continuing professional development and lifelong learning in health and social care*. Bridgwater: College of Paramedics. Available at: *https://www.unison.org.uk/content/uploads/2019/01/14.12.18_CPD_Principles_FINAL_Jan_2019-1.pdf*

Jameton A, McGuire C (2002) Towards sustainable health-care services: principles, challenges, and a process. *International Journal of Sustainability in Higher Education*, 3(2), 113–127.

Laver Fawcett A (2007) *Principles of assessment and outcome measurement for occupational therapists and physiotherapists: theory, skills and application*. Chichester: John Wiley & Sons.

McGee P, Inman C eds (2019) *Advanced practice in healthcare: dynamic developments in nursing and allied health professions*. 4th ed. Hoboken, NJ: Wiley Blackwell.

Mental Health Foundation (2019) *Mental capacity*. London: Mental Health Foundation. *Available at: https://www.mentalhealth.org.uk/a-to-z/m/mental-capacity*

National Examination Board in Occupational Safety and Health (2016) *Health and safety at work: a course book for the NEBOSH award in health and safety at work*. Leicester: NEBOSH.

NHS England, The Scottish Government, Health and Care Professions Council, Welsh Government, Council of Deans of Health, Northern Ireland Executive, General Osteopathic Council, Allied Health Professions Federation (2020) *Supporting allied health professionals and allied health professional support workers during the COVID-19 epidemic in the UK*. [s.l.]: [s.n.]. Available at: *https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/letter-supporting-ahps-19-march-2020.pdf*

O'Brien JC, Hussay SM, Sabonis-Chaffee B (2012) *Introduction to occupational therapy*. 4th ed. St Louis, MO: Elsevier Mosby.

Professional Standards Authority for Health and Social Care (2019) *Telling patients the truth when something goes wrong: evaluating the progress of professional regulators in embedding professionals' duty to be candid to patients*. London: PSAHSC. Available at: *https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/telling-patients-the-truth-when-something-goes-wrong---how-have-professional-regulators-encouraged-professionals-to-be-candid-to-patients.pdf?sfvrsn=100f7520_6*

Queensborough Community College (2018) *Definition for diversity*. Bayside, NY: Queensborough Community College. Available at: *http://www.qcc.cuny.edu/diversity/definition.html*

R (Burke) v. General Medical Council (Official Solicitor and others intervening) [2005] EWCA Civ 1003, [2006] QB 273. Available at: *https://www.familylawweek.co.uk/site.aspx?i=ed409* (paragraph 50).

Royal College of Occupational Therapists (2021) *Career development framework: guiding principles for occupational therapy*. 2nd ed. London: RCOT.

Royal College of Occupational Therapists (2019a) *Learning and development standards for pre-registration education*. London: RCOT.

Royal College of Occupational Therapists (2019b) *Scope of occupational therapy*. London: RCOT.

Royal College of Occupational Therapists (2018a) *Embracing risk; enabling choice: guidance for occupational therapists*. London: RCOT.

Royal College of Occupational Therapists (2018b) *Keeping records: guidance for occupational therapists*. 4th ed. London: RCOT.

Schell BAB, Scaffa ME, Gillen G (2014) *Willard and Spackman's occupational therapy*. Philadelphia, PA: Lippincott Williams and Wilkins.

Shann S, Ikiugu MN, Whittaker B, Pollard N, Kåhlin I, Hudson M...Townsend E (2018) *Sustainability matters: guiding principles for sustainability in occupational therapy practice, education and scholarship*. London: World Federation of Occupational Therapists. Available at: *https://www.wfot.org/resources/wfot-sustainability-guiding-principles*

Stancliffe R (2014) *Progress and reflections on sustainable healthcare in UK*. Presented at the Sustainable Healthcare London 3rd annual UK–Sweden Sustainable Healthcare Summit, 29 April 2014, London.

Unison (2003) *The duty of care: a handbook to assist health care staff carrying out their duty of care to patients, colleagues and themselves*. London: Unison. Available at: *http://www.unisonharingeyhealth.co.uk/duty%20of%20care%20hand%20book.pdf*

United Nations General Assembly (1948) *Universal Declaration of Human Rights*. (217 [III] A). UN General Assembly: Paris. Available at: *https://www.un.org/en/universal-declaration-human-rights/*

Victoria State Government – Education and Training (2019) *Teach with digital technologies*. [s.l.]: Victoria State Government. Available at: *https://www.education.vic.gov.au/school/teachers/teachingresources/digital/Pages/teach.aspx*

Wilcock A (2006) *An occupational perspective of health*. 2nd ed. Thorofare, NJ: Slack.

World Federation of Occupational Therapists (2019) *About occupational therapy*. London: WFOT. Available at: *https://www.wfot.org/about/about-occupational-therapy*

World Federation of Occupational Therapists (2012) *Environmental sustainability, sustainable practice within occupational therapy*. (Position Statement). [s.l.]: [s.n.]. Available at: *https://www.wfot.org/resources/environmental-sustainability-sustainable-practice-within-occupational-therapy*

World Health Organization (2002) *Towards a common language for functioning, disability and health*. Geneva: WHO. Available at: *https://www.who.int/classifications/icf/icfbeginnersguide.pdf*

Bibliography

All websites accessed on 29.04.20.

Anon (2019) *Bullying behaviour is unacceptable. It is unprofessional and unnecessary. It affects the wellbeing of individuals and the teams within which they work.* [London]: [NHS Resolution]. Available at: *https://resolution.nhs.uk/wp-content/uploads/2020/01/BullyingA4-final-Dec-2019-002.pdf*

College of Occupational Therapists (2017) *Professional standards for occupational therapy practice.* London: COT.

College of Occupational Therapists (2015) *Code of ethics and professional conduct.* London: COT.

Department for Constitutional Affairs (updated 2016) *Mental Capacity Act 2005: code of practice.* London: Stationery Office. Available at: *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf*

Department of Health (2009) *Reference guide to consent for examination or treatment.* 2nd ed. London: DH.

Great Britain. Parliament (2006) *Safeguarding Vulnerable Groups Act 2006.* London: Stationery Office. Available at: *http://www.legislation.gov.uk/ukpga/2006/47/contents*

Great Britain. Parliament (2005) *Mental Capacity Act 2005.* London: Stationery Office. Available at: *http://www.legislation.gov.uk/ukpga/2005/9/contents*

Great Britain. Parliament (1998) *Human Rights Act 1998.* London: Stationery Office. Available at: *http://www.legislation.gov.uk/ukpga/1998/42/contents*

Great Britain. Parliament (1983) *Mental Health Act 1983.* London: HMSO. Available at: *http://www.legislation.gov.uk/ukpga/1983/20/contents*

Health and Care Professions Council (2016) *Guidance on conduct and ethics for students.* London: HCPC. Available at: *https://www.hcpc-uk.org/globalassets/resources/guidance/guidance-on-conduct-and-ethics-for-students.pdf*

Nursing and Midwifery Council (2018) *The Code. Professional standards of practice and behaviour for nurses, midwives and nursing associates.* London: NMC.

Professional Standards Authority for Health and Social Care (undated) *Duty of candour.* (web page). Available at: *https://www.professionalstandards.org.uk/what-we-do/improving-regulation/find-research/duty-of-candour*

Rippon S, Hopkins T (2015) *Head, hands and heart: asset-based approaches in health care.* London: The Health Foundation. Available at: *https://www.health.org.uk/sites/default/files/HeadHandsAndHeartAssetBasedApproachesInHealthCare.pdf*

Royal College of Nursing (2019) *Duty of care.* London: RCN. Available at: *https://www.rcn.org.uk/get-help/rcn-advice/duty-of-care*

Royal College of Nursing (2011) *Spirituality in nursing care: a pocket guide.* London: RCN. Available at: *http://www.elament.org.uk/media/1205/spirituality_in_nursing_care-_rcn_pocket_guide.pdf*

World Federation of Occupational Therapists (2016) *Code of ethics.* United Kingdom: WFOT. Available at: *https://www.wfot.org/resources/code-of-ethics*

Professional standards for occupational therapy practice, conduct and ethics

These *Professional standards for occupational therapy practice, conduct and ethics* are produced by the Royal College of Occupational Therapists (RCOT) in consultation and collaboration with its members. They describe the essential practice, behaviours and values that RCOT members have a responsibility to abide by at all times. Maintaining these standards will help occupational therapists to be safe, effective and ethical practitioners, providing a high-quality, evidence-informed and inclusive service. They may be taken as appropriate standards of reasonable care, as defined by the professional body, which may be referred to by the Health and Care Professions Council (HCPC), the regulatory body for occupational therapists.

Reviewed every five years, this publication provides a useful reference point for members of the public, employing organisations and others who need to be aware of the expectations of the professional body.

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College of Occupational Therapists

COT/ BAOT Briefings

Record Keeping – Issues of Responsibility

Revision Date: March 2006
Lead Group: Practice
Review Date: September 2007
Country Relevance: England and Wales

Introductions

This COT/ BAOT Briefing will provide some guidance for practitioners on a number of issues of responsibility that arise in record keeping. It concentrates primarily on the current professional requirement for countersigning student and support staff record entries, as stated in the *Professional Standards for Occupational Therapy Practice (2003) p36.* This has recently been brought into question. The professional standards currently state that countersigning the record is 'to ensure and demonstrate their accuracy'. The College recognises that this is not always possible. For this reason, occupational therapists will note that this guidance supersedes the relevant sections of text in the professional standards, which will be revised in 2006.

The purpose of the records

It is a requirement under the *Professional Standards for Occupational Therapy Practice* (2003) that occupational therapy personnel, in all settings, keep records of 'all occupational therapy activity and intervention made with, or on behalf of, the service user' (COT, 2003 p35).

In its guidance on records management for the NHS in England, the Department of Health sees records as 'a valuable resource because of the information they contain…. Information is essential to the delivery of high quality evidence-based health care on a day-to-day basis and an effective records management service ensures that such information is properly managed and is available:

- to support patient care and continuity of care
- to support day to day business which underpins delivery of care
- to support evidence based clinical practice
- to support sound administrative and managerial decision making, as part of the knowledge base for the NHS services
- to meet legal requirements, including requests from patients under access to health records legislation
- to assist medical and other audit
- to support improvements in clinical effectiveness through research and also support archival functions by taking account of the historical importance of material and the needs of future research

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- whenever, and wherever there is a justified need for information, and in whatever media it is required.'

(Department of Health 1999, Section 1.2, p4)

Along with those purposes above, care records should also provide an accurate record of the service user's condition over time, detailing the assessment, planning and delivery of the care provided and its evaluation. This will then:

- provide an objective basis to determine the appropriateness of, need for and effectiveness of intervention
- demonstrate the practitioner's professional reasoning and the rationale behind any care provided
- highlight problems and changes in the service user's condition at an early stage
- facilitate better communication and dissemination of information between members of health and social care teams
- protect the welfare of service users by promoting high standards of care.

Records include any material that holds information regarding an individual, collected as part of his or her care provision. Such material can be written, electronic, auditory or visual. It includes computer data, letters, notes and duplicate copies.

Signing and countersigning occupational therapy entries in health and social care records

It is first and foremost an employer responsibility to ensure that services are effectively managed, and that all levels of staff have access to professional guidance and support appropriate to their roles, responsibilities and needs.

It is also primarily an employer responsibility to ensure that the care records created or used by their employees meet legal, national and/or local requirements. Regulatory bodies such as the Health Professions Council or Social Care Council set national requirements. Such requirements may be made of the professional or the workplace. **Occupational therapists should follow local procedures and protocols when completing care records, meeting all the regulatory body requirements set for the workplace and for themselves as professionals.**

The Health Professions Council states that 'If you are supervising students, you should also sign any student's entries in the notes.'

(Health Professions Council 2003, Section 10)

The General Social Care Council, the workforce regulator and guardian of standards for the social care workforce in England, has developed United Kingdom-wide codes of practice for employers and social care workers. These state:

'2 As a social care employer, you must have written policies and procedures in place to enable social care workers to meet the GSCC's Code of Practice for Social Care Workers. This includes:

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2.1 Implementing and monitoring written policies on: confidentiality; equal opportunities; risk assessment; substance abuse; record keeping; and the acceptance of money or personal gifts from service users or carers;'

'6 As a social care worker, you must be accountable for the quality of your work and take responsibility for maintaining and improving your knowledge and skills.
This includes:
6.2 Maintaining clear and accurate records as required by procedures established for your work.'

(General Social Care Council 2002)

The College of Occupational Therapists can set quality standards that are rooted in legal and national requirements and can provide guidance. It is currently a professional requirement for occupational therapists to "provide a clear signature, designation and date with all entries, additions or amendments." (COT 2003, p36), also to "countersign student or support staff records to ensure and demonstrate their accuracy". (COT 2003, p36)

When a practitioner signs a care record, they are signing to confirm that it is an accurate account of any communication, planning, intervention or outcomes related to the care of an individual service user. Unless otherwise indicated, they are also identifying themselves as the individual responsible for the action/s defined in the record entry and for the entry itself.

The College's requirement for countersigning student and support staff record entries has recently been brought into question. The professional standards currently state that countersigning the record is "to ensure and demonstrate their accuracy". The College recognises that it is not always possible to be absolutely sure that record entries made by students or support staff are accurate, if the activities themselves have not been witnessed. For this reason, the College will be amending the content of the professional standards documentation when it is reviewed in 2006.

Consideration should be given to the reason for countersigning care record entries. When an occupational therapist delegates a task to an occupational therapy student or a member of support staff, the occupational therapist retains ultimate responsibility for the care provided to the service user. The occupational therapist must be satisfied that the person to whom the task is delegated is competent to carry out the intervention or procedure. (College of Occupational Therapists 2000, Section 5.2) When countersigning the record entry of an occupational therapy student or a member of support staff, the occupational therapist identifies himself or herself as the individual responsible for the supervision of the student/ support staff member and of delegating the task to that person. The occupational therapist thereby takes responsibility for the appropriateness of the intervention recorded and for its performance.

When countersigning students' or support workers' record entries, practitioners should take reasonable steps to ensure the accuracy of such records. Occupational therapists in a

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service or locality may wish to agree to use a clause such as "I believe this is to be an accurate reporting and true record of this intervention/ activity".

Occupational therapists should ensure that they meet the requirements laid down by regulatory bodies and their employers in terms of countersigning care record entries. They should ascertain whether there is a local protocol and the purpose or meaning for countersigning record entries in their workplace.

Ensuring accuracy in electronic care records

The College suggests that the above approach should also be taken with the generation and use of electronic care records. Occupational therapists should again follow local policy. With electronic systems, practitioners are usually given a personal code that gives them access to the records and identifies their entries. There is not usually a way of 'countersigning' other peoples' entries on the computer system, although supervising therapists may check them.

Most employing authorities have a system for allowing support staff, students or temporary workers to access electronic care records. When this does not exist, the issue should be raised with the employer's lead in record keeping. The College would not recommend the practice of a supervising occupational therapist loaning their own access/ identity code to a student, support worker or temporary worker, but local guidance should be sought.

In 1998 the Chartered Society of Physiotherapy and the College of Occupational Therapists commissioned a project that focussed on the implementation of electronic care records in the two professions. An update on the work, now known as the Garner Project, is given in the March 2005 issue of the British Journal of Occupational Therapy.

Records held by service-users and duplication

Care records provide occupational therapists with evidence that their duty of care for their service users has been fulfilled in a competent, professional and responsible way.

There is growing use of service-user held records, especially in the fields of paediatric and cancer care. The use of service-user held records raises the possibility of duplication, as therapists feel the need to maintain a secure set of records, detailing the services that they have provided and to have a source of reference for monitoring, audit or research purposes.

There is no clear guidance available as to whether the service provider should keep duplicate records. The Modernisation Agency has published a *Patient-held records toolkit* (2003), developed by the Cancer Services Collaborative 'Improvement Partnership'. This toolkit suggest that a prior agreement is reached within the service/ organisation as to what information still needs to be centrally held. The *Nursing and Midwifery Council Guidelines for records and record keeping* state that 'keeping a supplementary record should be the exception rather than the norm… and should not extend to keeping full duplicate records' (Nursing and Midwifery Council 2002, page 13).

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The College advises occupational therapy practitioners to agree and follow a local policy. If employing authorities have policies that restrict the keeping of duplicate records, then these authorities take full responsibility for any issues of difficulties that may occur as a result.

The College will be publishing fuller guidance on the underlying principles and rationale that occupational therapists should be aware of concerning record keeping in April 2006.

References

Cancer Services Collaboration 'Improvement Partnership' (2003) *Patient-held records toolkit*. Leicester: NHS Modernisation Agency.

College of Occupational Therapists (2000) *Code of ethics and professional conduct for occupational therapists*. London: COT.

College of Occupational Therapists (2003) *Professional standards for occupational therapy practice*. London: COT.

Department of Health (1999*) For the record: managing records in NHS trusts and health authorities.* (HSC 1999/053.) London: DH.

Garner R, Rugg S (2005) Electronic Care Records: an update on the Garner Project. *British Journal of Occupational Therapy*. 68(3), 131-134.

General Medical Council (2001) *Good medical practice*. London: GMC.

General Social Care Council (2002) *Code of practice for social care workers and code of practice for employers of social care workers*. London: GSCC.

Health Professions Council (2003) *Standards of conduct, performance and ethics*. London: HPC.

Nursing and Midwifery Council (2002) *Guidelines for records and record keeping.* London: NMC.

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Record Keeping

Second Edition

College of Occupational Therapists

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The College of Occupational Therapists is a wholly owned subsidiary of the British Association of Occupational Therapists (BAOT) and operates as a registered charity. It represents the profession nationally and internationally, and contributes widely to policy consultations throughout the UK. The College sets the professional and educational standards for occupational therapy, providing leadership, guidance and information relating to research and development, education, practice and lifelong learning. In addition, 11 accredited specialist sections support expert clinical practice.

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1 Introduction

Good practice in record keeping can help to protect the welfare of service users. Occupational therapists need to see it as an intrinsic part of the care that they provide. In 2005 Bridgit Dimond wrote:

Failure … to maintain reasonable standards of record keeping could be evidence of professional misconduct and subject to professional conduct proceedings. Such failure could also lead to disciplinary action by an employer and have very strong influence on any action brought in the civil courts by a claimant who alleges that he/she has suffered harm as a result of inappropriate care or treatment possibly as a consequence of failures to maintain reasonable standards of record keeping.

(Dimond 2005a, p. 460)

Even with all the rules and guidance available, occupational therapists need to use their professional judgement in record keeping, as they do in their hands-on practice. Such judgement is aided by understanding the rationale that underlies some of the key record keeping requirements for occupational therapists, with reference to legal and governmental guidance, the guidance available from professional bodies, and other relevant publications.

This document was developed with regard to some of the record keeping requirements within the standards of practice of the College of Occupational Therapists and those of the Health Professions Council. It is relevant across the UK and useful to all fields of practice. This updated version contains more information concerning electronic record keeping than the first edition (COT 2006). Various sources of further information are signposted, where they may be of use.

For the purposes of this guidance, the records kept by occupational therapists are called 'care records', in order to encompass records kept in health, social, community and education settings. Those people who receive occupational therapy services are called 'service users'. This term encompasses all ages and groups of people, and is applicable in all settings. (Other terms may, however, be used in quotations.)

1.1 What constitutes a care record?

The *Data Protection Act 1998* refers to a health record as any record which:

(a) consists of information relating to the physical or mental health or condition of an individual, and

(b) has been made by or on behalf of a health professional in connection with the care of that individual.

(Great Britain, Parliament 1998, Section 68.2)

Care records include any material that holds information regarding an individual, collected as part of their care provision. Such material can be handwritten, electronic, auditory or visual, and would include computer or digital data, images, auditory or visual recordings, letters, notes, emails, text messages and duplicate copies.

1.2 The purpose of care records

In 2006 the Department of Health (DH) published *Records management: NHS code of practice* (DH 2006b). This is a guide to the required standards of practice in the management of records for those who work within, or under contract to, NHS organisations in England, including social care providers. Although aimed at National Health Service (NHS) organisations, the principles are applicable in all settings.

The document states:

Records are a valuable resource because of the information they contain. High-quality information underpins the delivery of high-quality evidence-based healthcare … Information has most value when it is accurate, up to date and accessible when it is needed. An effective records management service ensures that information is properly managed and is available whenever and wherever there is a justified need for that information, and in whatever media it is required. Information may be needed:

- *to support patient care and continuity of care;*
- *to support day-to-day business which underpins delivery of care;*
- *to support evidence-based clinical practice;*
- *to support sound administrative and managerial decision making, as part of the knowledge base for NHS services;*
- *to meet legal requirements, including requests from patients under subject access provisions of the Data Protection Act or the Freedom of Information Act;*
- *to assist clinical and other types of audits;*
- *to support improvements in clinical effectiveness through research and also support archival functions by taking account of the historical importance of material and the needs of future research; or*
- *to support patient choice and control over treatment and services designed around patients.*

(DH 2006b, Section 2.14)

Along with those purposes above, care records should also provide an accurate record of the service user's condition over time, detailing the assessment, planning and delivery of the care provided and its evaluation. This will then:

- Provide an objective basis to determine the appropriateness, need and effectiveness of intervention.
- Record decisions on consent to treatment/intervention and also where it has been impossible to gain consent due to lack of mental capacity.
- Demonstrate the practitioner's professional reasoning and the rationale behind any care provided.
- Highlight problems and changes in the service user's condition at an early stage.
- Provide an effective and accurate means of communication and dissemination of information between members of health and social care teams.
- Protect the welfare of service users by promoting high standards of care.

Occupational therapists should note that any care records that they create or use should fulfil these purposes.

1.3 The legal status of records and responsibility for them

Although there are no laws specifically addressing care records, there are several laws that apply to them and have an impact upon them. These include:

- *Freedom of Information Act 2000.*
- *Human Rights Act 1998.*
- *Data Protection Act 1998.*
- *Access to Health Records Act 1990.*
- *Mental Health Act 1983*.

There are a number of guides and codes of practice set down by regulatory bodies and at a local level. These aim to provide a structure and a standard for safe and good working practice. They are not in themselves legally binding, but a failure to follow this recommended practice, it could be argued, may constitute negligence (Lynch 2009).

Occupational therapists need to be aware of the requirements laid down in the *Data Protection Act 1998*. This provides a framework of standards. The Act regulates the processing of personal data, held in paper records and on computer. It applies to all personal information, not just that held in health records, and therefore applies also to records of employees held by employers, for example in occupational health departments.

Personal data is defined as:

data relating to a living individual that enables him/her to be identified either from that data alone or from that data in conjunction with other information in the data controller's possession. It therefore includes such items of information as an individual's name, address, age, race, religion, gender and physical, mental or sexual health.

(DH 2006b, Section 2)

Processing includes 'everything done with that information, i.e. holding, obtaining, recording, using, disclosing and sharing it' (DH 2006b, Section 19). Using includes 'disposal, i.e. closure of the record, transfer to an archive or destruction of the record' (DH 2006b, Section 20).

Under the *Public Records Act 1958*, the records created by governmental public bodies, which include state education, social services and the NHS, are public records (Great Britain, Parliament 1958, Section 3.12). Under the terms of the Act, organisations have a duty to ensure the safekeeping and eventual disposal of their records. They are guided and supervised by the Keeper of Public Records, who is answerable to Parliament. The *Public Records Act 1958* excludes Scotland, but many of its principles and provisions have been adopted there. The *Freedom of Information Act 2000* and the *Freedom of Information (Scotland) Act 2002* also require organisations to have strong records management procedures.

Records management should be seen as a corporate responsibility within the NHS. There should be a designated senior member of staff who has lead responsibility, and a local policy available on how the organisation manages all of its records, including electronic records, from creation to closure and eventual disposal or archiving. All line managers and supervisors must ensure that their staff, whether clinical or administrative, are appropriately trained so that they are aware of their responsibilities in respect of record

keeping and management and that they adhere to national and local policies. This should include training in the use of electronic recording systems.

Anyone who works for an NHS organisation is responsible for records which they create or use in the performance of their duties. *Any* record that they create is a public record and is therefore subject to legal obligations and has the potential to become a legal document. Further information on these legal obligations is available in Annex C of the *Records management: NHS code of practice. Part 1* (2006) (DH 2006b, Section 3.28–36).

Records management: NHS code of practice (Scotland) Version 1.0 (Scottish Government 2008) is a guide to the standards of practice in the management of records for NHS organisations in Scotland. The guidance aims to establish best practice regarding the creation, use, storage, management and disposal of NHS records.

In the private sector or industry, health records continue to be viewed as personal data and come under the requirements of the *Data Protection Act 1998*. Independent practitioners, or the bodies for which they work, are responsible for the records that they develop and should have systems in place which meet these requirements.

Practitioners working with service users subject to mental health legislation must ensure that they have a good working knowledge of the relevant law. They must comply as appropriate with the guidance given by the Mental Health Act Commission for England and Wales; the Mental Welfare Commission for Scotland; or the Mental Health Commission for Northern Ireland.

Records management: NHS code of practice (DH 2006b, Section 2.26) states that the management of social care records is outside the scope of the code. The good practice outlined is, however, applicable to all organisations, and colleagues working for social care organisations are encouraged to adopt similar standards of practice. Relevant information for social care practitioners may be found within the 'Custodian' database (the repository of standards and related learning for local government), available at: *http://www.legsb.gov.uk/custodian-/default.php* Accessed on 23.11.09.

The Department of Health and NHS Connecting for Health jointly produced an *Information Governance Toolkit* (2009). This web-based tool was launched in late 2003, and was updated in 2009. The Toolkit has been made available to assist organisations in achieving the aims of information governance. Information governance refers to the way in which the NHS handles all organisational information – in particular the personal and sensitive information of service users and employees. It is the tool by which organisations assess their compliance with current legislation, standards and national guidance. Further information is available from NHS Connecting for Health: *http://www.connectingforhealth.nhs.uk/systemsandservices/infogov* Accessed on 23.11.09.

The Department of Health states that social service managers need to demonstrate a commitment to record keeping as an important part of the services provided to users and carers, and to ensure that policies and procedures are established (DH 2000, Section 3.13). Social services departments should have a policy framework to ensure the quality of record keeping and processing. The Department of Health makes recommendations about what such policies should cover, including the service's responsibilities under the *Data Protection Act 1998*. They also recommend that employees should have guidance on best practice in record keeping, including coverage of the structure and maintenance of care record files.

A review of information governance in the Department of Health and the wider NHS carried out in 2005 commented on the absence of a single co-ordinating body (Cayton 2006). The review recommended that a National Information Governance Board (NIGB), covering both health and social care, should be established. The role of the NIGB is to support improvements in the practice of information governance in health and social care.

In 2004, the Department of Health, Social Services and Public Safely (DHSSPS), in Northern Ireland, published guidelines for managing records in health and personal social services organisations (DHSSPS 2004). This publication looks at the legislative background to record keeping requirements in Northern Ireland and details what is expected of anyone who works for DHSSPS staff.

Employers should ensure that care records created or used by their employees meet legal, national and/or local requirements, and that staff of all grades have access to professional guidance and support appropriate to their roles, responsibilities and needs. These responsibilities may be delegated to service managers who oversee the provision of therapy services and management of staff. Regulatory bodies, such as the Health Professions Council, set national requirements. Such requirements may be made of the professional, or of the workplace. Occupational therapists should follow local procedures and protocols when completing care records, meeting all the regulatory body requirements set for the workplace and for themselves as professionals.

Occupational therapists are recommended to read *Health records in court*, by Jane Lynch (2009). This is an accessible publication providing information on the legal aspects of record keeping. It also provides good practice guidance for keeping health records, which apply equally to social care and education records.

2 The quality of care records

Occupational therapists need to be able to show all that they have done for, with or in relation to a service user, including the clinical reasoning behind the care planning and provision. They also need to be able to demonstrate the outcomes of the care that they have provided, not only for the benefit of the service user and others in the care team with access to the records, but also as a testament to the value of occupational therapy.

The Department of Health states that:

Organisations need to ensure that their staff are fully trained in record creation, use and maintenance, including having an understanding of:

- *what they are recording and how it should be recorded;*
- *why they are recording it;*
- *how to validate information with the patient or carers or against other records – to ensure that staff are recording the correct data;*
- *how to identify and correct errors – so staff know how to correct errors and how to report errors if they find them;*
- *the use of information – so staff understand what the records are used for (and therefore why timeliness, accuracy and completeness is so important); and*
- *how to update information and update information from other sources.*

(DH 2006b. Section 3.40)

The Health Professions Council (HPC) is able to take action against practitioners who fall below the standards of conduct that they have laid down in their *Standards of conduct, performance and ethics* (2008) and their *Standards of proficiency – occupational therapists* (2007). The HPC Conduct and Competence Committee regard record keeping as a competency and have taken action against practitioners where the care records demonstrate a lack of competence, either in the record keeping itself, or in their practice. These include such deficiencies as an unacceptable standard of record keeping, false or failed entries, or there being no evidence of activities such as assessment, treatment planning, or the provision of information.

In the HPC's *Standards of proficiency – occupational therapists* (2007) the actual wording of the requirement directly related to record keeping (2b.5) is very short, but a practitioner can demonstrate that they meet almost all the other requirements of proficiency through their record keeping. For example, 2a.1 requires that the practitioner be able to gather appropriate information, and 2a.2 requires that he or she be able to select and use appropriate assessment techniques.

2.1 Legibility

Care records need to be legible in order to be of any use. If a service user is harmed because a practitioner's handwriting was illegible, that practitioner could be accused of professional negligence and be held liable as a result.

Legibility also includes the signature of the person making the entry. It is essential that this person is clearly and easily identifiable. This is one of the criteria in Standard 4 of the Clinical Negligence Scheme for Trusts (CNST 2005). CNST suggests that there should be a system in place in order to ensure that writers are properly identified, including the use of such tools as, for example, name stamps, personal identification numbers, and registries of example signatures. As a minimum, practitioners should at least sign and print their name and designation on their first entry to the records.

2.2 Inclusion

A court of law will adopt the approach that 'if it is not recorded, it has not been done, has not been considered, or was not said' (Lynch 2009, p. 45). A record of all occupational therapy activity should be kept, including any interventions and communication with, or on behalf of, the service user, including the following:

Decisions made as part of supervision

Decisions made in a supervision meeting concerning the care provided to an individual can be seen as part of the care process. Such decisions need to be recorded in the care records.

Official or unofficial discussions concerning a service user

Whenever a service user is discussed, in a team meeting, in the course of a phone call or even in an unplanned situation, the occurrence, the content and any outcomes of the discussion should be recorded in the care records. This was highlighted in the Victoria Climbié inquiry recommendations (DH 2003b).

Evidence-based care

Care records should show that the care provided was appropriate, in accordance with current best practice at the time and based on evidence, where evidence was available. If occupational therapists are following national or local guidelines, procedures, or care pathways, etc., evidence-based care will be demonstrated in the record, along with an explanation of any variance (NHS Modernisation Agency 2003).

Frequent and repetitious activities

Where activities are frequent and repetitious, it is tempting to think that minimal or no records are required. However, legally, if an activity is not recorded, it cannot be proven to have occurred. All activity should be recorded fully, including the service user's response or other outcomes.

Service user non-attendance

If a service user is unable to attend an appointment, or if a planned intervention does not occur, this should be recorded in the care records, if possible with an explanation. Including this in the record demonstrates that the therapist's planning and care was disrupted for unavoidable reasons, rather than being withheld, or not provided, because of disorganisation or incompetence.

Information provided to the service user

Any verbal or printed information or advice given to the service user or their carer(s) should be appropriately recorded. It is not enough to write 'Advice given': the nature and level of information given should be documented.

The source of information

It is important to record the source of any information gathered about the service user, especially if the accuracy of the information is uncertain, or circumstances around the individual's care change. The information about the service user may have come from medical notes, another professional's notes, from a carer or member of the family, or from the service user him or herself.

People present

There may be times when the occupational therapist sees the service user when others are present. This may have an effect upon the nature of the care given, or the conversation held, if confidentiality is a concern, or it may have an impact on the effectiveness of care.

An electronic record keeping system should make provision for all these elements to be included.

2.3 The use of violent warning markers

In 2006 the Information Commissioner's Office produced a Data Protection Good Practice Note on *The use of violent warning markers* (ICO 2006). It emphasises that the use of markers must comply with the *Data Protection Act 1998*. It provides good guidance when trying to balance employee safety with fairness to service users. It is available to download from the Information Commissioner's Office website: *http://www.ico.gov.uk* Accessed on 23.11.09.

There is no specific national information standard that specifies how violent warning markers should be applied in electronic care records. It is important for staff and students to ensure that their electronic record keeping training covers how the system uses and displays 'violent' warning markers.

2.4 The use of acronyms and abbreviations

The Nursing and Midwifery Council guidelines (NMC 2007) state that abbreviations should not be used in care records, but acronyms and abbreviations are nevertheless useful when trying to record information in a concise way, especially when it can be assumed that other members of the care team will understand the terms used. However, it should be borne in mind that service users are entitled to access their records upon request and should be able to read and understand what is written in them. It should also be recognised that terms and acronyms may change over time and that these differ across service providers.

Occupational therapists within services or teams should consider agreeing to use a limited number of acronyms or abbreviations and should ensure that these are defined in full within each set of care records. This will reduce the risk of misunderstanding, but cannot eliminate it altogether.

2.5 Service user/patient identifiers

A unique service user identifier must be used in all care records. In a hospital setting this is most often the hospital number or the NHS number. All information included in the care record should be identified by the service user's name and unique identifier.

The NHS in England is implementing the *NHS number standard for secondary care (England) data set change notice 32/2008* (Department of Health, Information Standards Board for Health and Social Care, December 2008). The standard requires that all secondary care electronic systems be compliant by 31 December 2009, and are using the NHS number by 31 December 2010. Further standards are being developed to authorise the use of the NHS number in other parts of the NHS.

Lynch (2009) recommends that the service user's full name, date of birth and identifying number should be on every page of information in the care record.

2.6 Signing and countersigning record entries

When a practitioner signs a care record, they are signing to confirm that it is an accurate account of any communication, planning, intervention or outcomes related to the care of an individual service user. Unless otherwise indicated, they are also identifying themselves as the individual responsible for the action(s) defined in the record and for the entry itself.

The person who carries out the intervention should write the record and sign the entry. All entries, additions and amendments must be clearly and legibly signed, and give a designation (see Section 2.1). Anyone making an entry to the records should be identifiable to another person reading the records at a later date.

This requirement includes assistants and students. The supervising occupational therapist must be satisfied that the person to whom any task is delegated is competent to carry out the intervention or procedure *and* the recording of it. The Health Professions Council no longer require practitioners to countersign student entries into records; instead the Council stipulates that: 'You have a duty to make sure, as far as possible, that records completed by students under your supervision are clearly written, accurate and appropriate' (Health Professions Council 2008, Section 10). Occupational therapists should know and follow their local policy on countersigning records and take reasonable steps to ensure the accuracy and appropriateness of the record entries made by others under their supervision.

2.7 Timing and dating record entries

As with any aspect of care provided to an individual, the day and time that it occurred is important. Recording the date and time of an event demonstrate that the occupational therapist's care was appropriate and as planned. It also enables monitoring of the frequency of care and the timeframe for the progress, or deterioration, of the service user. Should the care provided be examined at a later date, the time and date of an event may be a vital piece of evidence.

The date should be given in full, including the day, month and year. The time should define morning or afternoon. The time and date given should reflect when the service user was actually seen, or an event occurred. It should not reflect when the records were written.

2.8 Timely record keeping

It is vital that records are accurate. The longer the time that has elapsed between an event occurring and it being recorded, the greater is the likelihood of inaccuracies or omissions in the records.

During assessments and interviews, information may be shared by the service user that is important to the current and future care of the individual, including particular wishes or requests. Unless such information is recorded, the occupational therapist will not have anything to refer to later on in care, or should the information given ever be questioned. The Laming Enquiry on the death of Victoria Climbié highlighted the necessity to complete records fully, and especially to document concerns about the service user at the time of an event, even if the concern was raised as part of an unofficial discussion (DH 2003b).

There are situations when events occur or a record needs to be made when practitioners do not have access to the care records. It is good practice for practitioners to have a means of recording information in such situations, for example, by using pre-printed environmental assessment forms, or telephone message recording notebooks. These may then be added to the care records in an organised way. If such forms are not available, a note may be made in a notebook or diary, but it should be noted that this note, or record, then becomes part of the care record and needs to be treated as such in terms of confidentiality and security, even if temporary. The contents of the note should be transferred into the care records as soon as possible and with complete accuracy and consistency. The original note needs to be destroyed or kept securely, as would be the case with any clinical diary.

If records are written retrospectively, the time must be given when the service user was actually seen, or the event occurred. Some practitioners add the time of the record entry below their signature. If the delay is significant, an explanation should be given in the records, as in, for example, situations in which the service user or the practitioner has been unwell.

2.9 Recording consent to intervention

The practice of obtaining informed consent is well covered in other publications, both those publically available and those available from the College of Occupational Therapists (COTS 2005, 2007b). In this guidance the stress is on the importance of recording the fact that consent was gained and the form in which it was given. Records provide the evidence that valid consent was obtained by the practitioner. If consent is not recorded, a practitioner cannot state that consent was given. The records also need to demonstrate that the service user has been informed of all the options and possible risks. The nature and degree of any risks must be documented: it is not enough to write, ‘advised of risks’. It should be immediately clear to any other person reading the records what information has, or has not, been given to the service user.

As stated in Section 2.2, the nature and level of information provided to the service user must be recorded. This informs any other reader of the record that all the relevant and necessary information has been provided, in order for the service user to give or refuse consent.

In cases where it is impossible to gain consent from the service user, as for example in the care of young children or people without the mental capacity to give consent, this

must be recorded. A parent may be asked to give consent on behalf of a child who is too young to give informed consent themselves, but no one can give consent on behalf of another adult who does not have the capacity to give consent. It is good practice to involve others who are close to the service user in decisions over care. Ultimately the practitioner must work in the best interests of the service user. Further information is available from the Department of Health website.

Service users should always be informed and asked for their consent if a student or observer is to be present during any occupational therapy interaction. This should be specified in the care records.

2.10 Amending a record

A record can only be amended if there is an error. In this case the material that is incorrect should be scored out with a single line, then signed, timed and dated by the person who made the amendment. The original entry must remain clear to read. The reason for the amendment should be evident to other readers. It is good practice to state the reason for the correction, for example, if the patient's date of birth was entered incorrectly.

Under the *Mental Health Act 1983*, there are limitations on what may be amended in mental health records and errors may only be changed in specific circumstances. Mental health practitioners should familiarise themselves with the relevant legislation.

The same principles apply in keeping electronic care records. Records can be amended or archived when appropriate, but must not be deleted.

2.11 The Climbié Inquiry recommendations

Following the death of Victoria Climbié in February 2000, a public inquiry was held, led by Lord Laming. His report was published by the Department of Health in January 2003 (DH 2003b). Many of the recommendations that followed the Climbié inquiry related to the quality, processing and monitoring of records and the need for more effective information sharing between the agencies involved. Some of the recommendations were targeted at either social care or healthcare practitioners, but are relevant to occupational therapy practitioners in health, education and social care who may have contact with children considered or suspected to be at risk of deliberate harm. The College would suggest that occupational therapists who work with children read the report.

The recommendations stress that records must be complete and up to date. Any discussions or meetings concerning children or families where deliberate harm is suspected must be recorded, including all decisions made, the actions planned and who will be responsible for those actions (DH 2003b, Recommendations 51, 69, 80).

The report also recommended that a manager should approve all social services assessments of children and families, and any resulting action plans. That manager must ensure that the child and the family have been seen and spoken to (DH 2003b, Recommendation 25). This guidance is relevant to any occupational therapists involved in the care of any child who is considered or suspected to be at risk of deliberate harm.

Directors of social services must ensure that senior managers inspect a random selection of case files and supervision notes at least once every three months for children considered or suspected to be at risk of deliberate harm (DH 2003b, Recommendation 30). Supervising managers must also read, review and sign case files on a regular basis.

In 2006 the Department of Health updated the 2003 guidance entitled *What to do if you're worried a child is being abused* (DH 2006c). This is available to download from the Every Child Matters section of the Department for Children, Schools and Families website: *http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00182* Accessed on 03.11.09.

2.12 The Bichard Inquiry

In December 2003 the Bichard Inquiry was set up to look into child protection procedures in the Humberside Police and the Cambridgeshire Constabulary in the light of the conviction of Ian Huntley for the murder of Jessica Chapman and Holly Wells.

The inquiry examined the effectiveness of the relevant intelligence-based record keeping, the vetting practices of those forces since 1995, and the effectiveness of information sharing with other agencies. Although specific to the police, it does discuss the sharing of information across agencies.

The enquiry report (Bichard 2004) is available to download from the Home Office website: *http://police.homeoffice.gov.uk* Accessed on 23.06.2009.

2.13 The Haringey area inspection

Following the death of Baby P in Haringey in 2007 an inspection was commissioned to look at 'the quality of practice and management of key services which contribute to the effective safeguarding of children in the local area'. The inspection was carried out in November 2008 by a multi-disciplinary team of seven inspectors from Ofsted, the Healthcare Commission, and Her Majesty's Inspectorate of Constabulary.

The main findings of the inspection include a number of points related to record keeping and communication, which are as follows:

- *There is a managerial failure to ensure full compliance with some requirements of the inquiry into the death of Victoria Climbié, such as the lack of written feedback to those making referrals to social care services.*
- *Social care, health and police authorities do not communicate and collaborate routinely and consistently to ensure effective assessment, planning and review of cases of vulnerable children and young people.*
- *The standard of record keeping on case files across all agencies is inconsistent and often poor.*

(Ofsted 2008, pp. 3–4)

The report adds more detail, noting inadequate case file recording and little evidence of thorough supervision. Police and health files were seen to be poorly organised. Health records included handwritten notes which were illegible and did not identify the author, or were inaccurate.

The two relevant recommendations made in response to the findings were to:

- *establish rigorous procedures to audit and monitor the quality of case files across all partner agencies and ensure processes are in place to deliver improvement;*
- *establish clear procedures and protocols for communication and collaboration between social care, health and police services to support safeguarding of children, and ensure that these are adhered to.*

(Ofsted 2008, pp. 4–5)

Occupational therapists working with children and young people are advised to read the report. It is available to download from the Department for Children, Schools and Families website, under 'Publications'.

2.14 Prescription and medication records

Named occupational therapists may, under Patient Group Directions, supply and administer medications. Further information is given in *COT/BAOT Briefing 15: Prescribing, supply and administration of medicines and occupational therapists* (COT 2007a).

It is vital for occupational therapists in this extended scope practice situation to maintain clear, accurate and immediate records of all medicines administered, ensuring that the signature is legible. Any decision not to supply prescribed medication, or any refusal to take supplied medication, should also be recorded and accompanied by a full explanation.

3 The format of care records

Occupational therapy care records are kept in a variety of ways, from specific occupational therapy files to shared rehabilitation notes, or fully integrated into medical or social care records. Current developments in the integration of care records and the use of electronic systems may soon provide greater direction in terms of format, structure, content, location and access. Provided that the principles and standards for record keeping are maintained, and that current local or government policy is being followed, variations in format are less important.

3.1 Specific or shared care records

Communication and understanding can be improved by the sharing of care records, with all team members involved in the service user's care having appropriate access to each other's records. In order for this to work effectively, the records must be kept up to date and must use appropriate and understandable terminology. The author and their profession or role must be identifiable. Shared record keeping can support the use of shared treatment aims, supporting collaborative working to the benefit of the service user.

3.2 Electronic care records

Information about people is increasingly being recorded, stored and accessed electronically. Occupational therapists will therefore increasingly find that they need to be able to use the electronic records of NHS patients, and of clients in social care, education, the employment services, and in private practice.

The introduction of electronic records varies according to the requirements of different services, clients or patients, and the legal and regulatory frameworks that govern their practice. However, there are common themes and issues of which occupational therapists should be aware, and should consider in relation to their specific area of practice. These can be illustrated with reference to the development of electronic care records (ECRs) in the NHS, in England.

The Department of Health in England determines the top-level policies and strategies for the commissioning and provision of healthcare services, and service development, including the contribution of information and communication technologies (ICT) in the NHS. The programme for introducing ICT into the NHS is the National Programme for IT in England (NPfIT), which is managed by Connecting for Health (CfH) and reports to the Department of Health.

Connecting for Health has contracted out the procurement, implementation and maintenance of information systems in the NHS to private companies. These IT companies are gradually replacing existing electronic and paper-based recording systems with a small number of electronic recording systems designed to work together and share information electronically. The original timescale, which aimed for completion in 2010, has now been extended to 2015.

Part of the delay has been the difficulty of designing integrated systems that will fully support clinical practice across the enormous diversity of clinical areas in the NHS, such

as mental health care, learning disabilities, surgery, acute medicine, children's services, cancer and palliative care.

In addition, between them NHS trusts have many 'legacy' information systems that:

- Have not been designed to meet current national information standards.
- May have been designed to meet a specific requirement in a clinical specialty, without consideration for compatibility and integration with other parts of the patient's record.
- Are usually fully embedded into local clinical processes and pathways.
- Have a high level of support from local NHS staff.

The new generation of ECR systems do not always offer the same high level of functionality as the legacy specialist systems, but do provide compatibility and integration across all care services. Some NHS staff members are resistant to the introduction of the integrated systems, because they are perceived to be inferior.

NHS trusts sometimes have a number of legacy systems that are being replaced over several years. IT contractors face a significant challenge in managing this phased process. There are hundreds of NHS trusts in England, each with a different profile of legacy recording systems, and at different stages in the implementation of the new generation of electronic care record systems.

Occupational therapists need to be aware of the National Programme for IT in England and the ongoing introduction of ICT into the NHS. They will find that trusts vary greatly in the progress they have made with introducing the new systems, and in the pace of ongoing change.

It is essential that occupational therapists keep up to date on local developments in electronic care record systems and, wherever possible, that they contribute to those developments to ensure they will fully support occupational therapy practice.

Occupational therapists, and their students, will need to be trained to use the electronic care record systems, and will need to keep up to date with developments in their NHS trust if they are to use the systems competently.

The following websites provide information on ECR developments in the NHS across the UK.

Connecting for Health in England: *http://www.connectingforhealth.nhs.uk*

Connecting with allied health professionals: *http://www.connectingforhealth.nhs.uk/engagement/clinical/ncls/ahp*

London Programme for IT: *http://www.london.nhs.uk/lpfit*

North, Midlands, and East: *http://www.connectingforhealth.nhs.uk/area/nme*

Southern Programme for IT: *http://www.connectingforhealth.nhs.uk/area/southern*

Northern Ireland Department of Health, Social Services and Public Safety: *http://www.dhsspsni.gov.uk*

Scotland's Health on the Web (SHOW): *http://www.show.scot.nhs.uk*

Informing Healthcare (the National Programme for IT in NHS Wales): *http://www.wales.nhs.uk/ihc*

(All websites were accessed on 23.11.09.)

The NHS Care Records Service (NHS CRS) is a service provided by NHS Connecting for Health for the NHS in England. It will make electronic care records available to a range of care providers across acute and community care.

The *Care record guarantee* (DH 2009a) makes a series of commitments to service users in respect of information held about them on the NHS Care Records Service. These commitments function as rules that should govern record keeping practice. There are 12 commitments, concerning access, security, information sharing and confidentiality. The *Care record guarantee* covers people's access to their own records, controls on others' access to those records, and how access will be monitored and policed. It also includes options for limiting access further, access in an emergency, and what happens when someone cannot make decisions for him or herself. The *Care record guarantee* was first published in 2005, and then revised in 2006, 2007 and 2009. It applies to both paper and electronic records and applies to all staff accessing patient records, not only health professionals.

The *Information for social care* framework document, published in May 2001 by the Department of Health, sets out the Government's overall strategy for enhancing information systems in social care. A key part of this is the development of the Electronic Social Care Records (ESCR) system.

The ESCR has been developed through a mixture of national and local initiatives over recent years. It brings together all relevant information for a social care user in one place. It holds three types of information:

1. Structured information, which typically includes:
   - National forms, such as those used for recording information about children.
   - Local forms.
   - Forms completed by service users, such as self-referral or financial assessment forms.
2. Unstructured information which covers all other recording, including:
   - Letters.
   - Emails.
   - Records of phone calls.
   - Meetings notes.
   - Video clips.
3. Coded data, which is mainly for management and statistical reports.

The White Paper *Our health, our care, our say* (Department of Health 2006a) aimed for integrated health and social care plans for individuals with long-term conditions by 2008, and for integrated Electronic Health and Social Care Record by 2010. To ensure the delivery of integrated health and social care information systems in England by 2010, the Department's NHS Connecting for Health agency has established an Electronic Social Care Record Board (ESCRB). The Board has responsibility for overseeing national implementation of the Electronic Social Care Record, ensuring consistency across local authorities with social services responsibilities and integration with other information systems.

This information is taken from the Department of Health website page on the Electronic Social Care Record (Available at: *http://www.dh.gov.uk/en/Managingyourorganisation/Informationpolicy/Informationforsocialcare/DH_4073714* Accessed on 23.11.09).

The same principles for using and managing paper record systems in respect of content and security apply also to electronic ones. Electronic records should provide a complete picture of care, just as with any written record. As when keeping written care records, occupational therapists should follow local policy when they use electronic care records. Organisations using electronic records need to ensure that the system offers an audit trail that identifies all additions, updates, deletions and viewings of the records, including user identification.

3.3 The Integrated Children's System

The Integrated Children's System (ICS) is a framework, a method of practice and a business process to support the processes of assessment, planning, intervention and review in the context of children's care services. It is designed to be supported by an electronic case record system.

More information on the development of the ICS is available from the Every Child Matters section of the Department for Children, Schools and Families website *(http://www.dcsf.gov.uk/everychildmatters* Accessed on 23.11.09) and the Welsh Social Services Improvement Agency website (*http://ssia.wlga.gov.uk/ics* Accessed on 23.11.09).

In Scotland, 'Getting it right for every child' is a programme that aims to improve outcomes for all children and young people. One of the components of the programme is to develop the capacity to share demographic, assessment and planning information electronically within and across agency boundaries. This includes making available a child or young person's care record, drawing together all key information collected by professionals and the family. This task is being taken forward by eCare, the Scottish Government's multi-agency information sharing framework. More information is available from the Scottish Government website (*http://www.scotland.gov.uk* Accessed on 23.11.09).

3.4 Care records held by service users

Increasingly service users are holding their own care records, especially in the fields of community care, children's care and cancer care.

The record aims to involve and inform service users, and their carers, in their own care, and to aid communication between all the different people involved in caring for the individual. Service users need to know the purpose and importance of the care record and their responsibility to keep it safe.

The use of service-user-held records raises the possibility of duplication, as practitioners feel the need to maintain a secure set of records, detailing the services that they have provided, and to have a source of reference for monitoring, audit or research purposes. There is no clear guidance available as to whether the service provider should keep duplicate records. The NHS Modernisation Agency has published a *Patient-held records toolkit*, developed by the Cancer Services Collaboration 'Improvement Partnership' (2003). This toolkit suggests that a prior agreement should be reached within the service/organisation as to what information still needs to be centrally held. If a supplementary set of records is held by the service user, the organisation's records/information department should be informed and the record should be accessible to other members of the health/social care team involved in the care of the service user.

Occupational therapists should follow their local policy. If employing authorities have policies that restrict the keeping of duplicate records, then these authorities take full responsibility for any issues or difficulties that may occur as a result.

4 The handling and management of care records

Under the law and in respect of their duty of care for their service users, occupational therapists need to handle any information that they hold with due respect for their service users' confidentiality, consent, right to access and overall best interest.

4.1 The Caldicott Review recommendations

In 1997 the Chief Medical Officer of England commissioned a review, headed by Dame Fiona Caldicott, to examine the use of service user information within the NHS. The review was the result of increasing concern about how such information was being used and the accompanying risks to service user confidentiality, especially given the growth of computer-held records and the speed and ease of dissemination via computer networks.

The Caldicott Committee developed a set of general principles to underpin current and future use of records in all organisations that have access to service user information. It recommended that every 'flow of information' (i.e., when information is either used or shared) should be tested against these principles. In 2002 the Caldicott principles were extended into social care, providing a shared basis for joint working between health and social services.

Principle 1: Justify the purpose(s).

Every proposed use or transfer of patient-identifiable information within or from an organisation should be clearly defined and scrutinised, with continuing uses regularly reviewed, by an appropriate guardian.

Principle 2: Do not use patient-identifiable information unless it is absolutely necessary.

Patient-identifiable information items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

Principle 3: Use the minimum necessary patient-identifiable information.

Where use of patient-identifiable information is considered to be essential, the inclusion of each individual item of information should be considered and justified so that the minimum amount of identifiable information is transferred or accessible as is necessary for a given function to be carried out.

Principle 4: Access to patient-identifiable information should be on a strict need-to-know basis.

Only those individuals who need access to patient-identifiable information should have access to it, and they should only have access to the information items that they need to see. This may mean introducing access controls or splitting information flows where one information flow is used for several purposes.

Principle 5: Everyone with access to patient-identifiable information should be aware of their responsibilities.

Action should be taken to ensure that those handling patient-identifiable information – both clinical and non-clinical staff – are made fully aware of their responsibilities and obligations to respect patient confidentiality.

Principle 6: Understand and comply with the law.

Every use of patient-identifiable information must be lawful. Someone in each organisation handling patient information should be responsible for ensuring that the organisation complies with legal requirements.

(Caldicott Committee 1997, p. 17)

The Caldicott Review recommended that each organisation should nominate a senior person, preferably at board level, to act as a guardian, responsible for safeguarding the confidentiality of service user information. These Caldicott Guardians are responsible for protecting the confidentiality of patient and service-user information and for enabling appropriate information-sharing. The Guardian plays a key role in ensuring that the NHS, Councils with social services responsibilities, and partner organisations satisfy the highest practicable standards for handling patient-identifiable information.

More information on the Caldicott Review and its implications for health and social care is available from the Department of Health website.

4.2 Confidentiality and consent

The *Data Protection Act 1998,* and the *Humans Rights Act 1998* place statutory restrictions on the management and use of personal information. A duty of confidence arises when a service user shares personal information with a practitioner. Confidentiality is a legal obligation, and a requirement established within professional codes of conduct, and it must be included as a requirement in NHS employment contracts. Information provided in confidence should not be disclosed without the service user's consent. There are three exceptions to this, being situations in which

- The relevant service user has consented.
- Disclosure is in the public interest.
- There is a legal duty, for example, a court case.

Service users have the right to know when information about them is recorded, how it will be recorded and how it will be used. They must be made aware that the information they give may be shared in order to provide them with care, and may be used to support local clinical audit and other work to monitor the quality of care provided. Where an individual refuses to allow information to be disclosed, this may limit the care that the individual may receive. Service users must be informed of the potential outcomes of refusing to allow the sharing of such information.

Confidentiality: NHS code of practice (DH 2003a) is a guide for all who work within, or under contract to, NHS organisations. This can be downloaded from the Department of Health website. (Available at: *http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253* Accessed on 23.11.09).

Even with these clear guidelines in place, practitioners must use their judgement. If a service user discloses information that may have an impact upon their, or another person's care or safety, and then asks that this information is not recorded, the

practitioner has a professional obligation to record the information. The service user should be informed of this.

4.2.1 The *Data Protection Act 1998*

The *Data Protection Act 1998*, which applies throughout the United Kingdom, concerns the right of a living person to privacy in respect of personal information. The 1998 Act applies to personal data being processed either manually or electronically. It includes film, photography and material recorded in other media.

The Act imposes a responsibility on anyone who generates, uses or stores personal information to abide by eight Data Protection Principles. The Principles set down a framework for the lawful processing of such personal data.

The Principles are as follows:

1. *Personal data shall be processed fairly and lawfully and, in particular, shall not be processed unless:*
   a) *at least one of the conditions in Schedule 2 is met [see below], and*
   b) *in the case of sensitive personal data, at least one of the conditions in Schedule 3 is also met [see below].*
2. *Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes.*
3. *Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.*
4. *Personal data shall be accurate and, where necessary, kept up to date.*
5. *Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes.*
6. *Personal data shall be processed in accordance with the rights of data subjects under this Act.*
7. *Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.*
8. *Personal data shall not be transferred to a country or territory outside the European Economic Area unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.*

(Data Protection Act 1998, Schedule 1, Part 1)

Schedule 2 defines conditions that must be met for all data to be processed. For example:

The data subject has given his consent to the processing. …

The processing is necessary in order to protect the vital interests of the data subject.

(Data Protection Act 1998, Schedule 2)

Schedule 3 defines further conditions that must be met in situations when the data is personally sensitive. This would include most care records. For example:

The data subject has given his explicit consent to the processing of the personal data. …

The processing is necessary for medical purposes and is undertaken by:

(a) a health professional, or

(b) a person who in the circumstances owes a duty of confidentiality which is equivalent to that which would arise if that person were a health professional.

In this paragraph 'medical purposes' includes the purposes of preventative medicine, medical diagnosis, medical research, the provision of care and treatment and the management of healthcare services.

(Data Protection Act 1998, Schedule 3)

Schedule 3 also includes situations in which the individual withholds or may not be able to give consent, but where the vital interests of the service user or another person need protecting.

4.2.2 The *Human Rights Act 1998*

The *Human Rights Act 1998* implements the provisions of the *European Convention on Human Rights* (Council of Europe 1950). Article 8 of the ECHR ensures respect for a person's private and family life. Disclosure of personal medical information would be a breach of that right unless it was 'in accordance with the law' and necessary for the protection of health. This means that information that identifies a service user should not be disclosed unless there is a lawful basis to do so, such as the consent of the service user, compliance with a legal requirement, or the need to protect life.

Further information on confidentiality issues is available in the following publications:

- *NHS Scotland NHS code of practice on protecting patient confidentiality* (NHS Scotland 2003).
- *Confidentiality: NHS code of practice* (Department of Health 2003a).
- *Confidentiality: Code of practice for health and social care in Wales* (Welsh Assembly Government 2004).

4.3 Access to care records

4.3.1 Smartcards

The NHS in England is introducing Smartcards to control access to electronic care records. Local Registration Authorities issue Smartcards to NHS staff and students who have been through a rigorous process to check their identity, including having to provide three forms of ID and their address. The Smartcard controls who has access and what level of access they have.

Individuals use their Smartcard and passcode every time they log on to the local care record system. An audit trail records every access to a service user's record, and service users can ask to see this information.

Staff and students are only authorised to access records of patients with whom they have a legitimate relationship, that is those to whom they are currently providing some kind of care. Accessing a service user's record without a legitimate relationship is a breach of the *Data Protection Act 1998*, and leaves the offender liable to disciplinary action by the employer and the Health Professions Council. The Smartcard should be

considered at least as important as a debit or credit card, and never used by anyone other than the card holder.

4.3.2 Service user access

The *Data Protection Act 1998* gives an individual the statutory right to have access to their own health records, upon written request, whether they be held on computer or manually (with some conditions). The organisation holding the data has 40 days in which to respond. The individual is entitled to know the purpose of the record and who may have access to the information. They may challenge the accuracy of the record and may have records amended, deleted or destroyed if shown to be inaccurate. An individual may also request in writing that all or part of data processing, relating to their own records, is stopped on the basis that they or a third party may be significantly damaged or distressed by it. The organisation holding the data has 21 days in which to respond.

Under the *Data Protection Act 1998* there are two reasons why access may be denied:

- Providing access to the records may cause the individual distress or harm.
- A person's access to data may risk disclosing information concerning a third party, unless that third party gives permission.

Access to the care records of the deceased are governed by the *Access to Health Records Act 1990* and *Freedom of Information Act 2000*.

Under the *Access to Health Records Act 1990* an application for access to the health part of a care record may be made by the individual's personal representative or any person who may have a claim arising out of the individual's death.

The *Freedom of Information Act 2000* gives the individual the right to obtain information held by or on behalf of a public body, unless there is a good reason to keep it confidential.

4.4 Social care information governance

Since the introduction of the Caldicott principles, broader information governance work has continued in social care. Information governance is seen as addressing five broad aspects of information processing: how it is held, obtained, recorded, used, and shared.

Information governance is seen as having four aims:

- To support the provision of high quality care by promoting the effective and appropriate use of information.
- To encourage staff with responsibility for service users to work closely together, preventing duplication of effort and enabling more efficient use of resources.
- To develop support arrangements and provide staff with appropriate tools and support to enable them to discharge their responsibilities to consistently high standards.
- To enable organisations to understand their own performance and manage improvement in a systematic and effective way.

During 2003–04 the former NHS Information Authority (NHSIA), working with a reference group of social care experts, produced an early Social Care Information Governance Toolkit (SCIGT). With the closure of the NHSIA, the responsibility for the Toolkit's ongoing development transferred to the NHS Connecting for Health Digital Information Policy Team.

The standards incorporated into the *Information Governance Toolkit* (DH, NHS Connecting for Health 2009) were derived from earlier work started by the former NHSIA and are equivalent to standards required by NHS organisations. The toolkit forms part of the suite of NHS Connecting for Health's information governance toolkits for health and social care organisations which will be updated occasionally. The toolkit can only be accessed via named administrators in relevant organisations.

4.5 Transferring information to other professionals or agencies

A key purpose of care records is the sharing of information. However, service users still have a right to confidentiality, so the principle of gaining consent to share information should always be maintained. There are a number of laws that control and set conditions on the sharing or transfer of information with other professionals or agencies. There are also some laws that make the disclosure of information a requirement. The main statutory requirements are given in Annex C of the Department of Health's *Records management: NHS code of practice* (2006b), and further guidance is given in the *Information governance toolkit* (DH, NHS Connecting for Health 2009). In the NHS the Caldicott Guardians should be involved or be able to advise on any proposed disclosure of information.

It is always good practice to inform the service user of the purpose of the data being collected and who may have access to the data. Only those involved directly in a person's care should have access to the data. If information is to be shared more broadly, for example if the service user is to be referred to another service, informed consent should be sought. The *Data Protection Act 1998* states that disclosure of data must meet certain conditions. One of these requirements is to have obtained consent, and in the case of sensitive personal data, explicit written consent.

It is particularly important to check that service users understand what will be disclosed if you need to share identifiable information with anyone employed by another organisation or agency who is contributing to their care. Occupational therapists must respect the wishes of any person who objects to particular information being shared with others providing care (with some exceptions, as noted in Section 4.2). When information is disclosed, in any circumstance, it should be the minimum necessary to meet the requirements of the situation and should be fully recorded. The service user should be informed of the disclosure.

When the subject is unable to understand because they are too young or incapacitated for some reason, appropriate consultation should take place with carers or their representatives. Decisions should then be made always acting in the service user's best interest. For children without the ability to understand and consent for themselves, consent may be gained from a person with 'parental responsibility'.

The *Health and Social Care Act 2001* makes provision for the Secretary of State for Health to make regulations that require or allow service user information to be processed for certain purposes, where consent cannot be obtained. Those requesting the information have to prove that it would improve care or is in the public interest, such as for research projects.

Therapists who work across public and independent sectors, and may see the same individual in both contexts, should not transfer or share information from one context to another without the service user's consent.

In the case of children's services, information needs to be shared between all those involved in a child's care. It will also need to be transferred, with parental consent, if a child moves across services, or into different areas. The *Children Act 2004*, which applies throughout the United Kingdom, provides a legal framework to enable practitioners to share early information. It aims to ensure that children and families are getting benefit from services such as education and health care, and to enable them to get the support they need at the right time.

In October 2008 the Government updated their guidance on information sharing. It was extended to cover practitioners working with adults and families as well as those working with children and young people. The guidance is aimed at practitioners who have to make decisions about sharing personal information case by case, in any care sector. The guidance is also for managers and advisors who support these practitioners in their decisions. *Information sharing: Guidance for practitioners and managers* (HM Government 2008) is available to download from the Every Child Matters website (*http://www.dcsf.gov.uk/everychildmatters* Accessed on 23.11.09).

4.6 Storage of paper records

Occupational therapists need to be aware that they have a degree of responsibility for any records they create or use and have joint responsibility for shared records. Records may be kept within the department or service responsible for the related work, but must always be kept securely in order to reduce the risk of theft, loss or damage. Storage equipment or facilities should be safe and secure, but records should be accessible to those who need the information for their work.

The movement and location of records should be controlled to ensure that a record can be retrieved at any time. When records are taken from the central storage there should be an auditable tracking system in place to ensure that they are not lost. The tracking system should identify who is in possession of the records and where they are being taken. When transporting records, the principles of data protection remain. The information within the records must be kept safe, therefore practitioners should ensure they are not accessible to others outside of the direct care team, and that they are not left unattended anywhere that is potentially insecure, for example, in a car.

4.7 Retention of records

The *Data Protection Act 1998* states that records should not be held for longer than is necessary to fulfil the purpose of the record. The length of time a record is held depends upon the nature of the record, the person concerned and the nature of their condition or circumstances. Practitioners can gain advice from their local data or information manager on the retention or destruction of care records.

Revised NHS (England and Wales) retention and disposal schedules are given as an annex (DH 2009b) to the *Records management: NHS code of practice* (2006b). Guidance for the retention and destruction of health records for the National Health Service in Scotland is provided in *Records management: NHS code of practice (Scotland) Version 1.0* (2008). In Northern Ireland the Department of Health, Social Services and Public

Safety guidelines (DHSSPS 2004) include a disposal schedule. Occupational therapists should follow the relevant guidance and their employer's protocols.

In Social Services, where there is no legal reason for retaining information beyond the closure of the record, the information should not normally be held for more than six years after the subject's last contact with the service. This and details of records that are subject to statutory requirements is documented in *Data Protection Act 1998 Guidance to Social Services* (DH 2000, p. 16).

4.7.1 Retention of diaries

The diaries of health visitors, district nurses and allied health professionals should be retained for two years after the end of the year to which the diary relates. Service user-specific information should be transferred to the service user's care record. This includes any notes made in the diary as 'aide memoires'. Diaries should be destroyed under confidential conditions (DH 2009b, p. 19).

A diary should be kept if it contains particular details concerning an ongoing enquiry or concern, for example, a service user complaint. Advice should be sought from those leading or looking into the issue.

References

Bichard, Sir M (2004) *The Bichard Inquiry: Report, HC653.* London: The Stationery Office.

Caldicott Committee (1997) *Report on the review of patient-identifiable information*. London: DH.

Cancer Services Collaboration 'Improvement Partnership' (2003) *Patient-held records toolkit.* Leicester: NHS Modernisation Agency.

Cayton H (2006) *Information governance in the Department of Health and the NHS*. London: NHS.

Clinical Negligence Scheme for Trusts (2005) *General clinical risk management standards*. London: NHS Litigation Authority.

College of Occupational Therapists (2005) *Code of ethics and professional conduct.* London: COT.

College of Occuaptional Therapists (2006) *Record Keeping*. London: COT.

College of Occupational Therapists (2007a) *COT/BAOT Briefing 15*: *prescribing, supply and administration of medicines and occupational therapists.* London: COT.

College of Occupational Therapists (2007b*) Professional standards for occupational therapy practice*. 2nd ed. London: COT.

Council of Europe (1950) *European Convention on Human Rights.* Rome: Council of Europe.

Department of Health (2000) *Data Protection Act 1998: guidance to social services.* London: DH.

Department of Health (2001) *Information for social care: a framework for improving quality in social care through better use of information and information technology an initiative under the Social Care Quality Programme – revised*. London: DH.

Department of Health (2003a) *Confidentiality: NHS code of practice*. London: DH.

Department of Health (2003b) *The Victoria Climbié inquiry. Report of an inquiry by Lord Leming*. London: DH.

Department of Health (2006a) *Our health, our care, our say. A new direction for community services* (Command Paper 6737). London: HMSO.

Department of Health (2006b) *Records management: NHS code of practice. Part 1.* London: DH.

Department of Health (2006c) *What to do if you're worried a child is being abused. Children's services guidance*. 2nd ed. London: DH. Available at: *http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00182* Accessed on 03.11.09.

Department of Health (2009a) *Care records guarantee: our guarantee for NHS care records*. 3rd ed. London: DH.

Department of Health (2009b) *Records management: NHS code of practice. Part 2.* London: DH.

Department of Health, Information Standards Board for Health and Social Care (2008) *Information Standards: NHS number standard for secondary care (England) data set change notice 32/2008.* London: DH.

Department of Health, NHS Connecting for Health (2009) *Information governance toolkit.* Exeter: NHS Connecting for Health.

Department of Health, Social Services and Public Safely (DHSSPS) (2004) *Good management, good records: guidelines for managing records in health and personal social services in Northern Ireland*. Belfast: DHSSPS.

Dimond B (2005a) Legal aspects of documentation. Exploring the principles of record keeping in nursing. *British Journal of Nursing, 14(8)*, 460–462.

Great Britain. Parliament (1958) *Public Records Act 1958.* London: HMSO.

Great Britain. Parliament (1983) *Mental Health Act 1983*. London: HMSO.

Great Britain. Parliament (1988) *Data Protection Act 1998*. London: HMSO.

Great Britain. Parliament (1998) *Human Rights Act 1998*. London: Stationery Office.

Great Britain. Parliament (1990) *Access to Health Records Act 1990*. London: HMSO.

Great Britain. Parliament (2000) *Freedom of Information Act 2000*. London: Stationery Office.

Great Britain. Parliament (2001) *Health and Social Care Act 2001.* London: Stationery Office.

Great Britain. Parliament (2004) *Children Act 2004.* London: Stationery Office.

Health Professions Council (2007) *Standards of proficiency – occupational therapists*. 2nd ed. London: HPC.

Health Professions Council (2008) *Standards of conduct, performance and ethics*. 2nd ed. London: HPC.

HM Government (2008) *Information sharing: guidance for practitioners and managers.* London: Department for Children, Schools and Families; Department for Communities and Local Government. Available at: *http://www.governornet.co.uk/linkAttachments/Information%20sharing%20guidance%20for%20practitioners%20and%20managers.pdf* Accessed on 23.11.09

Information Commissioner's Office (2006) The use of violent warning markers. Cheshire: ICO.

Lynch J (2009) *Health records in court*. Oxford: Radcliffe Publishing Ltd.

NHS Modernisation Agency (2003) *Essence of care: benchmark for record keeping*. London: DH.

NHS Scotland (2003) *NHS code of practice on protecting patient confidentiality*. Edinburgh: Scottish Executive.

Nursing and Midwifery Council (2007) *Record keeping.* London: NMC.

Ofsted, Health Commission, HM Inspectorate of Constabulary (2008) *Joint area review Haringey Children's Services Authority area. Review of services for children and young people, with particular reference to safeguarding*. London: Ofsted.

Scottish Government (2008) *Records management: NHS code of practice* (Scotland) Version 1.0. Edinburgh: Scottish Government. Available at: *http://www.scotland.gov.uk/Publications/2008/07/01082955/0* Accessed on 23.11.09

Scottish Parliament (2002) *Freedom of Information (Scotland) Act 2002.* Edinburgh: Stationery Office.

Welsh assembly government, NHS Wales, Social Services Inspectorate for Wales (2004) *Confidentiality: code of practice for health and social care in Wales 2004.* Version 4.3. Cardiff: Welsh Assembly Government.

Bibliography

Department for Education and Skills, Department of Health, Home Office (2003*) Keeping children safe: the Government's response to the Victoria Climbié inquiry report and Joint Chief Inspectors' report safeguarding children*. London: The Stationery Office.

Department of Health (1998) *Information for Health, an information strategy for the modern NHS 1998–2005 (HSC 1998/168).* London: DH.

Department of Health (2000) *Data Protection Act 1998: protection and use of patient information.* London: DH.

Department of Health, Home Office, Department for Education and Employment (1999) *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*. London: DH.

Dimond B (2005b) Legal aspects of documentation. Prescription and medication records. *British Journal of Nursing, 14(22)*, 1203–1205.

Dimond B (2005c) Legal aspects of documentation. Documentation standards set by the Clinical Negligence Scheme for Trust. *British Journal of Nursing,14(11*), 610–612.

Dimond B (2005d) Legal aspects of documentation. Exploring common deficiencies that occur in record keeping. *British Journal of Nursing, 14(10)*, 568–570.

General Medical Council (2004) *Confidentiality: protecting and providing information*. London: GMC.

General Medical Council (2002) *Making and using visual and audio recordings of patients*. London: GMC.

Great Britain. Parliament (1989) *Infectious Disease (Notification) Act 1989.* London: HMSO.

Great Britain. Parliament (1991) *Age of Legal Capacity (Scotland) Act 1991*. London: HMSO.

Great Britain. Parliament (1993*) The access to health records (Northern Ireland) order 1993*. *Statutory Instrument 1993 No.1250. (NI 4).* London: Stationery Office.

Health and Safety Executive (2000) *Local authority circular. Violence at work. (LAC 88/2).* London: HSE.

Hutchinson C, Sharples C (2006) Informational governance: practical implications for record-keeping. *Nursing Standard, 20(36)*, 59–64.

Information Commissioner's Office (2007) *Guidance on the Data Protection Act 1998*. Cheshire: ICO. Available at: *http://www.ico.gov.uk/what_we_cover/data_protection.aspx*

Accessed on 23.11.09

Information Policy Unit – Social Care (2004) *Briefing paper – social care information governance.* London: DH.

McGeehan R (2007) Best practice in record-keeping. *Nursing Standard*, *21(17)*, 51–55, 58, 60.

Murphy J et al (1993) *Educational requirement of GEHR (Good European Health Record) architecture and systems.* London: Centre for Health Informatics and Multiprofessional Education.

Newland R (2008) Record keeping in practice: getting it right. *Nursing in Practice*, *44 (Sep–Oct)*.

Scottish Executive (2005) *Health for all children 4: guidance for implementation in Scotland. Getting it right for Scotland's children*. Edinburgh: Scottish Executive.

Scottish Parliament (2000) *Adults with Incapacity (Scotland) Act 2000*. Edinburgh: Stationary Office.

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Risk Management

Second edition

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The College of Occupational Therapists is a wholly owned subsidiary of the British Association of Occupational Therapists (BAOT) and operates as a registered charity. It represents the profession nationally and internationally, and contributes widely to policy consultations throughout the UK. The College sets the professional and educational standards for occupational therapy, providing leadership, guidance and information relating to research and development, education, practice and lifelong learning. In addition, 11 accredited specialist sections support expert clinical practice.

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1 Introduction

What is risk management?

This guidance document will enable you to be aware of the requirements and responsibilities that you have in the area of risk and its management. Given the growing variety of occupational therapy settings, it can provide only a broad understanding of the principles of risk assessment and management, but it will also identify a number of other information resources currently available. It aims to provide guidance that is relevant and useful to practitioners across the UK, although you need to be aware of your local and country's policies. You should be aware that manual handling is covered in detail in a separate specific guidance document (COT 2006a).

Risk management is an intrinsic part of governance, service user safety and the provision of a quality care service. It is written into national standards for health, social care and education across the UK. Risk assessment and its management are not optional extras for you, but should be an inherent part of your safe and effective everyday practice. All service providers should have a set of policies and procedures in place relating to the management of risk.

In most environments risk management is seen as the employer or worker looking at the risks that arise in the workplace and then putting sensible health and safety measures in place to control them. For you, as an occupational therapy practitioner, risk management should be a broader concept. Risk-taking can have positive potential for individuals and their carers/families. People frequently take risks with the expectation and hope of gaining a beneficial outcome, for example learning to drive. For this reason, risk management should involve assessing and managing any kind of incident, event or 'hazard' that might cause harm, but managing it so that the potential benefit is gained and any likelihood of harm is adequately reduced. The relationship between you and the service user is key to effective risk management. 'Users should be seen as equal partners in the process and outcomes of risk assessment and management' (Barry 2007). This process can guide care decisions, enabling service users to take positive risks in a safe and appropriate way.

The principles remain the same whether the potential harm or benefit is to people, buildings or organisations. When asked, most people consider risk management to include actions to prevent injury or harm from physical hazards such as chemicals or equipment, or even perhaps from other people. However, you need to give broader consideration to procedures and systems in the workplace, along with activities such as communication and team-working.

For the purpose of this document a hazard is anything that has the potential to cause harm in any way. Risk is the possibility or likelihood, at any level, that this may occur, together with a measure of the effect. Positive risks are those that have the opportunity for benefit or gain if well managed.

Risk assessment is the first stage in this process. It is the means by which all the factors in a particular situation are considered – identifying the hazards, the potential degree and nature of any risk, and those possibly affected. The information gained from this assessment forms the basis of the ongoing planned management.

Introduction

Risk management is a plan, strategy or programme that aims to manage the incident, event or hazard, removing those elements that would do harm, or reducing them to an acceptable level, and enabling any opportunity for positive gain to be taken as safely as possible. The situation is then closely monitored and periodically reviewed. For you, the primary aim is to protect people from harm, but there are secondary benefits of protecting a service or organisation from a loss of standards, safety or reputation, and of avoiding financial loss through compensation claims.

2 Regulatory context

Many regulations, policies and requirements surround the assessment and management of risk. The overarching legislation that concentrates on risk assessment and management is the *Health and Safety at Work etc Act 1974* and the *Management of Health and Safety at Work Regulations 1999* (Great Britain. Parliament 1974 and 1999) and their Northern Ireland counterparts (Great Britain. Parliament 1978 and 2000). Other legislation assumes an element of risk management in the actions that are required. Some of these pertain only to a particular field of practice, but many of the underlying principles are shared.

You should familiarise yourself with legislation that is relevant to your practice and your place and country of work. Legislation that is relevant to particular workplaces can be traced on the Health and Safety Executive website (*http://www.hse.gov.uk/legislation/trace*, 18.07.10), or the Health and Safety Executive for Northern Ireland (HSENI) website (*http://www.hseni.gov.uk/resources/legislation.htm*, 18.07.10).

If two sets of regulations both require risk to be assessed in the same given area, the assessment need only be done once, providing that the precautions taken meet the requirements of both sets of regulations.

All organisations should have their own local risk management procedures. You should familiarise yourself with these.

2.1 The Health and Safety at Work etc Act 1974

This Act (Great Britain. Parliament 1974) describes the general requirement for employers to ensure, as far as is reasonably practicable, the health, safety and welfare of their workforce and members of the public. This may be in terms of the environment, the materials or equipment used in the workplace, the demands of the work and the activities or actions of people in, or visiting, the workplace. Employers of more than five people must prepare a written health and safety policy and bring it to the attention of their employees. Employees are expected to co-operate with their employers and to take reasonable care for their own health and safety and that of others who may be affected by what they do, or do not do.

The Act (Great Britain. Parliament 1974) originally applied in England and Wales, Scotland (in part) and Northern Ireland (in part). Its requirements were redrawn for Northern Ireland with the *Health and Safety at Work (Northern Ireland) Order 1978* (Great Britain. Parliament 1978), which provides similar protection to employees in Northern Ireland.

The *Health and Safety at Work etc Act 1974* (Great Britain. Parliament 1974) created the Health and Safety Executive (HSE), the body responsible for the enforcement of workplace health and safety in England and Wales, and in Scotland in partnership with the Scottish Executive. Responsibility in Northern Ireland lies with the HSENI.

2.2 The Management of Health and Safety at Work Regulations 1999

The *Management of Health and Safety at Work Regulations 1999* (Great Britain. Parliament 1999), commonly termed the 'Management Regulations', require employers and the self-employed to assess the risks created by the hazards of their work. They must make arrangements for implementing the health and safety measures identified as necessary by risk assessments, appointing people with sufficient knowledge, skills, experience and training to help them to implement these arrangements. Employers must then monitor and review those arrangements.

Employees must be given clear information about any emergency procedures that might arise, along with any necessary supervision and training.

Employers must also work together with any other employer(s) operating from the same workplace, sharing information on the risks that other staff may be exposed to.

These regulations require employers to take particular account of risks to new and expectant mothers.

Those with five or more employees need to record the significant findings of a risk assessment – it is not necessary to record risk assessments for trivial or insignificant risks.

Although there is other more specific legislation for certain groups of people, situations or environments, the 'Management Regulations' (Great Britain. Parliament 1999) overlay all of these and require that *all* potential risks within the work setting are assessed and managed.

Residents of Northern Ireland should be aware of requirements laid down by the *Management of Health and Safety at Work Regulations (Northern Ireland) 2000* (Great Britain. Parliament 2000).

2.3 The Disability Discrimination Act 1995 and the Disability Discrimination Amendment Act 2005

The *Disability Discrimination Act 1995* (Great Britain. Parliament 1995a) is UK-wide legislation that brought in measures to prevent discrimination against disabled people. When you are working with colleagues or with service users, the fact that an individual has a disability does not necessarily mean that he or she signifies an additional risk to health and safety. As stated above, under the *Health and Safety at Work etc Act 1974* (Great Britain. Parliament 1974) employers must ensure, so far as is reasonably practicable, the health, safety and welfare of *all* their workforce.

The *Disability Discrimination Amendment Act 2005* (Great Britain. Parliament 2005a) builds on the previous legislation, so that employers must have due regard to their obligation to take disabled persons' disabilities into account and to make changes to the workplace where necessary, even where that involves treating disabled persons more favourably than other persons (Great Britain. Parliament 2005a, Part 5A, section 1(d)).

The risk assessment should identify the risks associated with the particular activity and should be specific to the individual carrying out a particular task, taking account of any reasonable adjustments put in place for the disabled person.

2.4 The Equality Act 2010

From 1 October 2010, the majority of the *Equality Act 2010* (Great Britain. Parliament 2010) replaces major parts of the provisions of the Disability Discrimination Act(s).

More information is available from:

- The Disability Rights Commission (DRC 2004), the Equality and Human Rights Commission website (*http://www.equalityhumanrights.com*, 18.07.10).
- The Government Equalities Office website (*http://www.equalities.gov.uk/equality_act_2010/equality_act_2010_what_do_i_n.aspx*, 18.07.10).

2.5 What is meant by 'reasonably practicable'?

An employer does not have to take measures to avoid or reduce the risk if it can be shown that it is technically impossible to do so or, if the time, the trouble or cost of the measures would be grossly disproportionate to the risk.

The HSE provides guidance on various terms used in health and safety legislation.

3 Risk assessment and management

There are five key steps to risk assessment and management, as shown in Figure 1. The figure also represents the continuous nature of the risk management process.

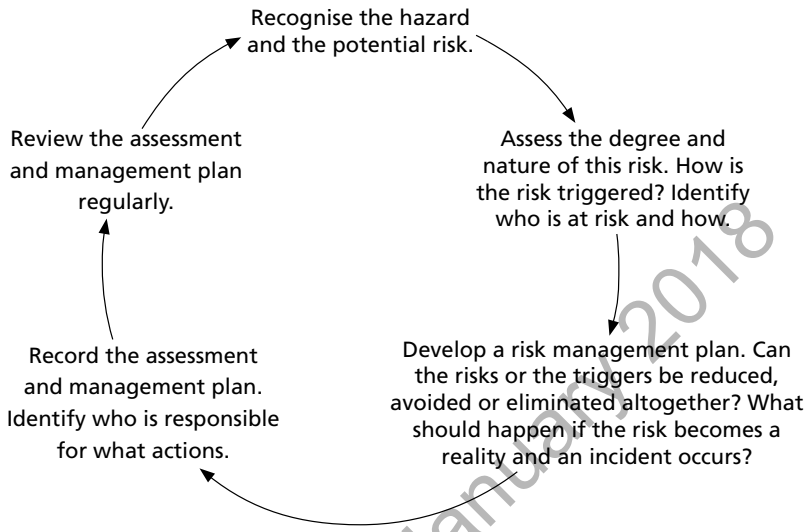

Figure 1 The risk management process

3.1 Recognising the potential risk – risk assessment

A risk assessment is a structured method of identifying the hazards and the potential risks in any activity or situation. It needs to identify how the risk is triggered – are there any factors that make the risk more likely to occur? Are there warning signs, perhaps in the environment or in a person's behaviour, that indicate the potential risk might be about to happen? The assessment should also identify who may be affected by the risks and how.

McILwain (2006) suggests that risk assessment involves asking a series of questions that fall under the headings of 'identify', 'analyse' and 'control'. These may be shown as a grid, as follows:

Identify	Analyse	Control
What could go wrong?	How often is this effect likely to occur?	How do you eliminate the risk/effect?
How could that happen?	How severe would be the effect?	How do you avoid the risk/ effect?
What would be the effect?	What would be the cost of that effect?	How do you make the risk/ effect less likely?

Figure 2 A risk assessment grid (taken from McIlwain 2006, p196 with permission of Radcliffe Publishing)

There are numerous tools for risk assessment, especially in areas such as falls prevention and manual handling. These tools can be useful to highlight or indicate possible hazards and for planning preventive action. However, information gathered from multiple sources needs to be put alongside clinical or professional judgement to give a comprehensive analysis of the potential risk. Where the situation involves service users, they, and all those involved in their care, need to be consulted. It is good practice, when a risk assessment concerns a particular service user, that you share your assessment with the individual (see section 3.5).

You need to be aware of any local policies or protocols that may exist for your organisation, as they may include preferred assessment tools or pro formas.

You will need to consider risk in each person's individual context. 'Risk is dynamic and may fluctuate – for example, a small task such as making a cup of tea may suddenly place an older person recovering from a broken hip at an increased risk of falling' (DH 2007b, section 1.5, p11).

3.1.1 Who is responsible?

In all cases, where the safety of employees, those who use their services and the public is concerned, it is the overall responsibility of employers or the self-employed to carry out the risk assessment. When the potential risk is to service users, through the work of an employee, the responsibility for carrying out the assessment may be devolved to the employee concerned. Whoever carries out the risk assessment should be appropriately trained to do so.

Although not responsible for carrying out risk assessments, trades union health and safety representatives are trained and accredited to participate in workplace inspections. They can also provide advice and information.

3.1.2 When to assess?

Risk assessment and management should be part of your everyday practice. You will be identifying possible hazards and risks as you observe, assess and work – as an individual, as part of a team or an organisation, or with your service users. Whether a specific risk assessment is carried out for a given activity/area of work depends upon the presence of hazards and the significance of any potential risk. You will need to consider what could occur, how and why it might happen, what the potential triggers or precursors to the risk occurring might be, when and how often it might happen and what the results could be. Assessment may confirm that adequate measures are already in place to eradicate or minimise the risk.

Formal risk assessments should be made before any significant changes are made to systems or practices, before any new project or activity is initiated, and before any particular actions or interventions are made that may engender risk. In these circumstances as much information as possible should be gathered to inform decision-making.

3.1.3 What risk?

'Risk assessment should be structured, evidence-based and as consistent as possible across settings and across service providers' (DH 2007a, p7). Consistency aids communication between practitioners and agencies, therefore improving care. The Department of Health document *Independence, choice and risk: a guide to best practice in supported decision making* (DH 2007b) aims to promote a common approach to risk

among all parties concerned in delivering care. Its guiding principle is applicable across the UK (see section 3.2).

Some hazards and risks are easy to identify: faulty electrical goods, uneven flooring or poor identification of care records. Other risks are more difficult to recognise, for example medication allergies, poor communication, or short-cuts in practice that might make something quicker or easier, but actually increase the potential for something to go wrong.

If you are trying to identify risks you need to consider how things happen in your work area. You need to use up-to-date, accurate information about how your service works, from both staff and service users, if possible. A collaborative approach will provide a fuller picture and a better understanding of the situation or circumstances that you are assessing.

Potential risks can be identified through data gathering and monitoring. Accident records, incident reports, sickness records and complaints can all highlight patterns of events or particular activities that are shown to be hazardous and potentially harmful. It is important that you routinely keep such information, as it will enable you or your organisation to identify risks at an early stage and to change your practice if necessary. Where you are making significant changes to existing systems or services, or if you are developing new projects, you will need to gather as much information as possible to inform your decision-making. Part of the risk assessment may need to include a literature/evidence search.

It is difficult to define how thorough or far-reaching risk assessments should be. When considering an occupational therapy service, you may need to consider risks arising from hazards related to:

- the physical working environment, including the use or provision of rehabilitation/ assistive equipment;
- the policies, procedures and/or practices of the organisation, the department and/or its personnel, including all therapeutic activity;
- the care plans for a service user or group of service users, considering their aims and priorities and influencing factors such as medication, recent events etc; and
- the actions, purposeful, accidental or unpredicted, of other people, including service users, their carers, other staff and members of the public.

3.1.4 Whose risk?

Having identified any hazards and the potential risk, you must then consider who or what is at risk of potential harm. Under the 'Management Regulations' (Great Britain. Parliament 1999), assessments should consider possible risk to all those affected by the work or activity. This may include service users, their families and carers, professional colleagues, other workers, students, volunteers and the public.

Some regulations do not specify that risks to the public should be assessed. However, considering the overarching requirement of the 'Management Regulations' (Great Britain. Parliament 1999), you still have to ensure that service users and/or members of the public are not adversely affected by any service activity.

3.2 Risk and choice

The Department of Health document *Independence, choice and risk: a guide to best practice in supported decision making* (DH 2007b), provides a governing principle behind good approaches to independence, choice and risk that is applicable across the UK. This is that:

People have the right to live their lives to the full as long as that doesn't stop others from doing the same. To put this principle into practice, people supporting users of services have to:

- *help people to have choice and control over their lives;*
- *recognise that making a choice can involve some risk;*
- *respect people's rights and those of their family and carers;*
- *help people understand their responsibilities and the implications of their choices, including any risks;*
- *acknowledge that there will always be some risk, and that trying to remove it altogether can outweigh the quality of life benefits for the person; and*
- *continue existing arrangements for safeguarding people.*

(Adapted from DH 2007b, pp12–13)

Mental capacity legislation (Great Britain. Parliament 2005b, Scotland. Scottish Executive 2000) states that although service users may make decisions that you may consider unwise or risky, it is not necessarily an indication that they lack capacity. In such a case your responsibility is to ensure that they are as safe as possible in their chosen circumstances.

3.3 Positive risk

Risk-taking is an integral component of good risk management. There is a growing amount of literature concerning positive or beneficial risk.

Positive risk-taking has been defined as:

weighing up the potential benefits and harms of exercising one choice of action over another. This means identifying the potential risks involved, and developing plans and actions that reflect the positive potentials and stated priorities of the service user. It involves using available resources and support to achieve desired outcomes, and to minimise potential harmful outcomes.

(Morgan 2004, p18)

Positive risk management acknowledges that some degree of risk, or challenge, is essential to skill acquisition, self esteem and progress (College of Occupational Therapists 2006b). Positively managing risk does not mean being complacent about risk, but encourages a person-centred approach to evaluating it. Being risk averse can be seen as being part of the lack of hopefulness on the part of practitioners and a barrier to recovery (Deegan 2001, Perkins 2004).

(Fieldhouse 2008, p501)

Morgan (2004) suggests a number of factors that enable positive risk-taking. Amongst these are:

- good supervision and organisational support;
- the development of appropriate management and intervention plans;
- working to realistic goals, broken down into shorter time frames;
- good communication; and
- clear lines of responsibility and accountability.

If you want to introduce safe and beneficial risk-taking, you may need to discuss this with your professional colleagues, using any evidence that is available to influence and change risk management plans, enabling service users to have more choice and become more engaged in activity.

3.4 Risk management

The assessment enables you to plan how risks are to be managed, what can reasonably and practicably be done or put in place to reduce the likelihood of the harmful risk occurring and how to increase the potential for a positive outcome. How can any warning signs or triggers be monitored and managed? What changes need to be made in systems and practices?

At the centre of this process should be a consideration of the service user's priorities, along with their personal skills and strengths that can be utilised as part of the management process. You need to use your professional reasoning and judgement to decide on the most appropriate action that will produce the desired outcomes. If the harmful risks cannot be eliminated or controlled to a reasonable level, the activity or situation should be amended or discontinued.

Risk management needs to be an organisational or 'whole system' approach, where everyone concerned understands and plays their part in managing the possible risk(s). This is an ongoing process that should enable you/your organisation to maintain a continuous reasonable level of safety, for yourself and those affected by your service.

3.4.1 What to do?

There are some obvious actions to take to manage harmful risk. First and foremost, you must follow the law. For example, hazardous chemicals must be stored securely according to the *Control of Substances Hazardous to Health Regulations 2002* (Great Britain. Parliament 2002). If local policies and procedures exist, such as fire precautions, then these must be followed. Some risks may be managed by reorganising work practices, work environments and/or providing protective equipment.

For less tangible risks, it is worth examining what causes the possible situation to arise. For example, violence and aggression, either verbal or physical, are a significant risk in some fields of work. Verbal aggression may be triggered for a number of reasons, including a perceived or real lack of information, a feeling of being rushed or of not being heard. Staff may reduce these possible precursors by adopting behaviours and communication styles that prevent anger or anxiety, or that can de-escalate situations should they occur. The introduction of communication skills training, alongside other strategies, could be the action taken to try to reduce the potential risk of violence and aggression in the workplace.

Appropriate training can be a significant factor in reducing and managing risk, although attendance at a training event does not necessarily ensure future safe working practice. The *Health and Safety at Work etc Act 1974* (Great Britain. Parliament 1974) states that employers must provide 'necessary information, instruction, training and supervision' (Great Britain. Parliament 1974, section 2, part 2). This encompasses training to prevent emergencies like fire, but also training that is relevant and necessary for any elements of a job that may entail risk, such as manual handling.

Section 13 of the *Management of Health and Safety at Work Regulations 1999* (Great Britain. Parliament 1999) similarly states that employers should provide health and safety training for their employees when they are recruited. Further training should be provided at any time when there is a change in the employee's responsibilities, the equipment used, the technology used or a change in systems of work.

The same regulations (Great Britain. Parliament 1999) also note that employers should take account of the capabilities of their employees when considering health and safety. This is encompassed in the College of Occupational Therapists' *Code of ethics and professional conduct* (COT 2010b), which states:

You must only provide services and use techniques for which you are qualified by education, training and/or experience. These must be within your professional competence, appropriate to the needs of the service user and relate to your terms of employment.

(College of Occupational Therapists 2010b, section 5.1, p27)

There are more general ongoing activities that can assist in the management or prevention of risk. Many of these are part of maintaining good standards of practice:

- Following evidence-based guidance and protocols can help you to keep your practice safe, enabling your (NHS) organisation to meet the National Health Services Litigation Authority (NHSLA) risk management standards and to benefit from reduced claims and risk management premiums. More information about the NHSLA risk management standards is available from its website (*http://www.nhsla.com/RiskManagement*, 18.07.10).
- Observing good infection control practices, whether in a community, hospital or other setting.
- Keeping good therapy records, whether independently or as part of multidisciplinary notes, is vital in ensuring that you are providing appropriate, safe care.
- Continuing professional development can ensure that you are up to date with your knowledge and skills, and aware of best practice.
- Supervision and performance review systems allow ongoing monitoring of practice.

3.4.2 When to review?

Assessing and managing risk should be an ongoing process. It is vital to ensure that management plans and strategies are still relevant and that the risks originally identified are still adequately managed. A review should be done whenever a change occurs in the work or people involved which introduces significant new potential risks, if there has been an accident or incident, and/or at planned regular intervals.

3.5 Recording the assessment and its outcomes

It is good practice to record any risk assessments made related to the service, along with their outcomes, although this is a legal requirement only if the organisation has five or more employees. Written records can demonstrate that an organisation or service has complied with health and safety requirements. They can also provide a reminder to monitor certain areas of the service, if there are potential risks. Any risk assessment made in the course of providing an occupational therapy service to an individual must be recorded and a copy kept in the individual's care record.

Risk assessments may be recorded using a formal, purpose-designed risk assessment form, or they may be included as part of ongoing assessment and intervention notes. In whatever format, the records should show that a suitable and sufficient risk assessment was carried out and its outcomes recorded. You need to be able to show that 'a proper check was made; you asked who might be affected; you dealt with all the significant hazards, taking into account the number of people who could be involved; the precautions are reasonable, and the remaining risk is low; and you involved your staff or their representatives in the process' (HSE 2006b, p5).

The actions required to manage or control the risk(s) should be recorded along with the assessment information. This should detail what should be done, by whom and when. Any residual risk should also be detailed. The management plan or strategy should also consider what is to be done should an incident actually occur. A review date should be included as a prompt for future action.

The HSE has a number of example risk assessments for different settings that are available from its website (*http://www.hse.gov.uk/contact/faqs/riskassess.htm*, 18.07.10).

You should be familiar with the risk assessments and management plans present in your workplace(s).

It is good practice, when a risk assessment concerns a particular service user, to share your assessment with the individual. Where there are possible risks at an organisational level, for example in employment or working practices, it is good practice to pass on the results of your risk assessments and your management plans to your employer. This means that they are aware of the risks and your actions and may choose to monitor them or take appropriate action.

3.6 Integrated risk management

Risk management should be integrated into the work of an organisation, a service and your individual practice. For it to be done well, 'all parties need to work together, with a clarity of roles, opportunities for sharing information [and] seeking advice' (Bird and Dennis 2005).

There need to be systems for disseminating information and for ensuring that any required action is taken, for example if a National Patient Safety Agency patient safety alert is circulated which requires a change in practice, there must be a feedback system to communicate that the actions have been taken. Information management is important for facilitating access to, storage of and sharing of appropriate and correct information.

Service leads and managers have a role in ensuring that all their staff are aware of their risk management responsibilities and that they are familiar with local risk management procedures. All practitioners should be adequately skilled to fulfil these responsibilities. The more that you, as individuals and teams, are involved in your organisation's risk management activity, the better the general understanding will be of the potential hazards and risks across the organisation, and the more open communication, information sharing and learning will be, making systems simpler, with less duplication.

4 What happens if the risk becomes a reality?

It is not always possible to stop an incident from occurring, however well the potential risks have been managed or controlled. As stated, any risk management plan should also identify the action(s) required should an incident occur. Employing organisations are likely to have action plans for large, significant events which all employees should be familiar with.

Incidents or accidents can be better handled if you are well prepared. For example, when out of the workplace, you should always carry some means of communication plus useful contact numbers, or when accompanying a service user with a known condition that might need intervention, e.g. taking a snack for an insulin-dependent diabetic.

4.1 Managing a workplace incident or accident

If an incident or accident occurs, your priority is the safety of any people involved, whether staff, service users or public. First aid and other medical attention must be given and emergency services contacted if required. To ensure this happens, you should check that your organisation's arrangements for provision of first aid comply with legislative requirements. If there are any environmental hazards, evacuation procedures must be implemented. Again, the organisation and management need to ensure that staff know how to evacuate a building in an emergency, including moving service users if necessary.

If the incident involves an individual demonstrating dangerous or offensive behaviour, it may require the removal of that individual from the situation. Appropriately trained and authorised people will need to be involved. You must follow local policies and protocols.

Those involved in an incident or accident should be given the opportunity to talk about their experience and support should be provided where necessary.

4.2 Reporting an incident or accident

You must report any incidents that occur using your organisation's reporting mechanism. Some organisations also require the reporting of 'near misses', when an incident almost happens. This allows an organisation to evaluate the event, learn from it and change practice where required. Collecting and analysing service user comments and complaints also produces information that can be used to improve the quality of the service that you provide. Information services have an important role to play in risk management.

Under the *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995* (RIDDOR) (Great Britain. Parliament 1995b), employers, the self-employed and those in

control of premises in England, Wales and Scotland must report specified workplace incidents to the HSE. These include deaths and major injuries, certain diseases, dangerous occurrences (near misses) and gas incidents. More information is available from the HSE.

A similar system exists with the HSENI, under the *Health and Safety at Work (Northern Ireland) Order 1978* (Great Britain. Parliament 1978) and the *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997* (Great Britain. Parliament 1997).

Should an incident occur involving a service user, it is vital that you enter a full record of the event in their care records, along with a record of any follow-up action taken. You should record recommendations for any changes to practice to prevent or manage future risk. Further information on record-keeping issues is available in the College of Occupational Therapists' 2010 guidance document *Record keeping* (COT 2010d).

The National Patient Safety Agency (NPSA) was set up to improve safety and quality of care through reporting, analysing and learning from adverse incidents and near misses across the UK health service. Its National Reporting and Learning System is an electronic database that facilitates the reporting of service user safety incidents, including the near misses. From this collated information the NPSA can distribute guidance or initiate preventative measures, so the benefits are gained across the country.

Further information is available from the NPSA website (*http://www.npsa.nhs.uk/*, 18.07.10).

The Medicines and Healthcare products Regulatory Agency (MHRA) ensures that medicines and medical devices work and are acceptably safe to use. It will monitor the safety of medicines and devices, approving them for use and providing advice or warnings to users. The MHRA ensures that manufacturers adhere to regulations, providing a certificate or licence before the product is released for general use.

Further information is available from the MHRA website (*http://www.mhra.gov.uk/,* 18.07.10).

5 Further information and resources

5.1 Community and social care

The move towards personalisation and the transformation of community equipment services may mean an increased focus on risk assessment and risk management by services in relation to individual service users (see sections 3.2 and 3.3).

Social Care Online (*http://www.scie-socialcareonline.org.uk/search.asp*, 18.07.10) is a useful knowledge database hosted by the Social Care Institute for Excellence. It is a large resource of information related to community and social care, including risk. Some documents are available for immediate download; other journal articles require payment to access.

5.2 Employment and recruitment

Concerns have been raised around risks associated with reduced staffing levels and the pressure of meeting targets and standards in service provision. Your priority in these circumstances is to ensure service user safety. Practitioners and service leads need to discuss their concerns with their management team and ask for guidance. Management should be informed that statutory targets and standards may not be met and the reasons why. If concerns are high within your service or department, a risk assessment should be carried out to support any discussion with your organisation.

Service leads may need to think in terms of organisational risks associated with downsizing, 'down banding' or delegating to lower grade staff and how such risks may be managed as far as possible. Organisational managers need to be made aware of such risks and of the approach being taken to minimise them. For example:

- Low morale and high stress levels can lead to poor practice and 'cutting corners', raising the likelihood of an incident occurring that may harm a service user or practitioner. Service leads need to ensure adequate training, monitoring and support for staff to minimise the risk of things going wrong.
- Supervision must be adequate to identify and manage poor or inadequate performance.
- Practitioners must be aware of and maintain good lone working practice if relevant.
- You must prioritise record keeping. A heavy workload is not acceptable as an excuse for inadequate records if litigation occurs.

The Royal College of Nursing has also highlighted the risks associated with low staffing (RCN 2010).

When working with children and young people, practitioners must be aware of the requirements generated by the *Safeguarding Vulnerable Groups Act 2006* (Great Britain. Parliament 2006) and the Scottish equivalent, *Protection of Vulnerable Groups (Scotland) Act 2007* (Scotland. Scottish Executive 2007).

5.3 Equipment and adaptations

You may use, and also teach service users, carers or colleagues to use, a wide range of equipment and adaptations. It is important to familiarise yourself with any national or local policies or guidance in the use or maintenance of equipment, especially in those areas where a detailed risk assessment may be required, for example use of bed rails or equipment for obese service users.

The Medicines and Healthcare products Regulatory Agency (MHRA) produces a range of resources that may be helpful to you, all of which are available on its website (*http://www.mhra.gov.uk/index.htm*, 18.07.10).

A specific section of the website has been adapted to meet the needs of occupational therapists and includes access to interactive education modules:

- *http://www.mhra.gov.uk/Safetyinformation/Healthcareproviders/Physiotherapyandoccupationaltherapy/index.htm* Accessed on 18.07.10.

Other useful publications from the MHRA include:

- *Medicines and medical devices regulations – what you need to know* (2008)
- *Faulty medical equipment – how do I report it?* (undated)
- *Managing medical devices: Guidance for healthcare and social services organisations* (2006)

For further information about the provision of equipment and adaptations by local authorities and NHS boards in Scotland see *Guidance on the provision of equipment and adaptations* (Scottish Government et al 2009), which has been endorsed by the College of Occupational Therapists. A specific section relates to health and safety responsibilities and risk. It is available to download from: *http://www.sehd.scot.nhs.uk/publications/CC2009_05.pdf*, 18.07.10.

5.4 Lone working/personal safety

Working alone does not automatically imply being more at risk, but it is worth considering any additional systems or processes required to ensure safe working, and the actions necessary to manage an incident should it occur.

If you are working off-site or in non-clinical areas, you may be around other workers, but they may not work for the same organisation or to the same incident management procedures. When any service is set up in such circumstances, an agreed system must be put in place where there is an assured response to an alarm call.

The following are all guides on lone working written by various organisations:

- Health and Safety Executive (2009a) *Working alone. Health and safety guidance on the risks of working alone*. London: HSE. Available from: *http://www.hse.gov.uk/pubns/indg73.pdf* Accessed on 18.07.10.
- NHS Security Management Service (2009) *Developing a policy for the protection of lone workers*. 2nd ed. London: NHS Counter Fraud and Security Management Service. Available from: *http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/Lone_Working_policy_template.pdf* Accessed on 18.07.10.

- NHS Security Management Service (2005) *Not alone: A guide for the better protection of lone workers in the NHS*. London: NHS Counter Fraud and Security Management Service. Available from: *http://www.nhsbsa.nhs.uk/SecurityManagement/Documents/not_alone.pdf* Accessed on 18.07.10.
- Partnership for Occupational Safety and Health in Healthcare, NHS Security Management Service (2009) *Improving safety for lone workers. A guide for managers*. London: NHS Employers. Available from: *http://www.nhsemployers.org/SiteCollectionDocuments/Improving%20safety%20for%20lone%20workers%20-%20managers%20guide%20FINAL.pdf* Accessed on 18.07.10.
- UNISON also has a number of guides on different elements of safe lone working practice available through its searchable documents database: *http://www.unison.org.uk/resources/docs_list.asp* Accessed on 18.07.10.
- The Suzy Lamplugh Trust has a growing resource of guides on personal safety. Further information is available on its website: *http://www.suzylamplugh.org/personalsafety/personal-safety-tips* Accessed on18.07.10.

5.5 Mental health

There are numerous resources concerning risk management in the mental health setting, especially in the benefits of positive risk.

The College of Occupational Therapists has prepared a briefing on *Mental health and care co-ordination* (COT 2010c) that provides information about the Care Programme Approach, the role and core competencies of the care coordinator, which is often an occupational therapist. It also considers the role in relation to risk management and medicines management.

Best practice in managing risk: principles and evidence for best practice in the assessment and management of risk to self and others in mental health services (DH 2007a) provides best practice points for effective risk management, stressing the importance of basing decisions on the best evidence, information and clinical judgement available, putting the service user at the centre, the benefits of positive risk, collaboration, and organisational strategy.

Living with risk. Mental health service users and their involvement in risk assessment and management (Langan and Lindow 2004) is an exploration of risk assessment and risk management for people being discharged from psychiatric hospital into the community.

The Sainsbury Centre for Mental Health (now The Centre for Mental Health) produced a practical tool for risk assessment and management in mental health services. *Clinical risk management. A clinical tool and practitioner manual* (2000) looks at the potential risks of suicide, self-neglect and violence/aggression and at the support networks available. The pack includes a template of the tool, a practitioner guide, and case studies exploring the issues that might be encountered in the field. It is available to download free from: *http://www.centreformentalhealth.org.uk/publications/clinical_risk_management.aspx*, 18.07.10.

A guide to risk management in mental health (O'Rourke and Bird 2001) gives the basic principles of risk assessment, the duty of care and the importance of learning the lessons from public inquiries, while also offering practical guidance for implementing

risk management in mental health services. It shows how effective risk assessment and management can be empowering for mental health service users.

Other publications that may be useful include:

- NHS Litigation Authority (2010) *NHSLA mental health and learning disability standards – 2010/11*. London: NHSLA. Available to download from: *http://www.nhsla.com/RiskManagement* Accessed on 18.07.10.
- Petch E (2001) Risk management in UK mental health services – an overvalued idea? *Psychiatric Bulletin*, 25(6), 203–205.
- Royal College of Psychiatrists (2008) *Rethinking risk to others in mental health services: final report of a scoping group* (College Report CR150). London: Royal College of Psychiatrists. Available at: *http://www.rcpsych.ac.uk/files/pdfversion/CR150.pdf* Accessed on 18.07.10.

5.6 Research

'Research can involve an element of risk, both in terms of return on investment and sometimes for the safety and well-being of the research participant' (DH 2005a, p2).

Research governance aims to 'improve the quality of research, and provide safeguards for the public by:

- enhancing ethical and scientific quality,
- promoting good practice,
- reducing adverse incidents and ensuring lessons are learnt and
- forestalling poor performance and misconduct'. (DH 2005a, p1)

Each of the four UK countries has a research governance framework which is similar in purpose and content.

The UK Research Integrity Office's *Code of practice for research* (UKRIO 2009) has been designed to encourage good conduct in research and help prevent misconduct, in order to assist organisations and researchers to conduct research of the highest quality. It provides general principles and standards for good practice in research, applicable to both individual researchers and organisations that carry out, fund, host or are otherwise involved in research. A one-page 'recommended checklist for researchers' can be found on the inside of the front cover. This is a non-technical checklist summarising the key points of good practice in research and is applicable to all subject areas. The checklist is based on the more detailed standards given in section 3. It suggests that the risk assessment should determine:

- *whether there are any ethical issues and whether ethics review is required;*
- *the potential for risks to the organisation, the research, or the health, safety and wellbeing of researchers and research participants; and*
- *what legal requirements govern the research.*

(UKRIO 2009)

The safety of participants and of research and other staff must be given priority at all times, and health and safety regulations must be strictly observed.

(DH 2005a, p14)

The Department of Health research governance risk assessment tool (DH 2005b pp30–33) identifies further key risk areas in relation to subject/participant characteristics, researcher competence, the nature of the information being sought, appropriateness of methodology to subject and quality of research design, methods/nature of data collection, level of privacy to participant, relationship between investigator and participants, and external considerations.

Risks must be in proportion to the potential benefit of the research and explained clearly to the research participant.

It is essential that as a researcher, you conduct a risk assessment as part of the development of your research proposal. If there are potential risks, you must identify how those risks will be minimised. Application forms for ethical approval will require you to provide details about assessed risks and their management.

Commissioners of health and social care are increasingly looking for services that can demonstrate they are cost effective and evidence based. Occupational therapy services are potentially at risk if they fail to collect comprehensive evidence of the effectiveness of occupational therapy interventions. Therefore, you need to support and actively engage in evidence-based practice and research-related activities.

The following resources provide further information relating to research governance:

- College of Occupational Therapists (2010a) *Applying for ethics approval for research* (COT/BAOT Briefings 82). London: COT.
- Department of Health (2005a) *Research governance framework for health and social care*. 2nd ed. London: DH.
- Department of Health (2005b) *Research governance framework resource pack*. London: DH.
- Department of Health, Social Services and Public Safety (2006) *Research governance framework for health and social care*. 2nd ed. Belfast: DHSSPS.
- Scottish Executive Health Department (2006) *Research governance framework for health and community care*. 2nd ed. Edinburgh: SEHD.
- UK Research Integrity Office (2009) *Code of practice for research. Promoting good practice and preventing misconduct*. London: UKRIO.
- Wales Office of Research and Development for Health and Social Care (2009) *Research governance framework for health and social care in Wales*. 2nd ed. Cardiff: WORD.

5.7 Work-related violence

The HSE defines work-related violence as: ‘Any incident in which a person is abused, threatened or assaulted in circumstances relating to their work’ (Health and Safety Executive 2004, p1).

The Government's acceptance of the recommendations of the 2001 *National task force on violence against social care staff* led to a £2m campaign to reduce violence in England. The DH website has reports and resources to enable employers to minimise the potential for their staff to be subject to violence and abuse (*http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010625*, 27.10.10).

There are a number of guides from the HSE and other organisations which may be helpful to you:

- Health and Safety Executive, Health Services Advisory Committee (1997) *Violence and aggression to staff in health services – guidance on assessment and management.* London: HSE Books.
- Health and Safety Executive (2000) Local authority circular. *Work related violence.* (LAC 88/2). London: HSE.
- Health and Safety Executive (2004) *Violence at work. A guide for employers*. London: HSE.
- Advisory, Conciliation and Arbitration Service; Department for Business, Innovation and Skills; Confederation of British Industry; Health and Safety Executive et al (2010) *Preventing workplace harassment and violence: joint guidance implementing a European social partner agreement.* London: ACAS; BIS; CBI; HSE; PPE; TUC. Available at: *http://www.workplaceharassment.org.uk/wp-content/uploads/2009/11/HRE_100_Guidance_report.pdf* Accessed on 23.07.10.
- UNISON (undated) *Violence at work. A guide to risk prevention*. London: UNISON.
- National task force on violence against social care staff website: *http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010625* Accessed on 27.10.10.

5.8 General information

You should seek advice and assistance from your local clinical governance, health and safety, risk management, quality and/or research departments.

- Dimond B (2004) *Legal aspects of occupational therapy*. 2nd ed. London: Blackwell Publishing.
- Lynch J (2009) *Health records in court*. Oxford: Radcliffe Publishing.
- Health and Safety Executive
  Britain's HSE is responsible for the regulation of almost all the risks to health and safety arising from work activity in Britain. Further information is available on its website: *http://www.hse.gov.uk/*, 18.07.10. The following are HSE publications, available from its website:
  - Health and Safety Executive (1997) *Successful health and safety management*. London: HSE.
  - Health and Safety Executive (1999) *Reducing error and influencing behaviour*. London: HSE.
  - Health and Safety Executive (2006a) *Essentials of health and safety at work*. 4th ed. London: HSE.
  - Health and Safety Executive (2006b) *Five steps to risk assessment*. London: HSE.

- ➲ Health and Safety Executive (2008) *Health and safety regulation – a short guide*. London: HSE.
- ➲ Health and Safety Executive (2009b) *Health and safety for disabled workers and those who work with them: an easy read guide*. London: HSE.

- Health and Safety Executive for Northern Ireland
  HSENI is the lead body responsible for the promotion and enforcement of health and safety at work standards in Northern Ireland. Further information is available on its website: *http://www.hseni.gov.uk/*, 18.07.10.
- Health and Safety Executive Scotland
  Workplace health and safety legislation is still overseen by the UK Parliament. The power to make or change health and safety legislation has not been devolved. The HSE works closely with the Scottish Executive. Further information is available on its website: *http://www.hse.gov.uk/scotland/index.htm*, 18.07.10.
- National Health Service Litigation Authority
  The NHSLA handles negligence claims and works to improve risk management practices in the NHS in England. Further information is available on its website: *http://www.nhsla.com/home.htm*, 18.07.10.
- Regulatory bodies
  There are a number of bodies across the UK that regulate health and social care:
  - ➲ The Care Quality Commission is the independent regulator of health and social care in England. It regulates care provided by the NHS, local authorities, private companies and voluntary organisations. Further information is available on its website: *http://www.cqc.org.uk/*, 18.07.10.
  - ➲ The Care and Social Services Standards Inspectorate for Wales regulates social care, early years and social services in Wales. *http://wales.gov.uk/cssiwsubsite/newcssiw/?lang=en*, 18.07.10.
  - ➲ The Healthcare Inspectorate Wales is the independent inspectorate and regulator of all healthcare in Wales. *http://www.hiw.org.uk/*, 18.07.10.
  - ➲ The Scottish Commission for the Regulation of Care regulates all adult, child and independent healthcare services in Scotland. *http://www.carecommission.com*, 18.07.10.
  - ➲ The Regulation and Quality Improvement Authority registers and inspects a wide range of health and social care services in Northern Ireland. *http://www.rqia.org.uk/home/index.cfm*, 18.07.10.

References

Advisory, Conciliation and Arbitration Service; Department for Business, Innovation and Skills; Confederation of British Industry et al (2010) *Preventing workplace harassment and violence: joint guidance implementing a European social partner agreement*. London: ACAS; BIS; CBI; HSE; PPE; TUC.
Available at: *http://www.workplaceharassment.org.uk/wpcontent/uploads/2009/11/HRE_100_Guidance_report.pdf* Accessed on 23.07.10.

Barry M (2007) *Effective approaches to risk assessment in social work: an international literature review*. Edinburgh: Scottish Executive.

Bird D, Dennis S (2005) Integrating risk management into working practice. *Nursing Standard*, *20(13),* 52–54.

Care and Social Services Standards Inspectorate for Wales website:
http://wales.gov.uk/cssiwsubsite/newcssiw/?lang=en Accessed on 18.07.10.

Care Quality Commission (CQC) website:
http://www.cqc.org.uk/ Accessed on 18.07.10.

College of Occupational Therapists (2006a) *Manual handling.* (Guidance 3). London: COT.

College of Occupational Therapists (2006b) *Recovering ordinary lives: the strategy for occupational therapy services 2007–2017: a vision for the next ten years*. London: COT, cited in Fieldhouse J (2008) Community mental health. In: J Creek, L Lougher, eds. *Occupational therapy and mental health*. 4th ed. Edinburgh: Churchill Livingstone.

College of Occupational Therapists (2010a) *Applying for ethics approval for research* (COT/BAOT Briefing 82). London: COT.

College of Occupational Therapists (2010b) *Code of ethics and professional conduct.* London: COT.

College of Occupational Therapists (2010c) *Mental health care co-ordination*. (COT/BAOT Briefing). London: COT [in press].

College of Occupational Therapists (2010d) *Record keeping*. 2nd ed. London: COT.

Deegan PE (2001) Recovery as a self-directed process of healing and transformation. *Occupational Therapy in Mental Health, 17(1)*, 5–21, cited in Fieldhouse J (2008) Community mental health. In: J Creek, L Lougher, eds. *Occupational therapy and mental health*. 4th ed. Edinburgh: Churchill Livingstone.

Department of Health (2005a) *Research governance framework for health and social care.* 2nd ed. London: DH.

Department of Health (2005b) *Research governance framework resource pack.* London: DH.

Department of Health (2007a) *Best practice in managing risk: principles and evidence for best practice in the assessment and management of risk to self and others in mental health services*. London: DH.

Department of Health (2007b) *Independence, choice and risk: a guide to best practice in supported decision making*. London: DH.

Department of Health, Social Services and Public Safety (2006) *Research governance framework for health and social care.* 2nd ed. Belfast: DHSSPS.

Dimond B (2004) *Legal aspects of occupational therapy.* 2nd ed. London: Blackwell Publishing.

Disability Rights Commission (2004) *Disability Discrimination Act 1995: code of practice: employment and occupation*. London: Stationery Office.

Fieldhouse J (2008) Community mental health. In: J Creek, L Lougher, eds. *Occupational therapy and mental health.* 4th ed. Edinburgh: Churchill Livingstone.

Great Britain. Parliament (1974) *Health and Safety at Work etc Act 1974*. London: HMSO.

Great Britain. Parliament (1978) *Health and Safety at Work (Northern Ireland) Order 1978*. (No.1039 (NI 9)). London: HMSO.

Great Britain. Parliament (1995a) *Disability Discrimination Act 1995.* London: HMSO.

Great Britain. Parliament (1995b) *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995*. London: HMSO.

Great Britain. Parliament (1997) *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997.* (Statutory Rule 1997 No. 455). London: HMSO.

Great Britain. Parliament (1999) *Management of Health and Safety at Work Regulations 1999.* (SI 1999 No. 3242). London: Stationery Office.

Great Britain. Parliament (2000) *Management of Health and Safety at Work Regulations (Northern Ireland) 2000.* (Statutory Rule 2000 No. 388). London: Stationery Office.

Great Britain. Parliament (2002) *Control of Substances Hazardous to Health Regulations 2002*. London: Stationery Office.

Great Britain. Parliament (2005a) *Disability Discrimination Amendment Act 2005*. London: Stationery Office.

Great Britain. Parliament (2005b) *Mental Capacity Act 2005.* London: Stationery Office.

Great Britain. Parliament (2006) *Safeguarding Vulnerable Groups Act 2006*. London: Stationery Office.

Great Britain. Parliament (2010) *Equality Act 2010.* London: Stationery Office.

Health and Safety Executive (1997) *Successful health and safety management*. London: HSE.

Health and Safety Executive (1999) *Reducing error and influencing behaviour.* London: HSE.

Health and Safety Executive (2000) *Local authority circular. Work related violence. (LAC 88/2).* London: HSE.

Health and Safety Executive (2004) *Violence at work. A guide for employers.* London: HSE.

Health and Safety Executive (2006a) *Essentials of health and safety at work.* 4th ed. London: HSE.

Health and Safety Executive (2006b) *Five steps to risk assessment*. London: HSE.

Health and Safety Executive (2008) *Health and safety regulation – a short guide.* London: HSE.

Health and Safety Executive (2009a) *Working alone. Health and safety guidance on the risks of working alone.* London: HSE.
Available from: *http://www.hse.gov.uk/pubns/indg73.pdf* Accessed on 18.07.10.

Health and Safety Executive (2009b) *Health and safety for disabled workers and those who work with them: an easy read guide.* London: HSE.

Health and Safety Executive website:
http://www.hse.gov.uk/ Accessed on 18.07.10.

Health and Safety Executive, Health Services Advisory Committee (1997) *Violence and aggression to staff in health services – guidance on assessment and management*. London: HSE Books.

Health and Safety Executive for Northern Ireland (HSENI) website: *http://www.hseni.gov.uk/* Accessed on 18.07.10.

Health and Safety Executive Scotland website: *http://www.hse.gov.uk/scotland/index.htm* Accessed on 18.07.10.

Healthcare Inspectorate Wales website:
http://www.hiw.org.uk/ Accessed on 18.07.10.

Langan J, Lindow V (2004) *Living with risk. Mental health service users and their involvement in risk assessment and management*. Bristol: The Policy Press.

Lynch J (2009) *Health records in court*. Oxford: Radcliffe Publishing.

McILwain JC (2006) A review: a decade of clinical risk management and risk tools. *Clinician in Management*, *14(4)*, 189–199.

Medicines and Healthcare products Regulatory Agency (2006) *Managing medical devices: Guidance for healthcare and social services organisations*. DB2006(05). London: MHRA.

Medicines and Healthcare products Regulatory Agency (2008) *Medicines and medical devices regulations – what you need to know.* London: MHRA.

Medicines and Healthcare products Regulatory Agency (undated) *Faulty medical equipment – how do I report it?* London: MHRA.

Medicines and Healthcare products Regulatory Agency (MHRA) website:
http://www.mhra.gov.uk/ Accessed on 18.07.10.

Morgan S (2000) *Clinical risk management. A clinical tool and practitioner manual.* London: Sainsbury Centre for Mental Health. Available from: *http://www.centreformentalhealth.org.uk/publications/clinical_risk_management.aspx* Accessed on 18.07.10.

Morgan S (2004) Positive risk taking: an idea whose time has come. *Health Care Risk Report, 10(10),* 18–19.

National Health Service Litigation Authority website:
http://www.nhsla.com/home.htm Accessed on 18.07.10.

National Patient Safety Agency website:
http://www.npsa.nhs.uk/ Accessed on 18.07.10.

NHS Litigation Authority (2010) *NHSLA mental health and learning disability standards – 2010/11.* London: NHSLA.
Available from: *http://www.nhsla.com/RiskManagement/* Accessed on 18.07.10.

NHS Litigation Authority [ca. 2010] *Risk management: NHSLA standards and assessments*. London: NHS Litigation Authority.
Available at: http://www.nhsla.com/RiskManagement/ Accessed on 18.07.10

NHS Security Management Service (2005) *Not alone: A guide for the better protection of lone workers in the NHS.* London: NHS Counter Fraud and Security Management Service.
Available from: *http://www.nhsbsa.nhs.uk/SecurityManagement/Documents/not_alone.pdf* Accessed on 18.07.10.

NHS Security Management Service (2009) *Developing a policy for the protection of lone workers*. 2nd ed. London: NHS Counter Fraud and Security Management Service.
Available from: *http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/Lone_Working_policy_template.pdf* Accessed on 18.07.10.

O'Rourke M, Bird L (2001) *A guide to risk management in mental health*. London: Mental Health Foundation.

Partnership for Occupational Safety and Health in Healthcare, NHS Security Management Service (2009) *Improving safety for lone workers. A guide for managers*. London: NHS Employers.

Available from: *http://www.nhsemployers.org/SiteCollectionDocuments/Improving%20safety%20for%20lone%20workers%20-%20managers%20guide%20FINAL.pdf* Accessed on 18.07.10.

Perkins RE (2004) *Recovery and rehabilitation*. Paper presented at the Avon and Wiltshire Mental Health Partnership Annual Rehabilitation Service Conference. 23 January 2004, Vassal Centre, Bristol, cited in Fieldhouse J (2008) Community mental health. In: J Creek, L Lougher, eds. *Occupational therapy and mental health*. 4th ed. Edinburgh: Churchill Livingstone.

Petch E (2001) Risk management in UK mental health services – an overvalued idea? *Psychiatric Bulletin, 25(6),* 203–205.

Regulation and Quality Improvement Authority website: *http://www.rqia.org.uk/home/index.cfm* Accessed on 18.07.10.

Royal College of Nursing (2010) *Public unaware of scale of NHS cutbacks*. London: RCN. Available at: *http://www.rcn.org.uk/newsevents/news/article/uk/public_unaware_of_scale_of_nhs_cutbacks* Accessed on 18.07.10.

Royal College of Psychiatrists (2008) *Rethinking risk to others in mental health services: final report of a scoping group.* (College Report CR150). London: Royal College of Psychiatrists.
Available at: http://www.rcpsych.ac.uk/files/pdfversion/CR150.pdf Accessed on 18.07.10.

Scotland. Scottish Executive (2000) *Adults with Incapacity (Scotland) Act 2000*. Edinburgh: Stationery Office.

Scotland. Scottish Government (2007) *Protection of Vulnerable Groups (Scotland) Act 2007 (asp 14).* Edinburgh: Scottish Government. Available at: *http://www.opsi.gov.uk/legislation/scotland/acts2007/asp_20070014_en_1* Accessed on 20.07.10.

Scottish Commission for the Regulation of Care (SCRCS) website: *http://www.carecommission.com* Accessed on 18.07.10.

Scottish Executive Health Department (2006) *Research Governance Framework for Health and Community Care.* 2nd ed. Edinburgh: SEHD.

Scottish Government, College of Occupational Therapists, COSLA (2009) *Guidance on the provision of equipment and adaptations*. Edinburgh: Scottish Government.
Available from: *http://www.sehd.scot.nhs.uk/publications/CC2009_05.pdf* Accessed on 18.07.10.

Social Care Online
http://www.scie-socialcareonline.org.uk/search.asp Accessed on 18.07.10.

Suzy Lamplugh Trust website:
http://www.suzylamplugh.org/personal-safety/personal-safety-tips/ Accessed on 18.07.10.

UK Research Integrity Office (2009) *Code of practice for research: promoting good practice and preventing misconduct.* London: UKRIO.

References

UNISON website:
http://www.unison.org.uk/resources/docs_list.asp Accessed on 18.07.10.

UNISON (undated) *Violence at work. A guide to risk prevention*. London: UNISON.

Wales Office of Research and Development for Health and Social Care (2009) *Research governance framework for health and social care in Wales.* 2nd ed. Cardiff: WORD.

Bibliography

Department of Health; Social Care, Local Government and Care Partnerships (SCLGCP) Directorate; Older People and Dementia (2010) *Nothing ventured, nothing gained: risk guidance for people with dementia*. London: DH.

Dimond BC (2004) *Legal aspects of occupational therapy.* 2nd ed. Oxford: Blackwell Science.

Health and Safety Executive (2004) *Violence at work: a guide for employers.* London: HSE.

Health and Safety Executive (2005*) Working alone in safety: controlling the risks of solitary work*. London: HSE.

NHS Scotland (2007) Clinical governance: educational resources. Edinburgh: NHS Quality Improvement Scotland, Clinical Governance Support and Development Unit. Available at: *http://www.clinicalgovernance.scot.nhs.uk/section3/identifyrisk.asp*
Accessed on 18.07.10.

Occupational Therapy Benchmarking Group (2001) *Benchmark statement: health care programmes: phase 1: occupational therapy.* Gloucester: Quality Assurance Agency for Higher Education.

Petch E (2001) Risk management in UK mental health services: an overvalued idea? *Psychiatric Bulletin, 25(6),* 203–205.

Social Care Online [database] *http://www.scie-socialcareonline.org.uk/search.asp*
Accessed on 18.07.10.

Risk Management

Second edition

Risk management is an intrinsic part of governance, service user safety and the provision of a quality care service. It is written into national standards for health, social care and education across the UK. Risk assessment and its management are not optional extras, but should be an inherent part of all occupational therapists' safe and effective everyday practice.

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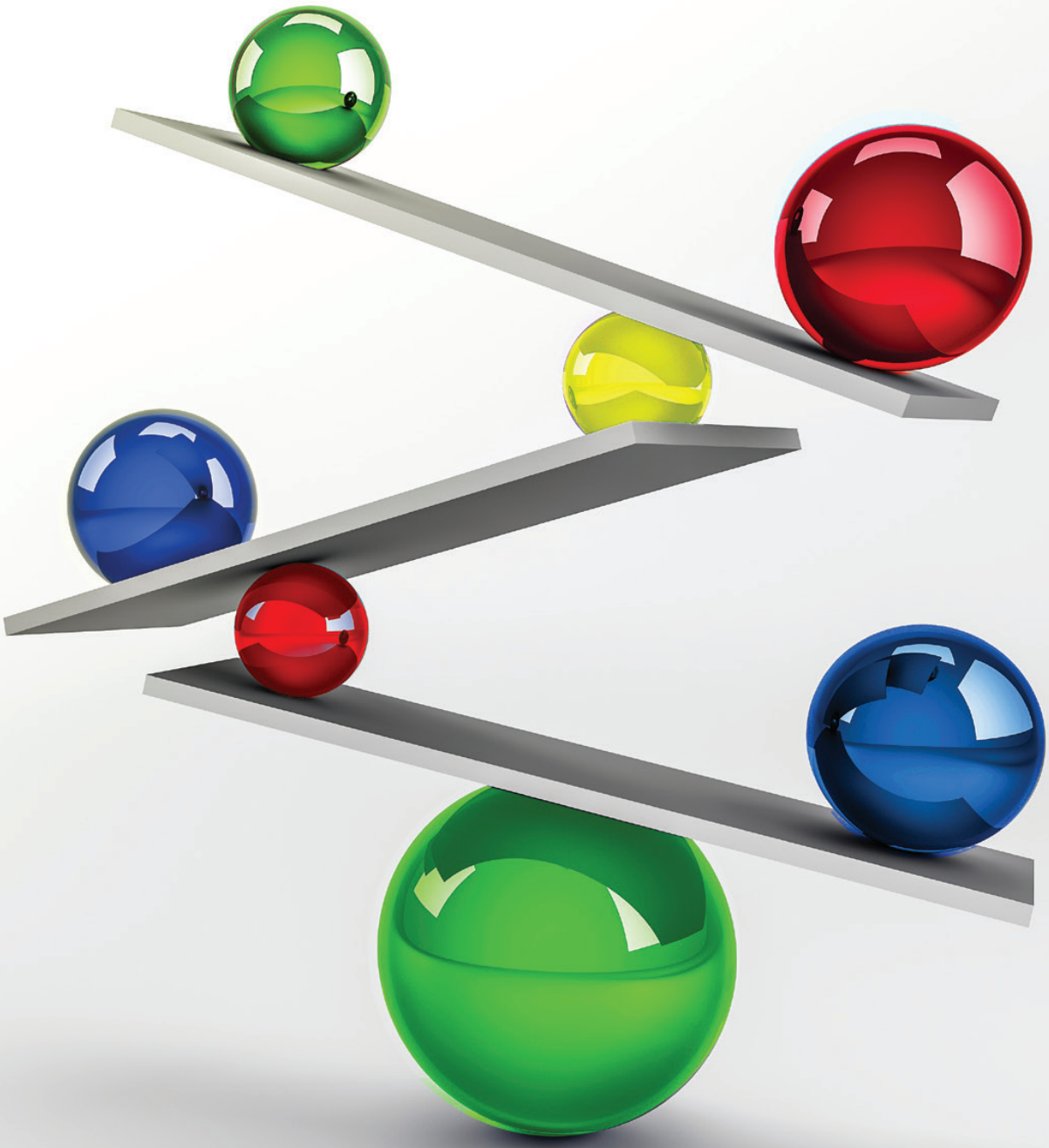

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The Royal College of Occupational Therapists is a wholly owned subsidiary of the British Association of Occupational Therapists (BAOT) and operates as a registered charity. It represents the profession nationally and internationally, and contributes widely to policy consultations throughout the UK. The College sets the professional and educational standards for occupational therapy, providing leadership, guidance and information relating to research and development, education, practice and lifelong learning. In addition, 10 accredited specialist sections support expert clinical practice.

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Guidance for occupational therapists

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1 Introduction

1.1 Why do you need to think about risk differently?

Consider:

- The grandmother who wanted to go home, but was kept in hospital because her cluttered home was perceived as a risk.
- The young man with learning disabilities who wanted to walk in the park, but was prevented from going out alone as there was a possible risk that he may get lost.
- The gentleman in the care home who had been a keen gardener, but was kept inside because the uneven garden path was considered a falls risk for him.

All of these decisions may seem to have been taken in the best interests of the individual, but are the result of falling into the trap of not fully taking all the factors into account.

Now consider the outcomes for the individuals:

- The grandmother entered a cycle of hospital-acquired infections and never went home, although her cluttered home was not the cause of her original admission to hospital.
- The young man began to demonstrate his frustration in episodes of anger.
- The gentleman in the care home became depressed and introverted, refusing to join in with social activities in the home.

These are not the outcomes that any practitioner would want. In each of these circumstances the perceived risk became the overriding factor. The decisions that were taken did not prioritise the choices and wishes of the individuals, taking into account their mental capacity to make a choice, or the deprivation of their liberty.

Occupational therapy should enable individuals to achieve their full potential. If you want service users to reach their chosen goals and to participate fully in life, this requires you to embrace and engage with risk.

This guidance provides a broad understanding of the principles and process of risk management for all occupational therapy personnel. **It focuses on how this process enables people to take the risks that they choose and achieve their chosen goals, as safely as reasonably possible**. It also highlights some factors related to the management of risk at an organisational level.

Section 6 of this guidance also identifies a number of information resources currently available. Moving and handling and equipment provision are covered briefly within this document, and covered in further detail on the Royal College of Occupational Therapists' website.

1.2 Occupational therapists need to embrace risk

> If we wish consumers to engage with the full potential of their lives, we need to consider whether the barriers we place in their way are to protect them or us.
>
> (Gallagher 2013, p339)

In occupational therapy, taking risks can be intrinsic to a service user's progress; e.g. learning a new skill, participating in a chosen activity, returning home after a stay in hospital. **As a practitioner, it is your role, as far as possible, to enable people to overcome the barriers that prevent them from doing the activities that matter to them; to take opportunities and not to see risk as another barrier.**

When you perceive that an activity or a chosen action has an element of risk, this should not usually cause you to stop or prevent the activity/chosen action. Nor does it mean that you ignore the risk. Managing risk is a statutory and regulatory duty (Great Britain. Parliament 1974, 1999) and it is included in your regulatory and professional standards (HCPC 2013, 2016; COT 2015, 2017). By embracing and engaging with risk, the process of assessing and managing it, in partnership with the service user, can be an enabler rather than a barrier (Gallagher 2013).

Risk enablement is a series of steps by which you can engage with and manage a risky situation or activity. The elements that would do harm are removed where possible and appropriate, or reduced to an acceptable level, enabling any opportunity for positive gain to be taken as safely as possible. This is reviewed and revised regularly (see section 2.7).

The risk enablement process should be seen as a positive resource for you as a practitioner. It can guide planning and decision-making and provides a method to overcome difficulties and make achievements safely.

1.3 Occupational therapists must embrace risk and enable choice

You are expected to put service users at the centre of your practice, working in partnership with them, being led by their needs, choices and aspirations (COT 2017, section 2.1). You have a continuing duty to respect and uphold their autonomy, encouraging and enabling choice and partnership working in the occupational therapy process (COT 2015, section 3.3).

In most circumstances, throughout your involvement with the service user, you are working with them towards their chosen aims and objectives. Those choices may be considered unwise, but must still be accepted as the individual's choice (see section 3.2).

> You uphold the service user's right to make choices over the care that they receive and the plans that they wish to make.
>
> (COT 2017, section 2.5)

Even when an individual does not have the mental capacity to make certain choices, risk should not necessarily limit best interest decisions, especially when these take into account the service user's stated preferences and wishes. Such decisions can incorporate and be supported by the risk enablement process. As facilitators, occupational therapists can use the process of risk assessment and enablement to expand an individual's abilities in a safe way, to 'avoid a focus on what cannot be done in favour of what can be done with greater certainty, accountability and transparency' (Gallagher 2013, p337).

1.4 Terminology

For the purpose of this document the following definitions or understandings of words are used:

- ***Positive risk*** is when taking a risk achieves positive outcomes; taking a risk in order to benefit. The term 'positive' is not about the risk, but about the *outcome* of taking a risk (Adapted from Morgan and Williamson 2014, p5).
- A ***risk factor*** is anything that has the potential to cause harm or be harmful.
- ***Risk*** is the possibility or likelihood, at any level, that harm may occur, together with a measure of the effect.
- ***Risk enablement*** is enabling people to take the risks they choose as safely as reasonably possible.
- The ***practitioner*** is you as the active individual, wherever you work and whatever your role.
- ***Service*** usually refers to any kind of occupational therapy that you provide, rather than referring to an occupational therapy department or facility.
- ***Service users*** are those to whom you provide advice, education, support, intervention or a service. This encompasses all ages, groups and communities of people, and is applicable in all settings.
- ***Carers*** – although not always specified in the document, the service user's carers and/or family should be actively involved, with the agreement of the service user where appropriate.
- ***Care*** and/or ***intervention*** is the work that you do for and with service users.
- ***Care records*** are the records kept by occupational therapy practitioners in all settings.
- The ***Royal College of Occupational Therapists*** may be referred to as RCOT or the College.

You are advised to use this guidance in conjunction with the *Professional standards for occupational therapy practice* (COT 2017) and the *Code of ethics and professional conduct* (COT 2015).

1.5 Embrace risk as part of your professional duty

Your responsibility for assessing and managing the identified risks involved in providing care to your service users (COT 2015, section 2.5.2) gives you the chance **to enable positive risk-taking within a safe environment, giving service users the opportunity to gain optimal occupational performance and autonomy in their lives.**

> You enable positive risks to be taken safely by service users, in cases where such risks are a necessary part of intervention.
>
> (COT 2017, section 14.3)

Risk management-related legislation, policies and procedures give you a structure by which you can do this, ensuring that you work safely and effectively, meeting your professional requirements.

If you are an independent practitioner, you are advised to put in place your own policies which are compatible with legislation, your professional standards and standard practice. If you are working on a consultancy or agency basis you should be aware of the risk management policies in place within the organisations with which you work.

> You must familiarise yourself with the risk management legislation that is relevant to your practice, and with your local risk management procedures.
>
> (COT 2015, section 2.5.1)

If you are concerned that your local policy, or any local action or practice that you witness, is causing you to fall short of your legal and professional duties in managing risk; or that it puts the welfare of service users, yourself or your colleagues at risk; you must raise this with your employer or the organisation with whom you are working. Keep a record of your concerns. You are advised to contact your local union representative and the Royal College of Occupational Therapist's Professional Practice Enquiries Service in such situations, as each may be able to advise you.

2 Engaging with risk

2.1 The risk enablement process

In order for occupational therapists to fully embrace risk, there are a number of steps to the assessment and enablement of safe risk-taking. Figure 1 shows the cyclical nature of the process.

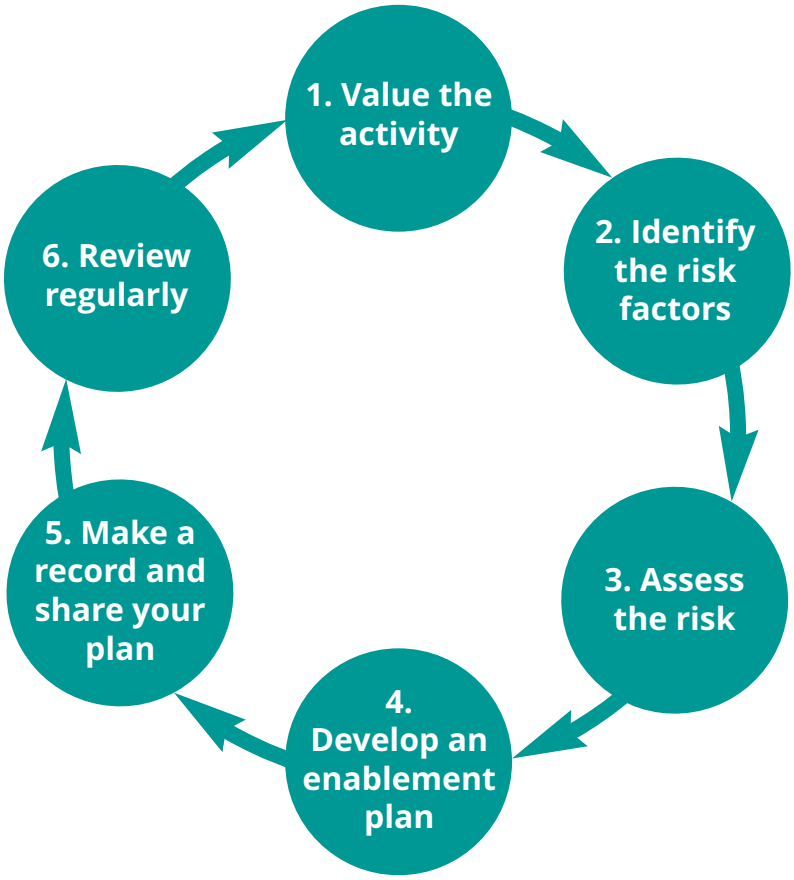

Figure 1 The cyclical nature of the risk enablement process

1. Value the activity

Look at the value and benefit of carrying out the activity or task, especially from the viewpoint of the service user. What will be gained occupationally, physically, psychologically and socially?

2. Identify the risk factors

Look at every aspect of the activity or task in which you are involved or for which you are responsible. Are there any factors which could possibly create risk? Look at the activity, the environment, any equipment involved, and the nature of the needs of the people involved.

3. Assess the risk

Assess the degree and nature of this risk. What is the likelihood of it occurring? Who is at risk and how? What would the possible harm be if an incident occurred? Look to see if there are any controls already in place. Is any data available from relevant past incidents?

4. Develop an enablement plan

> Users should be seen as equal partners in the process and outcomes of risk assessment and management.
>
> (Barry 2007)

Develop a plan for the activity or task which manages the risk to an acceptable level. Look at the risk factors and how these might be managed to reduce, avoid or eliminate the risk altogether so that the desired positive outcome is achieved without harm. Look at the strengths and skills of the service user and others involved. How might these counter-balance the risk? If others are involved in the activity, define who is responsible for what actions. Keep the service user at the centre of your plan, enabling and empowering them to take responsibility for managing risk when appropriate and possible. You also need to consider and plan for what should happen if the risk becomes a reality and an incident occurs.

5. Make a record and share your plan

It is essential that you fully record your risk assessment and your enablement plan, including the professional rationale for your decisions and actions. This supports your care of the service user and informs all those involved of any proposed action to take. It also demonstrates that you have fulfilled your duty of care. Share your enablement plan with all those involved.

6. Review regularly

Review the assessment and plan regularly. Is it still adequate? Have there been any changes? A plan related to a service user is likely to need amendments as their status changes.

2.2 Recording the assessment and enablement plan

It can be helpful to record risk assessments and enablement plans using a formal, purpose-designed form. There are numerous templates for risk assessments that are widely available, especially in areas such as falls prevention. There are a number of examples, templates and other resources available from the Health and Safety Executive website.

In whatever format, the records should show that a suitable and sufficient risk assessment was carried out and its outcomes recorded. The enablement plan should show how you have dealt with all the significant risk factors and that any remaining risk is low. The records can also provide a reminder to monitor certain activities or elements of your intervention if there is any remaining possible risk.

> The risk assessment process is not about creating huge amounts of paperwork; it is about identifying and taking sensible and proportionate measures to control the risks.
>
> (HSE 2014, p1)

Your records demonstrate that you have complied with health and safety requirements and fulfilled your duty of care.

It is important that the paperwork doesn't become so complex that it loses its usability and usefulness. An example of a very practical template is given in the *Living well through activity in care homes* toolkit (COT 2013). It suggests that risk assessment and enablement plans should list:

- The risks and benefits.
- The likelihood that risk might occur.
- The seriousness/severity of those risks.
- Actions to be taken to minimise the risks.
- Actions to be taken if the risks occur.

It then provides an example table that could be used to create a risk enablement plan, where 'myself' refers to the service user, central to the activity.

The value of the activity	The risks associated with this activity	Likelihood of risk High/ Medium/Low Myself Others	Severity of risk High/Medium/ Low Myself Others	How the risk will be managed

2.3 Who is responsible for assessing?

When working with service users within the context of an organisation, the responsibility for assessing and managing risk is generally devolved from the employer to you as the practitioner concerned. If you are working as an independent or sole practitioner, the responsibility is held directly by you. The person carrying out the risk assessment should be appropriately trained to do so. If you are unsure of your own abilities to carry out a risk assessment, seek advice or training. If you delegate the task of carrying out a risk assessment to another person, you should ensure that they are competent to carry it out (COT 2015, section 5.2).

Although the formal risk assessment may be officially devolved to one individual or role, everyone involved in a person's care carries a shared duty of care and responsibility for their safety and wellbeing.

2.4 When should I assess?

Risk assessment and enablement are part of your everyday occupational therapy practice and professional reasoning. In any context, you will be identifying possible risk factors as you observe, assess and work. Whether a specific risk assessment is carried out for a given activity depends upon the presence and potential impact of these risk factors. Assessment may show that a perceived risk is not actually significant or it may confirm that adequate measures are already in place to manage the situation. The process of assessing possible risk, and demonstrating how it can be managed, can help to establish how a service user can make safe progress.

Risk assessments should be made and an enablement plan put in place when any significant changes are proposed to systems or practices, when any new project or activity is planned, and before any particular actions or interventions are made that may engender risk.

2.5 What should I assess?

It is difficult to define how thorough or far-reaching risk assessments should be. With service users you will need to consider risk in each person's individual context. 'Risk is dynamic and may fluctuate – for example, a small task such as making a cup of tea may suddenly place an older person recovering from a broken hip at an increased risk of falling' (DH 2007b, section 1.5, p11). In this example, the perceived risk should not stop the older person from trying to make a cup of tea, but an assessment enables the risk to be managed and the person to achieve their goal.

> If professionals and paid workers do not know the person well they might not be aware of the ways in which the individual already manages risk, or how their family or supporters have already built up systems of support. Here, it is important to have discussions with the individual and those closest to them and pay close attention to what they say. They may be managing some risks well and just need support to exercise this power.
>
> (DH 2010, p45)

The service user needs to be central to your assessment of risk. You need to consider any factors that may generate risk/s as that individual carries out their chosen activities, for example:

- The physical and cognitive status of the individual.
- The environment.
- The chosen activity.

- The use or provision of rehabilitation/assistive equipment.
- The possible actions, purposeful or accidental, of other people.

2.6 Who should I assess?

Having identified any hazards and the potential risk, you must then consider who or what is at risk of potential harm. Under the *Management of Health and Safety at Work Regulations* (Great Britain. Parliament 1999), assessments should consider possible risk to all those affected by the work or activity. Any possible risk associated with your intervention can rarely be seen in relation to the service user only. There will almost always be other people who need to be considered. For example, if you are providing equipment to facilitate the service user's independence, does it create a risk to anyone else who might use it, move it, or trip over it? How can you enable the safe provision of equipment for everyone concerned?

2.7 When should I review?

Assessing and enabling risk should be an ongoing process. It is vital to ensure that enablement plans and strategies are still relevant and adequate. A review should be done at planned regular intervals and/or whenever a change occurs in the situation, any procedures, or with the people involved. A review should always take place if there has been an incident.

When a person's care or support plan is reviewed you should also consider how you may need to change any risk enablement plans. The frequency and depth of individual review should be proportionate to any changes in existing arrangements or the status of the service user.

3 Enabling choice

3.1 Managing the risk can enable the positive benefits of taking appropriate risk

Through assessment you can identify the nature of the risk. You can then consider what can reasonably and practicably be done, or put in place, to reduce or remove the probability and impact of the risk. What can be done to increase the potential for a positive outcome?

> Fear of supporting people to take reasonable risks in their daily lives can prevent them from doing the things that most people take for granted.
>
> (DH 2007b, p3)

Your assessment and your professional judgement should enable you to decide upon a course of action with the service user, depending upon the level of risk, the likelihood of occurrence, the ability to reasonably manage the risk and the service user's strengths and preferences. Your objective is to enable the individual to achieve their chosen goals.

The elimination, reduction or control of risk is often a problem-solving exercise where occupational therapy skills such as activity analysis prove particularly useful. Consider the following:

- Can you physically take action to remove the situation/activity/item that creates the risk?
- Can you physically take action to reduce the likelihood of the harm occurring?
- Can you involve other people to reduce the likelihood of the harm occurring?
- Can you change the environment to reduce the risk or create protection?
- Can you use techniques, approaches or behaviours to make a situation or activity safer?
- Can you introduce technology to make an environment, situation or activity safer?
- Can you change or learn behaviour/systems to reduce the risk or create protection?

Risk should rarely be an excuse for stopping an activity that is important to the progress of the service user. In the same way that you may look at a service user's overall objective and break it down into smaller goals, you can look at a situation, identify the risk factors involved and act to manage them.

Your plan needs to record any actions taken to enable the chosen risk to be taken in as safe a way as possible, in order to achieve the desired activity. It should detail what actions are to be taken, by whom and when. Keep the service user at the centre of your plan, defining what actions or responsibilities they may need to take. The plan should also consider what is to be done should an incident actually occur. The plan should be reviewed regularly and when any changes are proposed or made (see section 2.7). Share your plan with those involved in the activity and/or service user's care.

3.2 Risk and choice

When working with service users, their choices and priorities are always central to the care that you provide, including the risk enablement process. When planning your intervention with them, you need to use your professional knowledge, reasoning and judgement to decide on the most appropriate action that will produce the desired outcomes.

There may be times when the service user wants to pursue an activity that has the potential for a significant risk of harm and this ultimately cannot be managed to a reasonable level. You may consider discontinuing or not supporting the activity, but you might want to enable that activity to go forward as safely as possible, depending on its value to the service user and your professional judgement. For example a sportsperson may want to resume skiing following a leg amputation. This is inherently and significantly risky, but potentially achievable.

If you were to discontinue your involvement, a service user with mental capacity can choose to carry out the activity against your recommendations; they have the right to do so. They also have the right to refuse any intervention at any time in the occupational therapy process. It is recognised that this may not be the case for a person under the care of the *Mental Health Act 1983* (Great Britain. Parliament 1983).

> You seek to act in the best interests of service users to ensure their optimum health, wellbeing and safety.
>
> (COT 2017, section 2.3)

Should you consider that a service user with mental capacity has made a choice that is not in their best interest, you need to be sure that they are aware of all the potential risks involved and that it is not in accordance with your professional recommendation. You should still do all you can to control the risk as far as is reasonably possible. Your care records must record all your actions, the information and recommendations given, any communication (verbal or written) and your rationale for your decisions and actions. You should accurately record the service user's choice and actions taken, along with any outcome. Where possible and with consent (unless over ridden by a concern for public safety), you should discuss the service user's decision with other relevant professionals involved.

Mental capacity legislation (Great Britain. Parliament 2005, 2016; Scottish Executive 2000) states that although service users may make decisions that you may consider unwise or risky, it is not necessarily an indication that they lack mental capacity. If someone is able to make their own decisions, it is essential that they maintain control as much as possible.

The Department of Health document *Independence, choice and risk: a guide to best practice in supported decision making* (DH 2007b) provides a governing principle behind good approaches to independence, choice and risk that is applicable across the UK. This is that:

People have the right to live their lives to the full as long as that doesn't stop others from doing the same. To put this principle into practice, people supporting users of services have to:

- *help people to have choice and control over their lives;*
- *recognise that making a choice can involve some risk;*
- *respect people's rights and those of their family and carers;*
- *help people understand their responsibilities and the implications of their choices, including any risks;*
- *acknowledge that there will always be some risk, and that trying to remove it altogether can outweigh the quality of life benefits for the person; and*
- *continue existing arrangements for safeguarding people.*

(Adapted from DH 2007b, pp12–13)

3.3 Integrating risk enablement into your everyday practice

Risk enablement should be integrated into your individual everyday practice. Some of the following may help you to do this:

- Seek adequate training so that you are confident and competent in assessing and managing risk.
- Make sure that you understand your local policies, procedures and approaches.
- If you are unsure of your responsibilities in a particular situation, ask for advice and support from your supervisor or manager.
- Work with your colleagues to develop a culture of embracing risk to enable choice, using the risk enablement process to support service users in reaching their chosen aims.
- Develop circular systems of open communication to share information and instructions, with easy feedback of actions or results.
- Work in partnership with service users in assessments, decision-making and planning.

4 What if the risk becomes a reality?

It is not always possible to stop an incident from occurring, however well the potential risks have been managed or controlled. As stated, any risk management plan should also identify the action(s) required should an incident occur.

Incidents or accidents can be better handled if you are well prepared. For example, when out of the workplace, you should always carry some means of communication plus useful contact numbers.

4.1 Managing an incident or accident in the course of your work

If an incident or accident occurs, your priority is the safety of any people involved, whether the service user, their family, other staff or the public. First aid and other medical attention must be given and emergency services contacted if required. If there are any environmental hazards, evacuation procedures must be implemented. You must follow local policies and protocols.

If the incident involves an individual demonstrating dangerous or offensive behaviour, it may require the removal of that individual from the situation. Appropriately trained and authorised people will need to be involved. You must follow local policies and protocols.

Those involved in an incident or accident should be given the opportunity to review the event. Support should be provided where necessary and any learning required should be recognised and acted upon.

4.2 Recording and reporting an incident or accident

You must fully record and report any incidents that occur. Where service users are involved a full record of the incident should be included in the service user's care record, along with a record of any follow-up action taken. It may be necessary to inform others who are involved in the individual's care, for example their GP or carer. Consent should be sought from the service user to share information, although this is not strictly necessary for those considered to be directly involved in their care.

When reporting, use your organisation's reporting mechanism; for example, an accident/incident book. Some organisations also require the reporting of 'near misses', when an incident almost happens. This allows an organisation to evaluate the event, learn from it and change practice where required.

Check with your employer/organisation with regard to reporting serious events to the Health and Safety Executive, or other organisations, under the *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995* (RIDDOR) (Great Britain. Parliament 1995), or other nations' equivalents. Further advice is available on the Health and Safety Executive website.

4.3 Incident investigation

If an incident or accident occurs, there is likely to be an investigation or follow-up of some sort. This is to ensure that any weaknesses in policy and practice are identified, that learning takes place if necessary, and changes to systems and practice are made when required. In any investigation the service user's care records will be inspected.

As a practitioner you must be able to demonstrate that your intervention is based upon your professional reasoning, which is informed by the data you gather about your service user, recognised theories, frameworks and concepts, national guidance and any available evidence.

> You are able to explain and record your professional reasoning for anything you do for/with or in relation to service users.
>
> (COT 2017, section 1.3)

You have a duty of care to your service users. Your actions, or lack thereof, must not cause harm or loss to them. Your records are your evidence that your professional reasoning and actions have been appropriate and that you have carried out your duties in relation to the assessment and management of any risk. It is vital that your records are completed fully, accurately and in a timely manner. For further information on your duty of care, see section 3.1 of the College's *Code of ethics and professional conduct* (COT 2015, p14). For further information on keeping records see the College's guidance (RCOT 2017a).

> Your records are your evidence that you have met your duty of care within your practice, but the keeping of records is also part of that duty. You may be considered in breach of your duty of care if your records fail to show that you have performed your professional responsibilities to the standard expected of a reasonably skilled occupational therapy practitioner.
>
> (COT 2015, section 3.1.4)

5 Risk enablement at an organisational or service level

To fully embrace risk, organisations need to adopt a culture of personalisation, choice, and greater user and carer empowerment to enable positive risk management.

The principles and process for managing and enabling risk remain the same at all levels of working, whether with service users, organisations or the environment.

5.1 Regulatory and policy context

It is recognised that there may be regulatory differences across the countries of the United Kingdom. The overarching legislation that concentrates on risk assessment and management is the *Health and Safety at Work etc. Act 1974* (Great Britain. Parliament 1974) and the *Management of Health and Safety at Work Regulations 1999* (Great Britain. Parliament 1999). There are also orders and regulations pertinent to individual nations and particular settings which may affect your work.

> You should be aware of and abide by the current legislation, guidance and standards that are relevant to your practice, remaining up to date with relevant training where necessary.
>
> (COT 2015, section 5.1.2)

Under the *Health and Safety at Work etc. Act 1974* (Great Britain. Parliament 1974) you have a general duty to take reasonable care for your own health and safety and that of others who may be affected by what you do, or do not do (COT 2015, section 2.5.4).

The Act uses the term 'so far as is reasonably practicable' referring to the action required to mitigate risk. This means that the time, effort, cost and practicality of taking measures to avoid the risk should be balanced against the degree of risk in any specific situation.

If the risk is more significant, it is reasonable to go to more expense and trouble to reduce it. If the possible likelihood and impact of a risk are small, insistence on great expense would not be considered reasonable.

The Health and Safety Executive (HSE) is the national independent regulator for work-related health, safety and illness. It acts in the public interest to reduce work-related death and serious injury across workplaces in England, Wales and Scotland, alongside the Health and Safety Executive for Northern Ireland (HSENI). As health and social care are devolved matters, the HSE and HSENI work in partnership with different regulators across the UK. The powers, roles, remits and ways of working of each of these regulators are all different.

The HSE/HSENI websites provide information on the main legislation and regulations, highlighting possible changes in legislation as they are considered. The HSE website gives details of the various co-regulators and their roles across England, Scotland and Wales.

5.2 Assessing organisational or service risks

In all cases, where the safety of employees, those who use their services and the public is concerned, it is the overall responsibility of employers or the self-employed to carry out the risk assessment. When the potential risk is to service users, through the work of an employee, the responsibility for carrying out the assessment may be devolved to the employee concerned (see section 2.3).

Although not responsible for carrying out risk assessments, trade union health and safety representatives are trained and accredited to participate in workplace inspections. They can also provide advice and information.

At a broader organisational or service level, your assessment of risk is about ensuring and enabling safe everyday work and practice, for employees, service users and any others who may be affected by the work of the organisation/service. When considering an occupational therapy service, you may need to consider risks arising from risk factors related to:

- The policies, procedures and/or practices of the organisation, the department and/or its personnel, including all therapeutic activity.
- The physical working environment, including the storage, use or provision of rehabilitation/assistive equipment.
- The actions (purposeful, accidental or unpredicted) of people, including staff, service users, their carers and members of the public.

The concept of risk enablement is still relevant at a service level. For example, there are risk factors in an assessment kitchen which may vary according to the needs and capabilities of all those using it and the activities carried out in it; but the occupational and other benefits gained through the use of the kitchen are many. Identifying and managing the risk enables the use of the kitchen. In such a setting, the risk assessment process below may be useful. A detailed set of questions is suggested by McIlwain (2006) under the headings of 'identify', 'analyse' and 'control':

1 **Identify** – What could go wrong? How could that happen? What would be the effect?

2 **Analyse** – How often is this effect likely to occur? How severe would be the effect? What would be the cost of that effect?

3 **Control** – How do you eliminate the risk/effect? How do you avoid the risk/effect? How do you make the risk/effect less likely?

(Adapted from McIlwain 2006, p196 with permission of Radcliffe Publishing)

You may be working at an organisational level without direct contact with service users, for example with responsibility for an equipment store. In such a case the risks that you need to consider may be about systems and processes. In almost all circumstances there is an end user for an organisation. The effective management of risk within the organisation will have the outcome of protecting the end user.

Potential risks can also be identified through data gathering and monitoring. Accident records, incident reports, sickness records and complaints can all highlight patterns of events or particular activities that are shown to be hazardous and potentially harmful at a service or organisational level. It is important that you routinely keep such information, as it will enable you or your organisation to identify possible risks at an early stage and to change your practice if necessary. Where you are making significant changes to existing systems or services, or developing new projects, you will need to gather as much information as possible to inform your decision-making. Consider whether your risk assessment could benefit from a literature/evidence search.

5.3 Managing organisational or service risks

An organisation or service will need a 'whole system' approach to managing risk, where everyone concerned understands and plays their part. This is an ongoing process that should enable you/your organisation to maintain a continuous reasonable level of safety, for yourself and those affected by your service.

First and foremost, you must follow the law. For example, hazardous chemicals must be stored securely according to the *Control of Substances Hazardous to Health Regulations 2002* (Great Britain. Parliament 2002). If local policies and procedures exist, such as fire precautions, then these must be followed. Some risks may be managed by reorganising work practices, work environments and/or providing training or protective equipment.

For less tangible risks, it is worth examining what causes the possible situation to arise. For example, violence and aggression, either verbal or physical, are a significant risk in some fields of work. Verbal aggression may be triggered for a number of reasons, including a perceived or real lack of information, or a feeling of being rushed or not being heard. Practitioners and other staff may reduce these possible precursors by adopting behaviours and communication styles that prevent anger or anxiety, or that can de-escalate situations should they occur. The introduction of communication skills training, alongside other strategies, could be the action taken to try to reduce the potential risk of violence and aggression in a work situation.

There are more general ongoing activities that can enable the management of risk. Many of these are part of maintaining good standards of practice, such as:

- Having clear and consistent policies and procedures, and approaches which are shared and understood by everyone.
- Following evidence-based guidance and protocols.

- Observing good infection control practices, whether in a community, hospital or other setting.
- Keeping comprehensive and timely care records.
- Maintaining good communication to reduce the risk of misunderstanding, but also empower individuals and enable choice.
- Providing continuing professional development to ensure personnel are up to date with knowledge and skills, and aware of best and developing practice.
- Providing support, supervision and performance review systems to allow ongoing monitoring and encouragement of good practice.
- Having information management systems in place to collect and use appropriate data to highlight potential or actual hazards/risk so that they may be positively managed.

5.4 Competence, training and awareness

Appropriate training can be a significant factor in reducing and managing risk, although attendance at a training event does not necessarily ensure future safe working practice. Regular supervision, peer support and advice can also help to embed the knowledge and give confidence.

The *Health and Safety at Work etc. Act 1974* states that employers must provide 'necessary information, instruction, training and supervision' (Great Britain. Parliament 1974, section 2, part 2). This encompasses training to prevent emergencies like fire, but also training that is relevant and necessary for any elements of a job that may entail risk, such as moving and handling.

Section 13 of the *Management of Health and Safety at Work Regulations 1999* (Great Britain. Parliament 1999) similarly states that employers should provide health and safety training for their employees when they are recruited. Further training should be provided at any time when there is a change in the employee's responsibilities, the equipment used, the technology used or a change in systems of work. The same regulations also note that employers should take account of the capabilities of their employees when considering health and safety.

Individual practitioners are personally responsible for ensuring that they remain up to date with their learning, with legislation and guidance (COT 2015, sections 5.1.2 and 5.3 and appendix 2.i). This includes being aware of national events and developments related to safety and safe working practices.

There are a variety of organisations that collate information about adverse incidents and safety across health and social care in the UK. Safety alerts are periodically issued which highlight particular risky or dangerous circumstances, equipment, medicines etc. which practitioners should be aware of. You should be aware of your nation's relevant organisations and systems so that you can remain responsive to any information and guidance.

The Medicines and Healthcare products Regulatory Agency (MHRA) still co-ordinates information across the adverse incident centres in England, Scotland, Wales and Northern Ireland for issues concerning medical device safety. Some pieces of rehabilitation or care equipment are considered to be medical devices, such as moving and handling equipment.

5.5 Embedding risk enablement

In order to embed a risk enablement approach into your service, you may need to secure support from leadership to encourage this way of working. **You will need to develop a culture of embracing risk to enable choice, using the risk enablement process to support service users to enhance their participation and achieve their chosen aims.**

6 Further information and resources

6.1 Community and social care

Social Care Online is a useful knowledge database hosted by the Social Care Institute for Excellence. It is a large resource of information related to community and social care, including risk. Registration is required for full access.
Available at: *http://www.scie-socialcareonline.org.uk/*

6.2 Dementia

Bailey C, Clarke CL, Gibb C, Haining S, Wilkinson H, Tiplady S (2013) Risky and resilient life with dementia: review of and reflections of the literature. *Health, Risk and Society*, *15(5),* 390–401.

Morgan S, Williamson T (2014) *How can 'positive risk-taking' build dementia-friendly communities?* York: Joseph Rowntree Foundation.

Department of Health (2010) *Nothing ventured, nothing gained: risk guidance for people with dementia.* London: DH. Available at: *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215960/dh_121493.pdf*

Shared agreement about risk will not always be possible but it is important that everyone involved in reaching decisions about risk reaches a shared understanding of the viewpoints of all those who are affected by decisions involving risk.

(Department of Health 2010, p9)

It is important to recognise that ideas about risk are personal and are built up over a lifetime; practitioners should try to discuss risk openly and freely with people with dementia and their carers without imposing their own values and ideas.

(Department of Health 2010, p10)

6.3 Employment and recruitment

- **Staffing levels**

  If there are concerns associated with low staffing levels, your priority is to ensure service user safety. Practitioners and service leads need to ensure that their employers/management are aware of any risk concerns and of the approach being taken to minimise them. A formal risk assessment should be carried out to support any discussion.

Consider how staff can be supported in this situation:

- Ensure adequate training, monitoring and support for staff to minimise the risk of things going wrong.
- Provide supervision to give support, maintain open communication and identify struggling performance.
- Maintain good lone working practice if relevant.
- Ensure accurate and comprehensive record keeping. A heavy workload is not acceptable as an excuse for inadequate records if litigation occurs (RCOT 2017a, section 2.1.25).

- **Protecting vulnerable groups**

  Ensure you are aware of the requirements generated by safeguarding legislation when employing people to work with children, young people and other vulnerable individuals. All relevant checks must be made.

- **Employing a person with a disability**

  As an employer you are responsible for the health and safety of all your employees. There is no requirement to carry out a specific, separate risk assessment for a disabled person. If you become aware of a practitioner with a disability, you may need to review your existing risk assessment to make sure it covers risks that might be present for them. Each individual is different and must be considered as such. A 'blanket' response is not appropriate (HSE 2015).

  Consider any reasonable adjustments that will be required to enable the individual with a disability to perform the duties of the job and access any areas or facilities within the environment that are required (Great Britain. Parliament 2010). This includes the facilities and procedures required to make the workplace and all necessary activities safe.

6.4 Equipment/moving and handling

You may assess for, issue and also teach service users, carers or colleagues to use a wide range of equipment and adaptations. It is important to familiarise yourself with any national or local policies or guidance in the use and/or maintenance of equipment, especially in those areas where a detailed risk assessment and enablement plan may be required, for example use of bed rails (MHRA 2013) or bariatric equipment. You must consider the safety and wellbeing of the service user and any others involved in their care. Your risk assessment and enablement plans must consider the needs of all those involved. Further information is available from the College's briefing on equipment (RCOT 2017b).

When providing moving and handling or mobility equipment you will need to consider the aims and choices of the individual and the benefits they can gain from the use of any equipment, enabling them to manage any risks involved. It is vital that the correct equipment and methodology is used and full information and training are given to those involved. The HSE website gives details of risk assessment considerations when moving and handling, including dealing with falls, should they occur.

> Your records stand as evidence that you have carried out your duty of care; that you have acted on the basis of your assessment and your professional judgement. You must be able to demonstrate that you have provided adequate information.
>
> (RCOT 2017a)

The regulatory bodies for the safety of service users in situations such as the use of moving and handling equipment varies across the UK. Ensure you are aware of the requirements relevant to your field and location of practice. Further information on who regulates health and social care is available at: *http://www.hse.gov.uk/healthservices/arrangements.htm*

The Medicines and Healthcare products Regulatory Agency (MHRA) monitors and advises on the safety of equipment that is considered a 'medical device'. This includes rehabilitation and mobility equipment. The MRHA information is now available from the GOV.UK website.

For further information concerning moving and handling, please see the Health and Safety Executive and the Royal College of Occupational Therapists' websites.

6.5 Lone working/personal safety

Working alone does not automatically imply being more at risk, but it is worth considering any additional systems or processes required to ensure safe working, and the actions necessary to manage an incident should it occur. The responsibility for ensuring the safety of lone workers sits with the employer, although the worker has the responsibility to take reasonable care of themselves.

If you are working off-site or in non-clinical areas, you may be around other workers, but they may not work for the same organisation or to the same incident management procedures. When any service is set up in such circumstances, an agreed system must be put in place to guarantee an assured response to an alarm call.

The following are all guides on lone working written by various organisations:

- Health and Safety Executive (2013) *Working alone: health and safety guidance on the risks of lone working*. London: HSE. Available at: *http://www.hse.gov.uk/pubns/indg73.pdf*
- NHS Employers (2013) *Improving safety for lone workers: a guide for managers.* London: NHS Employers. Available at: *http://www.nhsemployers.org/~/media/Employers/Documents/Retain%20and%20improve/Managers%20guide_Le0882_3.pdf*

- UNISON (2009) *Working alone: a health and safety guide on lone working for safety representatives.* London: UNISON. Available at: *https://www.unison.org.uk/content/uploads/2013/06/On-line-Catalogue178763.pdf*

6.6 Mental health

There are numerous resources concerning risk assessment and enablement in the mental health setting.

In 2014 the Centre for Mental Health published a paper called *Risk, safety and recovery* (Boardman and Roberts 2014). This argues that traditional clinical management methods of assessing risk have stood in the way of helping people recover their lives, and that mental health services can manage risk more effectively by involving service users in planning for safety.

The Social Care Institute for Excellence website (Social Care Online) has a number of papers and resources related to risk and mental health. Registration is required. Available at: *http://www.scie-socialcareonline.org.uk/*

Other publications that may be useful include:

- Royal College of Psychiatrists (2008) *Rethinking risk to others in mental health services: final report of a scoping group.* (College Report 150). London: Royal College of Psychiatrists. Available at: *https://www.rcpsych.ac.uk/pdf/CR150%20rethinking%20risk.pdf*
- Department of Health (2007a) *Best practice in managing risk: principles and evidence for best practice in the assessment and management of risk to self and others in mental health services*. London: DH. Available at: *https://www.gov.uk/government/publications/assessing-and-managing-risk-in-mental-health-services*
- Langan J, Lindow V (2004) *Living with risk: mental health service users and their involvement in risk assessment and management*. Bristol: The Policy Press. Available at: *https://www.jrf.org.uk/report/mental-health-service-users-and-their-involvement-risk-assessment-and-management*

6.7 Research

> *Research can involve an element of risk, both in terms of return on investment and sometimes for the safety and well-being of the research participants. Proper governance of research is essential to ensure the public can have confidence in, and benefit from, quality research in health and social care.*
>
> (DH 2005, section 1.1).

It is essential that, as a researcher, you conduct a risk assessment as part of the development of your research proposal. If there are potential risks, you must identify how those risks will be minimised. Any risks must be in proportion to the potential benefit of the research and explained clearly to the research participant, but the 'rights, safety and well-being of the research participant prevail over the

interests of science and society' (Health Research Authority 2015, section 7.1). Application forms for ethical approval will require you to provide details about assessed risks and their management.

The RCOT has a number of research resources on its website, including the RCOT *Project ethics policy* (RCOT 2017c). This gives advice about research governance and links to further relevant organisations and resources. Members are expected to adhere to this policy when working as a part of RCOT branches. Available at: *https://www.rcot.co.uk/practice-resources/research-resources*

Other publications that may be useful include:

- Health Research Authority (2017) *UK policy framework for health and social care research*. [London]: HRA. [Unpublished]. (Issued for comment. Version 3.2 October 2017). Available at: *https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/*
- UK Research Integrity Office (2009) *Code of practice for research: promoting good practice and preventing misconduct.* London: UKRIO. Available at: *http://ukrio.org/wp-content/uploads/UKRIO-Code-of-Practice-for-Research.pdf*
- Department of Health (2005) *Research governance framework for health and social care.* 2nd ed. London: DH. Available at: *https://www.gov.uk/government/publications/research-governance-framework-for-health-and-social-care-second-edition*

Practitioners are advised to be aware of any national or local governance policies, frameworks or guidance in their place or field of work.

6.8 Workplace violence

The HSE defines work-related violence as: 'Any incident in which a person is abused, threatened or assaulted in circumstances relating to their work' (HSE 2004, section 17). Health and safety law applies to risks from violence, just as it does to other risks from work.

Following a European social partner agreement, a number of UK organisations combined in 2009/10 to produce a guide about *Preventing workplace harassment and violence*. It provides bullet point steps to prevent, identify and manage problems of harassment and violence in the workplace:

- Advisory, Conciliation and Arbitration Service; Great Britain. Department for Business, Innovation and Skills; Confederation of British Industry; Health and Safety Executive, Partnership of Public Employers; Trades Union Congress (2010) *Preventing workplace harassment and violence: joint guidance implementing a European social partner agreement.* London: ACAS; BIS; CBI; HSE; PPE; TUC. Available at: *http://www.workplaceharassment.org.uk/wp-content/uploads/2009/11/HRE_100_ Guidance_report.pdf*

Other publications that may be useful include:

- Health and Safety Executive (2006) *Violence at work: a guide for employers*. London: HSE. Available at: *http://www.hse.gov.uk/pubns/indg69.pdf*
- UNISON (2013) *It's not part of the job: a health and safety guide on tackling violence at work.* London: UNISON. Available at: *https://www.unison.org.uk/content/uploads/2013/07/On-line-Catalogue216963.pdf*

References

Advisory, Conciliation and Arbitration Service; Great Britain. Department for Business, Innovation and Skills; Confederation of British Industry; Health and Safety Executive, Partnership of Public Employers; Trades Union Congress (2010) *Preventing workplace harassment and violence: joint guidance implementing a European social partner agreement.* London: ACAS; BIS; CBI; HSE; PPE; TUC. Available at: *http://www.workplaceharassment.org.uk/wp-content/uploads/2009/11/HRE_100_Guidance_report.pdf*

Bailey C, Clarke CL, Gibb C, Haining S, Wilkinson H, Tiplady S (2013) Risky and resilient life with dementia: review of and reflections of the literature. *Health, Risk and Society*, *15(5),* 390–401.

Barry M (2007) *Effective approaches to risk assessment in social work: an international literature review*. Edinburgh: Scottish Executive.

Boardman J, Roberts G (2014) *Risk, safety and recovery*. (Implementing Recovery through Organisational Change Briefing). London: Centre for Mental Health. Available at: *https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=6461ca23-6a96-493b-a7c4-0411892ca6ef*

College of Occupational Therapists (2017) *Professional standards for occupational therapy practice.* London: COT. Available at: *https://www.rcot.co.uk/sites/default/files/COT-Professional-Standards_0.pdf*

College of Occupational Therapists (2015) *Code of ethics and professional conduct.* London: COT. Available at: *https://www.rcot.co.uk/sites/default/files/CODE-OF-ETHICS-2015_0.pdf*

College of Occupational Therapists (2013) *Living well through activity in care homes: the toolkit*. London: COT. Available at: *https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/living-well-care-homes*

Department of Health (2010) *Nothing ventured, nothing gained: risk guidance for people with dementia.* London: DH. Available at: *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215960/dh_121493.pdf*

Department of Health (2007a) *Best practice in managing risk: principles and evidence for best practice in the assessment and management of risk to self and others in mental health services*. London: DH.

Department of Health (2007b) *Independence, choice and risk: a guide to best practice in supported decision making*. London: DH.

Department of Health (2005) *Research governance framework for health and social care.* 2nd ed. London: DH.

Gallagher A (2013) Risk assessment: enabler or barrier? *British Journal of Occupational Therapy, 76(7),* 337–339.

Great Britain. Parliament (2016) *Mental Capacity Act (Northern Ireland) 2016*. London: Stationery Office.

Great Britain. Parliament (2010) *Equality Act 2010*. London: Stationery Office.

Great Britain. Parliament (2005) *Mental Capacity Act 2005.* London: Stationery Office.

Great Britain. Parliament (2002) *Control of Substances Hazardous to Health Regulations 2002*. London: Stationery Office.

Great Britain. Parliament (1999) *Management of Health and Safety at Work Regulations 1999.* (SI 1999 No. 3242)*.* London: Stationery Office.

Great Britain. Parliament (1995) *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995.* London: HMSO.

Great Britain. Parliament (1983) *Mental Health Act 1983.* London: HMSO.

Great Britain. Parliament (1974) *Health and Safety at Work etc. Act 1974*. London: HMSO.

Health and Care Professions Council (2016) *Standards of conduct, performance and ethics*. London: HCPC.

Health and Care Professions Council (2013) *Standards of proficiency: occupational therapists.* London: HCPC.

Health and Safety Executive (2015) *Health and safety for disabled people and their employers.* London: HSE. Available at: *http://www.hse.gov.uk/disability/*

Health and Safety Executive (2014) *Risk assessment: a brief guide to controlling risks in the workplace*. London: HSE. Available at: *http://www.hse.gov.uk/pubns/indg163.pdf*

Health and Safety Executive (2013) *Working alone: health and safety guidance on the risks of lone working*. London: HSE. Available at: *http://www.hse.gov.uk/pubns/indg73.pdf*

Health and Safety Executive (2006) *Violence at work: a guide for employers*. London: HSE. Available at: *http://www.hse.gov.uk/pubns/indg69.pdf*

Health and Safety Executive (2004) *Work-related violence*. London: HSE. Available at: *http://www.hse.gov.uk/violence/index.htm*

Health Research Authority (2017) *UK policy framework for health and social care research*. [London]: HRA. [Unpublished]. (Issued for comment. Version 3.2 October 2017). Available at: *https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/*

Langan J, Lindow V (2004) *Living with risk: mental health service users and their involvement in risk assessment and management*. Bristol: The Policy Press.

McIlwain JC (2006) A review: a decade of clinical risk management and risk tools. *Clinician in Management, 14(4),* 189–199.

Medicines and Healthcare products Regulatory Agency (2013) *Safe use of bed rails*. London: MHRA. Available at: *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/422784/Safe_use_of_bed_rails.pdf*

Morgan S, Williamson T (2014) *How can 'positive risk-taking' build dementia-friendly communities?* York: Joseph Rowntree Foundation.

NHS Employers (2013) *Improving safety for lone workers: a guide for managers.* London: NHS Employers. Available at: *http://www.nhsemployers.org/~/media/Employers/Documents/Retain%20and%20improve/Managers%20guide_Le0882_3.pdf*

Royal College of Occupational Therapists (2017a) *Keeping records: guidance for occupational therapists.* London: RCOT. Available at: *https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/keeping-records*

Royal College of Occupational Therapists (2017b) *Equipment.* London: RCOT. Available at: *https://www.rcot.co.uk/practice-resources/occupational-therapy-topics/moving-and-handling*

Royal College of Occupational Therapists (2017c) *Project ethics policy.* London: RCOT.

Royal College of Psychiatrists (2008) *Rethinking risk to others in mental health services: final report of a scoping group.* (College Report 150). London: Royal College of Psychiatrists. Available at: *https://www.rcpsych.ac.uk/pdf/CR150%20rethinking%20risk.pdf*

Scotland. Scottish Executive (2000) *Adults with Incapacity (Scotland) Act 2000*. Edinburgh: Stationery Office.

Social Care Institute for Excellence (n.d.) *Social Care Online*. London: Social Care Institute for Excellence. Available at: *http://www.scie-socialcareonline.org.uk/*

UK Research Integrity Office (2009) *Code of practice for research: promoting good practice and preventing misconduct.* London: UKRIO.

UNISON (2013) *It's not part of the job: a health and safety guide on tackling violence at work.* London: UNISON. Available at: *https://www.unison.org.uk/content/uploads/2013/07/On-line-Catalogue216963.pdf*

UNISON (2009) *Working alone: a health and safety guide on lone working for safety representatives.* London: UNISON. Available at: *https://www.unison.org.uk/content/uploads/2013/06/On-line-Catalogue178763.pdf*

All websites accessed on 19.09.17.

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Keeping Records

Guidance for occupational therapists

Third Edition

Royal College of Occupational Therapists

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The Royal College of Occupational Therapists is a wholly owned subsidiary of the British Association of Occupational Therapists (BAOT) and operates as a registered charity. It represents the profession nationally and internationally, and contributes widely to policy consultations throughout the UK. The College sets the professional and educational standards for occupational therapy, providing leadership, guidance and information relating to research and development, education, practice and lifelong learning. In addition, 11 accredited specialist sections support expert clinical practice.

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1 Introduction

Keeping records is an integral part of the practice of all practitioners in health, social and community care, education and research. It is an absolute requirement as part of your duty of care, and must be completed in line with relevant legislation, the standards of your registration and professional bodies, and local policy.

Your records primarily support and enable the provision of care to the service user, but they also demonstrate that you have carried out your responsibilities in line with legal, professional and local requirements. Care records are legal documents and may be used as evidence in an enquiry or court of law.

For the purposes of this guidance, the records kept by occupational therapy practitioners are called 'care records' and encompass those kept in all settings. People who receive occupational therapy services are called 'service users'. This term encompasses all ages, groups and communities of people, and is applicable in all settings. Other terms may be used in quotations. The Royal College of Occupational Therapists may also be referred to as the RCOT.

You are advised to use this guidance in conjunction with the *Professional standards for occupational therapy practice* (COT 2017) and the *Code of ethics and professional conduct* (COT 2015a).

1.1 Keeping records as part of your duty of care

> *A duty of care arises where there is a sufficiently close relationship between two parties … and where it is reasonably foreseeable that the actions of one party could, if carelessly performed, cause harm or loss to the other party. Discharging your duty of care requires you to perform your occupational duties to the standard of a reasonably skilled and careful practitioner.*
>
> (COT 2015a, section 3.1)

Your records are your evidence that you have met your duty of care within your practice, but the keeping of records is also part of that duty. It is reasonably foreseeable that your record-keeping, if carelessly done, could cause harm or loss to those for whom you provide a service.

You may be considered in breach of your duty of care if your records fail to show that you have performed your professional responsibilities, including record-keeping itself, to the standard expected of a reasonably skilled occupational therapy practitioner (COT 2015a, section 3.1.4). This guide defines certain key requirements for keeping records and explains some of the rationale that underlies them.

1.2 What constitutes a care record?

Care records include any material that holds information regarding an individual, collected as part of their care provision. Such material can be handwritten, digital, auditory or visual, and would include data held on a computer, a tablet or mobile phone. It would include images, auditory or visual recordings, forms, letters, notes, diary entries, emails, text messages and duplicate copies.

1.3 The purpose of care records

Care records serve many purposes. They are primarily a history of the assessment, decision-making, planning and care provided for a service user, along with the outcomes of that care. They may highlight problems and changes in a service user's condition. They are a record of the service user's objectives, preferences and choices, along with their consent to any intervention on their behalf. They protect the welfare of the service user by supporting high-quality, evidence- and rationale-based care, continuity of care and good communication between all those involved.

On a wider scale, the data recorded may be used for auditing practice and outcomes, service planning and business decision-making. They may also provide documentary evidence in an investigation or court of law.

Care records are also your evidence of good, safe and effective practice, especially should your work ever be questioned. They define and explain the work that you do as an occupational therapy practitioner in your particular role.

1.4 Legislation, standards and policy related to keeping records

This guidance does not name every piece of relevant legislation, recognising that many differ across the four UK countries. It will only identify and discuss some of the more universal pieces of legislation that apply to keeping records across the UK.

You are expected to be familiar and comply with any UK or national legislation, policies and best practice standards, along with employers' policies and procedures that are relevant to your own field of practice, setting and country of practice. This includes compliance to local policy and legislation around cultural identity and language needs.

If you are an independent practitioner, you are advised to put in place your own policies which are compatible with legislation, your professional standards and standard practice.

If you are concerned that your local policy, or any local action that you witness, is causing you to fall short of your legal and professional duties in keeping records, or that it puts the welfare of service users, yourself or your colleagues at risk, you must raise this with your employer. Keep a record of your concerns. You are advised to contact your local union representative and the Royal College of Occupational Therapists' Professional Practice Enquiries Service in such situations, as each may be able to advise you.

Guides, standards and codes of practice set down by professional and regulatory bodies, and at a local level, aim to provide a structure and a universal standard for safe and good working practice. They are not in themselves legally binding, but a failure to follow this recommended practice, it could be argued, may constitute negligence or a breach of your duty of care (Lynch 2009, p10).

1.4.1 *Data Protection Act 1998*

The *Data Protection Act 1998* (Great Britain. Parliament 1998a), which applies throughout the United Kingdom, concerns the right of a living person to privacy in respect of personal information. The Act applies to personal data being processed either manually or digitally. It includes film, photography and material recorded in other media. It applies to data held, or planned to be held, on computers or in a 'relevant filing system'. Defining a 'relevant filing system' can be difficult, but if your information is structured in such a way that specific information relating to a particular individual is readily accessible, it would be considered as a relevant filing system.

Contact details stored on a mobile phone, or identifiable addresses on a satnav system, would both constitute filing systems and must meet the requirements of the *Data Protection Act 1998*.

The Act imposes a responsibility on anyone who generates, uses or stores personal information to abide by eight Data Protection Principles. The Principles set down a framework for the lawful processing of such personal data.

The Information Commissioner's Office (ICO) has an online *Guide to data protection* (ICO 2017). This provides definitions for all terms in the Act and explains in detail the requirements of the Act. It is available to download from the Information Commissioner's Office website.

Personal information that is accessible would include:

- a health record that consists of information about the physical or mental health or condition of an individual, made by or on behalf of a health professional (another term defined in the Act) in connection with the care of that individual;
- an educational record that consists of information about a pupil, which is held by a local education authority or special school (see Schedule 11 of the Act for full details); or
- an accessible public record that consists of information held by a local authority for housing or social services purposes (see Schedule 12 for full details).

(ICO 2017, p5)

The Act regulates the processing of information.

> *Processing, in relation to information or data, means obtaining, recording or holding the information or data or carrying out any operation or set of operations on the information or data.*
>
> (ICO 2017, p8)

In the private sector or industry, records continue to be viewed as personal data and come under the requirements of the *Data Protection Act 1998* (Great Britain. Parliament 1998). Independent practitioners, or the bodies for which they work, are responsible for the records that they develop and hold, and should have systems in place which meet the requirements of the Act.

1.4.2 *Human Rights Act 1998*

The *Human Rights Act 1998* (Great Britain. Parliament 1998b) implements the provisions of the *European Convention on Human Rights* (ECHR) (Council of Europe 1950). Article 8 of the ECHR ensures respect for a person's private and family life. Disclosure of personal information would be a breach of that right unless it was 'in accordance with the law', necessary 'in a democratic society for a legitimate aim (in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others), and proportionate' (House of Lords and House of Commons, Joint Committee on Human Rights 2008).

1.4.3 Mental health and mental capacity legislation

All occupational therapy practitioners will, at times, work with people who have mental health conditions, so should be aware of their duties with regard to mental health legislation (Great Britain. Parliament 1983, 2005, 2007). This is perhaps most pertinent with respect to capacity and consent, along with deprivation of liberty and safeguarding. Practitioners working with service users specifically subject to mental health legislation must ensure that they have a good working knowledge of the relevant law. Further information on recording consent and capacity can be found in section 2.1.2.

1.4.4 The Health and Care Professions Council requirements

The Health and Care Professions Council (HCPC) requires you to 'keep full, clear, and accurate records for everyone you care for, treat, or provide other services to', and that 'you must complete all records promptly and as soon as possible after providing care, treatment or other services' (HCPC 2016, section 10).

You must also 'be able to keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols and guidelines' (HCPC 2013, section 10.1). HCPC clearly states that your records must demonstrate your clinical reasoning, in that you must 'be able to make reasoned decisions to initiate, continue, modify or cease treatment or the use of techniques or procedures, and record the decisions and reasoning appropriately' (HCPC 2013, section 4.2).

The HCPC sees failures in keeping records as misconduct and/or a lack of competence. When activity on behalf of a service user is not recorded, it cannot be shown to have happened, therefore the practitioner may be considered as unfit or unsafe to practise. Poor record-keeping may be an indicator of a practitioner who is struggling in terms of their knowledge and skills, their attitude and confidence, or perhaps their personal wellbeing.

Case notes from HCPC occupational therapists' final hearings identify record-keeping shortfalls in detail. It has been noted when records:

- are incomplete or not made;
- are not clear and concise;
- use wrong terminology and clinical terms;
- are not completed in a timely manner;
- do not document clinical [professional] reasoning;
- demonstrate poor completion of assessments;
- do not identify goals, interventions and outcomes;
- do not link interventions to care plans;
- give no indication of whether plans have been carried out or goals met;
- do not record risk assessments and actions taken;
- do not record meetings or communication with others; and
- do not identify referrals made.

(HCPC ca. 2016)

1.4.5 Your professional requirements

As with the HCPC standards, the Royal College of Occupational Therapists' *Professional standards for occupational therapy practice* (COT 2017) provide statements which capture the over-riding requirements for your record-keeping (see below). You will need to look at each statement and consider what it would take, in terms of your practice and your workplace, to meet each of these.

7. You keep care records that are fit for purpose and process them according to legislation.

7.1 You provide a comprehensive, accurate and justifiable account of all that you plan or provide for service users.

7.2 You record the evidence and rationale for all that you do.

7.3 Your care records are written promptly, as soon as practically possible after the activity occurred.

7.4 You are aware of and meet all requirements in relation to record keeping, whether in legislation, guidance or policies.

7.5 You comply with any legal and professional confidentiality, the sharing of information and service user access.

7.6 You keep your records securely, retain and dispose of them according to legal requirements and local policy.

(COT 2017, standard statement 7)

1.5 Competence and delegation

The Royal College of Occupational Therapists, *Code of ethics and professional conduct* states that:

> *You should be aware of and abide by the current legislation, guidance and standards that are relevant to your practice, remaining up to date with relevant training where necessary.*
>
> (COT 2015a, section 5.1.2)

This means that you must ensure that all care records that you create or use meet legal, national and/or local requirements. You should have access to appropriate training, professional guidance and support where and when necessary.

It also states that:

> *If you delegate interventions or other procedures you should be satisfied that the person to whom you are delegating is competent to carry them out. In these circumstances, you, as the delegating practitioner, retain responsibility for the occupational therapy care provided to the service user.*
>
> (COT 2015a, section 5.2)

If you supervise staff, delegating tasks and responsibilities to them, it is your responsibility to ensure that they are competent to carry out those tasks. This includes the keeping of records. Where they need additional help or guidance in record-keeping, it is your responsibility to provide this or arrange for it to be provided.

If you have a student, or new/inexperienced member of staff, you may take on some responsibility for teaching them good record-keeping practices. This may require you to directly oversee their record entries until such a time as they are deemed competent to carry them out unsupervised. You do not need to countersign entries unless your local policy requires this (see section 2.1.16).

If you are a student on placement and you are unsure of your record-keeping skills, you need to seek out guidance and support. This does not necessarily need to come from an occupational therapist, if one is not present. Use this published guidance alongside the support provided by other professionals in your location.

2 Records that are fit for purpose

Occupational therapists need to be able to show all that they have done for, with or in relation to a service user, including the clinical reasoning behind the occupation-focused care planning and provision. They also need to be able to demonstrate the outcomes of the care that they have provided, not only for the benefit of the service user and others in the care team with access to the records, but also as a testament to the value of occupational therapy.

When you consider the requirements of the HCPC and RCOT standards, there are key words that identify the necessary elements of quality which are required. Every service user with whom you have contact must have records that are:

- full/comprehensive;
- clear/comprehensible;
- accurate;
- promptly completed;
- demonstrating your clinical reasoning and evidence;
- compliant with legislation, guidance and policy on completion, confidentiality, sharing and service user access; and
- securely stored and suitably disposed of.

2.1 Requirements for best practice

To ensure that you meet legal, professional and registration body requirements, you are advised to take account of the following points.

2.1.1 Service user identifiers

The use of a consistent and unique identifier assists in the delivery of safe integrated care, data sharing and integrated digital care record systems.

A unique service user identifier should be used in all care records in all settings and in all UK countries. All information included in the care record should be identified by the service user's name, date of birth and unique identifier. You are advised to follow local policy.

2.1.2 Recording capacity and consent to intervention

The Royal College of Occupational Therapists' *Code of ethics and professional conduct* states that:

> *Informed consent is a continuing requirement. Unless restricted by mental health and/or mental capacity legislation, it is the overriding right of any individual to decide for himself (herself) whether or not to accept intervention.*
>
> *A service user can only give informed consent if he or she has the mental capacity to do so … You must assess service users' mental capacity to make decisions in relation to occupational therapy provision, in accordance with current legislation.*
>
> (COT 2015a, section 3.3)

Informed consent is when a person gives consent, or agrees to a course of action, based on a clear understanding of the information given, and the implications and consequences of the proposed action.

When seeking consent, it is presumed that a person has capacity and does not have to prove otherwise. Capacity would only need to be assessed when a person is unable to make a decision at a specific time, because their mind is affected by illness or disability. It is understood that capacity is a fluctuating state and may need to be re-assessed.

The *Mental Capacity Act 2005* (Great Britain. Parliament 2005) enables those in health and social care to carry out capacity assessments. If you are unsure of your ability to do this, seek guidance and suitable training from your employer.

This guidance is not about how to assess capacity, but the importance of recording your assessment and its outcomes. If you think that an individual lacks capacity, you need to be able to demonstrate it. Your records should show that it is more likely than not that the person lacks the capacity to make a specific decision at the time that they need to. You should document how the service user's capacity was assessed and whether any lack of capacity is considered permanent or temporary. You must be able to record the rationale for any actions or recommendations taken following your assessment. Your records are your evidence of this and how any further action taken is in the individual's best interests. You should follow your local policies and procedures.

Your records need to demonstrate that you have provided enough information about your proposed intervention or action, including all options and possible risks. You need to ensure that this has been understood by the service user in order to make an informed and valid decision, whether to give or refuse consent. You should also record the form in which consent is given, whether verbal, non-verbal or signed. If the gaining of consent is not recorded, you cannot state that consent was given.

The nature and degree of any risks must be documented: it is not enough to write, 'advised of risks'. It should be immediately clear to any other person reading the records what information has, or has not, been given to the service user, along with any specific requests or concerns raised by the service user.

Where valid consent is refused or withdrawn you must respect this and record it in the records, while informing the service user of any possible risks or consequences of their decision.

Signed consent is only necessary where there is a greater risk to the service user, or your proposed intervention may have significant consequences for the service user's employment, personal or social life (General Medical Council 2017). Where consent forms are used, be aware that they must enable you to enter all the necessary information.

2.1.3 Deprivation of liberty safeguards

The deprivation of liberty safeguards (DoLS) in England and Wales set out a framework whereby a person who lacks capacity to consent can be provided with care in a way that amounts to a deprivation of liberty. This can only happen if it is absolutely necessary and can only be done following a defined process. Your local authority will have guidance on the DoLS and your local processes to follow.

As a practitioner, you need to be aware when your practice may be affected by the DoLS and what you may need to do to be compliant. Seek training if you are unsure of your responsibilities. Your records must demonstrate your reasoning and the evidence upon which you make your judgements. If you are stating that a certain course of action, perhaps using particular equipment which will restrict liberty, is in the best interests of the service user, you must be able to justify this.

The Social Care Institute for Excellence (SCIE) website provides comprehensive guidance on deprivation of liberty safeguards for England and Wales (SCIE 2011). Scotland and Northern Ireland are developing similar legislation.

2.1.4 Comprehensive records

A court of law will adopt the approach that 'if it is not recorded, it has not been done, has not been considered, or was not said' (Lynch 2009, p 45). A record of all occupational therapy activity should be kept, including everything that is planned, done or occurs with, or on behalf of, your service users. You should also record your professional or clinical reasoning. All communication and information relevant to the individual's care, given and received, must be recorded.

You need to record the outcome of your practice, which means you need to identify the status of the service user and how it changes. This might include problems and any actions taken to resolve them.

> *If it is not recorded, it has not been done, has not been considered, or was not said.*
>
> (Lynch 2009, p45)

A practitioner does not record details of the equipment safety information provided to a service user. An accident occurs. How does the practitioner prove that information was provided?

Your records should not contain material that is of no value to the care of the individual, such as speculation, subjective statements or personal opinions.

2.1.5 The occupational therapy process

When you look at the faults in record-keeping highlighted in HCPC cases (see section 1.4.4), you can see how important it is to follow through and record each stage of the occupational therapy process. Should another person be required to read your records, they should be able to identify the process that you have gone through and why. Keeping this process in mind will help you to demonstrate that you have performed your professional responsibilities to the standard expected of a reasonably skilled occupational therapy practitioner.

Your records are the evidence that you: understand and can properly use, record and interpret assessments; that you have agreed the service user's objectives; that you have planned intervention based on the assessments, the service user's objectives, available evidence and sound professional judgement; and that the outcomes of your intervention have been evaluated.

If you are in a diverse setting where keeping records is not common practice, you must still keep a record of your activity and the rationale for your actions, even if you do not have direct contact with service users. Use the occupational therapy process to structure your actions and your record-keeping. It provides a guide for the format and content of your records.

> You may be a student on placement with a private fitness company. You are asked to look at the equipment with a view to its use by people with learning disabilities. Your records can follow through your information gathering, your assessment, your evaluation and professional reasoning, your planning, actions or recommendations, the outcome and review.

Always consider the purpose of your records in terms of the service user/s, your employer/organisation/business and yourself. Are you fulfilling your duty of care and meeting your standards as a registered professional?

2.1.6 Professional/clinical reasoning

You are required to record why you have chosen to carry out, or perhaps not carry out, a particular task or activity with, or on behalf of, a service user. You will probably be carrying out professional reasoning in your mind continually, for example, selecting suitable activities or equipment based on your assessments. You must record this process in your records so that your choice of actions is justified should it ever be questioned.

2.1.7 Evidence-based care

Care records should show that the care provided is appropriate, in accordance with current best practice of the time and based on evidence, where evidence is available. There is a benefit to following national, professional or local guidelines, procedures, or care pathways, etc. because the evidence base is integral to them and will be demonstrated in the record, but any variance must be explained.

2.1.8 Official or unofficial discussions concerning a service user

Whenever a service user is discussed, in a team meeting, in the course of a phone call or even in an unplanned situation, the occurrence, the content and any outcomes of the discussion should be recorded in the care records.

Decisions made in a team meeting, or as part of supervision, concerning the care provided to an individual can be seen as part of the care process. Such decisions need to be recorded.

2.1.9 Frequent and repetitious activities or standard practice

Where activities are frequent and repetitious, it is tempting to think that minimal or no records are required. However, legally, if an activity is not recorded, it cannot be proven to have occurred. All activity should be recorded fully, including the activity, the rationale for it, the service user's response and any other outcomes.

You must always record what you do for every service user, even if it is standard or routine practice. If you do not, you have no evidence that the action was done.

> Perhaps you always refer the service user to the social worker for a follow-up assessment. What if no further action occurred, but you have no record of your referral? The responsibility would be seen to remain with you.

2.1.10 Service user non-attendance

If a service user is unable to attend an appointment, or if a planned intervention does not occur, this should be recorded in the care records, with an explanation. Including this in the record demonstrates that the therapist's planning and care was disrupted for unavoidable reasons, rather than being withheld, or not provided, because of disorganisation or incompetence.

2.1.11 Information provided to the service user

Any verbal or printed information or advice given to the service user or their carer(s) should be appropriately recorded. It is not enough to write 'Advice given'; the nature and level of information given should be documented.

2.1.12 The source of information about a service user or their circumstances

It is important to record the source of any information gathered about the service user, especially if the accuracy of the information is uncertain, or circumstances around the individual's care change. The information about the service user may have come from medical notes, another professional's notes, from a carer or member of the family, or from the service user him or herself.

If you are given information by a third party, you must record the source, worded as 'reported by xxxxxx', giving their full name and job title/role, with their contact details if possible. Choose your wording carefully. You do not know it to be fact, but you need to make others aware, especially if there may be risk involved. Remember it could be challenged by the service user.

You might record:

Mary Jones, Social Worker (Tel 222 2222) reported that Mr X said he has not been taking his medication for the last week. Mary Jones reported that he appeared restless, agitated and unkempt.

2.1.13 People present

There may be times when the occupational therapist sees the service user when others are present (for example, students, colleagues, family members).

The service user's consent should be sought for this. Having others present may have an effect upon the nature of the care given; the conversation held, if confidentiality is a concern; or it may have an impact on the effectiveness of care.

2.1.14 Legibility

Written care records need to be legible in order to be safe and of any use. If care is delayed, miscommunication occurs, or a service user is ultimately harmed because your handwriting is illegible, you could be accused of professional negligence and be held liable as a result.

2.1.15 The use of acronyms and abbreviations

There is published evidence that a significant proportion of the acronyms used are either ambiguous or poorly understood, with many misinterpretations of the abbreviations across professions, posing imminent risk (Parvaiz et al 2008, Rees 2013).

The Nursing and Midwifery Council (NMC ca. 2015, section 10.4) and the *Record keeping guidelines* (NHS Professionals 2010, section 1.10) state that abbreviations should not be used in care records. This said, it is common practice. Some key organisations, for example NHS Digital, have produced online glossaries for acronyms to attempt a common use and understanding (NHS Digital ca. 2016).

It is vital that all members of a care team can read and correctly understand the care records. Service users are entitled to access their records upon request and should be able to read and understand what is written in them. It should also be recognised that terms and acronyms may change over time and that these differ across service providers.

If you continue to use acronyms, the meaning must be unambiguous. Practitioners within services or teams should use a limited number of acronyms or abbreviations and should ensure that these are defined in full within each set of care records. This should be monitored and enforced.

2.1.16 Signing and countersigning record entries

When you sign a care record, or an entry is made into a digital record system under your access code/password, you are confirming that it is an accurate account of any communication, planning, intervention or outcomes related to the care of an individual service user. Unless otherwise indicated, you are identifying yourself as the individual responsible for the action(s) defined in the record and for the entry itself. Thus the person who carries out the intervention should be the person who writes/enters the record and signs the entry.

Your signature should be legible. It is essential that you are clearly and easily identifiable. Anyone making an entry to the records should be identifiable to another person reading the records at a later date. You should sign and print your name and give your designation when completing written entries, additions and amendments to records.

If using digital records, each practitioner should have their own access code/password on the system. This should never be used by another practitioner. Local procedures should be in place for students and temporary staff.

Occupational therapists should know and follow their local policy on countersigning records. Unless local policy differs, you are not required to countersign records created by occupational therapy students or therapy assistants, but you are responsible for ensuring the competence of any practitioner before you delegate any task to them, which includes keeping records (see section 1.5).

2.1.17 Timing and dating record entries

As with any aspect of care provided to an individual, the day and time that it occurred is important. Recording the date and time of an event demonstrates that your care was appropriate and as planned. It also enables monitoring of the frequency of care and the timeframe for the progress, or deterioration, of the service user. Should the care provided be examined at a later date, the time and date of an event may be a vital piece of evidence.

The date should be given in full, including the day, month and year. The time should define morning or afternoon. The time and date given should reflect when the service user was seen, or an event occurred. If records are written retrospectively, the time must be given when the service user was actually seen, and a time and date given when the record was entered.

2.1.18 Amending a record

A record can only be amended if there is an error. Inaccurate records can be amended but must not be deleted or destroyed.

If you disagree with another professional's recording, it is suggested that you discuss this with the person, raising your concerns and giving your rationale. You must not change or delete another person's records for any reason, unless you know and can justify that they are factually inaccurate.

Where the information given is inaccurate in written records, the material that is incorrect should be scored out with a single line, then signed, timed and dated by the person who made the amendment. The original entry must remain and be clear to read. Similarly, a digital system should allow you to add to, or be re-directed from, any section which is shown to be inaccurate. Information should never be completely erased from a digital record, or over-written, but the system should automatically keep an audit trail of any changes: what was changed, when and by whom. The reason for the amendment should be given, for example, if the patient's date of birth was entered incorrectly.

Under the *Mental Health Act 1983* (Great Britain. Parliament 1983), there are limitations on what may be amended in mental health records, and errors may only be changed in specific circumstances. Mental health practitioners should familiarise themselves with the relevant legislation.

The former National Information Governance Board (NIGB) for Health and Social Care provided guidance on *Requesting amendments to health and social care records* (NIGB 2010) for when service users want information amended or removed from their records.

2.1.19 Recording when asked not to

If a service user discloses information that may have an impact upon their, or another person's care or safety, and then asks that this information is not recorded, the practitioner has a professional obligation to record the information. The service user should be informed of this. If, when warned that any disclosed information will be recorded, the service user chooses not to then share, this occurrence should also be recorded, in case it has future significance. You should consider sharing this information with your supervisor or another appropriate person.

You might record:

During the assessment Y said that she wanted to share some personal information with me. On stating that I would have to record this information she declined to say anything more. She did not identify the topic of the information she originally wished to discuss.

If another member of staff asks you not to record information, the same principles apply. Your professional responsibility to record should not be negatively influenced by another person. If you are concerned, you are advised to contact the Royal College of Occupational Therapists' Professional Practice Enquiries Service for further advice.

2.1.20 Recording risk

You must record the outcomes of any risk assessments you carry out, or any risk factors that you identify in the course of your work. You should identify the hazard, the potential for harm and the action taken to control the risk.

Moving and handling assessments and equipment provision are a key part of some practitioners' work. You are required to carry out a risk assessment in all moving and handling situations where there is potential risk of harm. Record your assessment and any necessary risk control measures in the care records. Information on generic and individual risk assessments in relation to moving and handling is available on the Health and Safety Executive (HSE) website (HSE n.d.).

Further information is available from the Royal College of Occupational Therapists' current guidance on risk management.

2.1.21 The use of hazard or violent warning markers

Where it is known that there is a potential hazard in relation to a particular service user or their environment, it is your responsibility to ensure that this information is shared and highlighted in records. Your employer will have a system for this, whether paper or digital systems of recording are used.

In 2006 the Information Commissioner's Office produced a Data Protection Good Practice Note on *The use of violent warning markers* (ICO 2006). It emphasises that the use of markers must comply with the *Data Protection Act 1998* (Great Britain. Parliament 1998a). It provides guidance when trying to balance employee safety with fairness to service users. It is available to download from the Social Care Institute for Excellence website (*www.scie.org.uk*).

Training should be sought for new employees and students on the local use and understanding of hazard or violent warning markers.

2.1.22 Recording medication

Named occupational therapists may, under Patient Group Directions, supply and administer limited medications. Further information is available from the RCOT website (*www.rcot.co.uk*).

Registered and non-registered practitioners may give non-injectable prescribed medicines, provided they are suitably trained. The medicine must be given to the person that they were intended for, when this is strictly in accordance with the directions that the prescriber has given.

It is vital for you, if in this situation, to maintain clear, accurate and immediate records of all medicines administered, following local policy and ensuring that you are clearly identified. Any decision not to supply prescribed medication, or any refusal to take supplied medication, should also be recorded and accompanied by a full explanation.

Where the task of collecting, transporting or administering medicines has been delegated to you, the records must include the identity of the person delegating, the full details of any medication, the action taken and any outcomes.

2.1.23 Discharge/case closure

You must record the point at which you discharge the service user, or close the case, and the reason why. This may be because the service user has met their objectives, has been transferred to another professional or service, refuses further input, or perhaps moves away. Any action which occurs after you discharge the individual must still be recorded (for example, a phone call from a service user with an enquiry).

2.1.24 Timely record-keeping

It is vital that records are complete and accurate. The longer the time that has elapsed between an event occurring and it being recorded, the greater is the likelihood of inaccuracies or omissions in the records. Records should be written as soon as possible after the activity/event occurred.

During assessments and interviews, information may be shared by the service user that is important to the current and future care of the individual, including particular wishes or requests. It is important that such information is recorded promptly, to ensure that the information is shared as necessary and/or ongoing care is appropriate.

If a service user in a palliative care setting informs you that they intend to follow a path of voluntary euthanasia, you must immediately record this and inform relevant people in the care team.

A delay in recording this type of information would not be acceptable in an enquiry or court of law.

There are situations when events occur or a record needs to be made when practitioners do not have access to the main care records. Practitioners should have access to appropriate means of recording information in various settings. This might be portable digital equipment for use in the community, or telephone message recording notebooks in an office. Any notes made, whether digital or on paper, become part of the care record and need to be treated as such in terms of confidentiality and security, for the time that they exist. The contents of the note should be transferred into the care records as soon as possible and with complete accuracy and consistency. Depending on its nature and format, the original note needs to be destroyed or kept securely if required.

As stated above, if records are written retrospectively, the time must be given when the service user was actually seen, or the event occurred. The date and time of recording should also be entered. If the delay is significant, an explanation should be given in the records.

2.1.25 Making your record-keeping a priority

A concern is often raised that practitioners have insufficient time to complete their records in a timely way. This cannot be used as an excuse for failing to complete care records and would not be acceptable in an enquiry or court of law. The keeping of records should be seen as an integral and equally important part of the delivery of care as any contact or activity time.

It is recognised that maintaining records which meet all the requirements takes time. Support should be given within a service to enable practitioners to complete their records in a timely manner. It may be possible to introduce systems and practices which facilitate more time-efficient working, but still maintain the standards, or it may be necessary to introduce protected time for the purpose of keeping records. Where an individual practitioner requires additional time or facilities to complete their records, perhaps due to dyslexia or other needs, this should be accommodated wherever reasonably possible.

Failure to complete records may be an indicator of a practitioner who is struggling in terms of their knowledge and skills, their attitude and confidence, or perhaps their personal wellbeing. Considering the responsibility that goes alongside any delegated task (see section 1.5), the relevant supervisor should raise this as a concern in supervision, providing support when required.

Further information on providing support is available in the RCOT's most recent guidance on supervision (College of Occupational Therapists 2015c).

3 The format and structure of care records

Occupational therapy care records are kept in a variety of ways: paper or electronic, from specific occupational therapy files to shared rehabilitation notes, or fully integrated into medical or social care records. The format of records can be varied, provided that the principles and standards for keeping records are maintained and that current government or local policy is being followed. The use of integrated digital systems will bring greater consistency in terms of format, structure and content across many occupational therapy services.

3.1 Digital care records

There is a common strategic intent across the UK to support integrated health and social care through better digital information systems. Shared recording systems are a necessity for the delivery of integrated health, social and community services.

The current strategies for the four UK nations are described in the following documents:

- Health and Social Care Board (2016) *eHealth and Care Strategy for Northern Ireland: improving health and wealth through the use of information and communication technology*. Belfast: Health and Social Care Board.
- National Information Board (2014) *Personalised health and care 2020: using data and technology to transform outcomes for patients and citizens: a framework for action.* [s.l.]: NIB.
- NHS Scotland (2015) *eHealth strategy 2014–2017*. Edinburgh: Scottish Government.
- Welsh Government (2015) *Informed health and care: a digital health and care strategy for Wales.* Cardiff: Welsh Assembly Government.

Facilitating effective digital records requires information to be recorded using a standardised structure, such that it can be shared and re-used safely in an electronic environment. Record heading standards aim to reflect the way that service users and practitioners work together, with a common goal of best practice and high-quality care (Health and Social Care Information Centre, Academy of Medical Royal Colleges 2013, p2). Record headings provide the context for record entries and a number of national standards for record headings have been published and endorsed by professional bodies/royal colleges.

The Professional Record Standards Body (PRSB) for health and social care, set up in 2013 by the Academy of Royal Medical Colleges, is a membership collaboration of groups who both provide and receive health and social care across the UK, as well as those providing IT systems that support care. Its aim is to develop standards for high-quality, consistent care records and to promote their use. The Royal College

of Occupational Therapists is a member of this body and signatory to a PRSB consensus statement, setting out their ambitions for the shared use of health and social care information contained in records in common use in the NHS and social care.

The PRSB Clinical and Professional Leadership Programme supports the effective implementation of PRSB standards. Online information packs are available containing materials to support individuals and organisations in this purpose. The consensus statement and other publications from the PRSB are available on its website (PRSB ca. 2017).

The RCOT has a ten-year strategic vision for occupational therapy informatics, *Managing information*: *a 10-year strategic vision for occupational therapy informatics* (COT 2014), and an implementation plan (COT 2015b), part of which is the use of digital care records.

Integral to the development of shared digital records is the development of, and agreement to, a standard set of nationally shared record headings and coded professional terminology to use in keeping records, with universally understood meanings for occupational therapists.

The RCOT, in collaboration with its members, has developed a number of occupational therapy-specific sets of professional terms, namely assessments, problems, findings, goals and interventions. Occupational therapy practitioners are encouraged to use these terms where possible in their records, whatever their work setting. They can also be used by occupational therapists when working with their local information management and technology department to agree sets of coded terms for use by occupational therapists in their care records. Consistency in the application of coded terms means that in addition to the primary recording of direct care, information can be used for secondary purposes such as: reporting on service activity, commissioning, clinical audit, service evaluation and clinical research.

The occupational therapy terms have been published as occupational therapy 'subsets' in SNOMED CT (Systematised Nomenclature of Medicine Clinical Terms). SNOMED CT is a national vocabulary of clinical phrases for use within health and care systems, to support the recording of information in the service user record. NHS England has mandated for NHS organisations to have SNOMED CT embedded in Primary Care systems by 1 April 2018 and in all NHS systems by 1 April 2020.

Further information is accessible from the RCOT website (*www.rcot.co.uk*).

3.1.1 Your involvement with digital record systems

The RCOT's informatics strategy states that:

> *Members will need to try to influence the agendas of their local service and service commissioners, to ensure that informatics-related developments fully support the practice and record keeping of occupational therapists.*
>
> (COT 2014, p14)

You and/or your service will need to be in dialogue with your local information management and technology department to ensure that the recording systems being developed, or currently in place, meet your local practical requirements and includes the appropriate professional coded terminology. This will assist in ensuring that you meet your legal, professional and registration body standards. The same principles for using and managing paper record systems in respect of content and security apply also to digital ones. Digital records should provide a complete picture of the care you provide, and your rationale, just as with any written record. Generic systems do not always provide a neat 'fit' but with consistent use of occupational therapy terms and the mandatory use of SNOMED CT terms, this may become easier.

Where your current systems do not meet your requirements, you are advised to talk to your digital services provider, giving them the information they require in order to understand your requirements for your daily practice and the national standards you have to meet. Care records need to fulfil their purposes to support the care of the service user, but also to evidence your duty of care.

If you are experiencing ongoing local difficulties, you may want to consider contacting the Royal College of Occupational Therapists' Professional Practice Enquiries Service.

3.2 Care records held by service users

Service user/patient/person-held records are primarily in use in the community in the care of pregnant women, people with cancer and those with long-term conditions.

Service user-held records have been shown to be useful in providing information and encouraging communication (Sartain et al 2015). They have also been shown to promote lifestyle changes (Jerdén and Weinehall 2004). However, their effectiveness is largely dependent upon their uptake from service users and practitioners alike (Sartain et al 2015).

The NHS Modernisation Agency publication *Patient-held records toolkit*, developed by the Cancer Services Collaboration 'Improvement Partnership' (2003), is still available online. This provides very practical advice and resources for those who wish to develop a service user-held record in cancer services and considers some concerns, such as the duplication of information.

The use of service user-held records may change with the full development of digital records, when people can have access to their own records and are able to add their own comments alongside the professional records.

Where service user-held records are used locally, you need to be sure that you are still meeting your legal and registration/professional body requirements. You are advised to follow your local policy. Influence and improve local practice as you are able. If you have concerns, raise this with your management or employer. You are advised to contact the Royal College of Occupational Therapists' Professional Practice Enquiries Service for further advice.

3.3 Systems for keeping records

There is no 'one size fits all' system for recording the stages of occupational therapy. The content and format of records may change according to the setting and nature of the service users. Some examples of systems are given here.

Problem-oriented recording (POR)/problem-oriented medical record (POMR), originally developed by the American physician Lawrence Weed (1970), enables structured record-keeping, formatted by the service user's problems and the intervention to resolve the problems. Each problem is numbered, with an action plan and a record of its implementation.

SOAP notes are used to structure the planned intervention and the rationale. They can be used within the POR system, or independently. The acronym SOAP is usually defined as:

- **S**ubjective information – this is usually the service user's representation of the problem. It may take the form of a direct quotation of the service user's words. It cannot necessarily be proved but is taken into account.
- **O**bjective information – this is the material collected through observation, assessment, data collection, etc. This information should be verifiable.
- **A**ssessment – this is the practitioner's conclusions taken from the information they have collected. It is the basis of their rationale.
- **P**lan – defines the proposed intervention that will resolve the identified problems.

The rigid format of SOAP notes is less usable with the introduction of structured multiprofessional care plans and care pathways. It does not suit every situation, especially where problems often overlap, but it does provide a systematic way of considering and recording care.

The COAST format, developed by Gateley and Borcherding (2012), is a system for writing objectives. It encourages the practitioner to identify and record all the elements of goal-setting.

- **C** – Client – the client will perform
- **O** – Occupation – what occupation?
- **A** – Assist level – with what level of assistance/independence?
- **S** – Specific condition – under what conditions?
- **T** – Timeline – by when?

The SMART format similarly provides a structure for recording objectives:

- **S** – Specific – a clear statement of the objective.
- **M** – Measurable – how will you measure change and achievement?
- **A** – Achievable – how is this objective achievable? Do you and the service user have the resources and support necessary for the achievement of the objective?

- **R** – Realistic or relevant – How does the objective fit in with the overall aims for the service user? Is the desired outcome relevant/useful to them?
- **T** – Timely – an agreed target date for achieving the objective.

As stated, there is no one particular system of keeping records that will meet everyone's needs or personal preferences. Systems such as those above do help the practitioner to remember all the necessary elements of the different stages of input and then present the information in a structured way. Practitioners need to consider whether using systems like these helps them to be efficient and concise. It is important that the system doesn't cause unnecessary work.

The development of fully digital records may help in the standardisation of record-keeping. Systems like those above, or elements of them, may be transferable into digital records, depending on their format and flexibility.

4 The handling and management of care records

Under the law, and in respect of your duty of care for your service users, you need to handle any information that you hold with due respect for your service users' confidentiality, consent, right to access and overall best interest.

4.1 The information governance review 2013 (Caldicott)

In 2013 Dame Fiona Caldicott was asked to look again at the state of information governance across health and social care in England. Information governance is seen as 'how organisations and individuals manage the way information is handled' (Caldicott 2013, p9). Following her earlier review in 1997, Caldicott devised six general principles of information governance. In 2002 the Caldicott principles were extended into social care, providing a shared basis for joint working between health and social services. These principles were reviewed in 2013, with the inclusion of an additional principle identifying the importance of sharing information when in the best interest of service users.

The revised list of Caldicott principles reads as follows:

1. ***Justify the purpose(s)***
   Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.

2. ***Don't use personal confidential data unless it is absolutely necessary***
   Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

3. ***Use the minimum necessary personal confidential data***
   Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.

4. ***Access to personal confidential data should be on a strict need-to-know basis***
   Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

5. ***Everyone with access to personal confidential data should be aware of their responsibilities***
   Action should be taken to ensure that those handling personal confidential data – both clinical and non-clinical staff – are made fully aware of their responsibilities and obligations to respect patient confidentiality.

6. ***Comply with the law***
   Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

7. ***The duty to share information can be as important as the duty to protect patient confidentiality***
   Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

(Caldicott 2013, p118)

4.2 Confidentiality, information sharing and consent

The *Data Protection Act 1998* (Great Britain. Parliament 1998a) and the *Human Rights Act 1998* (Great Britain. Parliament 1998b) place statutory restrictions on the management and use of personal information. A duty of confidentiality arises when a service user shares personal information with you. Confidentiality is a legal obligation, and a requirement established within professional codes of conduct and employment contracts.

Information provided in confidence should not be disclosed without the service user's consent. There are three exceptions to this, being situations in which:

- the relevant service user has consented;
- disclosure is in the public interest; or
- there is a legal duty (for example, a court case).

The Health and Care Professions Council have a document entitled *Confidentiality guidance for registrants* (HCPC 2012) (due for updating in 2017) available on its website. This gives some guidance on disclosure in the public interest.

You are aware that a service user is still driving against medical advice and that they have not informed the Driver and Vehicle Licensing Agency (DVLA) when advised to do so.

You ask for the service user's consent to share this information with the DVLA. Even if not given, it is in the public interest, on the basis of public safety, for you to contact the DVLA, but you must have a clear and evidence-based rationale for doing so.

Service users have the right to know when information about them is recorded, how it will be recorded and how it will be used. They should be made aware that the information they give may be shared in order to provide them with care, and may be used to support local clinical audit and other work to monitor the quality of care provided. Where an individual refuses to allow information to be disclosed, this may limit the care that the individual receives. Service users must be informed of the potential outcomes of refusing to allow the sharing of such information.

Staff and students are only authorised to access records of patients with whom they have a legitimate relationship, that is those to whom they are currently providing some kind of care.

Accessing a service user's record without a legitimate relationship is a breach of the *Data Protection Act 1998*, and leaves the offender liable to disciplinary action by the employer and the Health and Care Professions Council.

The 2013 Caldicott review highlighted the need for information sharing as part of the care of individuals. You have a duty to share information appropriately and when in the service user's best interest, for their safe and effective care. This should be limited to the information that is necessary and shared only with those who need to know. This does not remove the duty of confidentiality, so the principle of gaining consent to share information should always be maintained.

It is generally accepted that information is shared between members of a team involved in the direct care of an individual. Specific consent should be sought to share information more widely. A person has a choice whether to allow their personal information to be shared and this must be respected, unless there is an over-riding legal reason for disclosure, for example safeguarding concerns.

If a person lacks capacity to decide, a judgement may be made based on their best interests (Health and Social Care Information Centre 2013, p14). If there is a friend or family member who has lasting power of attorney, they can be involved. For children without the ability to understand and consent for themselves, consent may be gained from a person with 'parental responsibility'.

Information needs to be shared between all those involved in a child's care. It will also need to be transferred, with parental consent, if a child moves across services, or into a different area. The *Children Act 2004* (Great Britain. Parliament 2004), which applies throughout the United Kingdom, provides a legal framework to enable practitioners to share early information. It aims to ensure that children and families are getting benefit from services such as education and health care, and to enable them to get the support they need at the right time.

Therapists who work across public and independent sectors, and may see the same individual in both contexts, should not transfer or share information from one context to another without the service user's consent.

There is a range of information online about data sharing. Some of this is listed in the resources section of this publication.

4.3 Service user access to care records

The *Data Protection Act 1998* (Great Britain. Parliament 1998a) gives an individual the statutory right to have access to their own health and social care records, upon written request, whether they be held on computer or manually (with some conditions). This is known as a subject access request.

The organisation holding the data has 40 days in which to respond. The individual is entitled to know the purpose of the record and who may have access to the information. They may challenge the accuracy of the record and may have records amended, deleted or destroyed if shown to be inaccurate. An individual may also request in writing that all or part of data processing, relating to their own records, is stopped on the basis that they or a third party may be significantly damaged or distressed by it. The organisation holding the data has 21 days in which to respond.

If a service user asks to see the records you have made about them, there is nothing in law to prevent you from informally showing them to the service user. You can only provide copies if a formal written application has been made. You are strongly advised to follow local policy.

Under equality law an organisation has a duty to make sure that its services are accessible to all service users. An individual can request a response in a particular format that is accessible to them, such as Braille, large print, email or audio format.

If the files contain information about a third party, consent should be gained before sharing this information.

Under the *Data Protection Act 1998* (Great Britain. Parliament 1998a) there are two reasons why access may be denied:

- Providing access to the records may cause the individual distress or harm.
- A person's access to data may risk disclosing information concerning a third party, unless that third party gives permission.

Access to the care records of the deceased are governed by the *Access to Health Records Act 1990* (Great Britain. Parliament 1990) and the *Freedom of Information Act 2000* (Great Britain. Parliament 2000). Under the terms of the Acts, you will only be able to access the deceased's health records if you are either:

- a personal representative (the executor or administrator of the deceased person's estate); or
- someone who has a claim resulting from the death (this could be a relative or another person).

If you are an independent practitioner you must follow legislation and are advised to develop your own policy.

Further information is available on the Information Commissioner's Office website.

4.4 Secure storage of care records and personal data

All records, whether paper or digital, should be secure from opportunistic viewing, inappropriate access, theft, loss or damage.

Practitioners need to be aware that they have a responsibility for any records they create or use and have joint responsibility for shared records. Records may be kept within the department, room or service responsible for the related work, but must always be kept securely. Storage equipment or facilities and data protection measures should be secure, but records should be accessible to those who need the information for their work.

The movement and location of all records should be controlled to ensure that a record can be retrieved at any time. When paper records are taken from the central storage there should be an auditable tracking system in place to ensure that they are not lost. If digital data is held on portable devices, including mobile phones, tablets, DVDs or memory cards, they must also be trackable, or recorded and secure at all times. Personal data should always be secure and encrypted. The tracking system should identify who is in possession of the records and where they are being taken. When transporting records, the principles of data protection remain. The information within the records must be kept safe, therefore practitioners should ensure they are not accessible to others outside of the direct care team, and that records in any format are not left unattended anywhere that is potentially insecure, for example, in a car.

You should not hold information about your service users on your personal digital devices, including mobile phones or memory sticks. If you require such devices for your work, you should be supplied with them by your employer and you should follow local associated procedures. If you are self-employed, you will need to purchase devices specifically for your work.

A practitioner is writing records on computer when a colleague brings a visitor into the office. Service user information is clearly visible on the computer screen.

A practitioner has saved a number of service user reports on a personal memory stick. This gets lost. It is not encrypted or password protected.

Both these situations are in breach of the *Data Protection Act 1998*.

If you are an independent practitioner with computer-held records or files, you must ensure that no other person has access to the material you hold. You must protect the information with suitable security and data protection.

The Information Commissioner's Office website has information on data protection for small or medium-sized businesses. It also has information on storing and transferring personal digital data.

4.5 The use, transfer and security of digital images and films

Informed consent must be gained before any digital images or film are taken of a service user, whether by the practitioner or any other person present. The service user needs to understand why the image is being taken and what it will be used for. A record of any digital images or films made should be held. Check your local policy as written consent is usually required.

Digital images or film should be stored on a secure central system and not remain on any portable devices. They must be fully deleted on these. If you use social media or back-up sites, you must be sure that images do not automatically upload to them. Information on how to do this is widely available on the internet.

You may only transfer an image or film to another professional or service with the service user's informed consent. Any transfer must be done in a fully secure way. All personal data should be secure and encrypted when it becomes mobile.

There is nothing in law to say that a service user, or a parent of a child, cannot make a digital image or film, or a sound recording, of meetings or the care they receive. A practitioner should not be saying anything or providing any care that they do not wish to be recorded, unless the privacy and dignity of the service user is put at risk. A friend, carer or family member cannot make a digital image, film, or sound recording of a service user without their informed consent.

In this situation, you are advised to discuss any implications of taking digital images or sound recordings. Ask what the image/film/recording is going to be used for. Work co-operatively, discussing how it might be a helpful way to remember any information or instructions given. If you are at all concerned that there may be any elements of risk, for example for vulnerable adults or children, or the confidentiality of the information may be in question, you are advised to stop the intervention/meeting and seek help/advice from your employer, or seek legal advice.

If you are an independent practitioner, you may wish to consider what you would do in a situation like this before it arises. You may find it helpful to have a policy and consent form which you can use as standard practice, if required. There is some information for small business on data protection and digital security on the Information Commissioner's Office website (ICO n.d.).

4.6 Retention of records

The *Data Protection Act 1998* states that records should not be held for longer than is necessary to fulfil the purpose of the record. The length of time a record is held depends upon the nature of the record, the person concerned and the nature of their condition or circumstances.

The Information Governance Alliance for England has produced the *Records management code of practice for health and social care 2016*, which includes a

general retention schedule. It is now common practice for local authorities and health providers to define and produce their own schedules, which are available online.

Practitioners can gain advice from their local data or information manager on the retention or destruction of care records. The Information Commissioner's Office website gives general information. If you are an independent practitioner, you are advised to seek legal advice, especially if there has been any adverse incident which may increase the risk of action being taken against you.

4.6.1 Retention of diaries

Paper and digital diaries of health visitors, district nurses and allied health professionals should be retained for two years after the end of the year to which the diary relates, if the relevant service user-specific information is transferred to the service user's care record. If the information is not transferred the diary must be kept for eight years (Information Governance Alliance 2016, p60).

Data from a digital diary must be transferred to a secure central system, where it can be stored for the relevant length of time.

A diary should be kept for as long as necessary if it contains particular details concerning an ongoing enquiry or concern, for example, a service user complaint or incident. Advice should be sought from those leading the enquiry or looking into the concern.

Resources

All websites correct at time of publication

Acronyms

NHS Digital [ca. 2016] *Glossary of acronyms and abbreviations.* Leeds: NHS Digital. Available at: *http://content.digital.nhs.uk/article/2994/Glossary-of-acronyms*

Assessing capacity

Social Care Institute for Excellence (2015) *Mental Capacity Act (MCA) directory: assessing capacity*. London: SCIE. Available at: *http://www.scie.org.uk/mca-directory/assessingcapacity/index.asp*

Data sharing

Centre of Excellence for Information Sharing *http://informationsharing.org.uk*

Department for Children, Schools and Families, Communities and Local Government (2008) *Information sharing: guidance for practitioners and managers.* Nottingham: Department for Children, schools and families. Available at: *https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice*

Department for Children, Schools and Families, Communities and Local Government (2008) *Seven golden rules for information sharing*. London: Department for Children, schools and families. Available at: *http://webarchive.nationalarchives.gov.uk/20130401151715/http://www.education.gov.uk/publications/eOrderingDownload/Info-sharing_poster.pdf*

Department for Education (2015) *Information sharing advice for safeguarding practitioners*. London: DfE. Available at: *https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice*

Information Commissioner's Office (n.d.) *Information on data sharing.* Wilmslow: ICO. Available at: *https://ico.org.uk/for-organisations/guide-to-data-protection/data-sharing*

Skills for Care (n.d.) *Information sharing for social care employers.* Leeds: Skills for Care. Available at: *http://www.skillsforcare.org.uk/Documents/Topics/Digital-working/Information-sharing-for-social-care-employers.pdf*

Information governance

Information Commissioner's Office (n.d.) *Small business.* Wilmslow: ICO. Available at: *https://ico.org.uk/for-organisations/business*

NHS Digital (2016) *Information governance toolkit.* Leeds: NHS Digital. Available at: *https://www.igt.hscic.gov.uk/*

Record-keeping

Lynch J (2009) *Health records in court*. Oxford: Radcliffe Publishing.

NHS Professionals (2010) *CG2: record keeping guidelines*. Watford: NHS Professionals. Available at: *http://www.nhsprofessionals.nhs.uk/download/comms/CG2%20-%20Record%20Keeping%20Clinical%20Guidelines.pdf*

Professional Record Standards Body *http://theprsb.org*

Royal College of Physicians (2015) *Healthcare record standards*. London: RCP. Available at: *https://www.rcplondon.ac.uk/projects/healthcare-record-standards*

Royal College of Physicians (2013) *Standards for the clinical structure and content of patient records.* London: RCP. Available at: *https://www.rcplondon.ac.uk/projects/outputs/standards-clinical-structure-and-content-patient-records*

References

Caldicott F (2013) *Information: to share or not to share? The information governance review.* London: Department of Health. Available at: *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf*

Cancer Services Collaboration 'Improvement Partnership' (2003) *Patient-held records toolkit.* Leicester: NHS Modernisation Agency. Available at: *http://www.qualitasconsortium.com/index.cfm/reference-material/service-transformation/patient-held-records-toolkit*

College of Occupational Therapists (2017) *Professional standards for occupational therapy practice*. London: COT.

College of Occupational Therapists (2015a) *Code of ethics and professional conduct.* London: COT.

College of Occupational Therapists (2015b) *Managing information implementation plan 2015–2025*. London: COT.

College of Occupational Therapists (2015c) *Supervision: guidance for occupational therapists and their manager*s. London: COT.

College of Occupational Therapists (2014) *Managing information: a 10-year strategic vision for occupational therapy informatics.* London: COT.

College of Occupational Therapists (2010) *Risk management*. 2nd ed. London: COT.

Council of Europe (1950) *European Convention on Human Rights.* Rome: Council of Europe.

Gateley CA, Borcherding S (2012) *Documentation manual for occupational therapy: writing SOAP notes.* 3rd ed. Thorofare, NJ: SLACK.

General Medical Council (2017) *Consent guidance: expressions of consent*. London: GMC. Available at: *http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_expressions_of_consent.asp*

Great Britain. Parliament (2007) *Mental Health Act 2007*. London: Stationery Office.

Great Britain. Parliament (2005) *Mental Capacity Act 2005*. London: Stationery Office.

Great Britain. Parliament (2004) *Children Act 2004.* London: Stationery Office.

Great Britain. Parliament (2000) *Freedom of Information Act 2000*. London: Stationery Office.

Great Britain. Parliament (1998a) *Data Protection Act 1998*. London: Stationery Office.

Great Britain. Parliament (1998b) *Human Rights Act 1998*. London: Stationery Office.

Great Britain. Parliament (1990) *Access to Health Records Act 1990*. London: HMSO.

Great Britain. Parliament (1983) *Mental Health Act 1983*. London: HMSO.

Health and Care Professions Council (ca. 2016) *Hearings: advanced search*. London: HCPC. Available at: *http://www.hcpc-uk.co.uk/complaints/hearings/advancedhearingsearch*

Health and Care Professions Council (2016) *Standards of conduct, performance and ethics*. London: HCPC. Available at: *http://www.hcpc-uk.org/publications/standards/index.asp?id=38*

Health and Care Professions Council (2013) *Standards of proficiency: occupational therapists*. London: HCPC. Available at: *https://www.hcpc-uk.org/assets/documents/10000512Standards_of_Proficiency_Occupational_Therapists.pdf*

Health and Care Professions Council (2012) *Confidentiality: guidance for registrants*. London: HCPC. Available at: *http://www.hcpc-uk.co.uk/assets/documents/100023F1GuidanceonconfidentialityFINAL.pdf*

Health and Safety Executive (n.d.) *What you need to do: moving and handling*. Available at: *http://www.hse.gov.uk/healthservices/moving-handling-do.htm*

Health and Social Care Board (2016) *eHealth and care strategy for Northern Ireland: improving health and wealth through the use of information and communication technology*. Belfast: Health and Social Care Board.

Health and Social Care Information Centre (2013) *A guide to confidentiality in health and social care*. Leeds: HSCIC.

Health and Social Care Information Centre / Academy of Medical Royal Colleges (2013) *Standards for the clinical structure and content of patient records*. London: AMRC; Leeds: HSCIC. Available at: *https://www.rcplondon.ac.uk/projects/outputs/standards-clinical-structure-and-content-patient-records*

House of Lords and House of Commons, Joint Committee on Human Rights (2008) *Data protection and human rights, fourteenth report of session 2007–08.* (HL Paper 72 HC 132). London: Stationery Office.

Information Commissioner's Office (n.d.) *Small business*. Wilmslow: ICO. Available at: *https://ico.org.uk/for-organisations/business*

Information Commissioner's Office (2017) *Guide to data protection.* Wilmslow: ICO. Available at: *https://ico.org.uk/for-organisations/guide-to-data-protection*

Information Commissioner's Office (2006) *The use of violent warning markers*. Wilmslow: ICO.

Information Governance Alliance (2016) *Records management code of practice for health and social care 2016.* London: IGA.

Jerdén L, Weinehall L (2004) Does a patient-held health record give rise to lifestyle changes? A study in clinical practice. *Family Practice, 21(6),* 651–653. Available at: *http://fampra.oxfordjournals.org/content/21/6/651.abstract*

Lynch J (2009) *Health records in court*. Oxford: Radcliffe Publishing.

National Information Board (2014) *Personalised health and care 2020: using data and technology to transform outcomes for patients and citizens: a framework for action.* [s.l.]: NIB.

National Information Governance Board for Health and Social Care (2010) *Requesting amendments to health and social care records.* London: NIGB.

NHS Digital [ca. 2016] *Glossary of acronyms and abbreviations.* Leeds: NHS Digital. Available at: *http://content.digital.nhs.uk/article/2994/Glossary-of-acronyms*

NHS Professionals (2010) *CG2: record keeping guidelines*. Watford: NHS Professionals. Available at: *http://www.nhsprofessionals.nhs.uk/download/comms/CG2%20-%20Record%20Keeping%20Clinical%20Guidelines.pdf*

NHS Scotland (2015) *eHealth strategy 2014–2017*. Edinburgh: Scottish Government.

Nursing and Midwifery Council [ca. 2015] *The code: professional standards of practice and behaviour for nurses and midwives*. London: NMC. Available at: *https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf*

Parvaiz MA, Subramanian A, Kendall NS (2008) The use of abbreviations in medical records in a multidisciplinary world: an imminent disaster. *Community Medicine, 5(1),* 25–33. Available at: *https://www.ncbi.nlm.nih.gov/pubmed/19363877*

Professional Record Standards Body for Health and Social Care [ca. 2017] *PRSB publications*. London: PRSB. Available at: *http://www.theprsb.org/publications*

Rees G (2013) Staff use of acronyms in electronic care records. [Online]. *Mental Health Practice*, *16(10),* 28–31. Available at: *http://journals.rcni.com/doi/full/10.7748/mhp2013.07.16.10.28.e869*

Sartain SA, Stressing S, Prieto J (2015) Patients' views on the effectiveness of patient-held records: a systematic review and thematic synthesis of qualitative studies. [Online.] *Health Expectations, 18(6),* 2666–2677. Available at: *http://onlinelibrary.wiley.com/doi/10.1111/hex.12240/pdf*

Social Care Institute for Excellence (2011) *Mental Capacity Act (MCA): deprivation of liberty safeguards (DoLS*). London: SCIE. Available at: *https://www.scie.org.uk/publications/mca/deprivation-of-liberty*

Weed LL (1970) *Medical records, medical education, and patient care: the Problem-Oriented Medical Record as a basic tool*. Cleveland, OH: Case Western Reserve University Press.

Welsh Government (2015) *Informed health and care: a digital health and care strategy for Wales.* Cardiff: Welsh Assembly Government.

All websites accessed on 13 February 2016

Bibliography

College of Occupational Therapists (2010) *Record keeping*. 2nd ed. London: COT.

General Medical Council (2011) *Making and using visual and audio recordings of patients*. London: GMC.

Lynch J (2011) *Consent to treatment*. Oxford: Radcliffe Publishing.

Keeping Records

Guidance for occupational therapists

Third Edition

Keeping records is a necessary and integral part of practice in health, social and community care, education and research. It is an absolute requirement as part of a practitioner's duty of care, and must be completed in line with relevant legislation, the standards of registration and professional bodies, and local policy. Care records are legal documents and as such may be used as evidence in an enquiry or a court of law.

Produced for occupational therapists working across the UK, this guidance is an essential reference point in ensuring that members of the Royal College of Occupational Therapists keep care records that are fit for purpose and process them according to legislation.

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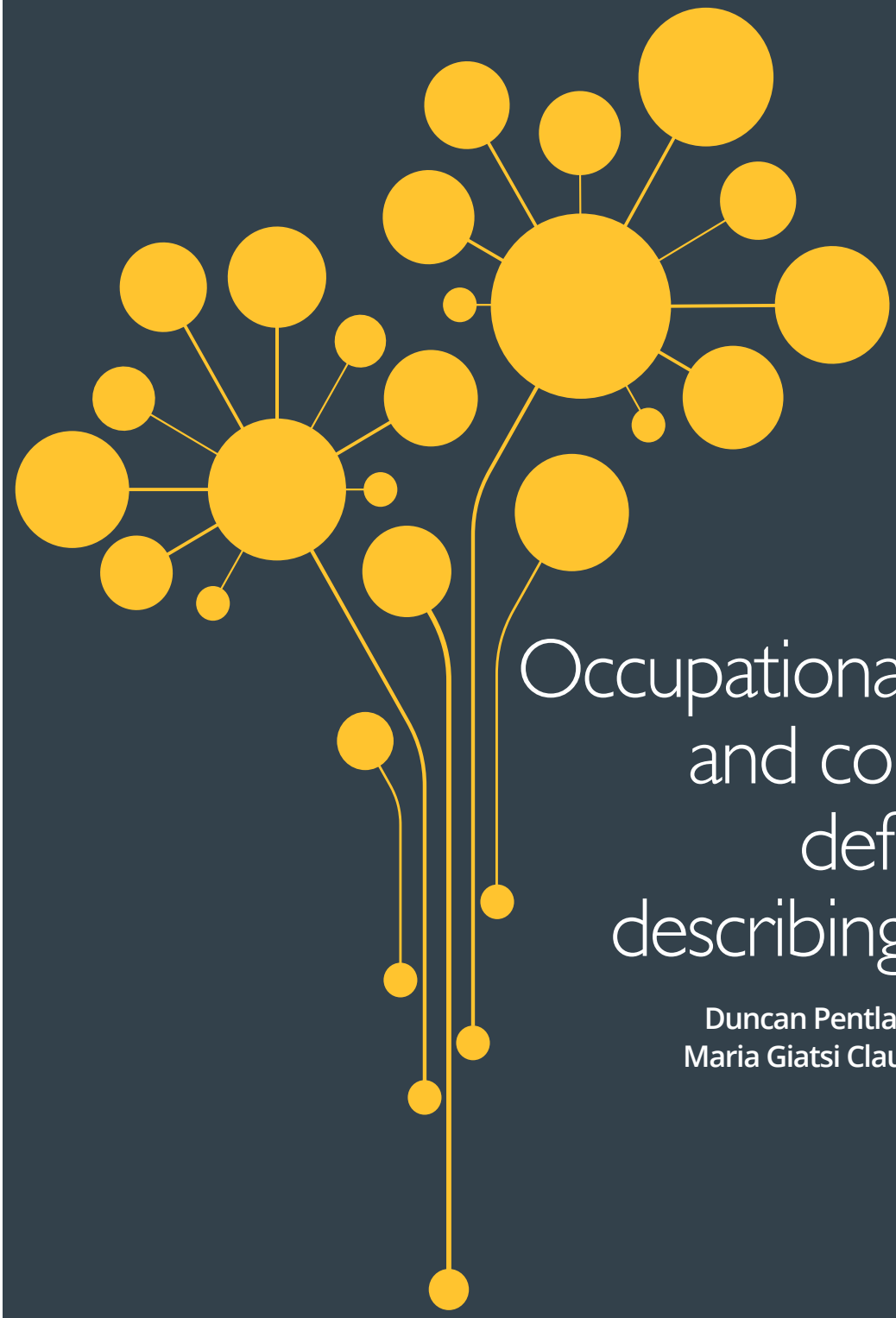
Royal College of Occupational Therapists



Occupational therapy and complexity: defining and describing practice

Duncan Pentland, Sarah Kantartzis,
Maria Giatsi Clausen, Kristi Witemyre

Royal College of Occupational Therapists

Other titles of interest:

The Career Development Framework: guiding principles for occupational therapy (2017)

Code of ethics and professional conduct (2015)

Professional standards for occupational therapy practice (2017)

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The Royal College of Occupational Therapists is a wholly owned subsidiary of the British Association of Occupational Therapists (BAOT) and operates as a registered charity. It represents the profession nationally and internationally, and contributes widely to policy consultations throughout the UK. The College sets the professional and educational standards for occupational therapy, providing leadership, guidance and information relating to research and development, education, practice and lifelong learning. In addition, 10 accredited specialist sections support expert clinical practice.

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We would also like to thank all those who completed the survey and who took part in the online focus groups. Without your contribution, it would not have been possible to complete this work.

1 Introduction and how to use this document

In 2016, the Royal College of Occupational Therapists (then the College of Occupational Therapists), the professional body for occupational therapists in the United Kingdom, commissioned a review of the document *Occupational therapy defined as a complex intervention* developed on their behalf by Jennifer Creek and published in 2003. This document had proved useful in describing occupational therapy within education, practice and research, but with considerable changes occurring in these areas as well as in the wider context over the intervening years, a review was considered necessary. Following a call for proposals, a research team from Queen Margaret University, Edinburgh, was appointed to carry out this review. While initially a revision to Creek's 2003 publication was the aim of this work, a new, contemporary view of occupational therapy emerged. This new publication describes the process and outcomes of occupational therapy, and it is hoped that it will provide useful guidance for all working within and in partnership with occupational therapy, both today and for some years to come.

Aims

This revision of *Occupational therapy defined as a complex intervention* (Creek 2003) aims to describe and define contemporary occupational therapy, and to consider if and how this description aligns with ideas about complex interventions. This was undertaken with the recognition that considerable changes, within both occupational therapy and the wider context, have occurred since the original publication. The theories associated with the concept of 'complex intervention' have also developed during this period.

Similar to the original, the objectives of this work were to:

i. Describe the current practices of occupational therapy based on data drawn from reports of, and reflections on, occupational therapy practice.

ii. Generate a model of contemporary occupational therapy that describes and explains the components.

iii. Identify and explain how contemporary occupational therapy aligns with the concept of complex interventions.

iv. Consider and suggest terminology and language to aid with practice, research and other work involving consideration of occupational therapy.

Overview of methodology and process

To address the aims and objectives of this project, it was essential to consider multiple perspectives on occupational therapy. Three different data collection approaches were used. In brief, these were a literature review of 256 papers published between March 2015 and October 2016 describing current practice; a survey of occupational therapy practitioners, educators and students (783 respondents); and online focus groups (17 participants). These three approaches were used so that written accounts of

occupational therapy practice from both peer-reviewed and non-peer-reviewed publications, as well as the perspectives, opinions and descriptions of occupational therapists, could be gathered. While the survey and online focus groups primarily involved occupational therapy practitioners, educators, researchers and students located in the UK, the literature review included all international occupational therapy journals widely accessible in the UK.

Following the analysis of the data obtained from each of these methods, the research team engaged in a range of activities to identify the different core components that feature in occupational therapy so that a valid description of practice could be developed. Alongside descriptions of these components, a model was constructed.

The final methodological step was to introduce the work to a range of 'critical friends'. These critical friends were asked to comment on the work (including elements of consistency, logic, language, validity and so forth) and ask provocative questions. The outcomes of these processes are described within this document.

Potential uses

The work presented here has several potential uses for readers, while recognising that limitations exist whenever there is a dual focus on theory and empirical data. The description of occupational therapy and associated definitions and explanations may serve as tools to support a range of critical activities. For example, readers (whether individuals or teams) focusing on understanding and considering their own practice may find this work useful. Used alongside the *Career development framework* (RCOT 2017), this document could support continuing learning and professional development. Similarly, it could aid practitioners to identify contexts and how these interrelate with practice, and uses specific terms and language that may be helpful when analysing and reflecting on practice. Alternatively, it may provide different perspectives for readers seeking to further their understanding of theoretical aspects of occupational therapy practice and associated concepts. Those engaged in developing and evaluating interventions may find this a useful framework within which to situate such work, so that it aligns with the wider debate around complex interventions. Finally, the document may be useful in describing and promoting occupational therapy to other professional groups and service user organisations.

Limitations

'Essentially all models are wrong, but some are useful.' (Box and Draper 1987, p.424)

To enable occupational therapy in the UK to be described, and associated terms to be defined, data was collected from multiple sources. Consequently, an extremely broad range of practices and underlying ideas required consideration. Any practice in which multiple components interact in dynamic ways will be difficult to describe. This work has attempted to do this by developing a single description along with a visual representation to consider and examine practice, collectively termed 'a model'. This model was largely informed by data collected from occupational therapists or reported in written work describing occupational therapy. As all models are attempts to represent something else on a smaller or more simplified scale, the model presented in this document is only one way of viewing occupational therapy and cannot provide a complete picture of practice. Furthermore, because many of the components that feature in the model of occupational theory are theoretical, it is influenced by viewpoints that are open to challenge. Other ways of considering and understanding occupational therapy based on different perspectives and other data are also valid, useful and necessary. To expand on Box and Draper's aphorism above: the model in this work provides an informed and simplified way of looking at contemporary occupational

therapy from a point of view informed by ideas of complexity. This does not mean that the model represents an entire or singular 'truth' about occupational therapy practice.

The information discussed in this work is not a theory or a statement about what 'should be' in the practice of occupational therapy. Rather, it provides a framework through which to think about what happens in therapy, and does so in a way that enables ideas about complexity to become apparent. Of course, not all occupational therapy practices will easily align with the model; divergent approaches and understanding may continue to exist, and their value or contribution is not to be seen as compromised. These may form part of the future discussions that we hope this work will encourage.

In addition to acknowledging the limitations associated with modelling current practice, a note should be made of the continually evolving theory of occupation. To allow this work to proceed, it was necessary to identify and think with a theory of occupation (more detail provided in the following section). Use of this theory of occupation was made with the recognition that including and exploring emerging definitions of occupation, which may be differently understood, was beyond the scope of this work.

There are also two necessary paradoxes to note. The first can be termed 'the reductive language paradox'. It was necessary to create a set of terms with clear definitions to allow occupational therapy to be conceptualised from a perspective that included concepts of complexity. There are multiple, potentially boundless, components that directly or indirectly influence occupational therapy. In recognition of this convergence, the identified components have been reduced and categorised in ways that allow them to be accessible for thinking and dialogue. However, in categorising these components and providing definitions for them, they have necessarily been simplified. Thus, some of the methods and efforts to understand and represent complexity have limited the degree to which complexity can be understood, hence the reductive language paradox.

The second paradox can be termed the 'dynamic–static model paradox' and it refers specifically to efforts to represent occupational therapy visually. The description of occupational therapy presented here recognises dynamism (constant flux), both in terms of the intersecting therapy contexts and the multiple practices and interactions which occur. However, visualising this required the development of static two-dimensional illustrations, which can be useful in showing how interactions might occur but which lack the ability to illustrate the dynamic nature of occupational therapy. The paradox is thus that occupational therapy as a complex dynamic process is represented as a static model.

Nevertheless, it is hoped that this conceptualisation will become a focus of debate and critique for how occupational therapy is thought about, both now and as practice develops in the future.

A (working) theory of occupation

The project adopted a theoretical perspective that positions occupation at the core of occupational therapy and recognises people as occupational beings. Occupation is fundamental to survival, to development across the life span, and to the construction of society as a whole.

Although occupation has been discussed in many ways in the literature and its relationship with tasks and activities has been widely explored, a broad and comprehensive understanding of the concept is used here, in line with Wilcock's (2006, p.xiv) definition of occupation as *'all the things we need, want or have to do'*. These ideas around occupation also indicate the essential interrelatedness of the person and

their context. While the satisfaction of needs and wants may be related to internal physical and psychological functioning, what we have to do places our occupation firmly into the world of relationships and external demands shaped by our social, economic, historical and cultural contexts. At the same time, how we are able to satisfy our needs and wants is also clearly shaped by environmental factors. This essential interrelationship is framed within the idea of person-in-context and places occupation at the core of the person–environment interaction. The complexity of this relationship reflects the understanding of occupation as more than observable doing; it also involves being, becoming and belonging (Wilcock 2006).

Complexity is also evident in the relationship of occupation to health and wellbeing. While all people *do* all the time, not all *doing* leads to health-supporting outcomes. While the meaning of an occupation is commonly linked to positive experiences and outcomes for the person, meaning may not always be experienced as positive or lead to positive outcomes. Some meaningful occupations may be deeply distressing or painful; some occupations identified as meaningful are dangerous or destructive. The same occupation may support health and wellbeing, or not, depending on how each person engages with and performs it in their particular context. At the same time, the context and wider structural conditions shape not only what occupations are available but also the value given to them and the range of beliefs and assumptions around them.

Occupation has traditionally been considered in terms of an individual, perhaps influenced by a historical focus on named doings and a close alliance with theoretical underpinnings supporting individual agency. More recently, literature and discourse have recognised that occupation happens in, and is often framed by, people in groups. These may be therapeutic groups, communities, families or classrooms. In such situations, focusing on the individual (one person and their occupation) may lead to a loss of recognition and understanding of those essential elements of occupation and health that emerge from the interactions between the numerous people involved.

The occupational therapy process considers occupation in multiple ways, namely occupation as means and occupation as ends (McLaughlin 1998). Occupation and the construction of a healthy occupational life is arguably the overall aim – the end – of many occupational therapy processes. Occupation as the means of therapy is subject to the various understandings of occupation. In some therapeutic contexts, a narrow perspective of occupation may be enacted, linked to a demonstrable process of change: for example, when occupation is primarily considered as ‘physical doing’ and is employed to develop muscle strength or range of movement. When more complex understandings of occupation are used, it becomes possible to consider the person who is belonging and becoming through their being in and with an occupation in their context.

In conclusion, constructing a healthy occupational life is complex and dynamic, shifting according to the changing needs of the person and their context. Understanding people as occupational beings places occupation as foundational to who we are and who we will become, to processes of change (doing *is* change), and to understanding the essential interconnectedness of people and their contexts.

Structure

This document has been structured to be accessible to a range of audiences. It is divided into two main sections. The first presents the description of occupational therapy, associated definitions and examples, and examines some core theories. The second section presents the methods and results of the research on which the description and

definitions are based. Therefore, while much of the content derives from research activities, it is not presented in the typical format of a research study. The structure of the document, along with brief descriptions of the chapters, is noted here.

- **Introduction**

  Chapter 1 (this chapter) introduces the work, gives an overview of the document, notes some limitations that may be useful for readers to be aware of, and frames the theory of occupation used throughout the document.

- **Section 1**

  Chapter 2 provides a revised description of occupational therapy and associated definitions. It is focused around a visual representation of occupational therapy that is intended to be the simplest depiction of the revised description. This visual representation and written description form the model of contemporary occupational therapy, and its components, that was developed for this book.

  Chapter 3 gives a detailed example using the model. This is intended to illustrate how the model of occupational therapy can be applied to a specific case example. It has been designed to highlight specific components of the model that can help in understanding the practice of occupational therapy.

  Chapter 4 revisits each core term used in the model. Additional and more detailed explanations of each term are provided and linked to selected examples drawn from analysis of the data gathered during the research process (survey, focus group and reviewed literature).

  Chapter 5 examines the core theory associated with the description and aims to clarify technical concepts from earlier chapters. These include theories about complexity, systems and processes. This chapter concludes with a brief discussion about how the description of occupational therapy fits with current understandings of complex interventions.

- **Section 2**

  Chapter 6 explains the methodological approach used during the development of this work.

  Chapter 7 provides detailed methods and findings from a literature review.

  Chapter 8 provides detailed methods and findings from a survey of occupational therapists, occupational therapy students and associated support workers.

  Chapter 9 provides detailed methods and findings from a set of online discussion groups.

Appendices – relevant appended materials such as reference lists and data summaries are located here.

Section 1

2 A model of occupational therapy as a complex dynamic process

The most recent Medical Research Council (MRC) framework for developing and evaluating complex interventions was *'intended to help researchers to choose appropriate methods, research funders to understand the constraints on evaluation design, and users of evaluation to weigh up the available evidence in the light of these methodological and practical constraints'* (Craig et al. 2006, p.4). More recently, Moore et al. (2015) offered guidance on conducting process evaluations of complex interventions. This was developed in response to the realisation that process evaluations can help to clarify the causal mechanism and identify contextual factors that are associated with intervention. Process evaluations aim to determine the degree to which a set of activities have been implemented as intended, and are therefore based on identifying components and their interactions. Moore et al.'s (2015) guidance provides useful terms for classifying components of interventions, and key terms used below are taken from their work. In the written description key terms are marked with (*) and appear on Figure 1. Further definitions and explanations of these may be found in the following section of this chapter, while descriptions based on the data obtained may be found in Chapter 4.

Core aspects of occupational therapy:

- Occupational therapy is a complex dynamic process undertaken to enhance the health and/or wellbeing of people.
- Occupational therapy is based on a causal assumption* that doing, as *'the medium through which people engage with occupations'* (Hitch et al. 2014, p.241), causes changes to occur within and between different components of person(s)-in-context*.
- The occupational therapy process comprises multiple practices – the actual application or use of an idea, belief or method, as opposed to theories relating to it (Stevenson 2010, p.1394) – which form the implementation content*. These practices include a range of strategies and techniques that are understood to cause change due to a variety of mechanisms; they are configured and used with the person(s)-in-context* in a way deemed optimal for causing changes. These changes occur in the unique person(s), their environments and their occupations.
- The selection and optimal configuration of these practices results from multiple components, including the understood mechanism(s) of impact*, a shared understanding of the person(s)-in-context* and the particularities of the therapist(s)-in-context*.
- Carrying out the implementation content causes multiple changes to the person(s)-in-context*.
- These changes may be expected and may occur due to the understood mechanisms of impact* or may be unexpected (non-determined) due to the individualities of the person(s)-in-context*. These mechanisms of impact are affected by numerous influencing factors* that have an impact on the type and size of change.
- The multiple changes to person(s)-in-context*, when identified in the intervention context*, may be considered as transitions. These transitions initiate responsive

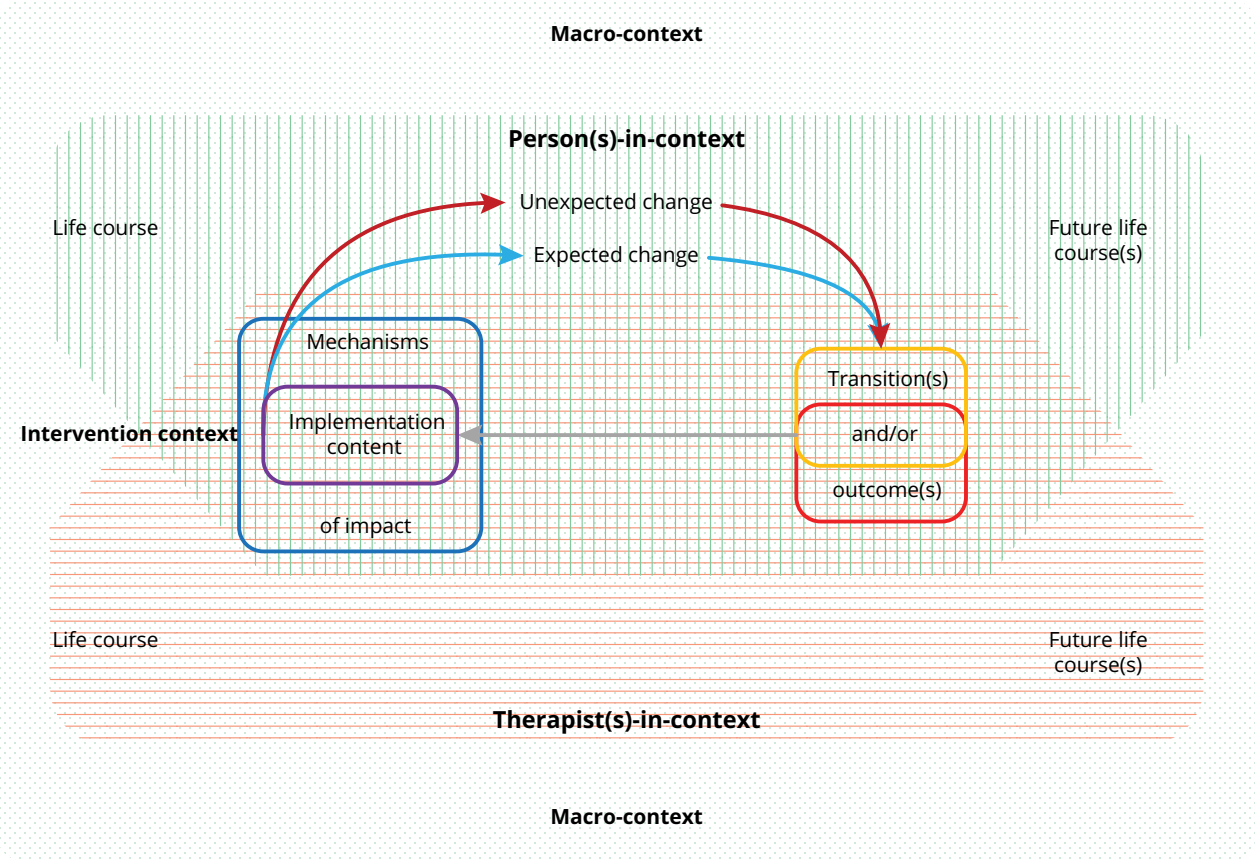


Figure 1 Visual representation of the model of occupational therapy as a complex, dynamic process

reconfigurations to the implementation content to accommodate new understandings of the person(s)-in-context* or may be measured or estimated as outcomes.

- This implementation content, change and response interaction continues dynamically until the end point of the process is reached. This end point may be determined by person(s)-in-context* and/or therapist(s)-in-context* factors.
- The end point of an occupational therapy process will not be the end of the change(s) that occur from occupational therapy. The person(s)-in-context* will continue along a life course that has been altered by their involvement in or experience of the process. Similarly, the therapist will continue along a life course that has been altered by their involvement in/experience of the process.

Core definitions

Detailed definitions for each of the core terms noted above are given in the following sections. Where relevant, some additional examples from occupational therapy have been provided. Additionally, an expanded visual version of the model that includes these definitions has been provided for reference (see Figure 2).

Causal assumptions

In the MRC guidance and associated literature (Craig et al. 2006, 2008, Moore et al. 2015, Greenwood-Lee et al. 2016), 'causal assumption' is a term used to refer to the theoretical understanding of how an intervention causes change. Therefore, constructing this

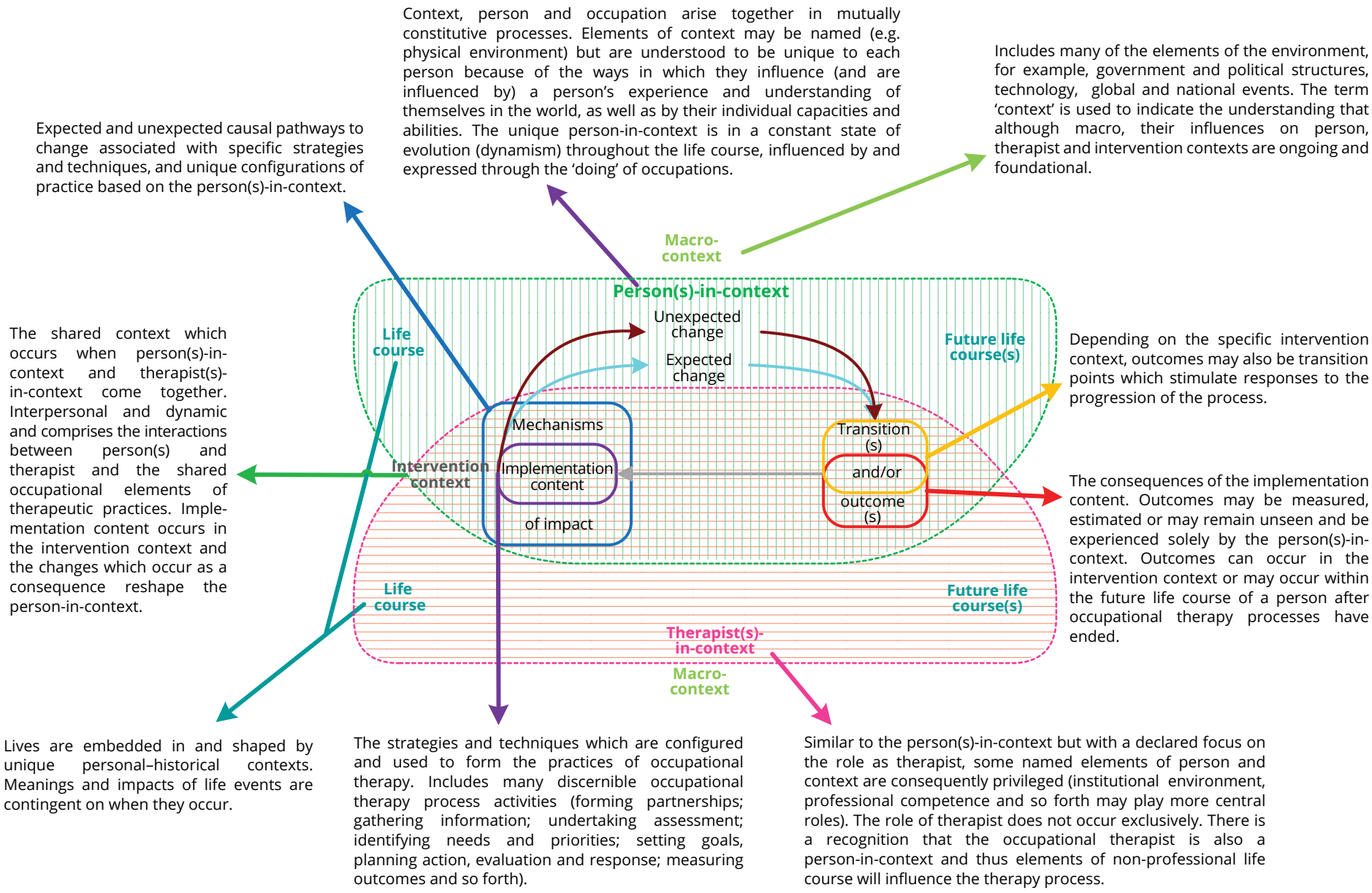


Figure 2 Expanded visual representation including definitions

model of contemporary occupational therapy was based on identifying underpinning causal assumptions.

In occupational therapy, *doing* (engaging with occupations) and *change* (the act or process through which something becomes different) are indivisible from one another. Doing causes changes within and between different components of the person(s)-in-context. These changes can occur immediately (at the same time as doing) and/or gradually (after the doing has occurred). The changes that occur while doing can be identified at various levels, from the individual's body structures and their operations, through to how groups of people perceive and engage with their world. By way of an example, consider reading this paragraph as *doing*. As you read, the process itself will lead to differences in your neurophysiology, and the way in which you choose to read it may cause changes to your posture, your cardiovascular function and so forth. The way you interpret the material may change the way you think and feel about yourself and others, and thus the way you interact with both your current and future contexts. Reading with a group may change how that collective critically understands their situation and perceives their potential for action leading to change.

The foundational philosophy of the profession is that doing can be therapeutic because doing and change are indivisible. This incorporates the recognition that certain types of doing may lead to optimal positive change. Hitch et al.'s (2014) work to explicate the relationship between doing and wider dimensions of the occupational perspective of health and wellbeing is potentially helpful in understanding this causal assumption. Key characteristics of this, identified consistently from the data obtained in this project, are first, the degree of positive meaning associated by the person(s) with the doing. 'Meaning' here refers to the meaning that is experienced during the particular doing (for example, the sensory and emotional experiences of joy during play), as well as the meaning that may be constructed through doing (such as establishing an ongoing sense of 'family' through playing together). These possible meanings associated with doing can be positively related to health and wellbeing.

A second key aspect is that doing should have purpose. This purpose can stem from the importance and relevance to the person's needs and/or the demands of their environment. When doing is understood to be an integral part of being, becoming and belonging, the four dimensions of occupation identified by Wilcock and Hocking (2015), the complexity of using doing to achieve optimal positive change becomes evident.

It is important to acknowledge that change is not always positive, and that the doing implemented therapeutically may not always have the requisite characteristics to enable optimal or possible change. There are many examples and much valuable discourse about the use of purposeless activity with minimal meaning for the person(s) and the reasons for its primacy during periods of the profession's history. Similarly, theories of complexity highlight that changes may have expected and unexpected outcomes, which may or may not be positive. While the argument put forward here states that doing causes change during occupational therapy, this is not to suggest that the doing is the *only* thing that causes change. Rather, as is discussed shortly, occupational therapy is never separate from context, because people are never separate from context. There will be many multiple contextual features that contribute to change and serve to enhance or impede positive changes associated with occupation. Some of these features may be utilised as part of therapy, but many will not be. Later in this document, the important role context plays in creating complexity is examined (see Chapter 5).

Nevertheless, the core idea in occupational therapy is that doing can be used to cause positive change. This idea featured as the foundational causal assumption in the data

collected about contemporary occupational therapy. The components of occupational therapy used to enable this positive 'doing that causes change' are multiple and are formed by the different practices implemented during the process.

It is important to note that there is a necessary (and artificial) separation here between doing that causes change as the causal assumption in occupational therapy, and recognising that occupation is core to understanding people as part of the wider philosophy upon which the profession is based. The concept that occupation is both the means (the causal assumptions that underpin the complex process of therapy – doing that causes change) and the end (the ultimate aim of the process; the realisation of *well beings* who can successfully engage in living) may create challenges to the ways in which therapists understand their roles and practices.

Implementation content

Implementation content refers to all the strategies and techniques that are configured and used to form the practices of occupational therapy. In a dynamic occupational therapy process, implementation content alters over time in response to person(s)-in-context changes and in adaptation to other contextual factors. Implementation content includes many discernible occupational therapy process practices (forming partnerships, gathering information, undertaking assessment, identifying needs and priorities, setting goals, planning and taking action, evaluation and response, measuring outcomes and so forth) and recognises that these practices cause changes to occur in their own right as part of complex mechanisms of impact.

Many of these practices might normally fall outside ideas of implementation content in other discussions of complex intervention. There is little reference in current literature to complex interventions and the impact that practices such as establishing trusting relationships and working with compassion might have on the process of an intervention and its consequent outcomes. In situations where intervention is founded on an interpersonal relationship, as is the case in occupational therapy, the role of this as part of the implementation content is therefore worth considering and is recognised in the literature reviewed as an important component promoting change.

Mechanisms of impact and types of change

The mechanisms of impact in occupational therapy refer to both expected causal pathways to change associated with specific strategies and techniques, and unexpected changes that may occur because of person(s)-in-context. Mechanisms of impact are strongly related to the causal assumptions in occupational therapy noted earlier and are typically the more discrete aspects of practice that are configured to produce expected changes in specific components of a person and their occupations. For instance, some of the mechanisms of impact in occupational therapy during which a joint protection intervention is provided are the application of ergonomic principles to ensure that the proper use of joint and body mechanics, body structures and function are protected or improved, and the maintenance of ability to engage in occupation. The broader causal pathway might include specific practices such as altered work methods or modification to components of occupations and/or the environment to allow these ergonomic principles to be maintained during everyday life. The broader causal assumption is that by actively focusing these practices on occupations that have meaning, value and relevance, the mechanisms of impact will have a greater effect on outcomes uniquely important to a person. It should be noted that other mechanisms of impact might operate at the same time. These may be distinct approaches in their own right, such as educational approaches aimed at improving time and energy management, or might be intrinsic and harder to identify, such as the impact of interpersonal relationships on the processes.

The combined mechanisms of impact are conditional to particular person(s)-in-context. To continue with the example above, the changes related to effective joint protection may also lead to changes in a person's perception about their condition, their psychological and physical health status, their social participation, and so forth (see Hammond 2004). These changes, which are further removed than the physiological changes associated with joint protection, can be termed unexpected, in that they are more dependent on variations in context and in person and therefore harder to consistently predict.

As the occupational therapy process is responsive and adaptive, the practices that allow these mechanisms of impact to cause change occur recursively in the continuing intervention context. Consequent changes can be incremental and may be difficult to anticipate. This can be seen when changes occur which enhance or create the conditions needed for further changes to happen. These recursive mechanisms of impact can happen over very short time periods during therapeutic interactions, or may happen over elongated timescales.

Outcomes and transitions

Outcomes are the consequences of the implementation content (the practices of occupational therapy), mediated by context. These may be evaluated in numerous ways, ranging from formal standardised measurement to clinical expertise and estimation or service user self-evaluation and feedback. There may also be consequences that remain within, and are experienced solely by, the person(s)-in-context. Outcomes can occur in the intervention context or may occur within the future life course of a person after occupational therapy processes have ended.

Depending on the specific intervention context, the consequence of the implementation content may be considered transition points rather than outcomes. These transition points occur when change is evaluated, measured, estimated or observed, but serve to stimulate responses to the progression of the process, rather than being considered outcomes.

Contexts

Context can be considered in four ways during occupational therapy: the person(s)-in-context, the therapist(s)-in-context, the intervention context and the macro-context.

The terms 'context' and 'environment' are typically used interchangeably or without distinction. However, contexts differ from environments. Environment(s) may be considered in isolation (i.e. the physical environment or the social environment) or in combination. However, context pertains to the unique combination (Latin *contextus*: from *con* 'together' and *textere* 'to weave' (Stevenson 2010, p.376)) of environments, personal factors and histories that influence the occupational being at a given point in time. Two people may be present in the same physical environment, but their context will be unique, given the particular characteristics of each and that which has gone before.

Person(s)-in-context expresses how context, person and occupation arise together in mutually constitutive processes. While components of the context may be named (such as the physical environment or social stigma around disability), they are understood to be unique to each person because of the ways in which they influence and are influenced by a person's experience and understanding of themselves in the world, as well as by their individual capacities and abilities. The unique person-in-context is in a constant state of evolution (dynamism) throughout the life course, informed by and expressed through the doing of occupations.

The person(s)-in-context concept may be reflected in the ways in which people are conceptualised or understood as part of occupational therapy. During practice, this understanding is often generated by the use of underlying theories and their corresponding models e.g. the Person, Environment, Occupation model (PEO model) (Law et al. 1996), the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Townsend and Polatajko 2007), the Model of Human Occupation (MOHO) (Taylor 2017), the Kawa model (Iwama 2006) and so forth, and typically produces a representation of the person at a given point in their life course.

The therapist(s)-in-context concept represents a similar idea, but with a declared focus on their role as therapist some components of person and environment are consequently privileged. For instance, institutional environment, professional competence and so forth are components that are more central or may recur more frequently. However, there is recognition that the occupational therapist is also a person-in-context and thus components of non-professional life course will influence the therapy process. Therapist(s) is used in the plural to indicate that the person(s) may encounter several therapists during their process of occupational therapy.

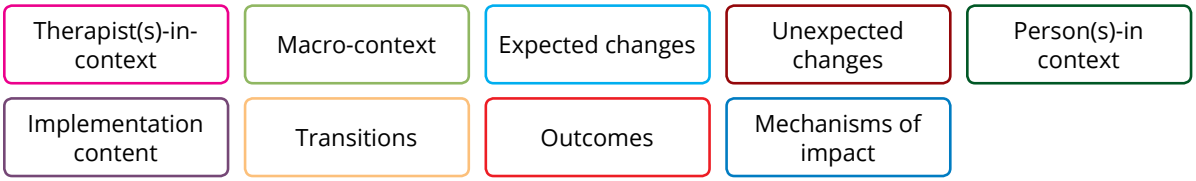
The intervention context can be understood as the shared context that occurs when person(s)-in-context and therapist(s)-in-context come together. It is inherently interpersonal and dynamic and comprises the interactions between person(s) and therapist(s) and the shared occupational components of therapeutic practices. Implementation content occurs in the intervention context and the changes that occur consequently reshape the person-in-context. Included within the intervention context are a range of components that can be identified as either facilitators or barriers to change, arising from the unique characteristics of the person(s)-in-context with the therapist(s)-in-context. These may incorporate the nature of the dynamic relationship between person(s) and therapist(s), governance structures, extent of available evidence, resources and so forth.

The macro-context comprises many of the components of environments, such as government and political structures, technology, and global and national events. The term ‘context’ is used to indicate the understanding that although macro, its influences on person, therapist and intervention contexts are ongoing and foundational.

3 Expanded model and exemplar

This chapter attempts to give a fuller, more detailed illustration of the potential interactions and influences between the multiple components that together comprise occupational therapy. A narrative account and explanation of this based on a hypothetical case is provided. An additional visual representation, linking components of this case to the model presented in the preceding chapter, is included (Figure 3).

At different points in the example that follows, components that feature in Figure 1 and Figure 2 are placed in boxes next to the text to illustrate how they cause the process to move in dynamic ways. The colours used to denote different components of the model have been replicated here (as indicated below). While this narrative account is an attempt to illustrate complexity, it does not capture all the different potential and interacting influences.



David and Sandra

David is a 68-year-old man who lives with Sandra, his wife of 45 years, at their home in Newcastle, north-east England. He has been retired from his profession as a structural engineer at a large building company for just over five years. Sandra retired from her job as a primary school teacher at roughly the same time and since then they have enjoyed retirement. They describe themselves as 'comfortable baby-boomers' as they own their own home and both receive good pensions.

Person
Social context
Physical and environmental context
Occupational context and performance

David has stayed in contact with some of his old professional colleagues. He occasionally teaches at his local technical college and sits as a trustee on the board of a local charity that organises outdoor residential courses for young adults who have had contact with the criminal justice system. He enjoys his daily routine, which starts with making himself and Sandra breakfast before taking their dog Digby for a walk to get the daily paper. David likes to spend an hour or so reading the paper and normally saves the crosswords for after dinner because he says he's 'useless' in the afternoon unless he has a good nap.

David and Sandra (and Digby) regularly go on short breaks around the UK – they would normally have about ten such breaks every year. David jokes that they are making up for lost time for all the holidays he skipped while he was working. David and Sandra have three grown-up sons, all living and working in London. Their two eldest sons have children and David and Sandra are proud grandparents to two grandsons and a granddaughter.

Three months ago, David started to show some signs of memory loss. He was diagnosed with likely mixed Alzheimer's disease and vascular dementia. He has been referred to the community service, where Julie is a practising occupational therapist.

Previous professional experiences
Continuing development
Personal dispositions

Julie has been a practising occupational therapist for three years since her graduation. Julie does not know Newcastle very well, having moved there from Leeds six months ago when her husband's job was relocated. Her previous job in Leeds was in a community rehabilitation centre working with people with long-term conditions like multiple sclerosis and motor neurone disease. Most of the people she worked with had experienced strokes and were learning to manage residual impairments. The service typically saw people over a three- to four-month period, usually on-site but occasionally at their home. They used the Canadian Occupational Performance Measure (COPM) (Law et al. 2000) as their primary outcome measure and as the process for setting goals with people. Julie's previous team comprised several occupational therapists, as well as two physiotherapists, a speech and language therapist, community support workers and a social worker. Specialist input from a clinical psychologist and neurologist were available as needed, though they were not based on-site.

While Julie has worked with people with dementia before, this has always been secondary to the role of the team she was working with previously. For instance, she had experience working with older adults in both general medical wards and orthopaedic rehabilitation during her student placements. She encountered people with dementia and other complex cognitive issues, but the focus of the services meant that dementia was never the primary cause for contact.

Policy/organisation expectations around practice

Demographics, populations and other macro-pressures

National strategies
Available funding

Reasoning, judgement, reflexive skills

Julie is settling into her new team but finds it very different to her previous role. She has found the move from working in a mixed team difficult, and feels less confident now she has less easy access to occupational therapists and other care professionals with more experience than she has. She is also a little daunted by the range of different people she is expected to work with and the high pressure to move through caseloads quickly. There is an 'unwritten rule' in place by the team's line manager (the social worker in charge of social care services for older adults in this sector of the city) that people should only get three visits from an occupational therapist: one for assessment, one to put an intervention in place, and one for follow-up or discharge. Julie has struggled with this and has been criticised for not completing her work in the 'three-visit window', having been used to seeing people over a much longer period of time.

The new team has no uniform approach to working with people, though there is an expectation that, if they are the first profession a person has contact with, they will complete a shared initial assessment that includes information about social circumstances and care needs. The team tends to collect measures of daily function to indicate outcomes, and while there is no agreed measure to use, the organisation's information management system has space to record the Barthel Index (Collin et al. 1988), so this is the tool most frequently utilised by the team.

Julie's team typically works with people in their own homes (one of the more senior therapists does 1.5 days per week in a specialist memory clinic attached to the teaching hospital), therefore Julie will work with David and Sandra at their home.

Julie knows that the NICE Clinical Guideline 42 (2006)[1] suggests she should be aiming to support 'independent functioning' through the use of adaptations and assistive devices, and should be encouraging David to stay active as much as possible. She is not sure how to achieve this and the clinical guidelines do not specify possible techniques or practices that might be used. She is confident that she can make recommendations for compensatory strategies and basic adaptations, and she is aware of the advice about maintaining physical activity, especially when vascular dementia is indicated. However, Julie is not sure whether the wider evidence base supports methods for implementing these in practice. She's also aware that there is evidence for cognitive stimulation therapy but that this pertains primarily to cognitive performance. Given the timescales she is expected to work within, she is not sure whether this is a feasible option.

Neuropsychology research and knowledge:

In early-stage dementia people may retain the ability to make new memories.

There is some evidence for cognitive rehab (compensatory and restorative strategies to enable people to continue with occupations).

Multiple approaches exist for supporting a person to retain the ability to learn and hold on to information and skills.

Occupational therapy research and knowledge: focusing on occupations of importance to the person and locating therapy at home is more likely to be effective/valued.

Julie must complete the service's initial assessment when she meets David and Sandra. This takes up a good portion of the available time permitted for the visit and generates a lot of information which Julie does not feel is particularly relevant (information about the physical layout of the property, for instance). Julie does manage to initiate wider conversations about the things that are important to them. Although she's not able to use the COPM (Law et al. 2000), Julie draws on her previous experience to begin conceptualising a picture of David and Sandra, the things they value and the issues they're currently experiencing.

Previous experiences of these concepts.

Exposure to an ability to internalise information about these concepts

Use of thinking tools (e.g. conceptual models for occupational performance)

Julie asks David to complete the Barthel Index (Collin et al. 1988) as a baseline as this features in the initial assessment. While answering the questions, Sandra becomes very upset and David starts to get anxious and upset too. When Julie inquires, Sandra says that the questions about continence and feeding have suddenly *'made their future real'*.

Policy/organisation expectations around practice

Assessment and information gathering

Julie immediately stops using the Barthel Index and changes the conversation. She reassures them that the reason for their referral to occupational therapy is so that they can start planning and working together so that even if David's ability to do things does start to decline, they can manage this and they will be able to stay at home doing the things that are important to them for as long as possible. She tells them that she's worked with hundreds of people with brain injuries and other conditions and that living life the way they want to is achievable.

Compassion

Active listening

Humour

Effective communication

Previous professional experiences

Continuing development

Personal dispositions

[1] NICE Clinical Guideline 42 (2006) *Dementia: supporting people with dementia and their carers in health and social care. https://www.nice.org.uk/guidance/cg42*

Julie starts to talk with David and Sandra about the things they want to be able to do, but has to stop so that she can move on to her next client. They arrange for Julie to visit again but due to her busy schedule, this is three weeks away. Julie asks David and Sandra to think about the things they are having difficulty with because of David's memory problems. She encourages them to keep a record of the daily activities that have become harder, and to write down other things that might be difficult to do but which are important to them.

Policy/organisation expectations around practice

Demographics, populations and other macro-pressures

National strategies
Available funding

Assessment and information gathering

Reasoning, judgement, reflexive skills

At her next visit, Julie begins by asking David and Sandra to tell her about the things they've found difficult and the things they're worried about. David and Sandra identified the following issues:

- David misplaces things in the house, specifically his keys, his newspaper or Digby's lead and treats. He has become frustrated looking for these things and has snapped at Sandra a couple of times. He's also forgotten to take his medication at the right time on several occasions.
- David is also worried about his ability to carry on with his work at the charity. He's worried he will forget what people have told him; he was really embarrassed at a meeting the previous week because he forgot the names of some people. David normally goes for a drink with some of the board members after meetings, but he found it difficult this time because he couldn't follow the conversation. He says he left early and came home feeling quite low. David says he was upset a few days ago because he couldn't remember some of his grandchildren's names.

Person
Social context
Physical environmental context
Occupational context and performance

- Sandra is worried that David will get lost at the shops or while he's out driving, even though this hasn't happened yet. She says she's worried whenever David goes out with Digby, or if he's going out to the college or to see friends, that he won't come back and will end up lost and at risk. She says she's looked at some 'satellite thingies' but that David won't even consider them because the ones she showed him were for children. He says having one would be like a big flag that says 'demented!' when he's out and about.

Prioritisation, goal setting

Self-confidence and perception of self

- Both of them are worried that they won't be able to continue their long weekends or visit their sons in London. David says he'd read on the internet how important familiar environments are to people with dementia, and he's worried that he may not cope in new surroundings. He says he doesn't want the holidays to become stressful for Sandra and that he'd rather not go than go and worry about her.

Julie says she has ideas to help with all of these concerns and tells Sandra and David that they could think about some small changes in the house. She recommends they put up a whiteboard, refreshed each day, to note down important messages, appointments and jobs for the day, including a checklist David can tick off when he's taken his medication. She suggests that

Previous experiences of concepts of cognitive rehabilitation and neuropsychology
Exposure to and ability to internalise information about these concepts

David could develop some habits around the things he often loses, like having a hook for his keys, a rack for his newspaper and a place to keep Digby's treats. She also suggests that David tries using a small notebook or diary to write things down when he leaves the house.

Assistive device/aids (support to learn and habituate use)

Changes to activities

Environmental adaptation

Available resources and funding

Julie says she knows how David's smartphone can be set up so that Sandra can see where it is if she's ever really worried about him. Her own husband showed her how to do this after she lost her phone, and she used the technique a couple of times successfully in her previous post. She explains that Sandra would need to have copies of David's username and password to be able to secure access, along with ensuring the phone's GPS or internet is turned on. Julie doesn't have time to explain how to do this, though, because again she has to move on to another client. Before she leaves they agree that over the next week David and Sandra will try to find a suitable whiteboard and notebook (these are not provided by Julie's equipment store) and they will try out a few things, such as listing what medications to take and noting jobs for the day.

Julie thinks it is important to see them again soon to assess whether the suggested adaptations have been working. She schedules an appointment for the end of one day the following week, so that she can run over time if needed and not have to go on to another client.

Reasoning, judgement, reflexive skills

Personal disposition

During that week David and Sandra follow all Julie's suggestions: they put up a hook in the hall for David's keys, buy a whiteboard and use it to keep track of David's medications and any appointments he has. However, he has difficulty using some of these, and his memory continues to cause problems. He left the house to go for a walk with Digby and forgot to take his keys because he went out the back door. He also forgot his phone, so he and Digby were locked out of the house for three hours while Sandra was having lunch and going shopping with friends. David also had a really difficult experience at a meeting of the charity's directors and trustees. They changed their normal meeting place and instead used a hotel function room. David hadn't been there before, and he got lost trying to locate and return from the toilets and needed to ask for help. In a fluster, the next day David and Sandra cancelled a trip to the Lake District they'd been planning.

Hopefulness and aspirations for the future

Self-confidence and perception of self

Perceived quality of life

Ability/capacity for occupational performance and engagement

Willingness and motivation to work with therapist

Assessment and information gathering

When Julie visits them the following week she sees that both David and Sandra look tired and worried. Sandra hasn't been sleeping because she's increasingly anxious, and David is frustrated that none of the things Julie suggested seem to be working.

Julie explains that on their own the aids probably won't work. What is necessary is to help David create new memories about how to use the aids and form this use

Reasoning, judgement, reflexive skills

Assistive device/aids (support to learn and habituate use of)

Response

into habits. Then they can feature as typical parts of his day. She explains how memory works, and how the disease might affect this. Julie proposes that it might help if they know some of the theory behind how they should learn to use the adaptations to help David during the day. She suggests that they look at each of the strategies in turn to figure out how best to do this.

There is some evidence for cognitive rehab (compensatory and restorative strategies to enable people to continue with occupations).

Multiple approaches exist for supporting a person to retain the ability to learn and hold on to information and skills.

Focusing on occupations of importance to the person and locating therapy at home is more likely to be effective/valued.

Julie suggests that instead of solely relying on the whiteboard in the kitchen, they could put a card on the front and back doors with reminders of the things David should check he has with him (his keys, his phone, his notebook, anything Digby needs).

To embed the strategy, Julie encourages David to start using his notebook to record lots of things, not just essentials – writing down things he's done during the day such as putting the laundry on or taking the bins out. Julie encourages David to keep the entries clear, showing him how he could record their conversation, as an example. Julie explains to David that repetition is thought to be key to learning the new memories he will need to use the strategies.

Assistive device/aids (support to learn and habituate use).

Previous experiences of concepts of cognitive rehabilitation and neuropsychology.

Exposure to and ability to internalise information about these concepts.

Julie feels it is important to inform David and Sandra that, unlike in her previous job, where she was able to work with people over a longer period, this current service does not permit such flexibility. As a result, Sandra and David will be required to work at building new 'strategy use' memories. Julie goes to the whiteboard and writes several upcoming appointments that David has planned.

She returns and begins speaking to David and Sandra about how they could use David's phone so that if Sandra is ever really worried she can check that he's not lost. A few minutes into this discussion, Julie stops and asks David what he's doing next Tuesday. She immediately prompts him to go and check his board, even if he thinks he already knows. When David comes back and tells them that he's due to take Digby to the vet for his check-up, Julie uses positive reinforcement by saying *'It's great to see David using the board so well'*. Julie explains to Sandra and David that they should repeat this sort of exercise regularly, randomly asking David questions about what he has to do (or things that he has done to record in his notebook). Julie tells Sandra that as David's responses improve she should start to lengthen by one second the gap between asking the questions and prompting David to use one of his strategies. Julie explains that this approach is called 'spaced retrieval' and that there is some research to show that it can improve the retention and recall of information. She also notes that they should initially try to use it at home when there are fewer demands on David's attention. Julie further explains that part of this approach uses a technique called 'cuing' and, over time, Sandra should reduce the number and frequency of cues provided as David develops his ability to use the aids. She suggests

There is some evidence for cognitive rehab (compensatory and restorative strategies to enable people to continue with occupations).

Multiple approaches exist for supporting a person to retain the ability to learn and hold on to information and skills.

Focusing on occupations of importance to the person and locating therapy at home is more likely to be effective/valued.

Previous experiences of concepts of cognitive rehabilitation and neuropsychology.

Exposure to and ability to internalise information about these concepts.

that Sandra can start by using a full phrase such as *'Could you go check the whiteboard please?'* and gradually move this back to *'Could you go check...'* and eventually *'check'.*

At the end of her scheduled time, Julie arranges to see David and Sandra a fourth time because she wants to review how these strategies are working. She also acknowledges how the stress and anxiety following David's problems at the hotel have affected David and Sandra. She wants to make sure they explore some ways to help David manage unfamiliar or busy situations so that he can stay involved with the charity, the college and the associated social activities. She manages to find a time slot over her lunch break in a fortnight.

Policy/organisation expectations around practice

Assessment and information gathering

Reasoning, judgement, reflexive skills

After Julie leaves, David and Sandra start practising the techniques. At first, David is a bit grumpy when Sandra keeps asking him about things he has planned or things he has coming up. However, he has a good couple of weeks. He manages the trip to the vet and uses his notebook to keep track of the changes to Digby's medication. He has no problems remembering to take things with him when he goes out, and on the way to get his paper one morning he sees an ad for a new exercise group for older adults at his local leisure centre and notes it down in his book. Sandra feels less anxious – not because she's less worried about David but because she feels that she's more confident and actually doing something to help manage things. She has developed a good habit of prompting David to transfer things from his book to the board and has been using the spaced retrieval strategies well.

Interactions with family and other social networks

Self-confidence and perception of self

Hopefulness and aspirations for the future

Knowledge and understanding of condition

Willingness and motivation to work with therapist

Confidence in managing memory problem

New memories/procedual knowledge – how to use

David's trip to the exercise class doesn't go as well as he'd hoped. He forgets to set his alarm for his after-lunch nap, is running late, and is flustered. At the class he finds it difficult to remember people's names and feels disorientated. He's not sure he'll go again.

Assessment and information gathering

At the start of Julie's next visit, they review how the strategies have been working. David tells Julie that although he's disappointed that the exercise class didn't go well, because other things have been working out he's willing to give it a go again, especially if Julie can look at how to help him manage the memory issues he experienced there.

Reasoning, judgement, reflexive skills

Response

Education about conditions and theory for techniques

Julie starts by explaining that David might have found the exercise class particularly challenging this time because he was feeling rushed and stressed, and that this might have reduced his ability to concentrate. Julie repeats some of the information about how memory works. She helps David and Sandra understand that busy social situations might affect the degree David can attend to information. This

barrier to his attention prevents him from encoding the information and laying it down as memory.

Changes to activities

Julie explains that there are things David can do to help in these situations and that he can start practising them in less busy and more familiar settings until he's able to do them more comfortably. When it comes to remembering people's names, Julie encourages David to repeat their name out loud. She says that an easy way of doing this is to say something like *'Gary, nice to meet you Gary'* and then for David to repeat the name several times in his head while looking at the person. Julie also says that if David can use rhymes or associations it will help to remember names. She also encourages David to use his notebook and write down a little bit about the person so that he can review it later: for instance, *'Gary from exercise class. Glasses and a beard, two sons also living in London'.*

Julie stresses that the most important thing is to concentrate on this as it's happening and to try not to be distracted by other things happening nearby. Julie also tells David not to be too hard on himself. She tells him she has a really good memory for faces and names but not for matching them up, and regularly forgets people's names. In her experience, most people don't mind if you forget their name; it can be nice if you ask again because it shows you're interested in them. Julie tells David and Sandra that if he continues having difficulty concentrating in busier situations they can try a similar approach to the spaced retrieval, but to focus on things that need his attention. This could include practising the names of new people and gradually increasing distractions at the same time until he's able to regularly use the strategies.

Confidence in managing memory problems

Julie also reintroduces the topic of their mini-breaks and asks whether they might wish to plan to go away again. David and Sandra are unsure, so Julie asks them to reflect on possible challenges or concerns. Apart from their worry about being in unfamiliar houses, they do not identify any single issue that really worries them. Julie encourages them to think about how they could use the strategies so they can still go on breaks. Sandra says she's been thinking about whether they could use grading for this, that is, taking it one step at a time from what they feel they can achieve at this time to more challenging situations in the future. To begin she suggests that they go away for one night, somewhere nearby, so if it's too difficult or they don't enjoy it, they can come home again and it won't feel as though they have lost a lot of money.

Reasoning, judgement, reflexive skills

Policy/organisation expectations around practice

Ability/capacity for occupational performance and engagement

Perceived quality of life

Julie is happy that David and Sandra are using the strategies and aids to help with memory problems and that they are beginning to develop their own solutions and strategies at home. She decides this will be her final visit because of pressure on the service but confirms that she will give David and Sandra a follow-up call to see how they're getting on. When she does, David and Sandra have been to visit their sons and their families in London. David took his notebook and the whiteboard with them and used techniques to help with remembering his grandchildren's names. They managed well, had a great time, and are planning another trip.

At a team meeting, Julie raises the issue of the use of the Barthel Index (Collin et al. 1988), reflecting that it did not feel like a relevant assessment. It had a negative

effect on her work with David and Sandra, and at the end of her sessions with them she had no meaningful way of capturing the positive outcomes. She says that writing her report was difficult, as she had to describe what she thought the key outcomes were, having to explain possible improvements to David's performance and quality of life, which was inefficient. She suggests the team members think about how to evaluate outcomes that are more relevant to their work, and also suggests these would evidence the need for longer involvement with some clients.

Reasoning, judgement, reflexive skills

Personal disposition

Figure 3 presents a visual representation of this case, indicating some of the relationships between different components. The potential for different components to act as influencers is also shown. The colours used in Figure 3 match the component areas shown in Figures 1 and 2, a key for which is presented here:

Therapist(s)-in-context

Macro-context

Expected changes

Unexpected changes

Person(s)-in-context

Implementation context

Transitions

Outcomes

Mechanisms of impact

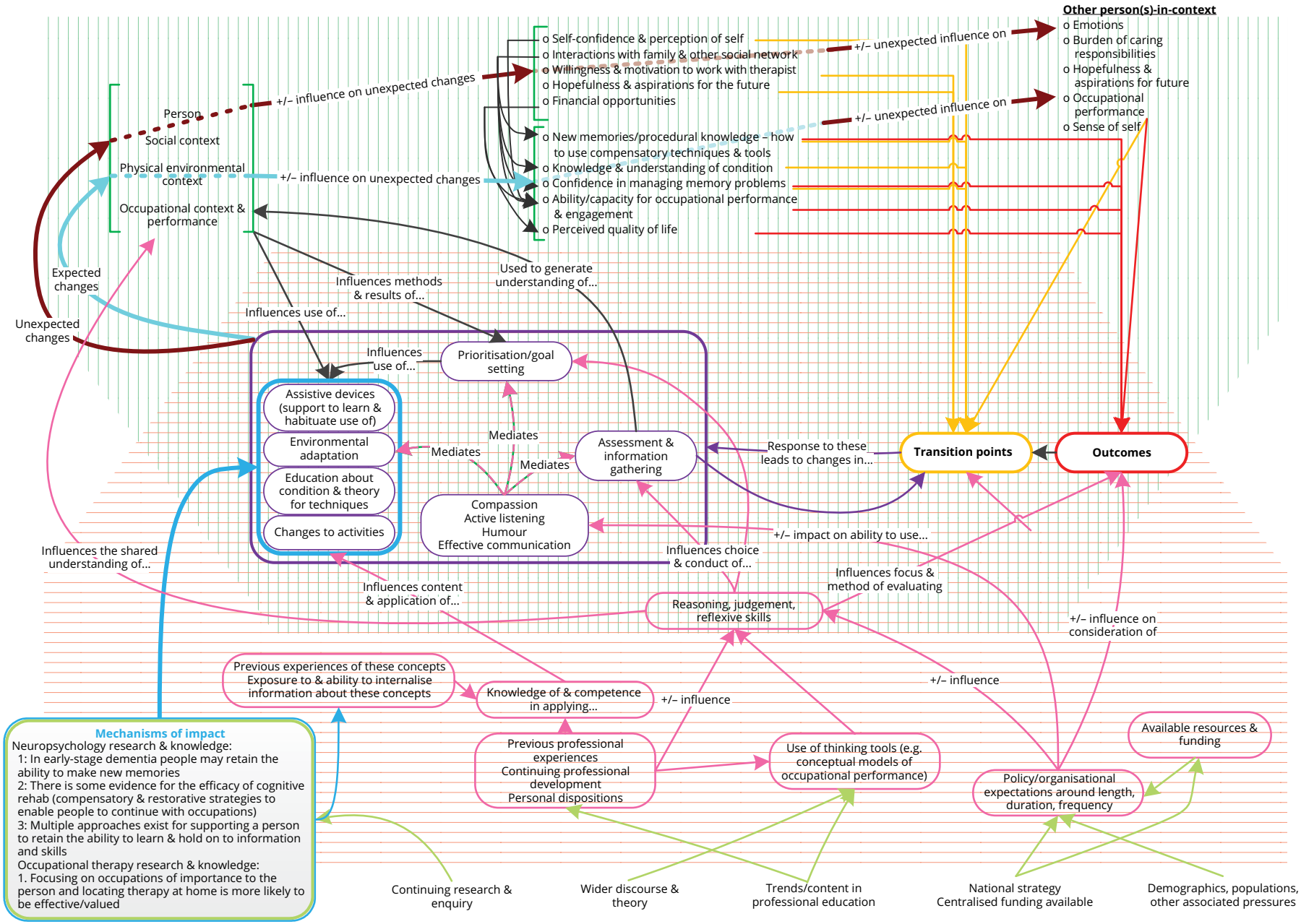


Figure 3 Case-linked visual representation

4 Expanded descriptions of model components

This section aims to provide further, detailed descriptions of each of the model components. To do this, it provides examples from the results of the survey, focus groups and literature review. These examples should not be presumed to be exhaustive of the wide range of components in contemporary occupational therapy, but are presented to illustrate and expand the descriptions. Detailed reference to data sources will not be provided here, and further information on the methodology and results underpinning this discussion is provided in Section 2. In the following discussion each component is named and described separately. However, they should be understood within an ongoing and dynamic interaction, and this will be evident in the descriptions provided.

Contexts

> *Context can be considered in four ways during occupational therapy: the person(s)-in-context, the therapist(s)-in-context, the intervention context and the macro-context. … Context pertains to the unique combination (Latin* contextus*: from* con *'together' and* textere *'to weave' (Stevenson 2010, p.376) of environments, personal factors and histories that influence the occupational being at a given point in time.* (p.13)

As previously introduced and presented above, context indicates the ongoing interweaving of the multiple factors that influence the occupational being at a given point in time. The terms 'person(s)-in-context' and 'therapist(s)-in-context' are used to indicate the idea that people are not separate from their contexts. Whenever attempts are made to isolate components, there is the risk that an awareness of interactions and understanding about how these influence change will be lost. One example would be looking purely at an environment, without considering how, when and why a person engages with or within that environment in particular ways.

In the model, four contexts are described. The person(s)-in-context and the therapist(s)-in-context come together for the duration of the occupational therapy process, and in doing so form the intervention context. These three contexts are situated within the much broader macro-context.

In the data obtained from the survey, the literature review and the focus groups, factors originating from these contexts are regularly identified as influencing the occupational therapy process and introducing complexity to the process. Examples include the influence of context on: the individualised nature of implementation content; the ways in which change occurs; and how outcomes are experienced and evaluated. In the data these factors are described as having positive, negative and possible influences on the occupational therapy process. Here they are presented as influencers (rather than as barriers and facilitators) in recognition of their potential to have both positive and negative effects on the process of occupational therapy.

Macro-context

The macro-context includes many of the components of environments, such as government and political structures, technology, global and national events, and social trends. The term 'context' indicates the significant influences, through an intertwined and ongoing relationship, that these macro components have with the person, therapist and intervention context.

The macro-context includes political ideologies, such as neoliberalism, that are seen to impact on the way health is understood (for example, the importance of individual self-management) as well as on how health and social services are structured and organised. It also includes the contemporary economic climate (moving on from the economic crisis of 2008) and continuing policies of austerity in the UK. Occupational therapy is influenced by theoretical ideas about health, wellbeing and occupation and components directly influencing practice, such as resource availability, national policies and legislation, national service framework quality requirements and professional codes of practice and conduct. Technological advances are influencing the daily occupations of people, as well as the impact of the possible uses of telehealth and virtual reality as components in occupational therapy.

Person(s)-in-context

In occupational therapy each person is understood to be unique and in a constant state of development. Their own individual capacities and abilities, the unique features of their own social and spatial environment, aspects of their life course, and their past, present and future occupations are important in shaping this development. The person(s)-in-context idea enables recognition of how occupational therapy is one small part of a life in progress for the person(s). Their rich history is essential to who they are in the intervention context that occurs during occupational therapy, and their history informs the shape of the process. On completion of the process, change – ideally – will have occurred that will positively influence the future life they will lead. Furthermore, the person(s)-in-context idea reflects the importance of these considerations in the approaches occupational therapists take to practice.

Components of person(s)-in-context identified from the data included:

- immediate and expanded social networks;
- personal and family values and worldviews;
- opportunities for participation in desired occupations; access to these in spaces local to the person;
- physical environments with which they interact;
- individual lifestyles and socio-economic characteristics (financial status, housing and employment);
- personal characteristics, including dispositions and abilities. Particular note was made of the ability to take responsibility, readiness to engage with therapy, and individual awareness and insights.

Therapist(s)-in-context

Describing the therapist(s) as 'in-context', as with the person(s)-in-context, enables the recognition that each therapist is unique, bringing to the therapeutic process their own professional and personal history, perceptions and abilities. Similarly, this idea of a therapist located in a specific context allows changes that happen to them during, and because of, each therapeutic encounter to be considered as a contribution to complexity.

Therapist(s)-in-context factors were discussed in the data in two broad categories. The first category relates to factors personal to each therapist. These include their knowledge and skills as well as the personal qualities they bring to the professional therapeutic relationship. The second category refers to a range of socio-institutional structures that create boundaries or broadly frame the context within which occupational therapy takes place. In each case, the various components are interrelated: for example, the knowledge a therapist holds about how practice is informed by their experiences, by the aims and structures of the service in which they practise, and by the social structures they encounter as professionals.

Therapist(s)-in-context factors identified in the data are listed below, along with examples from the data.

Personal factors: knowledge, skills and professional artistry of the occupational therapist

- Knowledge of and ability to apply specific theories and models to the process of therapy (e.g. recovery model).
- Degree of knowledge and understanding of associated information: for example, biomedical understandings of the human body.
- Ability to use and to reflect critically on evidence associated with practice.
- Practice skills, such as clinical reasoning, activity/occupation analysis, reflexivity, client-centred practice, verbalising an occupational perspective, group-work skills.
- Therapeutic use of self/professional artistry to facilitate trust. This may include kindness and compassion, persistence/determination, modesty, understanding, non-judgemental attitudes and the ability to use humour appropriately.
- Management skills to enable the creation of facilitative intervention contexts, including environmental conditions, availability of equipment, organisation of client programmes of therapy (particularly in relation to implementing occupation-based practice), time management.
- Practice experience and/or expertise.
- Personal values (ethics).

Socio-institutional structures

- Supervision, including the expertise of the supervisor and the frequency of access to supervision.
- Knowledge and expertise in the team and immediate professional networks.
- Collaboration between team members and other agencies; the degree of integration of services.
- Management structures, including operational meetings, annual planning, role clarity, service integrity, memoranda of understanding and leadership.
- Quality improvement processes and service delivery standards and guidelines.
- Service aims/models of practice and congruence with occupational therapy philosophy and models. Examples include appropriate referrals, understanding of expertise, autonomy, and power to change established practice.
- Financial factors. Examples include the availability of services such as home visits, community care or intervention beyond discharge; the opportunity to implement occupation-based and client-centred practice; the chance to establish new

interventions or develop practice; the opportunity to work collaboratively with family, carers or schools; and the number of occupational therapists available.

Intervention context

The intervention context occurs when person(s)-in-context and therapist(s)-in-context come together. The process of occupational therapy is located within this shared context. It is inherently interpersonal and dynamic and comprises the interactions between person(s) and therapist(s) and the shared occupational components of therapeutic practices.

Each unique intervention context includes components outlined in the descriptions of the person(s)-in-context and therapist(s)-in-context. The distinctive way in which these components come together means that the intervention context for one person(s) is different to that for the next person(s). Similarly, each time the person(s) and therapist(s) come together during an occupational therapy process, there will be differences from the previous and the following occasions. The intervention context provides the boundaries within which different occupational therapy practices are configured and used.

In this model the term 'person(s)' is used. Occupational therapists' clients are individuals, families, groups or organisations. In addition, while an occupational therapist may be working with a named individual, other people – for example, family members, carers and teachers – may be part of the intervention process, either directly or indirectly. The intervention context can therefore extend beyond the shared context of one individual and the therapist to include direct contact between a therapist and a family, a group, a classroom, an organisation and so forth, as well as indirect contact with similar social influencers.

A range of factors contribute to the unique interactions of the person(s) and therapist(s) within the intervention context. While some of these have also been referred to in the discussion of the person(s)-in-context or the therapist(s)-in-context, it is seen that within the intervention context these factors come together and operate in unique ways. Therefore, these factors are identified as important influencers (potentially with both a positive and negative impact) on the intervention process.

From the data these influencers are categorised as relating to motivation and knowledge, financial and other resources, culture and diversity, environmental factors, families and carers, research evidence and structural factors. Each of these is presented in continuation with examples from the data:

- *Motivation:* The person(s)'s motivation is essential to successful engagement in occupational therapy. Motivation may be reduced when confidence is low, interest in the process is reduced (e.g. therapy is seen as boring), or when social stigma is experienced (e.g. from classmates). Motivation is also affected by the ability to concentrate.
- *Knowledge:* The client's knowledge of the medical diagnosis and how this affects function or ability; limited perception of problems is seen to equate to limited participation in the intervention process.
- *Financial and other resources:* The availability of financial and other resources affects the intervention process in multiple ways. Examples include a person's ability to participate in certain occupations; the availability of certain interventions or the number of sessions; the amount of work that can be undertaken with families and/or carers; a person's ability to attend sessions due to transport costs or lost hours of work.

- *Culture and diversity:* This includes working with diverse groups as well as recognising the culture of services. Examples include respect for individuals' values and beliefs, as well as their varying occupation/daily activities; the culture of the service and whether it 'fits' with the needs of clients (for instance, an emphasis on safety and risk management rather than on occupation and wellbeing); language, both the accessibility of the 'language' of occupational therapy to people and families and the use of translators; applying evidence and research information with diverse groups (e.g. in terms of disability, sexual orientation or religion).
- *Environmental factors:* This means all components of the person's environment (physical and social) that affect the intervention process. Examples include whether a person's workplace will make required accommodations; availability of suitable leisure occupations in the community; restricted environments (prison, secure hospitals); suitability of the social and home situation for visits; social environment such as stigmatising attitudes; access to technology; geographical location (isolation) and transport links.
- *Families and carers:* The importance of the interrelationships client(s) have with their families and/or carers. Examples include working with parents; appreciation of variations in parenting styles and acknowledgement that parents may feel overwhelmed and unable to participate; carers may experience stress, or due to their own age/health condition may be unable to provide sufficient support.
- *Research evidence:* The availability of research evidence, particularly from robust trials. Examples include the difficulties of working with specific conditions; approaches and configurations of therapy where there is very limited evidence.
- *Structural factors:* These relate to the service within which the intervention takes place. Examples include the overall aim of a setting and what outcomes that service prioritises in terms of relevance and value; documentation (referral forms and assessments) that shape practice; challenges people (clients) experience when navigating health and social care systems and administration; the importance placed on safety and risk factors.

Causal assumptions

> *In occupational therapy,* doing *(engaging with occupations) and* change *(the act or process through which something becomes different) are indivisible from one another. Doing causes changes within and between different components of the person(s)-in-context. These changes can occur immediately (at the same time as doing) and/or gradually (after the doing has occurred).* (p.11)

The section in a preceding chapter (Chapter 2 Causal assumptions) gives an underpinning statement about the core theoretical causal assumption in occupational therapy: occupation is related to change. Change in occupational therapy focuses on improving or maintaining the health and wellbeing of people. This idea is largely based on the extent to which occupational therapists referenced this idea, or the conceptualisations that are based on it, in the three data sources analysed.

The importance of the active engagement of the person(s) in the occupational therapy process is a key characteristic of how changes occur. Engagement is often referenced as allowing occupation (rather than task or activity) to form part of the intervention, and this is seen to be important. In addition, centring therapy on occupation is referred to as being part of wider 'named approaches' such as person-, client- or family-centred practices. These in turn are used to frame a range of key practices, such as developing

relationships that enable a partnership approach to goal setting and evaluation, as 'fitting' the person(s). This fitting of practice to person(s) ensures they engage in occupations that have meaning for them, thus facilitating an effective process.

The interdependent nature of different components that allow occupation to occur (typically the person, their contexts and occupations) are referenced routinely when change is considered. Changes in one component are understood to lead to change in another. There is also the understanding that changes might occur simultaneously (or that the direction of change is difficult to estimate), due to multiple dependencies between these components. These understandings are often used to explain decisions on the focus of intervention.

These embedded references to conceptual understandings of occupation can be taken to point towards a set of root causal assumptions:

i. Occupation is intrinsically related to health and wellbeing.

ii. Occupation-embedded health and wellbeing emerges from a person and their context.

iii. Occupational therapy focuses on causing changes to a person and/or their contexts and/or their occupations to achieve health and wellbeing.

Mechanisms of impact

> *The mechanisms of impact in occupational therapy refer to both expected causal pathways to change associated with specific strategies and techniques, and unexpected changes that may occur because of context. Mechanisms of impact are strongly related to the causal assumptions in occupational therapy noted earlier and are typically the more discrete aspects of practice that are configured to produce expected changes in specific components of a person and their occupations.* (p.12)

Various mechanisms of impact are understood to produce change in occupational therapy. These can be linked to the component areas of occupation, environment and person, and links between these component areas are noted. As an example, changes in a person's environment are often linked to changes in occupation or occupational performance. Some examples of the different mechanisms of impact from the data are presented here, together with references to the associated impact on other components.

Environmental mechanisms of impact

- Modifying the physical environment to eliminate environmental barriers, associated with improved occupational performance, reduced risk and increased confidence and ideas about a sense of 'home'.
- Modifying the sensory environment to reduce additional stimuli/pressures and allow a focus on components of performance.
- Modifying the environmental context of intervention (sometimes referred to as 'ecological approaches in real-life situations') associated with concepts of conditioning, skill development, mastery and agency.
- Modifying social environments (peers, teachers, researchers, therapists, wider society) to allow opportunities balanced to the needs of the person. This is associated with occupational performance at the level of the whole person, including concepts of self and benefits from social processes such as shared experiences and goals; learning

from each other/'peer learning'; being part of a team; sense of community/emotional sharing.

Intrapersonal mechanisms of impact

Mechanisms of impact related to the components of a person are prevalent in the diverse examples shared. These range from mechanisms of impact associated with body structures and functions through psychological theories to more complicated theories such as concepts of the relational self, and are sometimes seen to have dynamic and recurring influences on each other. Further examples include:

- Changes to skills, functional ability and occupational performance are associated with ideas about the value of the person. Being seen and seeing themselves as a valuable, capable person is directly linked to increased confidence and self-esteem. This increase to confidence and esteem relates to further improvement at the skill and performance level.
- Increased self-awareness and sense of control and development of identity are associated with achieving occupational performance goals. Achieving a goal enables the person to 'see' that they are 'getting better'. This in turn has positive effects in terms of reinforcing habits and routines, creating meaning and value in performing occupations, encouraging confidence and confirming abilities and assets.

Functional mechanisms associated with the improved occupational performance of the person include:

- Developing an understanding of their circumstances and improving knowledge of self.
- Building knowledge and expertise in using strategies such as problem-solving and self-advocacy.
- Enhancing personal physical capacity.
- Improving motor, social and cognitive skills, neurological changes and emotional regulation.
- Developing the ability to make choices and to use assets and capabilities (personal and environmental), often referred to as an increasing ability to 'take control'.

Occupational mechanisms of impact

Occupation and engagement in occupations is a central causal assumption underpinning processes of change in occupational therapy. Several mechanisms of impact are associated with interventions focusing on occupations themselves. Some of these link directly to changes in the other component areas. For example, environmental adaptation and equipment provision changes the form of the occupation, and altering component aspects of an occupation means that its demands fit a person's capacity. Similarly, grading changes to occupations to allow measured exposure to increasing levels of demand allows capacities, skills or new strategies to develop.

Other examples relate to ideas associated with the psychological changes noted above. These include allowing or enabling a person to engage in occupations that:

- Are creative, related to self and/or community-focused, and are culturally relevant.
- Provide opportunities for healing; self-discovery; identity formation; participation and acceptance in the community; self-expression; change from focus on illness/impairment towards change/recovery; further occupational engagement; developing optimal occupational lives; increased motivation and self-efficacy.

- Give an experience of success so that feelings of competence, increased awareness of capabilities, and motivation to continue developing skills occur.

One final aspect of occupational mechanisms of impact identified in the data is the idea that engagement in occupation is self-replicating: successful engagement in occupation leads to further engagement in occupation. This is key not only to the intervention process but also to the ongoing daily life of the person beyond completion of intervention.

Named theories and approaches from other disciplines

Several papers included in the literature review identified various models other than those specific to occupational therapy, most notably the International Classification of Functioning, Disability and Health (ICF) (World Health Organization (WHO) 2008). It was a helpful framework to ensure holism and person-centredness, while there were also indications that it is used to structure the content of an intervention. Mechanisms of impact developed in other disciplines are also incorporated in the practices of occupational therapy to help explain, inform or frame aspects of both the mechanisms of impact and the implementation content. Specific theories relating to psychology and behaviour, neurology, cognition and ageing are referenced in the data.

Implementation content

> *Implementation content [is] all the strategies and techniques that are configured and used to form the practices of occupational therapy. In a dynamic occupational therapy process, implementation content alters over time in response to person(s)-in-context changes and in adaptation to other contextual factors.* (p.12)

Occupational therapy practices include both theory-driven activities (related to causing changes in person, context or occupation) and more non-specific practices that, nevertheless, are considered fundamental to effective therapy.

Common features or characteristics of implementation content identified from the data are:

- Multiple interventions in terms of the practices that take place, where they take place, and who is involved.
- The focus of the process is individualised and often variable and shifting, based on reasoned responses to changes in the person(s) and/or their context.
- The person(s) are actively engaged in most interventions.

Intervention content consists of a number of practices. These practices are strategies and techniques that are either associated with known theories or are aspects of a therapist's skill or expertise. These practices link to the mechanisms of impact previously outlined and examples from the data are briefly outlined below.

The active involvement of the person and working in partnership

The importance of the active involvement of the person was evident throughout the data. Central to this is the person actively identifying their own needs, setting their own goals, developing the plan and choosing activities, with a sense of trust in the therapist, the setting more generally, and others. The person shifts their perception of their future. Active involvement also involves engagement in occupation, doing both new and familiar occupations. Contact with others with similar experiences to the person, ensuring a

positive and enjoyable social environment, also promotes the person's participation both in therapy and more generally.

Information-gathering activities

Findings from the literature review and survey indicated limited consistent use of the language to describe information-gathering practices. The terms 'assessment' and 'evaluation' are both used (without a clear delineation of difference). Similarly, the intention of these activities is not always differentiated. For instance, 'function' is used in two different ways in reference to assessment: as 'motor function', consisting of muscle tone or range of movement; and to represent activities of daily living such as eating. Assessment ranges from a broad focus such as *'this was the first time the client could tell their whole story'* to a specific focus on explicit skills or body functions. Other assessments direct attention towards specific components of an occupation, such as knowledge of road signs and laws relevant to someone learning to drive.

Information-gathering techniques identified in the survey and literature include:

- interviews, observations and local checklists;
- gaming technology;
- goal attainment scaling;
- previous medical and other care records;
- feedback from colleagues;
- individually designed batteries of assessment;
- standardised measurement;
- opinions, reflections and perspectives of a person's family;
- the therapist's reflections in and on practice.

Goal setting

Goal setting, usually collaboratively with the person(s), is a common practice. Examples include working on care plans, identifying relevant situations with the person and family, building a common vision, creating mind maps, action planning, and prioritising goals with the person. Goal setting and revision may be an ongoing process throughout the intervention process.

Collaboration with others

Occupational therapists rarely work in isolation. To enable the person(s) to achieve their goals they are required to be skilled collaborators, working with a variety of agencies, staff, volunteers, families and carers. Some also work with service users and service user representative groups to design services, while others work with researchers, evaluators and those developing practice. Some examples of collaboration include working with:

- Agencies in the community to develop and co-ordinate interventions e.g. with a client, their employer, and their social insurance and employment services; with the ambulance service; with community groups.
- Staff within the same institution to co-ordinate optimal programmes, to plan discharge and/or to deliver remote services (e.g. prison wardens, care staff and multidisciplinary team members).

- Volunteers, students and classroom assistants to co-ordinate the delivery of intervention programmes.
- Teachers and others to provide consultancy and education.
- External experts, e.g. fitness trainers and financial and legal advisors.
- Policy-makers to drive system change.
- Carers, including parents, to support their mental and physical health, as well as to educate them about their family member's condition.

Occupation

Engaging in occupation is at the core of many interventions. Occupation is characterised in terms of being meaningful, relevant, rewarding, respectful, motivating, providing 'just-right challenge' and facilitating empowerment, enjoyment and engagement. Occupation-based approaches involve or are responsive to the person(s)-in-context, rather than being more limited in focus.

Occupation is employed as a practice in its own right. This may include re-engagement in valued occupations, as well engagement in new occupations that challenge the development of new skills and strategies, such as:

- Engaging in valued recreational activities in the community, including culture, arts, outdoor pursuits, volunteering.
- Occupation within services such as gardening and horticulture, cooking and shopping, play, pre-vocational and vocational training.

Core to practice is a variety of strategies designed to develop engagement in occupation. These include occupation/activity analysis, grading and adaptation. Ensuring motivation and a good 'fit' with individual needs and abilities is central to these practices. Terminology is less consistent here, with 'activity' also used frequently and interchangeably. Examples include:

- Activity/task analysis, used both in preparing occupations to be used during intervention and to identify barriers to participation in occupations.
- Activities graded to enable successful participation in both therapeutic sessions and occupations at home/community. Grading is applied in a number of ways. Examples include grading a series of occupations/activities to develop a person's skills, interests, physical abilities, their ability to engage in more complex tasks or to reduce the amount of support required; grading a specific task into component skills to enable mastery of each; grading frequency of participation (such as a graded return to work).
- Activities adapted or modified to enable participation. Assistive or compensatory devices and strategies support clients to engage with a range of occupations, including communication; bathroom, kitchen and home access; and driving. Therapists engage in assessment for these adaptations, their implementation and follow-up, and occasionally in their production.

Educational processes

Education takes a number of forms but is an integral aspect of many interventions. Included is direct education (typically explanatory), coaching, training and strategies for either component functions or specific skills.

- **Education**

  Practices involving direct education are common. These include imparting knowledge and information on specific conditions, explaining techniques and strategies, sharing information about local resources, explaining how to manage environmental barriers and how adaptations might work. Education is also directed towards the public through social media information campaigns.

- **Coaching**

  Coaching is described in some cases as an enablement skill involving specific models of coaching. More typically, the term is used in a general way to describe performance-related instructions that include observing and providing feedback. Coaching usually takes place in the natural environment with the aim of supporting occupational performance. Coaching of carers and parents to support the person is also undertaken.

- **Training and strategies for cognitive, physical and sensory components/skills/ functions**

  Various cognitive, physical and sensory components and skills are addressed through training, strategy instruction and interventions. The literature review identified a variety of named approaches (e.g. cognitive and sensorial stimulation, cognitive retraining strategies).

  With respect to motor function, a range of practices are mentioned, including exercise programmes (including walking and aquatics), fine motor strengthening exercises, gross motor intervention (including hopping and stepping), gross motor co-ordination (including strength and endurance), motor development strategies, training hand function, oedema and scar management and breathing exercises. Repetition is reported to be important in some of these programmes, and 'Repetitive Task Training' is named as a specific strategy.

- **Skill training**

  This includes the training of specific skills for activities involved in daily living (including safety in the home), for work (including return to work) and for school (such as handwriting). Skill training also includes skills in the management of certain issues and/or situations (e.g. stress, handling finances), or to support the person's ongoing engagement in occupation/daily activities (including skills in identifying opportunities for occupation in the community). Skill training may involve practice and repetition, including homework or self-directed practice.

Group-based interventions

Groups have potential for supporting changes, typically in terms of personal components (skills, capacity) or by providing opportunities for occupation. The development and support of groups is managed through in-group activities, creating a sense of 'our group'. Key components for fostering an 'our group' experience are that group members are seen, heard and treated with dignity, which in turn leads to positive relationships, self-acceptance and opportunities for growth.

Supportive practices for group interventions were identified to include:

- shared activities, team-building activities, community living and sharing stories;
- group members experiencing choice and ownership of the group, and shared decision-making.

The environment

As a strategy, environment is used in two main ways, with practices involving virtual environments and 'real' environments. Virtual realities and information communication technology to deliver practice are described in several ways:

- To provide contact between the client and the therapist due to rural locations or other contextual factors.
- To provide a virtual setting for treatment activities, such as for upper limb rehabilitation, or cognitive, perceptual or physical activity training, both individually and in groups. Technology used includes games, Wii™ and fully immersive virtual reality.
- Applications for media devices (such as smartphones) to support client's specific needs, such as time management.

Involving a wide range of 'real' environments – the home, workplaces, community centres, green spaces or classrooms – is identified as important practice for several reasons. The first relates to the importance of change within the actual environments in which daily life takes place. This includes the creation or facilitation of 'conducive environments' and 'real-life' situations that are familiar, safe (incorporating emotional and physical safety), relevant and meaningful. Adaptation to the environment, provision of adaptations to be utilised within different environments and advocating for physical and social accessibility are also central practices.

The relationship between person(s) and therapist(s)

The development of a relationship between person(s) and therapist(s) is a practice used in combination with a number of other strategies and techniques, but is seen as fundamental to successful change. Concepts related to the therapeutic use of self are identified as well as essential characteristics of the relationship. These include the importance of collaboration, working with clients as partners, and engaging with clients and their families. The therapist(s) should be encouraging, inspire trust and share their experiences.

Specific named programmes incorporating multiple strategies

Specific intervention programmes are also part of the intervention content. These typically combine a number of the previously mentioned practices or strategies within a specific protocol for intervention. These include programmes based on occupation (either to promote health or as an intervention targeting specific areas) and those designed to include theories and techniques that have been developed by other disciplines. These latter programmes are identified as causing changes to person, context and/or occupation.

Examples of occupational therapy developed programmes are Cognitive Orientation to Occupational Performance (Polatajko and Mandich 2004) and Sensory Integration (SI) (Ayres 1970).

Programmes developed in other areas but used during occupational therapy include Constraint-Induced Movement Therapy (CIMT), cognitive behavioural approaches, mindfulness and relaxation, and Functional Electrical Stimulation.

Outcomes and transitions

The multiple changes to person(s)-in-context, when identified in the intervention context, may be considered as transitions. These transitions initiate responsive reconfigurations to

> *the implementation content to accommodate new understandings of the person(s)-in-context, or may be measured or estimated as outcomes.* (pp.8–9)
>
> *Outcomes […] may be evaluated in numerous ways, ranging from formal standardised measurement to clinical expertise and estimation. They may also be consequences that remain within, and are experienced solely by, the person(s)-in-context. Outcomes can occur in the intervention context or may occur within the future life course of a person after occupational therapy processes have ended.* (p.13)

Outcomes and points of transition during the therapy process are closely aligned ideas. They both relate to the changes that take place because of occupational therapy. Certain changes are anticipated, identified during initial assessment and goal setting, and measured or estimated as outcomes at identifiable points in the process. Points of transition may be recognised as important stages or steps in change as an ongoing process, incorporated in the therapist's reasoning as they adjust and refine the implementation content to achieve 'best fit' with the person. Within the data, the difference between the two often appears to be related to the contexts in which therapy occurs.

Types of outcome and change reported are detailed below. Ten categories are identified, each of which aligns with one or more of the conceptual models of occupation, including underlying causal ideas about links to health and wellbeing. One further category was formed that captured outcomes and changes associated with the process of providing therapy rather than change in one of the component areas of occupation (see final point below). These are detailed below, along with illustrative examples.

- Body structures (scar healing, range of movement).
- Symptoms (depression, pain, fatigue).
- Body functions (cognition, impairment of arm, shoulder and hand, visual perceptual skill).
- Functional and activity of daily living performance (Barthel Index, Rookwood Driving Assessment Battery, handwriting skills).
- Risk and safety (falls, home safety).
- Environment (environmental impact scales).
- Occupational performance (MOHO tools, COPM).
- Participation (typically in specific occupational roles such as school, groups, work).
- Goal attainment (Goal Attainment Scale (GAS) and informal methods).
- Multi-attribute outcomes (including concepts such as quality of life, wellbeing and recovery).
- Process- and structure-related changes (satisfaction with services).

Change is described in many different ways. When referring to those changes associated with component area outcomes, language reflects linearity and directionality: 'increased', 'improved', 'greater', 'independence', 'function', 'occupational performance', 'skill', 'reduced', 'less', 'lowered', 'disability', 'impairment', 'burden', 'risk' and 'symptoms'.

However, therapists also describe change using language more reflective of stepped, incremental and gradual processes. There are indications that some foundational

changes or transition points must be achieved before further developments can take place. These foundational changes are commonly described as 'coming to terms with' or 'developing an understanding of' changed abilities, occupations or circumstances. Motivation and a willingness to engage in therapy and trusting relationships with the therapist are also seen as foundational to later changes in different areas.

Therapists also noted that unexpected changes occur. These are often located away from the intervention, taking place in the person's context. They may be associated with the effect of therapy, or may occur independent of therapy (such as changes in social networks and circumstances that affect a person's ability to engage in occupations or the occupational therapy process). The reflection that changes in different components of the person(s)-in-context are interrelated and therefore can stimulate or inhibit one another is identified. Examples were previously presented in the section on mechanisms of impact (please see pages 30–32).

Developing an understanding of change in occupational therapy incorporates recognising that it can be difficult to predict accurately all the changes that might happen, when they might occur, and what the impact of change may be. As will be discussed further in Chapter 5, this is not the same as suggesting that changes happen in a non-linear way. Rather, there are clear indications that occupational therapists address specific areas that contribute to concepts of health and wellbeing, do so in ways that are often informed by theory and evidence, and generally report outcomes and changes in terms of direction and magnitude. The 'unexpectedness' of some changes can stem from uncontrolled aspects of a person's context or the variable responses individuals show to particular practices.

Varying approaches are used to capture change and outcomes in occupational therapy. These are presented in categories, but it should be noted that the descriptions of practice indicate that combining evaluative strategies is common.

- *Standardised measurement:* Standardised approaches are designed to capture outcomes in each of the different categories noted above, with the majority of different tools being used to evaluate changes in body function, symptomology and functional performance. Many tools were aligned to models of occupation.
- *Professional estimation:* A variety of non-standardised approaches to evaluating outcomes were reported. Collecting feedback and information from people and their families is the most common method. Other evaluation approaches identified are goal review, feedback from colleagues, observation and expert judgement, and non-standardised assessment of functional performance.
- *Structural outcomes:* Various outcomes are associated with service-related aims and factors. These are classified as structural outcomes as they are seen to arise from the need to demonstrate outcomes against criteria specified by institutional or organisational factors. They include a person's discharge destination, whether or not equipment is provided and used, risk management factors (including safe discharge, a change in care needs, re-admission status, person-reported satisfaction, productivity statistics that include time on waiting lists, number of people seen, length of contact and so forth) and return to work.

5 Is occupational therapy a complex intervention?

Examining if, and how far, this model of occupational therapy aligns with ideas about complex interventions is a key aim of this work. Occupational therapy, as will be noted in detail in Section 2, includes a broad range of practices, based on many different scientific and theoretical bodies of knowledge. This chapter examines whether the model presented above, which describes occupational therapy as a complex dynamic process, supports the application of the definition of 'complex intervention'. The work of the MRC (2000), which was the stimulus for the original work by Creek (2003), and the updated version (Craig et al. 2006, 2008) remain widely cited definitions of complex intervention. It is against the latter that the proposed model of occupational therapy is considered. It is also worth noting that there are different definitions of what may constitute or cause *complexity* in intervention. These are considered later in this chapter, where attempts are made to consider why occupational therapy might be considered a complex intervention.

Craig et al.'s (2006) guidance on developing and evaluating complex interventions offered the following definition:

> *Complex interventions are usually described as interventions that contain several interacting components. There are, however, several dimensions of complexity: it may be to do with the range of possible outcomes, or their variability in the target population, rather than with the number of elements in the intervention package itself. It follows that there is no sharp boundary between simple and complex interventions. Few interventions are truly simple, but there is a wide range of complexity.* (p.7)

Additionally, Craig et al. (2006, 2008) offered a number of key dimensions of complexity. These have been used as a framework to consider the updated model of occupational therapy, and each is discussed here in turn.

- **Number of interacting components (within the experimental and control interventions)**

The model developed during this work to revise occupational therapy defined as a complex intervention highlights a substantial degree of interaction between components of occupational therapy. These components have been identified as occurring in the intervention context and comprise a broad range of practices. These include the application of theories and bodies of knowledge, specific activities considered part of the occupational therapy process, and a range of interpersonal therapeutic techniques or behaviours.

The number of interactions in occupational therapy is typically difficult to establish, as will be seen when the degree of tailoring is considered later (p.42). One aspect that contributes to the high number of interactional components in occupational therapy is that there tends to be little, if any, separation between the intervention and a person's wider context. Indeed, the position that the intervention context in occupational therapy occurs when the person(s)-in-context encounters the occupational therapist(s)-in-context is intended to represent the idea that all components from these two contexts

may feature as components which directly or indirectly interact to influence the structure of an occupational therapy process. The high degree of variability in practices that occur when holistically considering occupational therapy as a complex dynamic process means it is unfeasible to suggest there will be a universal set of components that interact. It is possible, however, to highlight those that occurred regularly in the data collected. These are given in more detail in Section 2 and have been noted in the expanded definitions given in Chapter 4 but, as a brief illustrative example, the survey showed that occupational therapists typically employ an average of 11 different strategies and techniques during practice.

- **Number and difficulty of behaviours required by those delivering or receiving the intervention**

Data collected from the literature review and online survey indicated a number of behaviours on the part of the therapist and the person(s) with whom they are working. Open-ended survey responses and the literature review revealed a range of behaviours commonly frequently reported as central to occupational therapy processes. For a person these behaviours included ideas such as the ability to develop confidence, the willingness to experiment and take risks, the ability to exercise choice, increase knowledge, and develop and maintain skills, being motivated and remaining engaged in therapy. Interestingly, as noted below in the section considering outcomes (p.41), becoming able to demonstrate some of these behaviours was seen as transition points or outcomes during a longer process of therapy.

For occupational therapists these behaviours included the ability to understand multiple components of a person, including their needs; causes of issues with health and wellbeing; a person's priorities and aspirations; and their social and environmental contexts (in themselves comprising multiple components). Similarly, the way various activities were performed was considered to be an important aspect of intervention, including, for example, assessment and measurement, goal setting, continual monitoring and consequent responses. Several practice skills such as compassion, presence (for example presenting as professional, skilled and confident) and humour were also named as being important components of intervention.

- **Number of groups or organisational levels targeted by the intervention**

Just over half of survey respondents (56.8%) reported only working with one type of service user (in this case, 'type' refers to classifications used in the survey: individuals, families, other social groups, community organisations, private organisations and public organisations). The remaining 43.2% reported working with anywhere between two and six different types. The most frequent combination was for therapists to work with people and their families. Although the reasons for working with multiple cases were not comprehensively investigated, plausible arguments can be made for the influence of a therapist's context on this, in particular the service structures that influence practice, as well as an understanding by occupational therapists of the essential interrelatedness of people and their families and carers.

One interesting point to note is that while occupational therapy may predominantly target individuals, there is the potential for changes to happen which have benefits for other people. For instance, immediate family and social networks were noted to benefit from, or be affected by, occupational therapy (this is considered in more detail in the following section considering the number and variability of outcomes (p.41)). This again appeared to be linked to the concept of context. People and their occupations always happen in a context, which typically involves other people. Thus, occupational therapy,

in attempting to improve health and wellbeing through occupation, has a direct impact on this context and may therefore affect the other people within it.

- **Number and variability of outcomes**

The data analysed from the survey and the literature review demonstrated a high degree of variability in outcomes. The literature review identified 106 intervention objectives and 108 measurement methods or assessments across several different categories. Similarly, survey respondents on average reported using three different approaches to collecting evaluation outcome data from 22 different strategies. This was further discussed by occupational therapists in the qualitative survey responses and focus groups, where the experience of witnessing multiple outcomes from therapy was clear. Some of these outcomes were directly related to the practices used and some were unexpected additional outcomes or consequences. These additional consequences were often located in a person's wider context, and examples included references to wider social networks and occupations.

Beyond these descriptive indicators, the model suggests variability in outcome in at least three ways. The first is related to variability in terms of the direction and magnitude of a change and its associated outcomes. While many components of practice are associated with expected changes (typically reported in terms of directional relationships such as 'increase in independence'), reliably estimating when and what size this change would be is much less common. Therapists often reported incremental changes, which were often founded on the establishment of some previous change before outcomes were reached, or where the establishment of one change led to the next until outcomes were reached. More details are given in Section 2, but one example is the common use of the language of 'growth' reflecting slow and incremental development in relation to ideas associated with a person's agency.

The interactional qualities of person(s)-in-context components means that occupational therapy practices can vary in terms of the mechanism of impact, even though the eventual outcomes may be the same. For instance, using practices that adapt physical environments may lead to a person being able to *do* an occupation despite continuing body function impairments. Alternatively, the same outcome may be reached if practices that ameliorate the body function impairments are used, or if the form of the occupation is altered. Regardless of practice used, changes will happen in the other interrelated components and an outcome will have been effected. Consequently, determining the direction of impact can be challenging.

The second component of variability suggests that not all changes that occur during a process of occupational therapy are positively associated with outcome. Realising an outcome in one area (often an outcome that could be considered one of several small transitions) might be conceived as a loss or a negative impact in some other way. Framed within a single illustrative example, the process of 'coming to terms' with altered physical capacity could be seen as a transition point upon which therapy started to be effective, at the same time as reflecting a loss of aspiration.

The final component of variability relates to when and how outcomes are measured or estimated. Some changes associated with occupational therapy could not be captured or adequately explained. These related to both types of change presented in the model – expected and unexpected. They ranged from changes within a person (for example, a person's perception of issues associated with health, wellbeing and occupation) to changes in that person's wider context. These changes were sometimes

seen as outcomes in their own right or as significant points of transition that stimulated a response from the therapist in terms of the practices used.

Reported difficulties around outcome measurement provide evidence of this variability and range. In addition to using many different methods of collecting evaluative information, therapists reported difficulty in finding means of adequately evaluating outcomes. This difficulty was partly due to the nature of unexpected changes, which might occur away from the intervention context but be significant to a person's progression, and partly because many occupational therapists felt there was an absence of tools that adequately measured aspects of human experience such as meaning, and the experience of engaging in occupation.

Occupational therapists reflected that this led to situations where outcomes were judged using discrete and often service-related outcomes or where therapists relied on qualitative accounts, typically termed feedback. One way of thinking about this would be to use Senge's (1990) argument that in complex situations *'cause and effect are not closely related in time and space and obvious interventions do not produce expected outcomes'* (p.364). Because of this it may not be feasible to collect information at baseline that would allow for the traditional 'before and after' estimation of change.

- **Degree of flexibility or tailoring of the intervention permitted**

This is perhaps one of the defining characteristics of occupational therapy. There were strong and consistent indications in the data that occupational therapists configure the content of their practices in response to a range of components. The need to fit practices to the needs, aims and contexts of people came across as a core idea underpinning therapy. This was seen to be fundamental to making sure that a process of occupational therapy proceeded in a way that ultimately contributed to outcomes of value for a person or persons. This was not universal. There were accounts of mechanistic practices, although many of these were tied up with expressions of frustration and discontent at not being able to respond to a person and their context. Conversely, there were also reports in the reviewed literature expressing frustration that people did not follow instructions or comply with recommendations and prescriptions.

Flexibility and tailoring, when they did take place, were seen as key to the early stages of the therapy process and core components of its continuation. The therapist(s) and the person(s) engaged in dynamic processes where practices were continually adjusted and altered in response to continuing knowledge and understanding of a person, their contexts, and – importantly – how these changed as therapy progressed. In other words, a high degree of tailoring and flexibility is not only permitted in occupational therapy practice, but it is seen to be essential.

These ideas are described in more detail below where explanations of why occupational therapy is complex are considered, along with the impact this complexity might have on concepts of standardisation and evaluation.

Occupational therapy as a complex intervention

Describing occupational therapy as a complex dynamic process reflects the wide array of techniques, skills and activities that were reported to form contemporary practice. Judging the model developed from these reports against the core dimensions suggested by Craig et al. (2008) allows a credible claim to be made that the dynamic processes of occupational therapy can be thought of as a complex intervention. In considering

occupational therapy as a complex intervention there are further aspects to be considered, including whether it is *always* a complex intervention, what perspectives on complexity might be helpful, and what impact thinking about therapy as a dynamic process has on how therapy is studied.

In the following sections, several ideas and issues will be considered. First, as complexity remains an emerging concept in science, different types of complexity will be considered. Two current perspectives will be considered: that complexity in interventions is a characteristic of internal features (number of components and degrees of interaction), and that complexity arises as a characteristic of contextual influences on practice. It will be proposed that the model developed in this work more closely aligns with the latter perspective (though still meets the criteria outlined by the MRC), and the reasons for this position will be explained.

Complexity as an internal feature of intervention

Moore et al. (2017) have described the MRC's perspective on complexity as being one in which it is '*an internal property of a new way of working*' (paragraph 1). The term 'internal property' is used because the causes of complexity are theorised as being directly linked with the intervention itself (the dimensions of complexity that were used as a framework to consider whether occupational therapy aligns with the MRC definition earlier, the number of interacting components and so forth). From this perspective, complexity in intervention is associated with the idea that high numbers of interacting components cause a difficulty in establishing which combinations of these form the 'active ingredients' that lead to change. The main body of the MRC guidance (Craig et al. 2008) proposes a range of approaches and methods that can be used to enable interventions to be developed so that their 'internal' complexity can be understood and their outcomes evaluated.

However, the guidance (Craig et al. 2008) also mentions that complex interventions and their real-world implementation can be further influenced by a range of external circumstances. A process model to support evaluation that pays *'greater attention to the contexts in which interventions take place'* (Craig et al. 2008, p.1) was included in their update, in response to discourse which followed the original guidance suggesting that *'complex interventions may work best if they are tailored to local contexts rather than completely standardised'* (p.1). Similarly, the degree to which an intervention can be altered or tailored features as the last of Craig et al.'s (2008) dimensions of complexity.

Underlying this dimension is the understanding that there will be a coherent logic and pathway to change associated with an intervention. Components of context can allow or restrict the degree to which this pathway operates, and can thus influence outcomes. Therefore, altering aspects of how the intervention is applied to respond to the specificity of the context may be necessary to achieve the desired outcomes. Process evaluation that takes place at the same time as the evaluation of an intervention's effectiveness is put forward as a way of understanding the degree of tailoring that takes place and the effects this may have on outcome. Moore et al.'s (2015) proposals for designing such process evaluations specify monitoring the degree of fidelity and the adaptations required as two key components of process to be considered, noting that there is still unresolved debate around the degree of adaptation (and thus potential loss of fidelity) that is acceptable.

> *Fidelity is not straightforward in relation to complex interventions. In some evaluations, such as those seeking to identify active ingredients within a complex intervention, strict standardisation may be required and controls put in place to limit variation in*

> *implementation. But some interventions are designed to be adapted to local circumstances.* (Craig et al. 2008, p.2)

The challenge in considering these ideas in occupational therapy practice is that there is a fundamental tension at play. The occupational therapy process is founded on understanding individuals and their needs, issues, strengths and contexts before decisions are made about how to practise. The centrality of individualising an intervention to fit these various considerations emerged repeatedly in the data, and has been reflected in the visual and textual representation of the model. As stated earlier in the section presenting core definitions of the occupational therapy process:

> *The occupational therapy process comprises multiple practices . . . which form the implementation content. These practices include a range of strategies and techniques that are understood to cause change due to a variety of mechanisms. They are configured and used with the person(s)-in-context in a way deemed optimal for causing changes.* (p.8)

From this perspective, adaptation of the intervention happens at the individual level in response to people in their contexts. Consequently, the cause of complexity can be considered differently and can be seen to stem not only from the interactions of multiple components (though these are still present). Rather, these multiple interactions happen because responsively fitting practice to individual context is a fundamental part of the intervention process. Conversely, literature relating to complex interventions tends to give examples of adaptations occurring in broader settings. Craig et al. (2006) use the example of sexual health interventions in countries with different levels of wealth to demonstrate this idea. As will be discussed later in the section titled 'What does this mean for occupational therapy and complex interventions?' (p.48), the position that adaptation in occupational therapy happens at the level of the individual does not preclude study using controlled experimental techniques to identify causal pathways, nor does it endorse the idea that outcomes of occupational therapy are inherently unpredictable.

Complexity as a characteristic of context

Since the publications of the MRC guidance in 2000 and Craig et al.'s 2006 update, discussion about complex interventions has continued apace, as has the wider discussion of complexity in science. The same has been true in relation to Creek's original work to define occupational therapy as a complex intervention (2003) and the follow-up work by Creek et al. (2005). Duncan et al. (2007) provided a perspective that sought to clarify technical issues around the concepts of complexity. They identified many of the challenges inherent in using a term that has many different and evolving definitions, and challenged the theoretical basis for claims made by Creek et al. (2005) about the unpredictability of occupational therapy and the impossibility of standardisation for study.

Duncan et al.'s (2007) position was that there is a technical difference between the idea of complexity in an intervention and the idea of complexity in a complex adaptive system. Complex interventions, as defined by Craig et al. (2006) and considered above, include multiple interacting components in which the active ingredients can be hard to determine. Complex adaptive systems are characterised by the emergence of intricate structures from individual components following simple rules (Lewin 1999). They have the hallmarks of a system and tend towards internal self-organisation and sustainability through adaptation (Mitchell 2009). In conflating the two conceptualisations of complexity and arguing that the process of occupational therapy functioned like a complex adaptive system, Duncan et al. (2007) argued that Creek et al. (2005) developed their arguments on a misapplied theory for which no empirical evidence existed.

An alternate point of view permits a reconciliation of these two theoretical positions and aligns with the proposed model of occupational therapy developed and presented earlier. Complexity in occupational therapy is not solely a result of internal features of intervention (though they may be multiple), nor is it solely because the process itself is inherently complex and adaptive (though responsiveness and flexibility feature). Rather, occupational therapy is complex because it is focused on causing changes to take place to person(s)-in-context, by therapists operating in context, both of which can be thought of as systems. The purpose of occupational therapy is to alter how these systems function, so that occupation emerges in a way that contributes to health and wellbeing.

There is theoretical precedent for this perspective. Hawe et al. (2009) claimed that interventions can be theorised as events that take place within systems. In reference to community-level psychology and health interventions, Hawe et al. (2009) make a convincing case in arguing that an intervention serves to *'change the future trajectory of the system's dynamics. To be an effective intervention, this change in direction must lead to positive outcomes'* (p.274). The systems considered in their paper are termed 'dynamic ecological systems', and interactions between people, their roles, symbols, time, funds and physical resources are identified as the components of the system. Hawe et al. (2009) and Craig et al. (2006) proposed similar indicators for the dimensions of complexity (number and variability of outcomes, number and difficulty of behaviours required, number of groups or organisational levels targeted), but the former suggested that such features arise in response to the dynamic systems in which an intervention is applied, rather than being inherent to the intervention itself and how it effects change. Thus, the success of an intervention is related to the degree to which it is configured so that the dynamics of the system itself are changed: *'A useful new heuristic in intervention research is to think of interventions as events in systems that either leave a lasting footprint or wash out, depending on how well the dynamic properties of the system are harnessed'* (Hawe et al. 2009, p.270).

These ideas have utility in occupational therapy where the use of systems theories is predominant in Western models of occupation. For example, the original iteration of the Model of Human Occupation (MOHO) (Kielhofner 1985) was explicitly based on understanding human beings as open systems, with the more recent edition claiming a basis in dynamic systems theory (O'Brien and Kielhofner 2017). The Canadian Model of Occupational Performance and Engagement (CMOP-E) (Townsend and Polatajko 2007) and the Person, Environment Occupation (PEO) model (Law et al. 1996) do not explicitly use the language of systems, though reference to systemic perspectives was made in Fearing et al.'s (1997) process model. The CMOP-E and PEO models are arguably based on systems theories. The interactional nature of multiple components and the resulting emergence of occupation and/or health outcomes reflect systemic properties.

Recognising that most ways of thinking about people as occupational beings is founded on systems theories is important because it allows the two different ideas of complexity to be considered. Nevertheless, it is useful to provide some information about systems and the link to occupational therapy here.

A first point is the importance of adopting systems as a 'way of thinking' about occupational therapy. The term 'systems thinking' is used across many scientific disciplines with reference to the idea that thinking about things as systems can be a useful way of describing, analysing and simplifying reality to enable greater understanding (Dekkers 2017). Systems are typically identified at a conceptual level. As systems are open and continually interact with wider environments, any identified boundary is purely conceptual. When something is described as a system, it is because

there has been a purposeful decision to view it as distinct from the wider universe (Dekkers 2017):

> *The separation should serve the nature of the study and an investigation will take only those elements and relationships within the system into account plus the relationships with its environment, i.e. those elements in the universe with which the internal elements have direct relationships.* (p.37)

This concept of selecting a system to allow it to be studied leads on to a second key idea about systems thinking. Different types of situation or phenomena may require different methodological approaches to be used to structure enquiry. The scope of this work does not allow for a detailed description. However, Jackson (1991) gives a useful overview, noting that these systems approaches range from 'hard' functionalist perspectives of phenomena to 'soft' interpretive ways of organising information. Like other approaches to enquiry, different underpinning theoretical assumptions shape how ideas of systems are used, and the different approaches will fit different types of enquiry.

This is an important set of distinctions for occupational therapy, and adds to the challenge of understanding occupation (and thus occupational therapy). The current models available for understanding occupation require different systems approaches to be used concurrently, despite having different underlying assumptions. For instance, in understanding the role of physical capacity in occupation, the human body is typically understood from a functionalist perspective (systems that represent a 'hard' physical reality, understood by identifying patterns and regularities in interactions between component parts). The index for the International Classification of Diseases (ICD-10) (WHO 2016) demonstrates how much of the human body is understood as a functional system (nervous, respiratory, circulatory, digestive, musculoskeletal and genitourinary systems). The systems perspectives here only provide approximations, though, as most musculoskeletal systems are alike but no two are identical.

Concurrently, dominant models of occupation draw attention to specific concepts that seem incompatible with this functionalist systems perspective. The CMOP has at its centre spirituality, defined as an element residing within a person that gives meaning to occupation (CAOT 1997). Similarly, the MOHO draws attention to the concept of volition as one of the core aspects of occupation and suggests that the volitional process is partly shaped by the interpretation of experiences (Yamada et al. 2017). Although never explicitly addressed, it would be plausible to suggest that both of these core ideas are rooted in interpretive theories. Understanding spirituality or volition and their roles in the occupational being must be approached subjectively, so that the points of view and intentions of the people who construct them can be considered.

As another example, 'environment' is identified and featured in most conceptualisations of occupation. Typically, these include classifying environments as physical, institutional/organisational and social/cultural settings. Each of these aspects of environment can be thought about using different systems perspectives. Dekkers (2017) provides a useful response in the discussion of applied systems theories whereby examples of physical environments are described as complex adaptive systems and organisations as cybernetic systems. All of these are valid, as the systems concept is simply a way of categorising a phenomenon to allow it to be considered in a more coherent and structured way.

From a systems point of view, then, occupation and associated health and wellbeing results from the interaction and operation of multiple systems. Each of these systems can be constructed using different perspectives, for good reason. It is possible and

helpful to build quantitative models which give a precise approximation of how cardiovascular systems work under certain conditions. However, it would not be possible to understand a person's spiritual drive or volition in the same way, even though a systems perspective could be used to structure enquiry into these components. Lying in the realm of metaphysics and outside the purview of this document, we can consider the complexity of the rationale for such a declaration of difference. It invites debate and reflection as to whether there *is* a difference, or simply an inability to separate the concepts such as free will from a current inability to examine reality beyond the quantum scale to establish determinism in the universe. As a working proposition, however, it would be reasonable to suggest that occupational therapists think about people as occupational beings using systems approaches underpinned by both functionalist and interpretive theories.

A third key idea is that *'all systems approaches are committed to holism – to looking at the world in terms of "wholes" that exhibit emergent properties, rather than believing, in a reductionist fashion, that understanding is best obtained by breaking wholes down into their fundamental elements'* (Jackson 1991, p.7). In systems thinking, there is a fundamental perspective that individual components or properties, when studied in isolation, become meaningless without the context provided by the whole (the wider system) and the resultant characteristic properties that emerge. Examples, such as this from Checkland and Poulter (2010), are typically given to understand this idea of emergent characteristics from a functional system of interacting components: *'Thus, the parts of a bicycle, when assembled correctly, and only then, produce a whole which has the emergent property of being a vehicle, the concept "vehicle" being meaningful only in relation to the whole'* (p.191).

For occupational therapists, emergence is less straightforward but nevertheless it is central in how to think about people and occupations. Systems thinking enables therapists to understand that occupations are more than just collections of tasks and that people are more than their physical and psychological make-up. Furthermore, systems thinking can help illuminate why different occupations have different values and meanings for people. For instance, the analysis of making a cup of tea using systems thinking facilitates the identification of interrelated components – the tea, hot water, a receptacle for making and drinking, and so forth. However, because these activities are part of a system that includes a person and their occupations, the properties that emerge can only be understood at a system level. In occupational therapy, this is typically the person-in-context. Therefore, it is possible to understand that making a cup of tea may have radically different properties when understood in the wider system of the person, despite having similar components and processes.

Again, examples can be drawn from systemic perspectives offered in contemporary models of occupation. The CMOP-E considers occupational performance and engagement to occur from the interaction of component parts. The PEO model specifically refers to the transaction of components determining occupational performance. Finally, the MOHO suggests *'the concepts of heterarchy and emergence can be used to generate a comprehensive and dynamic understanding of occupation'* (O'Brien and Kielhofner 2017, p.28).

The way in which occupational therapists think about people and how to bring about change to and through their occupations is based on an understanding of the interaction of different types of systems, and may be useful, therefore, in thinking about complexity and interventions. Viewing people as occupational beings based on a conceptualisation of interrelated sets of complex systems allows occupational therapy to be thought about as a process that aims to alter the ways in which these systems function. Occupational therapy can be considered in a similar way to that which Hawe et al. (2009) proposed for

community interventions: complexity and positive change originate from the way intervention principles can be applied to harness the dynamics of the system. In occupational therapy, however, this means using occupation as a way of altering the dynamics of multiple systems. This perspective follows, along with arguments about how it fits with the current discourse about complex interventions.

What does this mean for occupational therapy and complex interventions?

The development of the model was completed so that a contemporary perspective of occupational therapy could be considered against current theory and ideas about complex interventions. As has been noted elsewhere, it is not a definitive description of what does happen, or what should happen, and as a model it is inherently limited to being a simplified tool for viewing a professional practice that has been influenced by various perspectives and theories. It allows two different ways of thinking about complexity to be considered. The first is that complexity is internal to an intervention with multiple components. The challenge is understanding which components are essential and how they should be configured to achieve the best outcomes. Different contexts add to this internal complexity because they may require these configurations to be further adjusted. The second is that complexity is a property of the contexts in which interventions occur. These contexts are dynamic and composed of multiple interacting sub-systems unique to individuals and do not present a 'stable' system in which an intervention is delivered. Interventions become complex because interactions between their component parts and contexts become less predictable.

This latter perspective on complexity has several potential implications for occupational therapy and how practitioners, researchers and scholars approach its study and development. First, adopting a systems view of occupation may affect how therapy can be thought of as a complex intervention. This perspective suggests that the degree to which occupational therapy is complex will be a function of the level at which it is examined. To borrow and expand on an example from Duncan et al.'s (2007) paper: '*Although some interventions will be relatively straightforward – the provision of a wheelchair, for instance – others will involve a permutation of roles, tasks and relationships*' (p.202). The provision of a wheelchair as an example of an intervention could indeed be seen as simple, if the adopted perspective and evaluative metric is one of 'presence or absence of wheelchair'. For the same intervention, however, examining its impact from the perspective of a person's ability to feel engaged in their community or to continue in a familial role may be much more complex.

This example links to a second key idea: that complexity in occupational therapy is shaped by the system(s) that provide the context for an intervention and the degree to which these underpin a therapist's practices. Earlier in this chapter it was argued that occupational therapists think about people-in-context using a range of systems perspectives. These perspectives are often either components of specific models of occupation, or reference broader bodies of associated knowledge which use systems theories. Of course, this is not always the case; there were indications that a therapist's context can interfere with the extent to which they think about the interacting systems underpinning occupation. Similarly, the strong indications that occupational therapists use their understanding of a person to guide their practice align with Lambert et al.'s (2007) assertions that:

> *… the patient should be used as the central point of reference for a system within which an intervention can be provided. It is often the complexity within this patient-based system that results in some degree of unpredictability, rather than the provision of the intervention itself.* (p.536)

Varying the implementation of occupational therapy to be sensitive to individual circumstances is central to guiding frameworks for practice such as the Occupational Performance Process Model (Fearing et al. 1997) and the Occupational Therapy Practice Framework (AOTA 2014). Recognising that this is a source of complexity is not new, nor is it limited to occupational therapy alone. However, claims like that put forward by Creek et al. (2005) suggesting that this context-related complexity means that occupational therapy is inherently unpredictable and thus cannot be studied remain an issue.

Recognising that complexity arises in occupational therapy practice due to context, and that high degrees of individualisation and adaptation occur, does not preclude the use of the MRC framework (Craig et al. 2008) to help understand how and why components of interventions work. Rather, recognising that occupational therapists select from a range of different practices and fit these to the individuals they work with necessitates a continued determination to establish which techniques and practices have most value in terms of eliciting change, even if the application of these may involve a therapist selecting several different components and fitting these to a person.

However, there may be value in recognising that rigorous scientific enquiries, including randomised controlled trials (RCTs), will only provide part of the picture. This claim is not based on any adherence to the idea that some 'magical' and entirely unpredictable change happens during occupational therapy, or that individualisation means that the results of an RCT will never be valid in practice. Similarly, there is no endorsement of the idea that the study of occupational therapy cannot include the standardisation of interventions. Indeed, the sections discussing change in this work make no such claims and instead refer to the finding that the most common ways of describing change related to therapy use language associated with linear directionality, even if these are embedded in processes that tend to be dynamic and responsive. There is a suggestion that some changes that occur during occupational therapy may be unexpected because of the context in which they are applied, but this is no different from any other type of health intervention where some people will respond differently from the majority, due to factors that were unseen or underappreciated.

Rather, this claim that the methods of designing and evaluating complex interventions will only provide part of the picture is based on recognition that our ability to understand the contexts of therapy (the dynamic and complex systems that interact to allow occupation, health and wellbeing to emerge) is extremely limited, at present. The field of complexity theory and the burgeoning complexity sciences remain comparatively new. There are countless instances where the application of complexity theory fails to begin to facilitate an adequate understanding of how phenomena operate in the real world, with human beings being a clear example, as Strevens (2017) notes:

> *The quantum chemistry of large atoms is difficult enough; that of large molecules is more challenging still. Modelling the complex genetic networks at work in embryological development is fiendishly hard. Predicting many of the significant consequences of interacting human minds—housing bubble collapses, Hollywood megahits, popular revolutions—is quite beyond us.* (p.44)

These ideas may impact how those studying occupational therapy as, or as part of, a complex intervention think about designing their research. One element to consider is that if, as Strevens suggests, understanding causal interactions in complex human

phenomena is 'beyond us' at present, the role of the researcher's point of view, and the impact this has on how an intervention is understood, is elevated. Petticrew (2011) offered further practical perspectives by noting:

> *Underlying most definitions* [of complex interventions] *is the assumption that 'simplicity' and 'complexity' are inherent characteristics of interventions. However, there is another possibility: that in fact there are no 'simple' or 'complex' interventions, and that simplicity and complexity are instead pragmatic perspectives adopted by researchers to help describe and understand the interventions in question.* (p.397)

Petticrew goes on to argue that the choice of what to evaluate in an intervention determines its complexity. He suggests that a multicomponent intervention (the example given is an urban regeneration programme) can be considered complex if research focuses on understanding the synergies among the component parts, the interactions between multiple health and non-health outcomes, and whether these have an impact at a community level. Alternatively, research into the same intervention could '*be simplified for the purpose of assessing outcomes'* (Petticrew 2011, p.397). Rather than trying to examine the whole, the different component parts can be considered and their effect established, as Petticrew noted:

> *Thus, simpler and more complex perspectives on the same question will yield different, and probably complementary, answers. A simpler perspective may focus on individual level outcomes alone, whereas a more complex perspective may focus on outcomes at different levels. … These different analyses may be more or less useful to different types of user. Some users may want to know about outcomes; some are more interested in processes; many want information on both aspects. Some researchers and users of research require simpler answers, while some want more complex explanations.* (p.397)

Broer et al. (2017) go further than recognising that these choices will be driven by different requirements and ideas about what will be valuable, by claiming that the decision about which way to view an intervention is driven by researchers and thus is not value-free:

> *Realising that there is no such a thing as one kind of complexity constitutive of and produced through an intervention might liberate researchers in thinking about and carrying out evaluation studies. Each form of complexity has its own consequences, and therefore using a specific definition of complexity (including leaving its definition open) is not an innocent choice that can be justified by pointing to the intervention itself. Rather, it is a choice with methodological, normative and political components and consequences.* (p.156)

This may have an impact on the approaches taken to evaluating complex interventions that include occupational therapy, or focus solely on occupational therapy, and there will be much debate to come that will inform this. Some discourse has already taken place that may be of value in thinking about this in the context of occupational therapy, and this is noted briefly below.

Hawe et al. (2009) suggest that research in healthcare tends to adopt the latter approach, where interventions are examined using methods established to understand the multiple 'simple' interactions that occur within complex interventions. They caution that in taking this approach, *'it could be argued that all that has been achieved is more meticulous ways of doing the same thing'* (p.269). Similarly, Broer et al. (2017) wrote of a degree of *'methodological determinism'* (p.155) in the evaluation of complex interventions

in which quantification determines the investigation into, and thus the perspective on, complexity. In other words, evaluative approaches based on quantifying components of interventions (such as the frequency, duration and intensity of certain components, and the associated magnitude of outcome) will privilege a focus on some aspects contributing to complexity at the expense of others.

Hawe et al.'s earlier arguments (2004, 2009) in favour of a systemic perspective on intervention may offer some solutions to this dilemma where the value in considering standardisation and fidelity differently was recognised. They argue that standardising form (typically understood as fidelity to dose, frequency and intensity, and delivery mechanism) can quickly fail to work in a specific dynamic context. Therefore, rather than standardising form, it is the *function* of an intervention that should be standardised. 'Function' refers to component steps which need to take place as an intervention progresses towards an outcome. The way in which these functions are achieved is of secondary importance and thus can be altered to fit context, resulting in interventions which can be studied for impact, but which also 'work' in the real world. Hawe et al.'s (2004) paper gives several examples of how standardisation can be achieved for form or function in a complex intervention. One useful illustration of this difference which could be adapted and applied to occupational therapy is given in relation to educating people about depression (p.1562). Standardised form would entail ensuring all therapists provide people with exactly the same written information sheet, whereas standardised function would entail each therapist finding the best way to distribute information tailored to literacy, language, culture and learning styles.

The position taken by Hawe et al. (2004, 2009) may be useful if occupational therapy is conceptualised as a dynamic process that causes changes within a set of complex systems. Standardising the functions of therapy rather than specifying fidelity to form could be a useful way of understanding how implementation in real-world contexts will happen, and will thus give a better understanding of key mechanisms and their impact. Similarly, this approach might have more value when additional theory about occupation is considered. If a truly occupational perspective on understanding health and wellbeing is taken, then occupational therapy research will tend towards the complex. The range, number and level of potential pathways to change and their associated outcomes may reside in and be dependent on multiple systems. Whether or not current measurement methods adequately capture these outcomes is open to debate, but suggesting that it can be difficult to quantify all the changes associated with occupational therapy is partly borne out by the data collected for this work.

This chapter has aimed to address the question framed in its title: 'Is occupational therapy a complex intervention?' As previously stated, the development of the model was completed so that a contemporary perspective of occupational therapy could be considered against current theory and ideas about complex interventions. It is proposed that the model allows two different ways of thinking about complexity to be considered, and that both provide valuable perspectives from which to understand occupational therapy. The first relates to complexity as internal to an intervention with multiple components. The model presented in this work, developed from several data sources, demonstrates the multiple components of occupational therapy intervention, leading to practices that entail numerous and various configurations to achieve the best outcomes. The second way of thinking is that complexity is a property of the contexts in which interventions occur. This introduces ideas around systems and how the contexts of occupational therapy are composed of multiple interacting sub-systems unique to each person. Occupational therapy intervention therefore becomes complex because

interactions between the component parts (implementation content) and contexts become less predictable. These understandings of complexity in occupational therapy may be significant in the continuing research into best practice that leads to health and wellbeing. The understandings have also led to the description of occupational therapy as a complex, dynamic process, comprising multiple and varied interventions or practices.

Section 2

6 Methodological overview

Epistemology and ontology in occupational therapy

In practice, occupational therapists may work with multiple ontologies, often held in balance and brought into focus to serve pragmatic purposes during a therapeutic process. At times, much of the knowledge used to inform practice is firmly rooted in a reductionist ontology, and in particular the idea that there are layers of connected understanding that represent the reality of a situation or this phenomenon. Strevens (2017) illustrates nicely:

> *Different sciences have different ontologies—different ways of dissecting the world into individuals, categories, properties. Fundamental physics does particles, chemistry does molecules, biology does cells and organisms and ecosystems, and so on. The list suggests that a certain neat structure is the rule in this grand ontological project: the things at one level are spatiotemporally composed of the things at the next level down. Animals are made of cells, which are made of molecules, which are made of particles…* (p.42)

Key terms

Ontology *is a term that relates to what is and is not real or in existence, and to ways of categorising 'real' things.*

A ***reductionist ontology*** *is one based on the idea that 'reality' is made up of a minimum number of entities or substances, and therefore all objects, properties and events that occur from their interactions can be* ***reduced*** *to understanding a single substance.*

Key terms

Pluralism *is the idea that there are many different ways of understanding or describing the world which are true, despite conflicting with or contradicting each other. No single view of reality can account for all the phenomena of life.*

Epistemology *is a term that relates to the study or understanding of how we know things, and how we justify what we believe.*

Specific, named epistemologies declare a perspective about how the knowledge of reality occurs. For instance, an empirical epistemology suggests that all knowledge of reality comes first from human experience of it.

Many frames of reference in occupational therapy work within this reductionist ontology (human physiology, biomechanics, developmental theory and so forth), and arguably so do some of the conceptual models we use to understand occupation.

At the same time, core aspects of occupational therapy are located within different ontologies. The profession aspires to keep occupation at the core of practice by understanding and respecting how people (both individually and collectively) value different occupations, and how these come to shape identity. The methods used to understand these issues are often founded in interpretivist ideas, and numerous ontological perspectives can be applied to such understandings of occupation, all of which are arguably valid ways of understanding the subjective nature of what it is to be a person. For example, these include subjectivism (the idea that the nature of someone's reality is dependent on their consciousness of it); existentialism (a view that people define their own meaning in life, and try to make rational decisions despite seemingly irrational contexts); and phenomenology (reality consists of objects and events (phenomena) as they are perceived or understood in the human consciousness). This multiplicity of working ontologies in practice suggests that occupational therapy is based on a

pluralist perspective that recognises that the reality of people's occupations cannot be understood as a single set of universal laws, and that understanding the practice of occupational therapy cannot be achieved only by mapping component parts.

Epistemology and ontology in complex interventions

Craig et al.'s (2008) MRC guidance on developing and evaluating complex interventions reflects this duality, noting the important role that qualitative research can play in *'exploring the experiences people have of illness, health services and treatments in order to develop theory, identify need and evaluate the working of interventions in practice'* (Griffiths and Norman 2013, p.584). However, there is a lack of consistency at the heart of ideas about complex interventions, which continues to evolve as a field of study and discourse. This debate is outwith the scope of this work; however, it is worth noting the work of Broer et al. (2017) in critically addressing the influence of the evaluative approach on how complexity is understood in healthcare interventions. They suggest a *'methodological determinism'* (p.155) in how complexity is understood in the discourse and work surrounding the development and evaluation of complex interventions, arguing that the methodological positions of an evaluator (and therefore the ontological and epistemological assumptions underpinning their stance) fundamentally influence how complexity is considered. They note that:

> *When realist evaluators or other social science researchers claim that one method or another is better able to grasp complexity … they elide* [omit or leave out of consideration] *the possibility that making a choice to use one paradigm over another emphasises some complexities and lets others fade into the background.* (p.156)

Elsewhere in their work Broer et al. (2017) note the focus the MRC guidance gives to quantifying complexity, suggesting that, while it is useful in determining whether an intervention works for given outcomes, it fails to recognise the role of qualitative research in redefining effectiveness and understanding how interventions work.

These observations are noted here simply to draw attention to the continuing debate and fluidity surrounding some of the key concepts that need to be considered for this work.

Methodological approach

The consequence of this duality in ontology and epistemology, both in a practical sense in terms of how occupational therapists think in practice, and how complexity is considered as it continues to evolve as an approach to understanding and improving health and social care interventions, directly impacts the methodological approach taken to understanding occupational therapy as a complex intervention.

The methodology developed for this work was focused on answering specific questions:

- What does contemporary occupational therapy look like?
- Once this is known, does occupational therapy align with the ideas of complex intervention outlined by the MRC? If so, what causes this complexity?

The approaches used to answer these questions needed to be based on an epistemology that permitted multiple elements to be considered – not in isolation, but in a way that allowed them to contribute to an understanding of the phenomenon of

occupational therapy. These multiple components in occupational therapy, as with many professions, are understood to be socially constructed, influenced and shaped by particular and changing social, economic, cultural, temporal and spatial conditions. Furthermore, recognising that occupational therapists can and do work with, and because of, multiple different types of knowing adds a further challenge to this understanding. Thus, the epistemology underpinning this work is constructivist. It is undertaken with recognition that understandings of occupational therapy are contingent on socially mediated experiences, perception and interpretation, and influenced by convention.

To access data so that multiple perspectives on occupational therapy could be considered in attempting to answer the two primary questions noted above, three different data collection approaches were used: literature review, survey and focus groups. These were used so that written accounts of occupational therapy from both peer-reviewed and non-peer-reviewed publications featuring accounts of practice, and the perspectives, opinions and descriptions of occupational therapists, could be gathered. After each of these processes had been completed and the data analysed, a range of activities were undertaken to identify the different core components that feature in occupational therapy so that a valid understanding of occupational therapy could be developed.

The final methodological element was to introduce the work to a range of ‘critical friends’. These critical friends were asked to comment on the work (including elements of consistency, logic, language, validity and so forth) and ask provocative questions, suggest alternative explanations and terminologies, and support the refinement of the work. The critical friends were selected to include people with backgrounds in practice, development, applied research and theory development.

7 Literature review

This chapter presents details of the methods and findings of a literature review that provided data related to published descriptions of contemporary occupational therapy.

Search strategy

Searches were developed and run for the Cumulative Index of Nursing and Allied Health Literature (CINAHL) using the EbscoHost interface. Given the range of titles indexed in CINAHL, it was decided not to develop searches in other databases (Medline, PsycINFO, etc.) to avoid unnecessary duplication. CINAHL indexes over 3,000 journal titles and on review it appeared that all relevant profession-specific publications were included.

An initial search including indexed Major Subject (MM) and Medical Subject Headings (MH) containing occupational therapy was executed. Subsequent searches were built to exclude MM and MH terms that appeared to be returning irrelevant results. These subject headings included in the 'not' string were selected from iterative screening of results. When a heading was recognised as being common to irrelevant results during screening, the search was rerun with the identified term included using the 'not' operator. This continued until screening indicated broadly relevant results.

The final search (detailed below) was executed before being limited to English language only sources published between 1 March 2015 and 11 October 2016 to capture contemporary practice.

(MM "Occupational Therapy+" OR MM "Occupational Therapy Practice" OR MM "Occupational Therapy Practice, Research-Based" OR MM "Occupational Therapy Practice, Evidence-Based") NOT (MM "Clinical Competence" OR MM "Education, Continuing" OR MM "Instrument Validation" OR MM "Professional Competence" OR MM "Professional Development" OR MM "Serial Publications/EV" OR MM "Writing for Publication/EV" OR MM "Congresses and Conferences" OR MM "Students, Occupational Therapy" OR MM "Student Recruitment" OR MM "Student Attitudes" OR MM "Historical Research Methods" OR MM "Education, Occupational Therapy" OR MM "Education, Clinical" OR MH "Insurance, Health, Reimbursement+" OR MM "Serial Publications")

As no limits were placed on the peer-review status of papers for consideration, initial breakdowns of publication source were generated after initial screening. It was clear at this point that articles published in *Occupational Therapy News* (OTN) were not routinely or comprehensively indexed on CINAHL. To ensure current practice descriptions of UK-based occupational therapists not appearing in peer-reviewed (and thus fully indexed sources) were included for review, a full search of OTN indexes for the same period (March 2015–October 2016 inclusive) was conducted and full texts identified for consideration.

Exclusion and inclusion criteria

Few inclusion and exclusion criteria were put in place. To be included, a paper had to be written in English and present some content reporting the actual provision or practice of an occupational therapy intervention. Opinion pieces, research protocols and purely

theoretical papers were excluded, as were papers in which descriptions of practice were not sufficiently detailed to allow for relevant data extraction.

Results and screening

From the search conducted in CINAHL, 508 citations were identified. A further 123 articles were identified for consideration from OTN. Initial titles were screened in CINAHL or in hard copy for OTN papers by two researchers. Reviews of abstracts and data extraction were completed by four researchers. If individual researchers were unsure whether a paper should be included or not, it was either flagged in a separate folder for consideration by another team member or resolved during discussion with other members of the team.

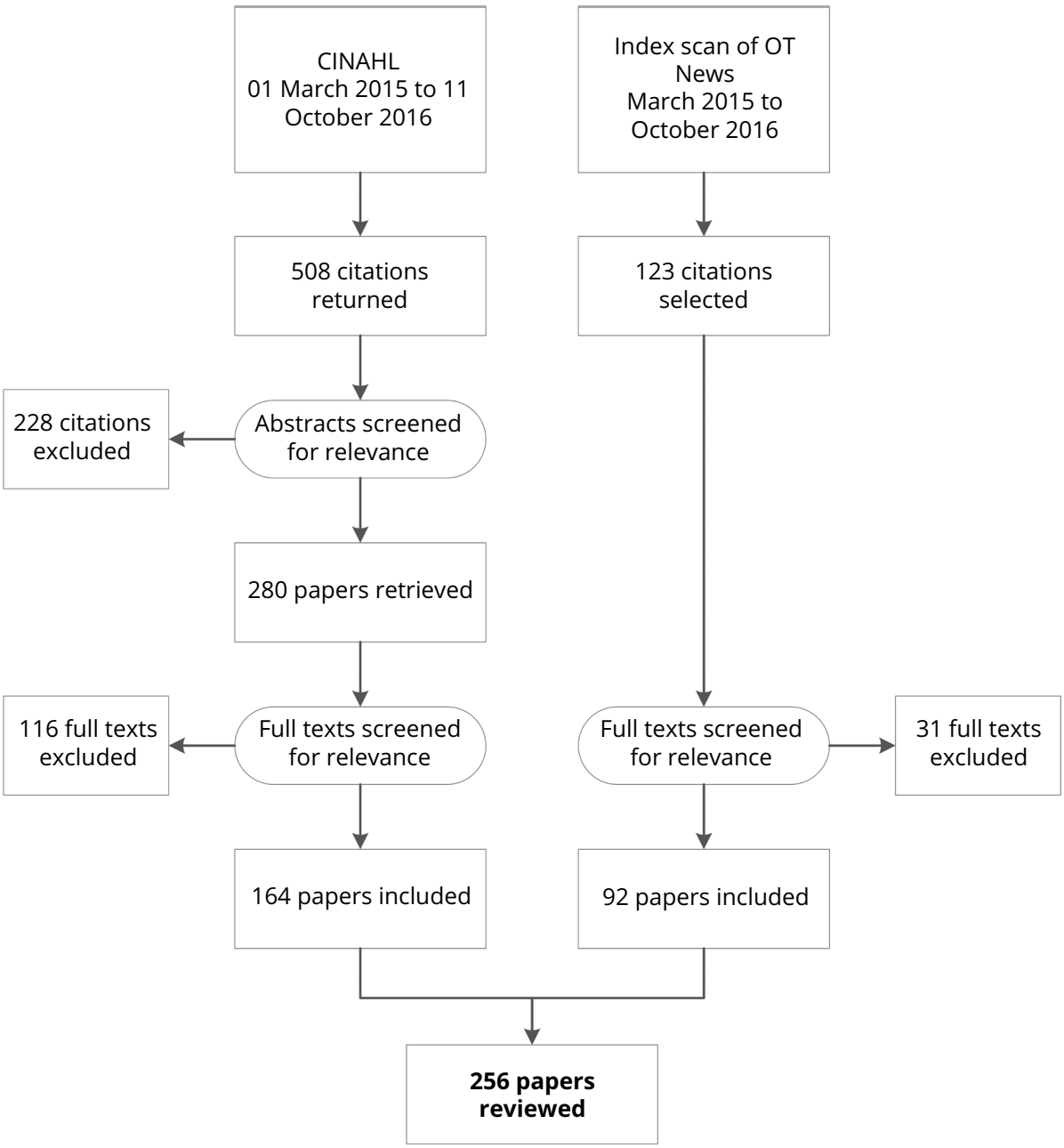


Figure 4 Literature search process

Following further screening, 256 papers were reviewed, 164 papers from the initial search and an additional 92 articles from OTN. Figure 4 presents an overview of this search process.

Data extraction and code formation

Included articles were imported into QSR International's NVivo 10 software (QSR 2012) for analysis. An initial set of codes was developed to capture descriptive information about each paper. These included the country or countries where the intervention took place, an indicator of source type (peer-reviewed primary research, peer-reviewed literature reviews and so forth), the population for which the intervention was delivered, and the location or setting of the intervention.

As analysis proceeded, code structures were developed to capture information relevant for identifying components of occupational therapy interventions: 782 of these were inductively developed and categorised under 17 descriptive headings on an iterative basis (listed below). These headings represented a range of components including the procedural content of interventions as well as more nuanced, qualitative information about their components. The 17 descriptive code headings were:

1. Aim of setting
2. Country of practice
3. Explanations of change
4. Facilitators of occupational therapy process
5. Influences on role and intervention
6. Intervention content
7. Intervention duration and/or frequency
8. Intervention objective
9. Intervention theoretical framework
10. Location of intervention
11. Method of measuring outcomes
12. Obstacles to occupational therapy process
13. Population
14. Practice setting
15. Reported outcomes
16. Source type
17. Indicators of complexity.

Once data from all selected sources had been extracted and coded under these descriptive headings, a process of reviewing and synthesising them was completed. Each code and its content were examined, and where consistent messages or ideas were detected, more discrete codes were generated with additional interpretive and explanatory notes attached. This continued until no further synthesis and categorisation was appropriate.

Descriptive results

Source types

A summary of the types of article included is given in Table 1 in Appendix A. The most commonly included type of article was non-peer-reviewed magazine articles (n=133), followed by peer-reviewed research papers (n=107). Thirteen literature reviews were included and three papers of other types that appeared in peer-reviewed journals were also included.

Geographic area of practice

The geographic area of practice for each article is detailed in Table 2 in Appendix A. Area of practice was recorded with respect to the location in which the intervention took place, rather than the nationality of the authors. Most papers were from the UK and Ireland. This is partly due to the *OTNews* articles included in the review. Literature reviews were excluded from this classification as they included papers from multiple countries. Some references appear in more than one category because the practice described took place in more than one location.

Aim of setting

The 'aim of setting' categories were developed to capture information about the reported aims of the unit, service, team, etc., featured in the account of practice. Some papers reported multiple aims that would typically be pursued in the setting: therefore, sources are often recorded in more than one category (for details, see Table 3 in Appendix A). Of the 24 separate categories developed, occupational performance was the most frequently cited aim (n=50), followed by mental health assessment and treatment (n=27), life skills (n=24), physical rehabilitation (n=23), social integration (n=21), independent living (n=17) and education (n=17).

Practice settings and location of intervention

The locations in which occupational therapists were based, and in which practice took place, varied and included a range of institutional settings (Accident & Emergency, acute medical settings, in-patient rehabilitation units, secure psychiatric units), outpatient services (clinics, day hospitals, local authority services), schools, workplaces, community and third-sector spaces, and supported living settings. People's homes featured frequently and included face-to-face as well as virtual interactions (telehealth).

Population

Demographic information about the people receiving occupational therapy was extracted when possible, and in particular details about medical condition, other diagnostic indicators, and characteristics of other populations that were otherwise identified. The age ranges of people that occupational therapists reported working with spanned infancy through to old age (65 years and over). Table 4 in Appendix A gives an overview of the 48 categories describing the conditions reported in the literature. In addition to these categories that reflect typical medical diagnoses, 68 papers reported on populations that could be defined by circumstance rather than any specific medical issues. Full details are provided in Table 5 in Appendix A, but include carers, veterans, refugees, prisoners and homeless people.

Intervention objective

The intervention objectives identified by the author relating to the therapeutic goals established in collaboration with the client and family were recorded for analysis. These objectives were organised into nine categories for study, including: (1) Social integration; (2) Related to service processes (length of stay, etc.); (3) Performance capacity and skill-related improvements; (4) Independent living; (5) Health, wellbeing, quality of life;

(6) Health promotion; (7) Environmental modification; (8) Education and awareness; (9) Occupation, activity and routine. Full details of the references attributed to these categories are given in Table 6 in Appendix A.

Social participation and inclusion were among the most commonly identified intervention objectives. Interventions such as community reintegration through the formation of social groups were commonly utilised by therapists, with the goal of increased social awareness, meaningful discussion, family participation and inclusion.

In the areas of performance capacity and skill-related improvements, the most common intervention objectives were to improve performance skills and function, with specific focuses on upper limb function, sensory needs and communication skills. Several papers suggested links between improved physical function and increased capacity for independent living, and greater satisfaction with daily occupation.

Intervention duration and/or frequency

The frequency and duration of therapeutic sessions during occupational therapy varied greatly. Data was extracted if sufficient information was given in the source. This included both reports of the number of interventions and overall duration of therapy, although these were often not precisely reported. One paper (Habovick 2016) reported a single session intervention, while at the other end of the range one paper (Tomita et al. 2016) reported a 19-month process. Fifteen papers reported on interventions that had no set timeframes and instead provided variable levels of therapy. An overview of extracted data is provided in Table 7 in Appendix A.

Intervention content

Information about intervention content was collected from descriptions of the strategies, techniques and practices used by the occupational therapists. They were organised into 11 main categories. The four most frequent types of intervention content were: 1) use of and facilitation of engagement with occupation and activity; 2) alterations to environments; 3) skill training and development; and 4) education, coaching and methods to increase knowledge and understanding. The other seven categories were identified as: specific named programmes comprising multiple techniques; health promotion; virtual environment and information communication technologies; group-based interventions, training and strategies for cognitive, physical and sensory function; collaboration with client's family, carer, teachers, support, education; and collaboration with other agencies and staff. Table 8 in Appendix A provides reference information for all 11 categories.

Theoretical framework

A variety of different theories and models were referred to in the literature. These were classified as client-, person- and family-centred approaches; various non-occupation-specific models; non-occupation-specific theories; occupation models; and some specific occupational therapy theories. Table 9 in Appendix A gives more details and suggests that there was no clearly dominant theoretical approach.

Thematic analysis

Certain categories were identified for further review and analysis as being particularly pertinent to the aims of this project. These categories were: Explanations of change; Factors influencing occupational therapy; Facilitators of occupational therapy; Obstacles to occupational therapy; and Indicators of complexity. Following the development of code headings and the coding of data within these categories, a clear description was

developed of each, summarising the main ideas and concepts. This process led to the development of the main themes that formed the discrete findings of the review, reported below.

Explanations of change

In the literature, change was most frequently discussed in relation to *what* had changed as a result of intervention rather than *how* that change had occurred, underpinned by a theoretical explanation. Change was described in relation to the three components of environment, occupation and person, either individually or in various combinations. In addition, analysis identified three key components of the nature of change in general. These were:

Change involves multiple components: Multimodal change was a common characteristic either within or across the components (environment, occupation, person). An example given was of successful change that included the therapist, youth and family working together, building family strengths and addressing environmental barriers.

Change occurs in incremental stages: Change in one component was understood to lead to change in another. This might lead to decisions on the focus of intervention: for example, working towards change in the environment or occupation rather than initially building up the person's abilities; participation (quantitative change in number of activities engaged with) being needed before change in satisfaction and emotional engagement (qualitative aspect); success in occupational performance leading to further success.

The direction of change is not predetermined: Change in a number of components may occur simultaneously, with multiple dependencies between components: for example, change in the person together with change in the occupation/activity and environment, leading to an overall increase in engagement in meaningful occupation.

Characteristics of change in relation to the environment, person and occupation were identified. The intertwining of the three components is evident. Changes in the environment and in occupation were primarily referred to in relation to the changes in the person to which they contributed.

The environment: The environment (physical, sensory, temporal and social) was understood to shape the occupation and the occupational performance of the person that takes place within it. Therefore, changing components of the environment as a therapeutic intervention was understood to lead to change for the person and their occupation. These changes were frequently referred to as 'modifying' or 'enabling' the environment in some way to 'fit' the person. Again, characteristic of change in the environment was the overlap between the change in the various types of environment (physical, sensory, temporal or social).

- Modifying the physical environment included eliminating environmental barriers that the person faced; creating a home that was safe and had a sense of home for the person.
- Modifying the sensory environment.
- Modifying the temporal environment of intervention, e.g. the timing of sessions to provide time to complete occupation, enabling individual adaptation and achievement.
- Enabling a social environment that was balanced to the needs of the person, that enabled 'recognition' of the whole person and awareness of the person's goals (by

peers, researchers, therapists and 'society'). The social environment was recognised to include several key people, and change in certain features of their relationship with the person led to corresponding change in the person. Specific examples included:

- Caregivers enabled to provide the right amount of support, to find the right balance; increasing their awareness of sensory input and bodily changes.
- Parents encouraging an adolescent to take ownership, and *'sensitive, responsive parenting'*.
- Teachers creating an *'appropriate classroom environment'*.
- Care staff providing the person with opportunities to make choices; seeing the person as a whole person; being aware of the person's sensory needs.
- Group members: being recognised; *'we together'*; shared experiences and goals; learning from each other/ peer learning ; being part of a team; a sense of community/emotional sharing.

Occupation(s): Occupation and engagement in occupations were seen as important to the process of change, including facilitating occupational adaptation. Occupation and change were connected in three ways in the literature:

i. Characteristics of occupation that facilitated change:

   Certain characteristics of occupation(s) were identified as being particularly important in facilitating change. These included that the occupation was creative; related to the self; involved group work; inspired others; was community-focused; and was culturally relative. Specific occupations were rarely named in relation to change: rather, these characteristics of occupation were the focus, with clear importance given to the relationship of the person with the occupation and therefore to individualised approaches.

ii. Opportunities for change in the person that occupations provide:

   Occupations were also seen to be related to change in that they provided experiences that led to change in the person. The opportunities for change that occupation offered may be seen to be on a continuum from the very broad (e.g. developing optimal occupational lives, healing, changing from a focus on illness/ impairment towards a focus on change/recovery), through a more local level (e.g. participation and acceptance in the community, occupational competence) to the specific and intrapersonal (e.g. the development of specific skills, self-expression).

iii. Changing occupations as part of the intervention process:

   Grading and adaptation of occupations were undertaken to facilitate change in the person's ability to engage in occupations. Engagement in occupation was seen to lead to further engagement in occupation. Repetition and practice of occupations were seen to facilitate the development of skills.

The person

As can be seen, change in the person was inextricably interlinked with their environment and their occupation. In understanding change in the person, the relational self was important, with identity linked to others and the world around them. Change was recognised to occur in both the person's sense of self (primarily psychological concepts were identified) and in their skills for occupational performance. Change in how the person saw themselves as an occupational being was referred to only once.

Change in the person during or as a result of occupational therapy was discussed in terms of:

- Confirmation of the value of the person: being seen and seeing themselves as a valuable, capable person, with increased motivation, confidence and self-esteem.
- Development of self-identity: increased self-awareness, sense of control and self-efficacy.
- Achieving occupational performance goals: enabling the person to 'see' that they were getting better; reinforced habits and routines; created meaning; encouraged confidence; and confirmed abilities.

Changes in occupational performance were seen to be achieved through multiple changes in various areas of personal functioning:

- developing understanding and use of strategies (e.g. problem-solving, self-advocacy);
- developing knowledge of self and performance;
- improved motor, social and cognitive skills;
- neurological change (e.g. theory of mirror neurons, neuroplasticity);
- developing ability to use capabilities (personal and environmental); increasing ability to take control; personal capacity.

Factors influencing occupational therapy

The literature review identified occupational therapy as taking place within and as part of a complex interweaving of components. These components could be considered as factors influencing the process of intervention in dynamic and particular ways, shaping the possibility for optimum change for the person(s). These factors related to the person or groups engaged in occupational therapy, the occupational therapist, the service in which the intervention was taking place, and the wider context, as well as to the interaction between these various components.

Frequently, the factors could operate as both facilitators and obstacles to practice, depending on the circumstances. The factors identified in the review that were seen to be either neutral influencers or positive facilitators of occupational therapy are presented below. It is useful to note that here that factors that were facilitators of the intervention process itself were particularly identified. Comparatively fewer factors were identified as obstacles to occupational therapy (discussed in the following section). This suggests that occupational therapists predominantly consider they can provide a positive intervention involving themselves and the person(s) if there are no obstacles to this from the wider context of the person, the service or at a macro-level.

The key facilitating factors relating to each component are briefly presented. An overview of these along with their source references are provided in Appendix A, Table 10.

Factors relating to the person(s): That the person had motivation for change and that they shifted their perception of their future.

Factors relating to the person(s) and their context: That the person's physical environment was accessible, that they had supportive social environments and emotionally safe environments.

Factors relating to the interrelationship of person(s) and occupational therapist: That the person engaged with the process of occupational therapy. Facilitators of the person's engagement were identified to include:

- The person's active involvement in the process of occupational therapy (e.g. by identifying their own needs, setting their own goals, developing the plan and choosing activities; a positive and enjoyable social environment; and contact with others with similar experiences).
- The person having trust in the therapist, the process, in others involved and in the setting.
- The experience of occupations provided being a good 'fit' with the person (e.g. whether the occupation should be familiar or not, depending on whether a surprise or prior experience was required; for provision of equipment the possibility to try things out).

Factors relating to the therapist: Therapists required knowledge (e.g. of models and medical conditions), skills (e.g. in management, the occupational therapy process) and reasoning, and these were recognised to develop with experience. However, there was understanding of the importance that the therapist engages with each person in a unique way, and the subtlety of this was eloquently summed up in the phrase 'professional artistry'.

Factors relating to the intervention: A range of factors related to the interventions offered, including where, with whom and with what focus, were identified:

- Natural environments, both green spaces and built environments in the community (e.g. hotels, schools, home).
- Collaboration with others (e.g. other services, team members, volunteers, students, people with particular areas of expertise, families and carers).
- Group processes, particularly those where group members are treated with dignity; that provide positive relationships and opportunities for growth; where group members experience choice and ownership of the group; where there are opportunities for shared decision-making and shared support.
- Occupation-based approaches (also referred to as purposeful/meaningful activity) as the core of intervention, including assessment, adapted occupation to support engagement and occupation as outcome (working towards occupations that were important for the person). Occupation-based approaches were seen as holistic approaches that engaged all aspects of the person, facilitating empowerment, enjoyment and engagement.

Factors relating to the service: These were frequently expressed in neutral terms as possible influencers that should be considered: for example, the mix of staff across disciplines as well as across the occupational therapy team, and whether there were both experienced and new graduates, together with time for discussion and exchange of experiences, were noted to be important. Other factors included:

- Supervision and governance structures (e.g. operational meetings, annual planning, quality improvement processes and service delivery standards and guidelines).
- Geographical location – rural and remote areas might provide longer and a greater number of treatment sessions, there might be no locally located services, and the occupational therapist's practice might be more diverse than in urban locations, with the possibility of lone working.

- Service user involvement in the design of services beyond the immediate intervention process.

Factors relating to the wider context: These included new roles for occupational therapy associated with the increasing recognition of the importance of occupation for health and wellbeing, and occupational therapists being involved in driving system change.

Obstacles to occupational therapy

Obstacles to occupational therapy were identified that challenged the possibility of optimum outcomes for persons accessing services. Table 11 in Appendix A provides an overview of the obstacles and their source references. Obstacles arose or occurred in any of the multiple components of the occupational therapy process (as seen also in the discussion of facilitators): that is, related to specific aspects of the person or the therapist, but also to a particular environment (or context) of the person or therapist. Obstacles arose as person and therapist came together, also influenced by the characteristics of the particular setting. Obstacles also related to the practice setting more generally as well as to the wider context. Obstacles arose in dynamic processes that potentially included all components of the intervention: person and their environment, therapist and their environment, service and wider contextual factors. Listed below, with examples, are obstacles in relation to:

- *The individual's process,* including factors internal to the person (e.g. the person's knowledge of their condition and their perception of functional problems, their motivation for change) as well as factors related to the person and their particular context (e.g. financial restraints on the person's ability to engage in certain occupations; physical or social barriers; including limited ability of their workplace to make accommodations, institutional environments, social stigma, limited access and knowledge of technology, family situation where parents or carers were unable to provide sufficient support).
- *The person and service they were accessing*, including cultural discordance regarding language, including use of translators, variation in 'typical' occupations, assessment tools developed by the dominant culture; costs of attendance in terms of direct financial costs, lost working hours and limited time availability; complicated healthcare administration making access difficult; limited transport and/or geographical isolation.
- *The person and wider context*, including limited or absent research regarding the specific condition of the person, robust trials and qualitative studies, and recognition of the situated nature of practice; the geographical location of the person in relation to available services.
- *The occupational therapist*, including their limited experience or expert knowledge, and a reliance on formal evidence.
- *The occupational therapist and person*, including the therapist's limited appreciation of the confidence and motivation of the person and therefore their limited engagement with the programme; difficulties for the person in understanding the language of occupational therapy; applying evidence-based practice/research outcomes to people from diverse groups (e.g. in terms of disability, sexual orientation, religion). These factors also related to the occupational therapist and the person's wider context: for example, people from the wider social context, such as parents and teachers, having limited chances to engage with the therapeutic intervention.
- *The service*, including restrictions to the scope of occupational therapy practice as a result of the service's aims and focus, which could also be evident in the referrals and

assessments used, as well as limited understanding of occupational therapy; conflicting models of practice; difficulties in evaluating outcomes; financial restraints limiting the availability of certain interventions, the development of new interventions, or the focus of intervention, also leading to discharge too soon; reduced staffing levels or staff expertise; an emphasis on safety and risk management; environmental barriers such as limited space for occupational therapy or treatment rooms located a long way from wards.

Indicators of complexity

An understanding of the complexity of occupational therapy was evident throughout much of the literature, although it was rarely discussed explicitly in such terms. It was indicated in multiple ways which are listed below with some examples:

- The combination of practical solutions with aesthetic/emotional aspects – referred to as the 'art and science' of practice. An example was understanding 'home' for people who were receiving adaptations to the physical environment.
- The absence of 'hard' rules and specific procedures which required knowledge, skills and reasoning. An example was navigating the grey areas around risk, where risk was understood to be rarely black and white.
- The uniqueness of each person and their situation, which included a variety of components:
  - The individual circumstances of each person's life, their pathology, their family, their own and others' wishes, dreams and so forth.
  - The complexity of people's needs as a result of the complexity of pathology, which resulted in fluctuating symptoms from day to day, multiple morbidities or areas of impairment, varying energy levels, and changes with age and development.
  - The complexity of the person's situation involving health and social difficulties (e.g. a person on a low income, needing to return to work and their child becoming ill).
  - Cultural differences that challenged the 'fit' of existing interventions with a particular person or situation, but also between the therapist and the person in terms of power and differences in values and beliefs.
  - Each person was connected to partners, family, friends and carers with varying needs and relationships with the person. Many of these people were also involved in the intervention.
- Interventions were not standardised and had multiple components, including:
  - Interventions tailored to each person (e.g. individual care plans/goal setting). Even in group situations, each person was understood to be an individual.
  - Use of grading.
  - Time required for change/learning/the intervention varied from person to person.
  - Frequently there were multiple aims and multiple components to the intervention.
  - Outcomes might be unexpected or go beyond what was planned or those immediately involved (e.g. knowledge obtained by one family member was transferred to others; an adaptation provided for one purpose was innovatively transferred to address other issues).
- Occupational therapy was often part of a multidisciplinary team/approach; there may be conflicting aims and outcomes.

- The reasoning processes of the therapist discussed in the literature indicate multiple considerations.
- The varying impact of the setting and the 'fit' of the setting with client-centred practice. This was also indicated by the following:
  - The setting in relation to the person's performance (e.g. at the clinic versus at school or at home). In addition, the same environment may impact differently on different people, and the difficulties in providing an optimum environment.
  - The potentially conflicting demands/aims of the service and of occupational therapy: for example, the prioritisation of safety aspects; how well documentation 'fits' with the person's priorities.
  - Restrictions to the natural environment of the person: for example, by social stigma or by institutionalised restrictions (e.g. prison).

This chapter has outlined the methods used, and results of, a review of contemporary literature that included descriptions of occupational therapy. It is evident that occupational therapy is composed of varied practices that are used when therapists work in a broad range of settings with people of all ages and with conditions (related to the person and/or their environment) that impact on their health and wellbeing. Occupational therapists demonstrate flexibility, innovation and considerable skills in reflective and reflexive working to build collaborative partnerships with people (service users and their families and carers, colleagues and many others) to enable positive change for each person.

8 Online survey

This chapter provides detailed methods and findings from an online survey of occupational therapists (practitioners, educators and researchers), occupational therapy students and associated support workers.

Aims

1. To identify the key components of current occupational therapy practice.
2. To identify components of current occupational therapy practice reported to indicate complexity during intervention.
3. To identify and distinguish components of process and outcome during occupational therapy.

Methods

A cross-sectional survey was developed to generate quantifiable and exploratory data related to current occupational therapy. Ethical approval was granted by Queen Margaret University (protocol ref: Complex_OT_20160603_version_1).

Sample

The sample population comprised a range of occupational therapy professionals and included all those who had completed formal education in occupational therapy (whether currently in professional practice or not), those currently enrolled on programmes of formal education in occupational therapy, and those currently employed in roles supporting occupational therapy practice. No exclusion was applied based on geographic location of practice.

Convenience sampling was employed. Potential participants were made aware of, and invited to consider, completing the survey via a range of methods. These included placing an advert on the Royal College of Occupational Therapists' (RCOT) website, in the January 2017 edition of *OTNews*, and via informal networks of professionals on Twitter. Invitations were also sent directly to RCOT specialist sections and functional boards.

We estimated a population of 48,000 (approx. 38,000 Health and Care Professions Council (HCPC)-registered occupational therapists plus 10,000 additional population for students, non-registered therapists, retirees, support workers and so forth). A sufficiently powered representative sample was calculated to be 382 (95% CI (confidence interval) with a margin of error at 5%).

Data collection

An online questionnaire was developed based on initial ideas and reflections from the literature review along with considerations of some elements of contemporary theory about complex interventions (Craig et al. 2008, Moore et al. 2015). The questionnaire

was reviewed by members of RCOT staff, and recommendations made to improve elements of fluency and clarity of items, item order and scoring options. An iteration of the questionnaire was also piloted and reviewed by professional members of the RCOT. This process was organised and managed by officers from RCOT, rather than the authors, for privacy and data protection reasons. A final questionnaire comprising 9 closed-response items and 19 open-response items was agreed:

- questions to generate background information about the participant and where they work;
- questions to help understand the nature of their practice;
- questions to help explore the concept of complexity in practice.

The Bristol Online Survey software (BOS 2016) was used to collect responses. Each respondent was anonymous at the point of completion, and unique identifying numbers were generated to enable tracking during analysis. This process was programmed into the online survey software so at no point were individual respondents identifiable.

Data analysis

Data from closed-response options data was imported into SPSS v.21 (IBM 2015) for analysis. Additionally, some open-response items were coded numerically to enable their inclusion into statistical analysis. The full questionnaire dataset including all the text captured in responses to open-ended questions was imported into NVivo v.10 for inductive, thematic analysis. Descriptive statistics were used to analyse data, the results of which are presented below.

Data from the survey questions with open-response options was thematically analysed. Thematic analysis methods allow the encoding and interpretation of written or spoken information through the identification of themes that share common characteristics (Kellehear 1993). Although the inductive nature of analysis was maintained – in the sense that there would be little point in conducting such a study unless there would be genuine interest in the raw information to reveal new themes – the final type of analysis was of a hybrid mode. The researchers' involvement in the data collection and analysis at other stages of the study (literature review and quantitative analysis of survey) led to a subsequent familiarisation with certain concepts, a conceptual organisation suggested by Boyatzis (1998) and Joffe and Yardley (2004).

The survey's aims were:

Aim 1: To identify and distinguish components of process and outcome during occupational therapy.

Sub-themes:
a. Change (e.g. 'what changes' and 'nature of change', as a result of occupational therapy)
b. Change as a process
c. What facilitates/mediates change
d. How is change captured?

Aim 2: To identify elements of current occupational therapy practice which indicate complexity during intervention.

Sub-theme:
a. What constitutes complexity in occupational therapy?

Descriptive results

Respondent profiles

Seven hundred and eighty-three questionnaires were returned. The majority of survey respondents were occupational therapists (n=691, 88.7%), with the remaining 92 participants employed in a range of other roles (see Figure 5). The mean time in current role was a little under 8 years: however, 17% of respondents had been in post for over 15 years (Figure 6).

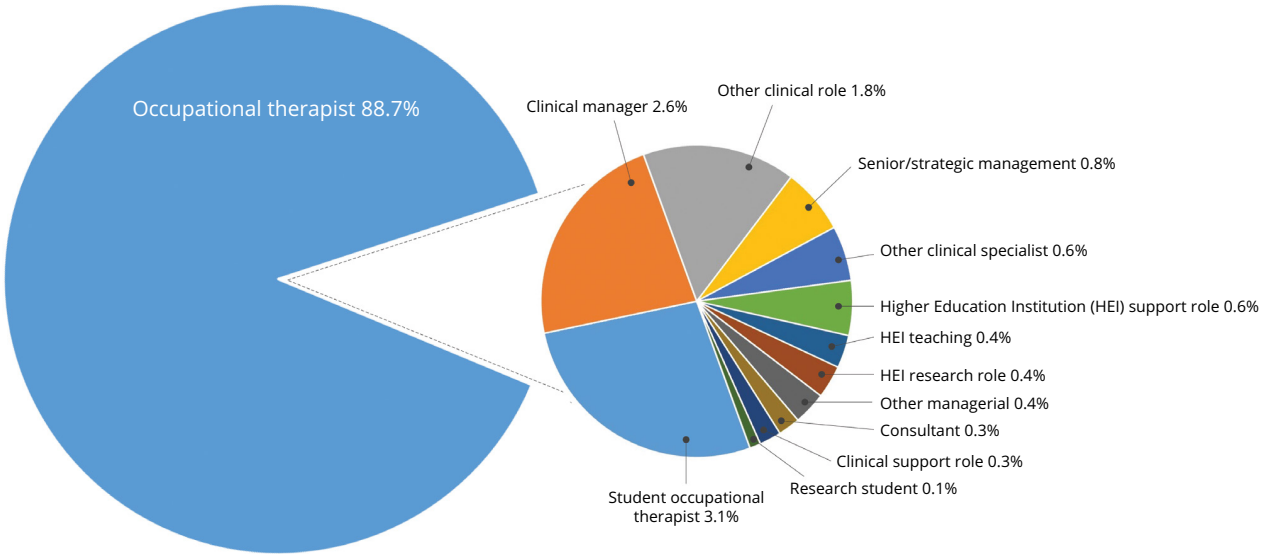


Figure 5 Professional identity of respondents

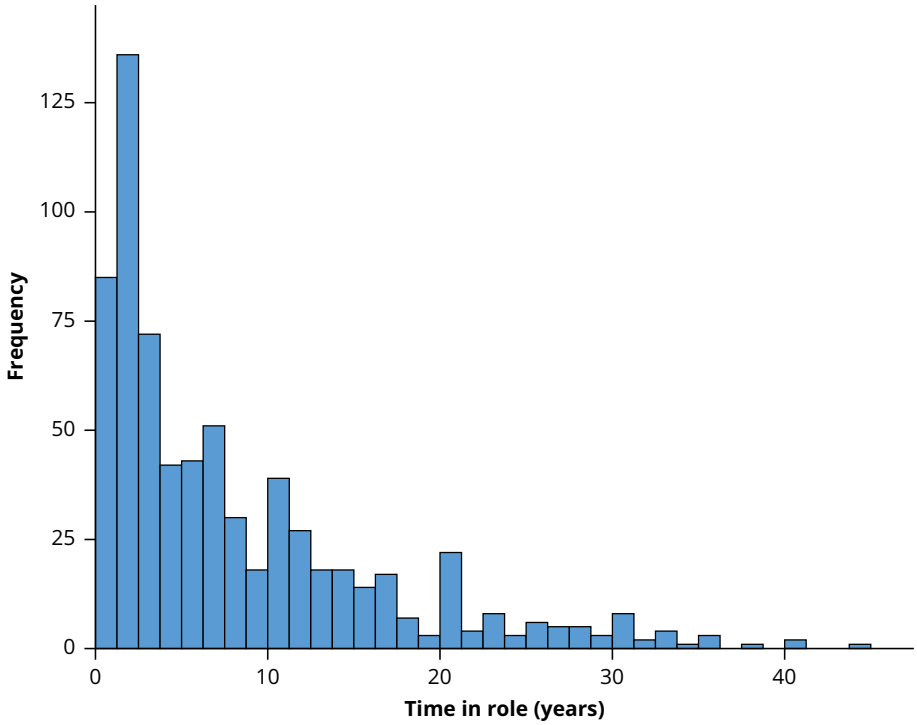


Figure 6 Respondents' time in role

Who occupational therapists work with

Several survey items asked about elements of current practice, including with whom occupational therapists worked, and the reasons for encountering these people. Individuals made up the largest single type of service user, with 709 (90.5%) of respondents indicating they worked with individuals. However, respondents were able to score multiple response items to indicate whether they worked with more than one type of client. Figure 7 shows these cross-referenced values. The most common overlap was respondents who worked with both individuals and families (287 cases), followed by respondents who worked with both individuals and public organisations (106 cases).

Figure 8 shows the percentage of cases by the mean number of types of service user they worked with. The majority (56.8%) worked with only one type of service user, with slightly over a quarter (26.6%) reporting they worked with two types of service user. The mean score was 1.73, with a small number of respondents (13; 1.7%) indicating they worked with six different types of service user.

Respondents were also asked to indicate why they encountered people. Physical conditions and psychological/mental health conditions accounted for almost identical results. These were followed in order of magnitude by issues related to social circumstances, occupational issues related to opportunities for participation and engagement, then developmental conditions or learning disorders (see Figure 9). Again, there was a substantial degree of crossover, with individual respondents indicating that they saw people for multiple reasons or were in a position where they would encounter people for a range of reasons. Figure 10 gives an overview of the crossover between responses and Figure 11 indicates the number of respondents reporting seeing different numbers of presenting reasons.

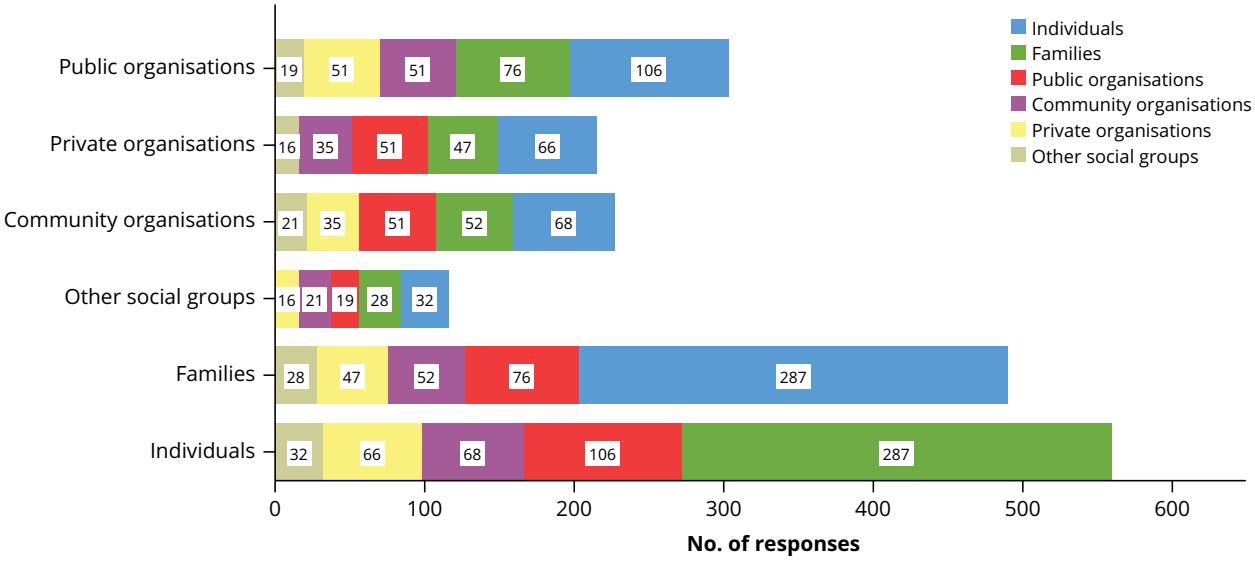


Figure 7 Who respondents work with – cross-referenced

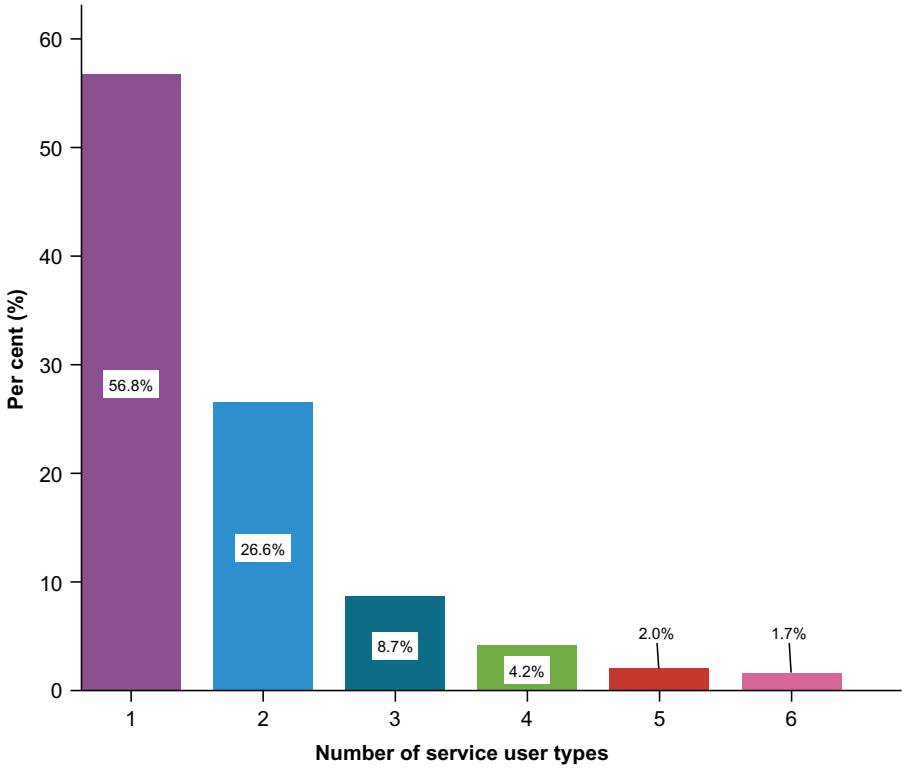


Figure 8 Percentage of respondents identifying different client types

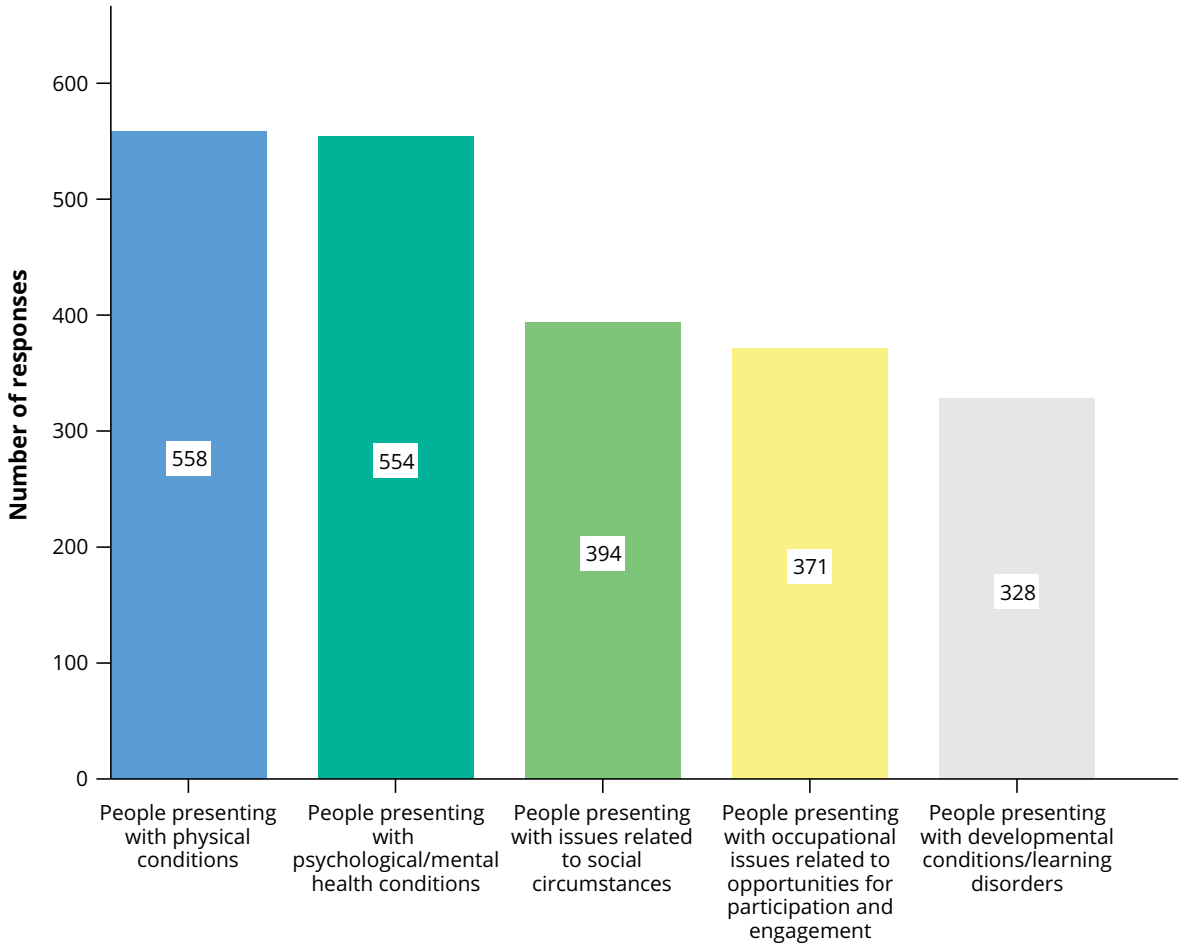


Figure 9 Reasons for encountering clients

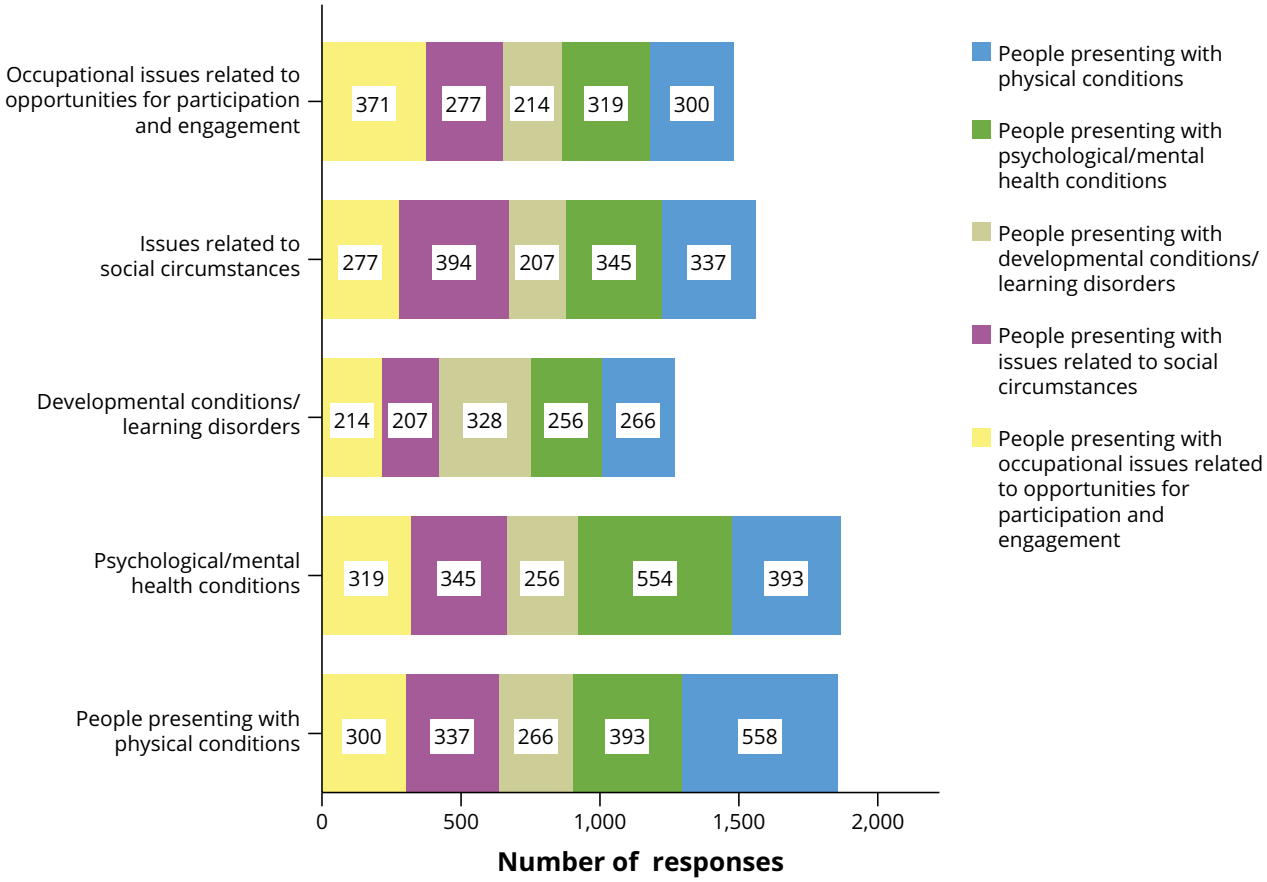


Figure 10 Reasons for encountering clients – cross-referenced values

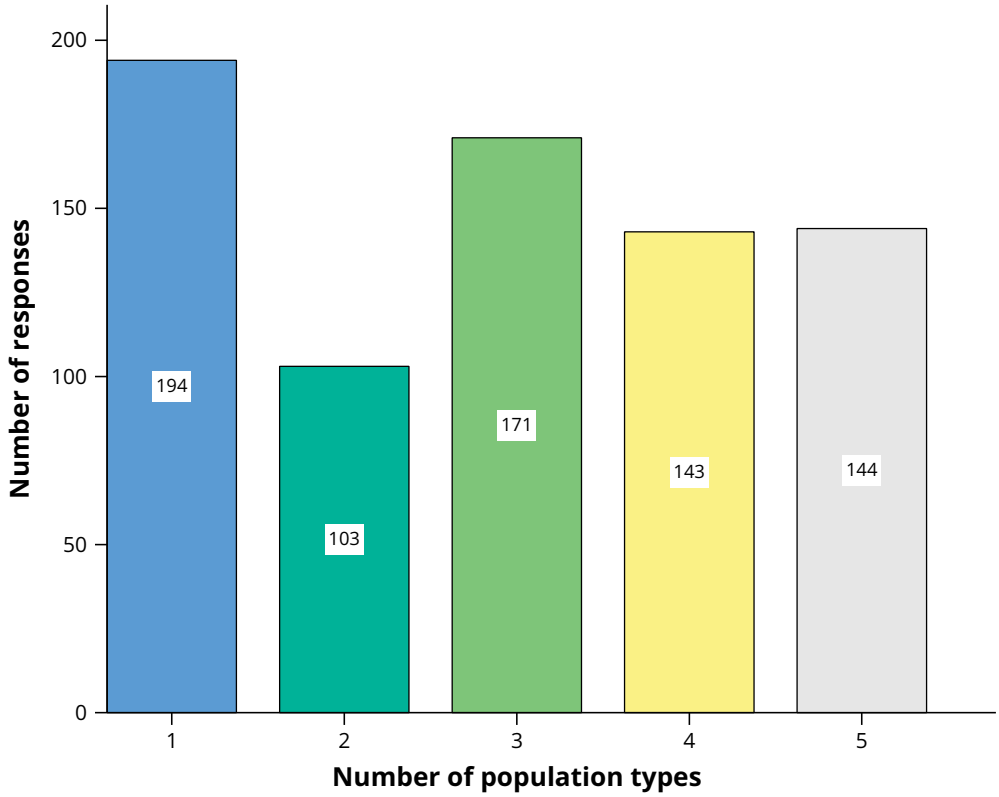


Figure 11 Number of presenting reasons seen

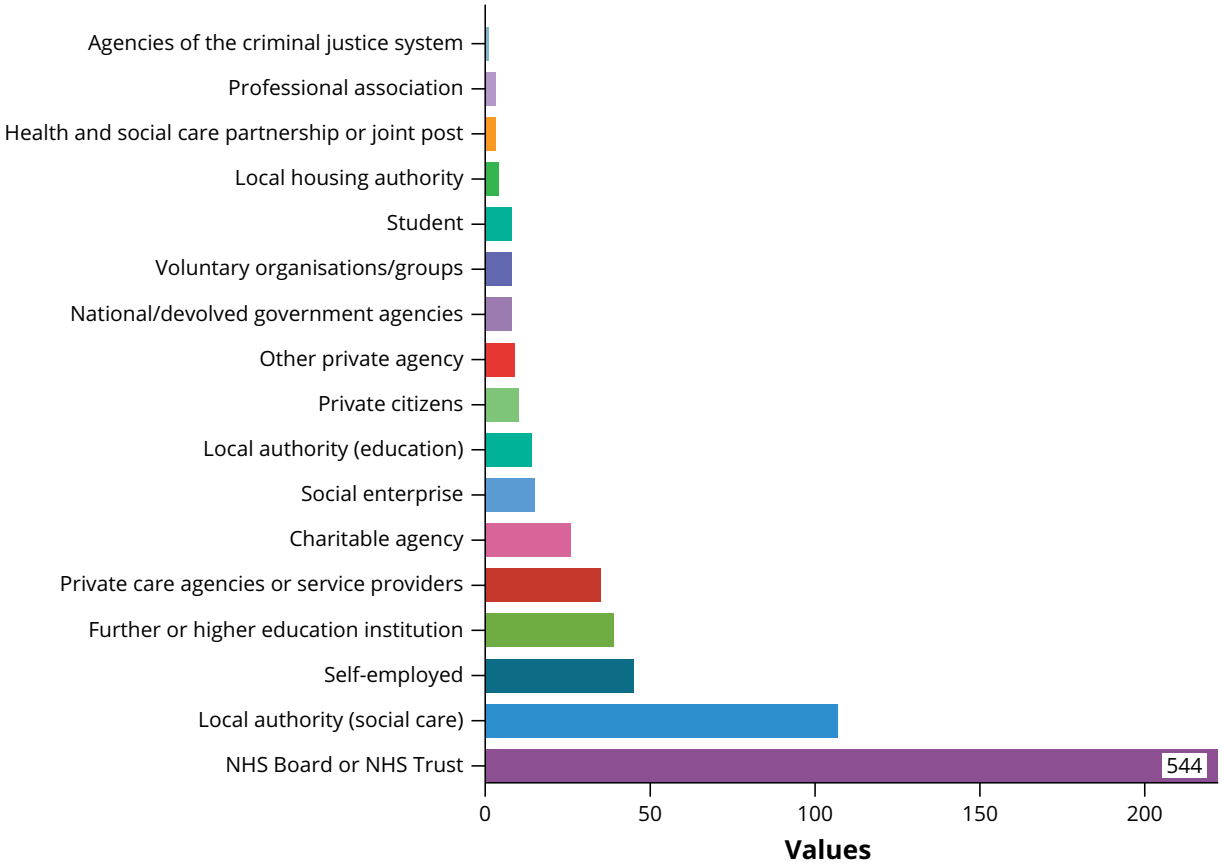


Figure 12 Number of responses by employer

Who occupational therapists are employed by

The profile of employers was diverse, with 17 different employer types identified. National Health Service Boards or Trusts were the single largest category with 544 responses (69.5% of respondents), followed by local authority social care agencies and self-employed therapists (see Figure 12 for details). The majority (90.9%) of respondents were only employed by one agency. Most respondents practised in England (500), followed by Scotland (208), Northern Ireland (53), Wales (39) and a range of other locations (the European Union, Singapore, British crown dependencies and American countries) accounting for 14 responses. A small number of respondents reported practising in more than one location (21; 2.7%).

Service and practice aims

Respondents were asked to describe the aims of (1) the service they worked for, and (2) their practice as occupational therapists. Word frequency analyses were completed to identify the most common ways of describing the aims of services and practices. Commonly occurring words (mainly prepositions and conjunctions) were excluded from analysis. Analysis was expanded to group words sharing the same stems together (for instance, ‘occupation’, ‘occupations’ and ‘occupational’ would appear as a single category). Table 12 gives a side-by-side comparison of the top 50 most frequently occurring words in the pooled responses to each item. Thirty-two out of fifty terms appeared in both categories, and their relative positions are shown in brackets. Terms that appear in one category only are shown in bold.

Table 12: Comparative word frequency analysis – service and practice aims

Aims of service				Aims of practice		
Weighted Percentage (%)	**Count**	**Word**	**Rank**	**Word**	**Count**	**Weighted Percentage (%)**
2.68	248	Health (+11)	1	Occupations (+21)	268	2.31
2.32	215	Service (+4)	2	Support (+1)	257	2.21
2.13	197	Support (–1)	3	Assessments (+5)	244	2.10
2.06	191	Mental (+27)	4	Independence (+8)	223	1.92
1.91	177	People (=)	5	People (=)	184	1.58
1.80	167	Care (+9)	6	Service (-4)	170	1.46
1.73	160	Community (+18)	7	Functional (+35)	146	1.26
1.67	155	Assessments (–5)	8	**Working**	145	1.25
1.62	150	**Works**	9	**Activity**	137	1.18
1.32	122	Homes (=)	10	Homes (=)	134	1.15
1.26	117	Independence (–8)	11	Enable (+15)	128	1.10
1.26	117	Hospital (+32)	12	Health (–11)	127	1.09
1.07	99	Patients (=)	13	Patients (=)	127	1.09
1.06	98	Discharge (+8)	14	Needs (+5)	126	1.08
1.04	96	**Rehabilitation**	15	Care (–9)	119	1.02
0.97	90	**Adults**	16	Individuals (+4)	118	1.02
0.93	86	**Disabled**	17	Living (+1)	116	1.00
0.92	85	Living (–1)	18	Promote (+27)	105	0.90
0.91	84	Needs (–5)	19	Intervention (+18)	96	0.83
0.89	82	Individuals (–4)	20	Clients (+14)	91	0.78
0.88	81	**Acute**	21	**Engaging**	90	0.77
0.86	80	Occupations (–21)	22	Discharge (–8)	90	0.77
0.81	75	Aim (+10)	23	**Skills**	90	0.77
0.69	64	**Physical**	24	**Person**	87	0.75
0.68	63	Safely (+4)	25	Community (–18)	86	0.74
0.68	63	Enable (–15)	26	Management (+19)	85	0.73
0.67	62	Social (+14)	27	Life (+9)	85	0.73
0.63	58	**Treatment**	28	**Participation**	82	0.71
0.61	56	**Conditions**	29	Safely (-4)	77	0.66

Aims of service				Aims of practice		
Weighted Percentage (%)	**Count**	**Word**	**Rank**	**Word**	**Count**	**Weighted Percentage (%)**
0.61	56	**Providing**	30	**Meaningful**	70	0.60
0.57	53	**Children**	31	Mental (–27)	69	0.59
0.56	52	**Admission**	32	Improve (+17)	67	0.58
0.55	51	Within (+7)	33	Aim (–10)	64	0.55
0.52	48	Clients (–14)	34	**Develop**	64	0.55
0.52	48	Equipment (+4)	35	**Facilitate**	64	0.55
0.52	48	Life (–9)	36	**Maintain**	64	0.55
0.52	48	Intervention (–18)	37	**Users**	63	0.54
0.51	47	**Reduce**	38	**Daily**	61	0.53
0.50	46	**Learning**	39	Equipment (–4)	61	0.53
0.50	46	**Team**	40	Within (–7)	61	0.53
0.50	46	Therapy (+2)	41	Social (–14)	60	0.52
0.49	45	Functional (–35)	42	**Increase**	59	0.51
0.49	45	Promote (–27)	43	Therapy (–2)	59	0.51
0.48	44	Adaptations (+6)	44	Hospital (–32)	58	0.50
0.48	44	Management (–19)	45	**Family**	57	0.49
0.48	44	**Quality**	46	**Possible**	56	0.48
0.48	44	**Prevent**	47	**Practice**	56	0.48
0.46	43	**Older**	48	**Ensure**	55	0.47
0.43	40	Improve (–17)	49	**Using**	55	0.47
0.43	**40**	**Settings**	50	Adaptations (–6)	54	0.46

Activities during therapy

Respondents were asked how often they would normally complete a range of activities with their service users. These were categorised as assessment practices (three categories), activities to improve or restore performance or skills (four categories), and activities to alter elements of role, environment, routine or opportunity (five categories). Figure 13 gives an overview of the frequency of responses (the deeper red, the less frequent the response, and the deeper green, the more frequent) for each category, and Figure 14 is a stacked bar chart showing the same data.

Strategies and techniques used during therapy

Respondents were asked to identify the strategies and techniques they used during therapy. A list of 20 categories was presented in the survey, along with an option to list techniques that did not appear on this list: 41 additional comments were provided and were screened and considered for recoding into existing categories. All but four of these were recoded into existing categories. These remaining comments were either identified

	Never	Almost never	Occasionally	Often	Almost all the time	Always
Assessing occupational performance	13	8	46	115	196	387
Assessing functional performance	12	5	35	104	150	462
Assessing needs	7	1	16	68	123	549
Improving or restoring occupational performance	12	15	55	172	222	287
Improving or restoring sensorimotor function/skills	51	108	206	175	122	92
Improving or restoring physical function/skills	29	73	171	152	156	180
Improving or restoring mental function/skills	29	81	161	182	156	147
Learning, resuming and/or maintaining activities, roles and routines	13	23	68	157	225	280
Changing the client's environment(s)	27	47	120	175	199	204
Creating opportunities for meaningful occupation	26	50	119	185	190	197
(Re)patterning occupations	59	89	169	193	143	81
Preventing loss/deterioration of occupational performance	20	29	110	208	207	192

Figure 13 Heat map of typical practices

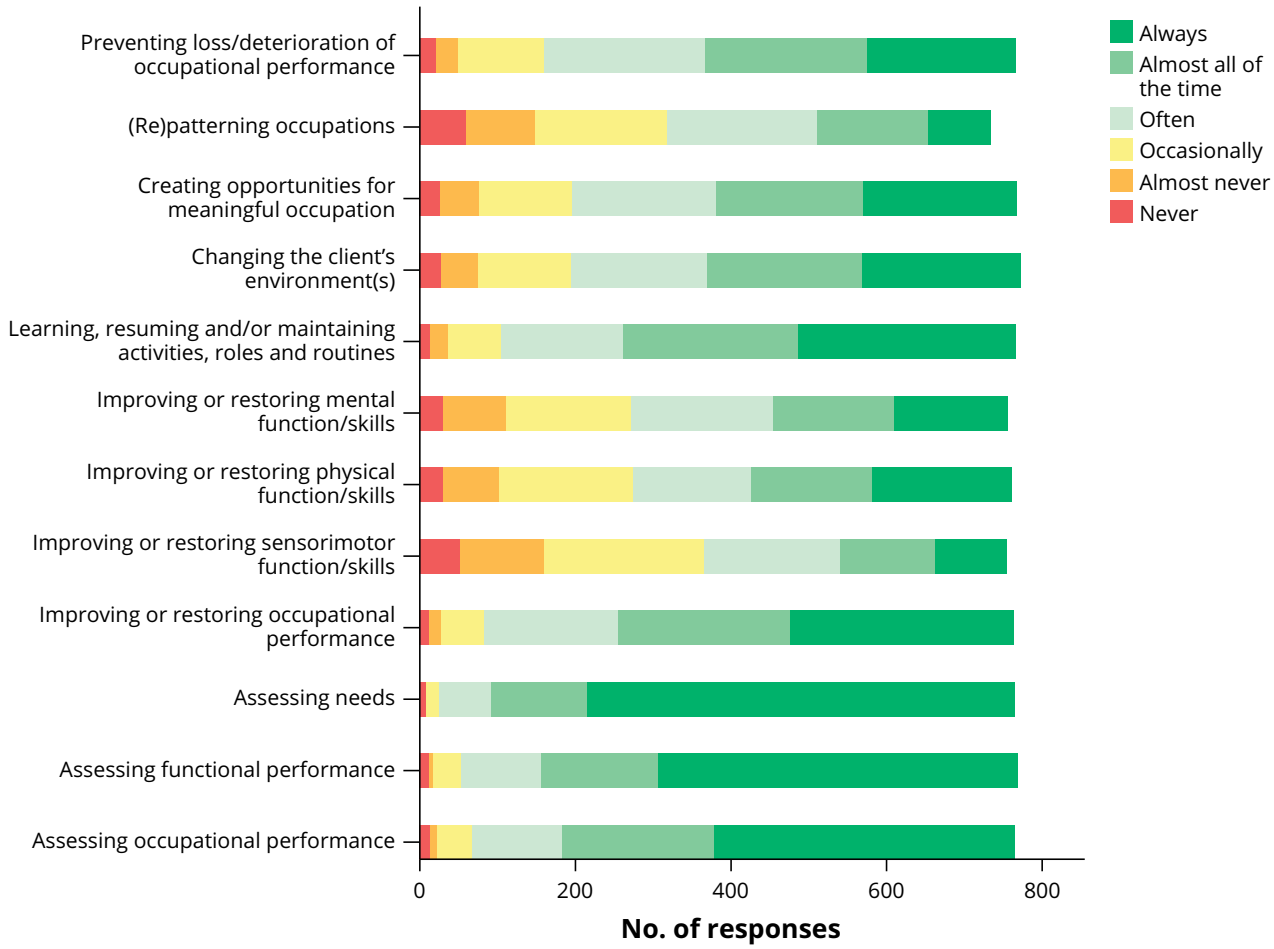


Figure 14 Stacked bar chart for frequency of activity

by respondents as being inapplicable because they no longer provided clinical services (3) or lacked sufficient detail (1). The frequency of responses in each category is shown in Figure 15.

This question allowed for multiple responses. Figure 16 shows how many respondents indicated they used different numbers of strategies and techniques. The mean number of strategies and techniques respondents reported using was 11, with some respondents indicating they used all 20 techniques in practice and some reporting none (though it should be noted that this also includes respondents who chose not to answer this question).

Figure 17 shows the most common combinations of strategies and techniques as a heat map, with dark green indicating the most frequent combination and red the most infrequent. The most common combination was 'compensation/enablement by assistive or adaptive device, aids or equipment' with 'environmental modification' (552 responses) followed by 'therapeutic use of self' combined with 'use of occupation' (524 responses) and 'use of occupation(s)' and 'educational processes' (also with 524 responses).

Evaluating therapy

Analysis indicated that occupational therapists use a wide range of methods for evaluating their therapy. On average, therapists used three different means for evaluation, though a minority reported using seven or more (see Figure 18). The most

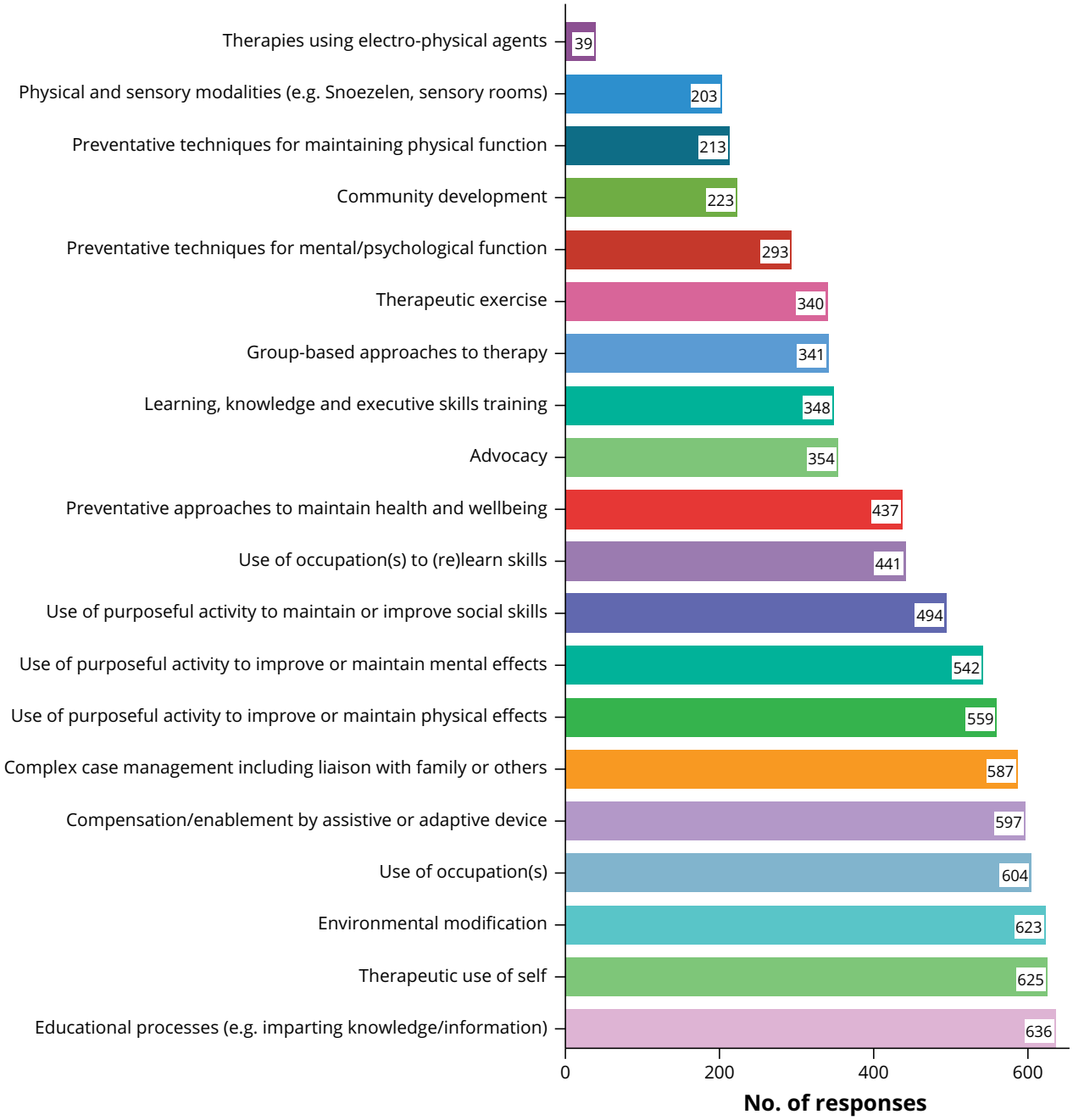


Figure 15 Strategies and techniques used during therapy (by frequency)

frequently used evaluative methods were to gather feedback from the service user, followed by collecting feedback from their family members, carers or other relevant social networks. The third and fourth most commonly reported methods were to use outcome measures (though no other details were provided in these responses) or outcome measures specifically linked to a conceptual model of occupational therapy. Figure 19 provides an overview of the frequency with which different evaluation methods were reported, and Table 13 provides a view of the most common combinations of evaluative methods. The most frequently used combinations included a range of outcome measures, observation and experience, reviewing goals and gathering feedback from people, their families and other health and social care colleagues. Twinning service user reports with feedback from their families or carers was the most frequent combination.

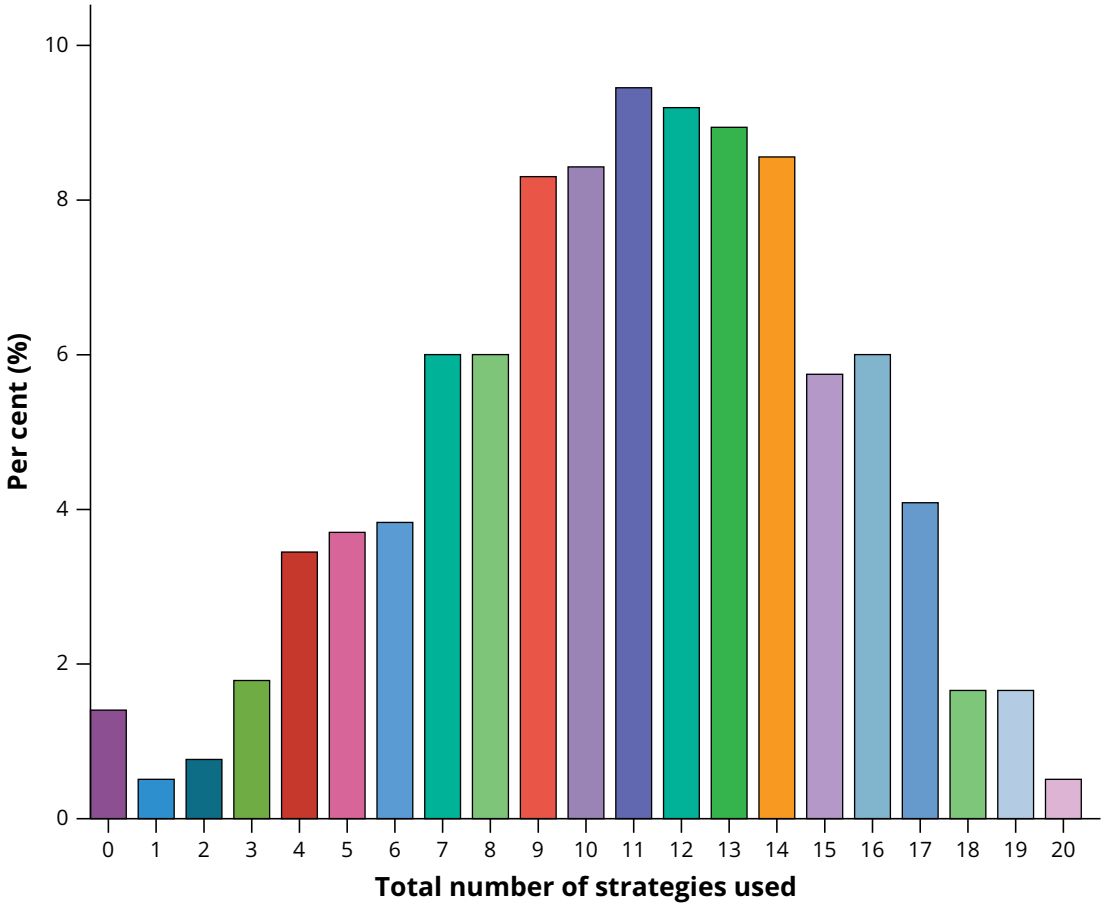


Figure 16 Number of strategies used by number of respondents

Table 13: Most common combinations of evaluation method

	Functional outcome measures	Outcome measures (no detail specified)	Goal status	Obs. & exp.	Service user reports	Family or carer reports	MDT reports
OT model outcome measures	42	25	50	32	83	43	37
Functional outcome measures		13	28	20	50	23	17
Outcome measures (no detail specified)			55	45	84	65	50
Goal status				26	70	48	34
Observation and experience					80	59	45
Service user reports						138	99
Family or carer reports							84

	Use of occupation(s)	Use of occupation(s) to (re)learn skills	Use of purposeful activity to improve or maintain physical function or ability	Use of purposeful activity to improve or maintain mental function or ability	Use of purposeful activity to maintain or improve social skills	Educational processes	Environmental modification	Therapeutic exercise	Compensation/enablement by assistive or adaptive device, aids or equipment	Preventative techniques for maintaining physical function	Preventative techniques for mental/psychological function	Preventative approaches to maintain health and wellbeing	Learning, knowledge and executive skills training	Therapies using electro-physical agents (e.g. heat/cool packs, electrical stimulation techniques)	Complex case management including liaison with family or other professionals	Advocacy	Physical and sensory modalities (e.g. Snoezelen, sensory rooms, SI techniques etc.)	Community development	Group-based approaches to therapy
Therapeutic use of self	524	391	452	473	434	534	505	295	474	175	266	365	312	32	490	306	179	202	303
Use of occupation(s)	412	469	479	440	524	490	292	461	177	257	357	309	31	469	302	187	198	309	
Use of occupation(s) to (re)learn skills	358	379	357	389	369	240	341	136	210	271	258	27	354	231	161	156	236		
Use of purposeful activity to improve or maintain physical function or ability	446	391	467	484	293	479	198	226	361	285	36	441	273	164	169	251			
Use of purposeful activity to improve or maintain mental function or ability	444	473	441	282	411	153	272	340	296	33	430	273	175	197	291				
Use of purposeful activity to maintain or improve social skills	435	393	264	361	135	250	310	284	27	394	257	173	197	290					
Educational processes	510	305	490	193	266	387	326	34	499	306	178	199	305						
Environmental modification	280	552	195	235	383	288	35	505	304	173	176	252							
Therapeutic exercise	272	140	171	230	217	35	275	176	122	127	204								
Compensation/enablement by assistive or adaptive device, aids or equipment	203	220	371	269	37	483	285	155	151	236									
Preventative techniques for maintaining physical function	94	136	130	35	181	110	74	57	97										
Preventative techniques for mental/psychological function	221	190	24	242	161	103	128	189											
Preventative approaches to maintain health and wellbeing	235	24	356	228	114	152	216												
Learning, knowledge and executive skills training	28	283	199	121	135	207													
Therapies using electro-physical agents (e.g. heat/cool packs, electrical stimulation techniques)	31	23	16	16	25														
Complex case management including liaison with family or other professionals	309	161	177	265															
Advocacy	110	126	183																
Physical and sensory modalities (e.g. Snoezelen, sensory rooms, SI techniques etc.)	83	132																	
Community development	156																		

Figure 17 Combinations of intervention strategies and techniques

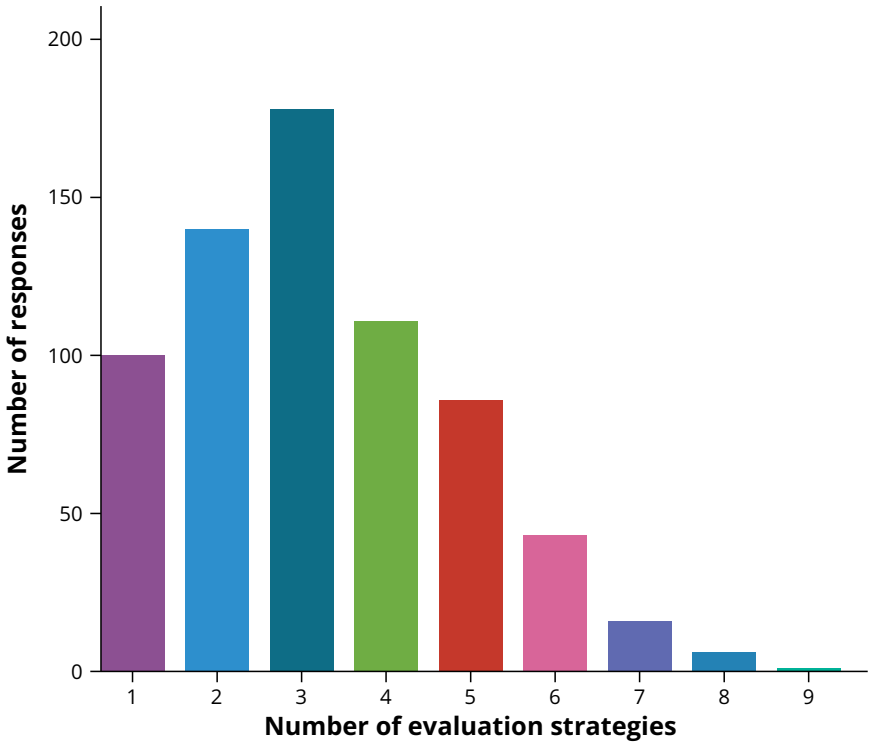


Figure 18 Number of evaluation strategies used

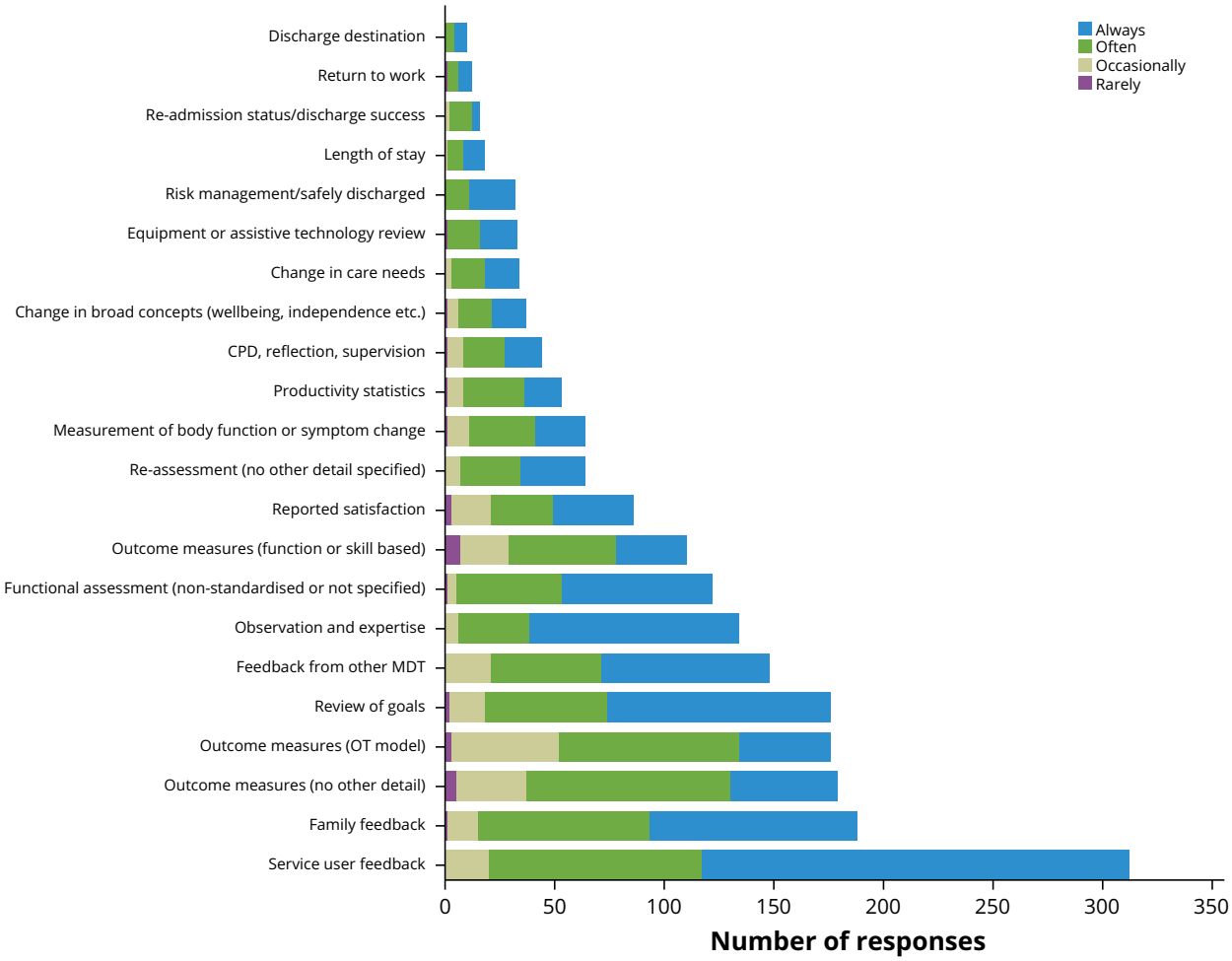


Figure 19 Evaluation strategies by frequency

Influences on practice

Figure 20 displays the responses given when participants were asked to indicate the impact a range of different phenomena had on their practice. Practice experience, clients' values and views, clients' daily lives and participants' professional codes of practice and conduct were among the options consistently scored as having positive effects on practice. Conversely, financial considerations, service structures, social trends, geographic locations and policy (both local and national) were most likely to be scored as having a negative impact on practice (though these negative responses remained in the minority).

Views on complexity

Participants were asked to indicate whether they thought occupational therapy was complex. Most respondents (n=687, 88.8%) indicated they considered their practice to be complex. No associations between other variables and this question about complexity were detected. Of the remaining responses, 6.8% were scored as 'not sure' and 4.4% (n=34) as 'no'. No patterns were noted in the data for those who indicated that they did not feel occupational therapy was complex.

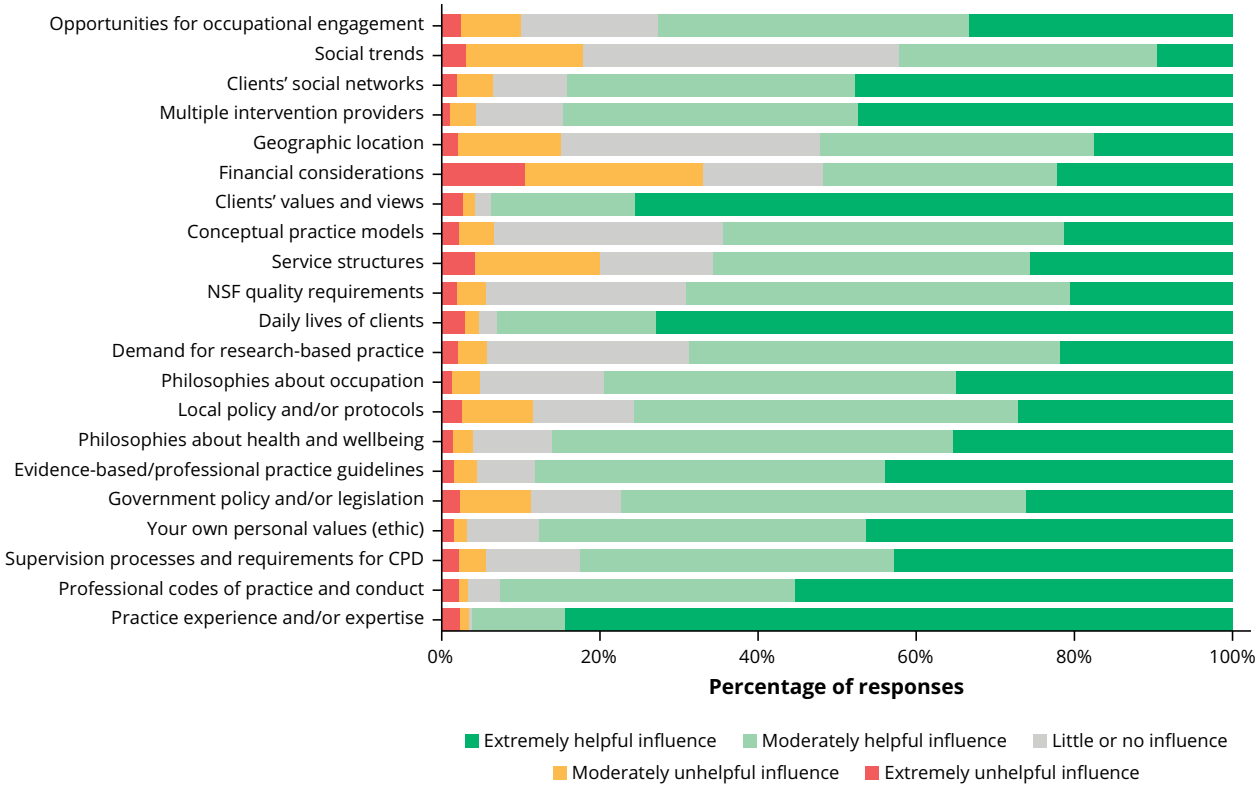


Figure 20 Influences on practice

Findings from thematic analysis

Change occurs in many different ways

Four hundred and twenty-one separate statements related to the nature of change were identified in the survey analysis. Coding and categorisation of these statements led to three distinct thematic areas being identified, each related specifically to what actually changes during, and because of, occupational therapy. Each thematic area was composed of a number of more discrete ideas. These were identified as changes to components of perception and associated attitudes and behaviours, changes to functional characteristics, and changes to a number of concepts.

Changes in areas of self-perception and associated attitudes and behaviours included:

- increased self-awareness; increased or improved understanding/making sense of what has happened or is happening;
- acceptance and changes in perception;
- personal identification of strengths and limitations;
- changes in the way the person thinks about activities and their ability to engage in those; realisation; adaptability; creative ways of thinking (a 'can do' attitude); learning coping strategies, taking control of what is important;
- increased confidence (through co-operatively/actively participating in occupations);
- improved self-esteem;
- improvement in satisfaction with occupational performance;
- restoration of hope, re-emergence of sense of self and purpose;
- self-efficacy; effective adaptation to loss of skill within chosen occupations;
- changes to family's/carers' perceptions of their relative;
- improved motivation and self-worth); notice positive changes/differences in self and occupations;
- sense of empowerment (making informed choices and decisions about what occupations will maintain or enhance physical and psychological wellbeing);
- positive changes to family and social dynamics and interpersonal relationships.

Changes to functional characteristics:

- improved self-management; new knowledge/new ways of managing a condition; finding new ways to cope;
- resuming important roles in life;
- regaining/restoring/maintaining independence; reduced dependency; improved functional ability.

Changes to conceptual areas:

- improved occupational performance and participation;
- enhanced wellbeing; achieving a meaningful and fulfilling lifestyle; better quality of life.

Respondents commonly referred to several of these ideas in the same response, possibly suggesting that multiple changes in several domains are typical of how change is understood to happen in occupational therapy. Similarly, there were indications that some of the above ideas are inherently interlinked during a process of change. This idea is discussed in more detail in the following section examining the process of change.

A word frequency analysis of the statements identified in this theme provides some confirmation of these themes, with 'confidence', 'skill', 'self', 'ability', 'independence', 'activity', 'function', 'life' and 'engagement' all appearing in the top 15 most used terms (a list of the top 50 frequently used words is given in Table 14 of Appendix A).

In terms of the relationship between occupational therapy and change, there were clear and repeated references to expected relationships between the content of therapy and the outcomes that resulted. As a starting point, the word frequency analysis shows that 'improved' and 'increased' both feature in the top five most common terms. Furthermore, 'development', 'achievement', 'regaining', 'reduce' and 'greater' all appear in the analysis and can all be considered as indicators of a directional relationship between therapy and change.

Reponses typically included one of these terms as a qualifier when the change being noted could be considered in terms of some sort of magnitude. These were spread across the three main themes, with numerous examples referring to 'improved confidence', 'increased independence' and 'greater quality of life' as paraphrased examples. Additionally, there were a range of changes which were referred to in binary terms (typically as a presence or absence of some change or characteristic). 'Acceptance' and 'taking control' were common examples of this type of response.

A subset of responses referred to these concepts of magnitude differently, noting that while detectable changes had occurred during therapy, these varied in terms of scale, but that there was not necessarily an obvious relationship between the scale of a change and its outcomes. One respondent noted: "*Change can be small, such as a change in routine to promote health or a whole new direction and purpose in life"*, while another commented: "*Change can be slight or significant within OT treatment. Both of these can be life-changing to an individual."*

Further responses suggested that these ideas could be attributed to variability in need and circumstance, and that changes were not always predictable and not necessarily positive, as suggested by the following respondents' extracts: *"Change is dependent on the individual and their individual circumstances. Change occurs within the roles, routines and level of autonomy of the individual", "Every patient has different changes to make and they are not always what you expect. Sometimes it's simply accepting their condition and making sense of what has happened" and "Changes in confidence/mobility/independence/mood/ ability to access home and community – normally all 'positive' but the word 'changes' could include for better or worse…".*

Change occurs as a process

Change during occupational therapy was described as a transitional process, either directly, or in descriptions which indicated multiple changes occurring on a pathway towards outcomes. The volume of data referring to processes of change is much less than that referring to the nature of change (142 distinct process of change statements compared with 421 nature of change statements), and there was less commonality in terminology and examples given. It should also be noted that respondents did not tend to state explicitly that a multistage transitional process occurred. Rather, numerous examples were given of situations where a range of different changes linked together to cause some effect, either an outcome or an identifiable point of transition during the process.

Two broad themes were identified. The first was that agency is a medium for positive change, and it was frequently linked to outcomes such as 'ownership', 'a feeling of being in charge' or 'control'. Change was also often referred to in terms which indicated it is thought about as an ongoing phenomenon. The language of 'growth' and 'building' was used to indicate this idea of continuing change and slow incremental development (along with suggestions that occupational therapists assist this growth to happen).

Specific examples indicating change processes included:

- Changes in the perception of difficulties faced can lead to a person becoming better able to cope with the same unchanged symptoms or causes of occupational disruption.
- Establishing or improving self-management skills is often founded on a demonstrated understanding of their condition and how it is affecting their life and ability to complete occupations.
- The point at which a person comes to realise that doing something (typically an activity as part of therapy) makes them feel better can lead to increased motivation and hope, which stimulates further engagement in occupation.
- Increased self-awareness, typically about functional performance, leads to an identification of strengths, which in turn positively influences how these are applied to daily life issues. This in turn can affect components at the level of occupational participation.
- Taking control and responsibility for choices/actions relating to lifestyle behaviours and attitudes can contribute to improved health and wellbeing.
- Simple personal pleasure in a meaningful activity can lead to feelings of achievement and/or fulfilment and purpose; this can lead to improvements in health and wellbeing and, on occasion, personal growth.
- Achievement can also be facilitated by improving an individual's physical, social and/or psychological skills.
- Improved function in activities of daily living (also termed improved occupational performance) can lead to increased confidence and enhanced wellbeing. Similarly, engagement in occupations or activities that people want to do, or value, can lead to a sense of increased wellbeing.
- Similar feedback loops can be seen when a person continually develops the skills and motivation to change through participation in occupation, with increases in each of these leading to changes in the others.
- Different examples had multiple change processes occurring at the same time: (a) developing new compensatory techniques or adapting to contexts; (b) changes to perception; (c) undertaking/re-engaging with valued occupations.
- The development of skills and understanding of a person's situation, along with success in finding solutions to difficulties (following and during work with a therapist), leads to a growth in confidence. This improved confidence alters how a person engages with their context, which allows greater opportunity for further positive change.

Influencers on change

Several factors that were considered to influence changes during occupational therapy were noted. These were identified in three categories as: influencers which could be identified as being primarily related to the occupational therapist and their context, influencers which could be identified as being primarily related to a person and their context, and influencers which were typically identified as only existing during the process of occupational therapy.

Influencers associated with the occupational therapist and their context:

- Joined-up working, effective team-working and inter-professional communication.
- Supervision and support from management to develop professional skills, including ongoing training.

- Positive professional role models and a supportive set of peers in the immediate professional context.
- Legislation, finances, service structures and external resources (typically quoted to be barriers to therapy). These were noted by several respondents to directly affect their own health and wellbeing.
- Local support by immediate team and local organisation.
- Ability to react to changing needs and presentations (also termed adaptability and positive adjustment).
- Personal values (compassion, strong work ethic, high professional standards and commitment).
- Lack of professional focus/structural requirements towards generic occupational therapy roles and the need to have an extremely broad knowledge base in some services.
- Service models based on named theories and methods can be detrimental and curtail the ability to take an occupation-focused approach.

Influencers associated with person(s) and their context:

- The nature of a person's social networks, including peer supports, which may occur as a result of therapy.
- A person's values and, at times, their family's values.
- Opportunities for participation in desired occupations, and the ability to access these.
- Physical environment, including geographic considerations such as physical and social isolation.
- Pre-existing lifestyle patterns.
- A person's financial status.
- Willingness and ability to take responsibility; readiness to engage; individual awareness and insights.

Influencers associated with specific intervention contexts:

- Client-centred, client-led approach; informed and empowered service users.
- Being able to adopt and maintain an holistic approach.
- Being able to respond and adapt to changes in circumstances as therapy progresses.
- Being able to pinpoint and capture change.
- Allowing engagement in meaningful activity.
- Exploring a person's history to generate an understanding of their occupations.
- Establishing relationships based on trust. At times this includes the therapist acting as an advocate.
- Retaining a focus on education so that a person can learn during the process (multiple focuses for learning including condition, ability, new ways of doing and so forth).
- Being able to implement a co-productive approach during therapy.

These influencers were often written about in terms of their interactions with each other. For instance, while a clear set of professional values and a wish to work in a person-centred way were associated with the therapist and their context, they were seen to be important in the context of providing occupational therapy, playing a key role in establishing relationships and ensuring that a person's needs remained in focus. Similarly, there were many responses indicating the negative influence of factors associated with the therapist's context on the therapist's ability to carry out actions and behaviours which they felt would be of direct benefit during occupational therapy.

How change is identified, quantified and qualified

Respondents reported a range of activities associated with how change was identified and evaluated. These were identifiable as fitting into three core themes:

i. Measurement

ii. Professional estimation

iii. First-hand accounts.

Again, while these approaches are listed in separate categories here, the picture provided in the open responses is of therapists using a range of techniques to identify change. Thematic analysis suggested two categories that could be used to order responses. The first related to a concept of observable or visible change and the approaches used to capture these, while the second related to changes that were harder to detect and more challenging to quantify.

Approaches to capturing the more visible changes included:

- Comparing observed and reported functional performance to baseline or pre-therapy levels using both professional estimation and standardised measures.
- Goal attainment, either formally established using goal-scaling methods or using simpler methods.
- First-hand feedback from people and their families.

Responses indicating attempts to capture changes that are harder to detect tended to focus mainly on explaining or reporting perceived inadequacies in currently available methods. The data suggest multiple potential reasons for this. Some responses indicated a mismatch between changes evaluated by currently available measures and actual impact. In these responses it appeared that tools designed to evaluate specific concepts related to occupation were useful, but failed to capture the impact of change on a person. Similarly, there were indications that some therapists could not find tools that would effectively capture change for all the people in their service user population. Several respondents noted a need to capture changes that do not feature as outcomes but are central to success, and suggested informal methods to achieve this.

A range of contextual factors were also noted as causing challenges to how these less visible changes were evaluated. These included a lack of agreement about what to record at strategic level, and a belief that individual professional opinion is more effective at capturing the nuances of change and its likely transferability to 'real life' than currently available measures.

Some respondents also noted a disconnect between the methods available for capturing change in occupational therapy and what wider health and social care professionals

might want to see, or be able to understand. At times, this was noted to lead to a focus on more discrete and reductionist approaches to evaluating change, typically associated with symptomology, physiological/psychological function or structural and process-related performance (bed days and care hours, for instance). These were seen to be of greater interest or professional relevance to more powerful/influential members of care teams. Consequently, identifying and noting changes associated with concepts around occupation were less consistent and less valued.

There were some responses that reported on alternative methods for evaluating change, beyond collecting combinations of data. These examples tended to focus either on reasoning activities undertaken by occupational therapists or on narrative and storytelling methods. Reasoning processes included examples such as reflecting on all interactions that took place between a person and an occupational therapist to evaluate a broad range of potential changes to mood, motivation, cognition, interpersonal skills and so forth. Similarly, one respondent indicated: *"We feel stories capture a richer, fuller, more qualitative picture of the true difference our services can make",* potentially suggesting that the range of measures currently available do not capture all of the impact associated with occupational therapy.

Ideas of individualisation and tailoring approaches to individuals came through in a number of responses.

- *"Depending on the client and their situation, different methods used to capture any changes, usually informal observations and specific outcome measures, would be used for everyone."*
- *"As an OT I look at everything, I spread it out and then synthesise it to hypothesise and project the best course of action. I do not look at one component. My clients are individuals with complex backgrounds and I must liaise with many different agencies to ensure the best possible intervention for my clients."*

What makes occupational therapy complex? 'People are complex'

Analysis indicated that the majority of respondents thought occupational therapy was complex. The open responses provided were developed into five distinct themes, which explain why this might be the case:

i. Complexity is associated with conditions and their impacts
ii. Influence of person's context
iii. The need to individualise therapy
iv. Influence of therapist's context
v. Complexity results from the interaction of the factors above.

1. Complexity is associated with conditions and their impacts

A common and straightforward explanation provided by respondents was that complex illness and conditions impacting on occupation were a source of complexity, summed up in one response*: "Complex symptoms = complex problems."* Attention was often drawn to this when the condition affected a range of body functions:

- *"Complex because customers have both physical and cognitive deficits and they are often referred due to crisis of family carer breakdown or complex hospital discharge."*

- *"Intervention is long and has to be carefully designed in order to simultaneously consider emotional, social, physical, cognitive and language needs, all of which impact on a client's ability to engage in their chosen occupations and roles."*
- *"Complex physical presentations, behaviour, mood and cognition."*

Although less frequently expressed, there were indications that the nature of illness or condition alone was not the cause of complexity. Rather, the interactions of these condition-related features, the ultimate aims of occupational therapy and the challenges associated with achieving these due to context, were reported.

2. Influence of person's context

The influence of a person's context was frequently and clearly identified as a cause of complexity. It was common for responses to identify components of a person's context that influenced them, their health and occupations, and how they engaged with therapy. The sources of these components of a person's context spanned from the immediate environment and circumstances through to issues identified at much broader macro or societal levels.

- "*We work with service users who have multiple problems – physical and mental illnesses, physical and learning disabilities, complex family situations, unsuitable home environments, varying financial circumstances."*
- *"Often people have a number of social circumstances/concerns (benefits, housing/ homelessness, addiction) that need to be addressed before they feel they can even begin to consider a more self-directed means of working/support."*
- *"I work in a poor socio-economic area, the project I am involved in aims to return individuals to work, my clients have multiple health conditions, many live in poverty, experience abuse, have criminal history, and come from households that do not value or have no experience of employment."*
- *"I work in a very deprived area … and our patients often have multiple physical and social difficulties along with their mental health problems. Chronic unemployment and poverty can often result in what I term 'occupational poverty' as patients are surviving doing what they must occupationally, but with a lack of pleasurable and leisure focus. The reasons for their difficulty engaging in occupations are also complex. It is easy to identify what a person does or does not do, but understanding the why is much more challenging and requires a strong therapeutic relationship and prolonged therapy."*

3. The need to individualise therapy

The final extract above also begins to draw attention to another way in which a person's context can lead to complexity. There were clear indications that variability in individual circumstances leads to perceived complexity in the process. For some respondents this variability in individual circumstances required an in-depth understanding of a person so that individual factors affecting occupation could be considered. Similarly, there was a clear idea that all instances of providing occupational therapy are unique and potentially complex because of this degree of individualisation.

- *"I have to consider a wide range of influences when I am working with service users. People are complex! Their lives are complex! Everyone is different and has their own unique circumstances and issues which influence their lives and the decisions that they make. I not only have to consider the person's physical function and cognitive function but also their social environment and their personal preferences along with their family's preferences.*

I also have to consider the organisation influences and to liaise with all health and social care staff involved."

- *"Each individual has their own way of carrying out their tasks so it can be complex in that everything is so different."*
- *"At times the 'cases' can be complex, but others are relatively straightforward. You just need to tackle every person and situation differently."*

4. Influence of therapist's context

The influence of context on occupational therapists, and how this added to complexity in practice, emerged clearly as the fourth theme. As with reports about a person's context, the ways in which a therapist's context were reported as adding to complexity spanned from factors immediate to a therapist to much broader influences. Often context was identified as an influencing factor that complicated or limited the ways in which therapists worked. This included additional layers of information that needed to be considered, factors that were felt to be restrictive in how therapy was delivered, and the additional complexity involved in balancing a range of different contextual factors with core concepts of occupational therapy.

Many respondents referenced the complicating influence of service structures, and the broader policies that drive these:

- *"Increasing financial restrictions mean that we limit our interventions to resolving issues which meet critical/substantial eligibility criteria. This means we're not able to do much preventative work, quality-of-life work, or any kind of wellbeing promotion."*
- *"Not only do we have to contend with government policy, local guidelines, finance, the human aspect of service users with long term health issues, more complex health issues as people are living longer and the stress placed on carers all adds to the need for the OT to juggle numerous issues at the same time as well as a large caseload."*

At times some of these factors were noted to impact on therapists' ability to develop expertise and skills:

- *"Demands on service also impact on the learning of junior staff to spend time with more experienced staff to promote future learning opportunities."*

Some respondents also noted that components of context relating to evidence and theory influenced their practice:

- *"I have to draw on a wide range of knowledge (both occupational therapy-based and psychological approaches, e.g. CBT* [Cognitive Behaviour Therapy]*) to provide support or treatment for that particular person."*
- *"Occupational therapy can appear simple, but it is a very complex process drawing on many theories and frameworks while keeping the SU* [service user] *at the centre of the process."*

5. Complexity results from the interaction of the factors above

The most dominant theme indicated that complexity in occupational therapy comes about when these various factors interact. Working with people with multiple conditions, recognising the extent of individual variability that comes from the influence of context on people, additional complications and restrictions associated with therapists' contexts,

and the range of different approaches that can be brought to bear, all featured repeatedly in descriptions of complexity:

- *"Complex because of numerous considerations during practice (needs of person, needs of service – financial and resource considerations)."*
- *"Working with individuals in the community is challenging and frustrating at times due to paperwork and systems that prevent fullness of role being realised."*
- *"Complex physical, cognitive and psychological impairments, having knowledge of the evidence base around interventions, challenging social situations, ensuring participation by challenging societal barriers."*
- *"Multiple interrelated factors to consider in every situation. There are often a number of different options for providing occupational therapy intervention and this adds complexity to an already complex situation."*
- *"Complex because I deal with high numbers of children with complex and profound difficulties, all of which are different. I am involved with children right across their lives – home, school, communication, short breaks. I participate in* [healthcare partnerships]*, Children in Need … the family, meeting to ensure children's complex needs are being met. I assess children with complex postural needs for complex equipment. I deal with complex major adaptations for hospital discharge and complex social circumstances where children with complex needs are living at more than one address."*
- *"Complex client group due to neurodevelopmental issues. Also, complex due to interface with other services such as mental health and learning disability, and a lack of resources."*
- *"Balance between wishes of client against service remit and budgets, while retaining core occupational therapy values."*
- *"There are so many factors to consider when working with thinking, feeling people who operate within a wider social system. We are thinking, feeling people operating within health and social care. There are so many interacting factors that, in order to be able to achieve a successful therapeutic interaction, the level of complexity in the 'everyday', taken-for-granted things in life must be acknowledged."*
- *"Working with people who have complex needs in a system that has many layers of management and legislation as well as liaising with different departments and organisations. There is simply too much bureaucracy."*
- *"Layers of psychological, mental health, physical and social issues in a complex funding situation."*
- *"In the community setting we are trying to keep service users with complex needs at home when it is very difficult to source care packages due to care staff shortages. We have to balance service user wishes, available resources and risk assessment to ensure needs are met in a safe manner."*
- *"Lots of intertwined factors: key is that occupational therapy is uniquely designed for each individual so complex reasoning skills, adaptability essential, underlying model of practice."*
- *"It can be complex in view of conditions and the needs associated with that, or complex in terms of communication needs of the client/their support network. Complex in view of family dynamic or systems that are working against the client's best interests. Complex in terms of environment and the limitations to what is reasonable and practical because of it."*

A final theme that was clear in the survey responses was the need to be able to respond and adapt to individual scenarios as they arose. Variability in a person, their conditions,

their particular needs and their contexts leads to situations where an occupational therapist may be creating a bespoke intervention each time they work with someone. There were clear indications that much of this response or adaptation was grounded in the reasoning processes of occupational therapists and informed by their expertise and knowledge, rather than by the availability of discrete technical approaches. The influence of factors originating from the therapists' contexts was often identified in these descriptions as adding to complexity.

- *"The fact I cannot summarise this suggests the complex nature of the job. The wide range of variability – from condition, to family dynamics, to approaches used, joint approach with other professionals, organisational challenges and barriers, and the changing nature of all of the above – makes it consistently complex, and every day I learn something new or different. We are constantly evaluating, adjusting, reflecting on our practice, and rarely does one size fit all. We use our reasoning, judgement, compassion, experience and knowledge to inform an agreed outcome and, even then, this can change several times during one patient episode."*
- *"We work with service users who have multiple problems – physical and mental illnesses, physical and learning disabilities, complex family situations, unsuitable home environments, varying financial circumstances. We have to take all this into account, assess needs in line with the employer's eligibility criteria, and then balance this with service user and family preferences, available resources, priorities/interventions of other professionals, and our own professional opinions."*
- *"It's multifaceted – looking at opportunities, challenges, constraints, needs, and coping with fluctuations across all of these. Balancing them and figuring out methods to make it all work towards a desired outcome while valuing and focusing on the individual steps and coping with taking backward steps. Supporting the person's motivation, and your own, along the journey."*
- *"Working with patients will always be complex as humans are complex beings. We choose to work with people, therefore this must only be a positive attribute."*
- *"We have to reflect on our practice and make adjustments if necessary. We are constantly re-evaluating our practice with the patient and adapting, but also at a professional level. We have to work with other agencies, consider complex care packages, assess risk and risk management, etc."*
- *"I spend a lot of time testing out hypotheses and trying out approaches before I get it right. Very time-consuming and complex area of work for which there are often no definite solutions and where much time is spent trying to find acceptable ways for people to achieve what they need to achieve."*
- *"I think it's complex as all patients* [are] *different and you have to modify your approach for every individual patient."*
- *"People are complex, and each situation brings different challenges."*
- *"Everyone is different, they have a different deficit, different occupations normally engaged in, and often complicated social situations. These all combine with the pressures of ward-based working (patients not being available when you go to see them, discharge pressures/plans, rigidly structured protected meal times) to make patients' therapy very different, challenging and rewarding the vast majority of the time!"*
- *"At times it can be challenging, but I don't consider this a negative. We embrace individuality and act to provide the most person-centred care while maintaining professional standards."*

One final extract provided an additional interesting insight into complexity in occupational therapy. It noted that complexity may arise because of the way in which a person is seen as an individual, and thus not necessarily likely to respond to interventions in a predictable or determined way:

- *"National Health Service demands are usually a "one for all" approach to care. The complexity of occupational therapy is that its focus is uniquely individual, and no two people are the same. The science of occupational therapy is relatively unknown among other hospital-based professions and what we do, rather than why we do it, is what is seen. However, when opportunities to demonstrate this happen it is usually appreciated once explained. Occupational therapists uniquely assess the person as a whole, trying to understand the individual's past and present and then help shape their future life."*

The survey achieved very useful responses with 783, primarily practising occupational therapists, participating. The extensive qualitative responses given were of particular note, providing an opportunity for in-depth analysis of key aspects of occupational therapy. These included perspectives on the way changes occur during therapy, key components of practice, and information about the varied influences and relationships between these.

9 Online focus groups

This chapter sets out the detailed methods and findings from a set of online discussion groups. These were conducted following the online survey so that initial findings and themes could be explored in more depth.

Asynchronous online focus groups – methods

Qualitative data for this project was generated through focus groups, which were populated with survey participants based on their response to certain survey questions. Four hundred and six survey respondents indicated their willingness to be considered for the online focus groups. Ninety-five potential occupational therapists were identified based on the quality of their responses to these survey questions. From these, 35 people were selected from this pool and invited to take part in online focus groups. The sample was chosen to include a range of experiences and was based on geographical location, type and area of practice or work, and years of experience. Seventeen people ultimately contributed to these discussions. The specialist interests of the selected occupational therapists included children's mental health, neuro-rehabilitation, paediatric physical rehabilitation, surgical and vascular conditions and general medicine as well as adult and older adult mental health. Participants were allocated into one of three groups, with each group led by one member of the research team, who posted one question on an online discussion board each week over three consecutive weeks and requested contributions.

The focus of the discussions was change. Change was identified as being central to the process and desired aims of occupational therapy, but initial analysis of the data from the survey and the literature review indicated that it was not often reported or considered. Each focus group was asked the following questions:

Q1. What do you identify as change, as the result of occupational therapy? How can you tell when change has happened?

Q2. What do you think are the 'active ingredients' which actually cause or contribute to a process of change to occur?

Q3. During the second week of our discussions, you were asked to comment on 'active ingredients' for change. Can you make a distinction on whether some of those are preconditions while others are contributors/facilitators? Please try to justify your answer. Also, what can impede change? Are there any potential 'barriers'?

No time or word restrictions were placed upon participants' responses, and participants were able to read the responses of others who had posted prior to themselves.

Findings

The transcripts of the three focus groups were analysed using NVivo software. The transcripts were coded into nodes and sub-nodes, and from these themes and descriptions of the themes were developed. The themes developed were:

1. Change as a complex, transitional process
2. The nature of change
3. Essential components of change
4. Facilitators of, and barriers to, change
5. The challenges of identifying change.

These themes and their descriptions are presented below, along with supporting quotes from the focus groups.

Change as a complex, transitional process

From the responses provided, it was clear that therapists considered change in occupational therapy as an ongoing process, rather than as one distinct change occurring at a certain point in time, and multiple elements were typically involved. One participant noted: *"I tend to describe OT as change – with us working with the client to change either the person, the environment or the task, or a combination of all or any of those."* Change was also seen to extend beyond the end of the named therapy process with one participant noting that "*change can be perceived by diverse perspectives (e.g. in terms of time). It can be an instant change (e.g. relaxation of children with spastic quadriplegia cerebral palsy, modulation-regulation of high arousal) or a long-term change (e.g. social participation, ADL independence). Some changes can be captured and measured while others not*."

These ongoing changes were also seen to be complex:

- The end point may be continually changing and therefore change is seen *"more as a journey than a destination"*.
- There are multiple possible points of intervention.
- Carers or family members might also become part of the change process.
- Multiple changes might occur, including momentary changes that are not maintained.
- Change is not permanent. Relapse might also occur. Change is not unidirectional.
- Change may result from unexpected and unplanned events.
- Change involved the person, occupation and environment in an ongoing dynamic and fluid process.

The nature of change

As a complex, transitional process, identifying the nature of change, that is 'what changes' during occupational therapy, was difficult. Change was described in terms of long-term changes, and sometimes identified as the outcomes of therapy, as well as immediate and mid-term changes that contribute to these.

Long-term change was frequently discussed in terms of what is observable in people's occupation, and often measurable outcomes of the therapeutic process:

- making positive choices and using strategies for healthy living;
- greater independence and safety;
- achieving community participation in work, leisure, education and social situations;

- greater engagement in occupations that are meaningful and valuable;
- greater balance of occupations.

Mid-term change referred to strategies and skills, knowledge of occupation and improved function as well as psychological aspects such as feeling hopeful, being able to take control, change in the acceptance of a new or different state.

Immediate change during a session included sensory and motor change as well as changes in mood or eye contact; for example, "*It can be an instant change (e.g. relaxation of children with spastic quadriplegia cerebral palsy, modulation-regulation of high arousal)".*

It was also recognised that change might not be restricted to change in the person and their occupation, but may also be seen in the environment and in the therapist.

One clear example of this idea of multiple changes as immediate, mid- and long-term can be seen in the following extract:

> *"My hopes for our group are to: assist them to see the life worth living, away from mental health services through trying new or revisiting old meaningful activities in their local community; through participation in a co-produced service I hope that members would develop transferable skills such as communication, negotiation, taking responsibility, planning, organising, chairing meetings, minute taking and assertiveness; educating the group with regards to the health benefits of meaningful occupations and self-motivation so that they understand the need to pace, plan and participate in a range of activities to stay well in the future, as well as maintain a sense of self and identity."*

Essential components of change

Participants discussed what they considered to be the essential components of the change process in occupational therapy – what could be described as preconditions for change. These were also referred to as active ingredients or critical components.

It is important to note that there was only some consistency across participants in relation to what they understood to be essential components. For example, while most participants stated that acceptance of the diagnosis or situation and recognition of its impact, together with a person's motivation and desire for change, were essential components, one participant noted that change sometimes happened anyway due to changes in the person's environment.

There was also overlap with what were not seen as essential components but as facilitators of change (see below for more detail). This diversity would seem to again indicate the complexity of the process of change, where optimal change occurs due to an individualised combination of factors, relevant to the person and therapist, rather than due to a specific combination of components. However, it is useful to identify what were commonly seen as active ingredients of change:

- The acknowledgement that change is possible, the acceptance that change is required, the desire to make change, and that support for change is available (social, physical, economic). *"I think the first active ingredient in change is the acceptance that change is actually required and can be achieved. This then leads to the motivation to change and be actively involved in the change process."*
- The role of the therapist in assisting people to develop motivation, hope, empowerment and resilience. This was seen to be achieved both through the relationship established with the client (incorporating the personal characteristics of

the therapist and recognition of the person as an individual, described by one participant as the *"foundation of facilitated change"*) and through occupation (experiencing meaning, graded and adapted occupational opportunities, setting goals, experiencing achievement, feeling connected).

- The need for flexibility and responsiveness to change throughout the therapeutic process by the therapist, as well as their awareness that these key components must have subtle and sensitive application.

Facilitators of, and barriers to, change

As well as identifying what the perceived critical components of the process of change were, participants also identified a range of factors that acted to facilitate or hinder change. As already stated, there was some overlap here with what were regarded as essential components, and participants noted that the combination of components facilitating maximum positive change is unique to each individual situation. Factors identified as influencing change included:

- The person's resilience and recognition of failure as part of change.
- The therapist's knowledge, clinical experience, skills, training and continuing professional development. Their collaboration with professionals and significant others. The ability to work with others and not for them.
- A person-/child-/family-centred approach, ensuring intervention addresses their needs.
- Occupation-based interventions, considering the person's various environments.
- Family members', carers' and others' acceptance of the issues, and engagement with the process of change.
- Resources available (costs of therapy, equipment and technology required, space for therapy, post-intervention support and so forth) were frequently cited as barriers: *"The restrictive timeframe comes about from another active ingredient which is our organisation's pressure for patient flow through the hospital – goals change rapidly within an acute setting."*
- A supportive environment (policy-makers, legislation and laws, environment accessibility, adaptability).
- The recognition that environments can be severely limiting. Examples of non-supportive family environments identified by participants included *"parents with addiction problems, families in poverty, parents who want their children attached to them and they inhibit change, parents who cannot manage their child's disability, parents who prioritise other personal needs over their children's needs, parents in denial towards [their child's] disability, parents with a disability, etc.,".*
- *"Often occupational therapists have difficulties communicating with the client as well as the family to advocate for the needed support. These concepts are not always easy to explain to service users, so being able to explain transitional change to manage expectations assists greatly"* reported one participant.
- *"I sometimes feel that the power imbalance that I work with means that the expected outcome of therapy is often related to risk reduction and safety, not the goals that maybe the individual and their family would have selected for themselves – getting washed and dressed, money for the bus, tolerating the journey, managing the voices, dealing with difficult people, getting there on time, doing the shift, coming home, only to have their parent tell them that they'll never do it, or their drug dealer tell them I'm useless and they're better off."*

The challenges of identifying change

The complications of understanding and identifying change, expressed in the comment *"I think that change happens almost accidentally sometimes"*, also indicates difficulties in identifying and measuring change due to occupational therapy. One participant commented: *"We struggle as occupational therapists with being able to define what change looks like and whether that change really happened as a result of our intervention. How can we really know if that change would have happened anyway?"* While some of the changes identified were the outcomes of goal setting and intervention planning, other changes were unexpected. Participants also discussed how some change could not be easily identified or measured. One participant commented: *"Some changes can be captured and measured, while others not."*

Areas of change that were reported as being more visible and easier to capture included:

- reduced care packages;
- reduced carer strain;
- increased community engagement;
- change in engagement in occupation;
- improved skill performance;
- impact of change in occupations, such as changes in mood, anxiety level, physical condition and financial state.

Methods for capturing changes included:

- change in observed performance, or as reported in feedback or discussions;
- standardised assessments, self-report tools, checklists and videos;
- changes reported by family, friends and schools, or by colleagues;
- changes were noted and discussed with colleagues during supervision.

Typically, participants reported using multiple methods to capture change, including measurement, goal achievement, professional reasoning and qualitative feedback.

The reported problems in measuring change may be seen in the quotes below. The first highlights the difficulty of measuring the extent of change and the contributing factors due to the complexity of occupational therapy:

> *"I totally agree that occupational therapy is a complex intervention. Personally, I think it is not possible to know or measure the extent to which occupational therapy brings about changes. Therapists', clients' and environments' characteristics are comprised of many uncontrolled variables that realistically make the pure measurement of occupational therapy outcome impossible."*

The second quote refers to complexity, not only of the occupational therapy intervention but of the entire situation of which the client is part:

> *"Obviously very much a basic, noticeable way of seeing change is a therapist reviewing that person face to face and having a discussion. Agreeing what has been achieved and seeing that in its physical form is the most obvious way of noting change, but it can be difficult,*

certainly in the areas I have worked in, to put a numerical figure to prove the impact and effect of treatment specifically relating to occupational therapy."

The third quote recognises the intricacies of identifying change in clients with complex needs and in complex situations (in forensic mental health, in this case):

"I'd love to know how to describe how they would like to change, what that would look like, and be able to remember that feeling when something did change (even for a moment), so that we could isolate what would need to keep happening to sustain change and the motivation for change."

The fourth quote recognises that change may happen in areas that the service was not targeting:

"We have used a variety of measures to help evaluate our service and were surprised to see that group members reported change in areas we were not specifically targeting – for example, addictive behaviours. From the evaluations it looked as though changes in other areas brought about changes elsewhere in the person's life. We also found the same with identity, trust and hope."

The final quote recognises that there are often differences between how change is estimated and valued between professionals and people receiving therapy:

"There are also changes that happen that may not be entirely perceived by either the therapist or the client, and people's view on the level of their ability/disability/pain/anxiety varies significantly depending on what they see as their 'norm'. I was discussing this with a group of stroke survivors last week. Although their level of disability (as perceived by therapists/support staff) was significant, they saw themselves as reasonably healthy, only slightly affected by their strokes – because they had got used to 'this is how it is'. We are looking at taking a 'patient perceived'/completed measure before and after intervention to try and demonstrate levels of change."

Findings from the three online focus groups provided further depth of understanding around the changes that occur at the core of occupational therapy. In particular, insights into the different pathways of change, and discussion about the components which participants felt were essential to change processes were explored in more detail. Change in occupational therapy was described as being a transitional process during which multiple changes and developments took place in different components of people and their contexts. Additional information about facilitators and barriers to change, and challenges associated with identifying and quantifying outcomes associated with change, points towards further aspects of complexity.

References

American Occupational Therapy Association (AOTA) (2014) Occupational therapy practice framework: domain and process, 3rd ed. *American Journal of Occupational Therapy, 68 (Supplement 1),* S48.

Ayres AJ (1970) *Sensory integration and the child*. Los Angeles: Western Psychological Services.

BOS (2016) *Bristol online surveys.* Bristol: JISC. Available at: *https://www.onlinesurveys.ac.uk/*

Box GEP, Draper NR (1987) *Empirical model-building and response surfaces*. New York: John Wiley & Sons, Ltd.

Boyatzis RE (1998) *Transforming qualitative information: thematic analysis and code development*. London: Sage.

Broer T, Bal R, Pickersgill M (2017) Problematisations of complexity: on the notion and production of diverse complexities in healthcare interventions and evaluations. *Science as Culture, 26(2),* 135–160.

Canadian Association of Occupational Therapists (1997) *Enabling occupation: an occupational therapy perspective.* Ottawa: CAOT Publications ACE.

Checkland P, Poulter J (2010) Soft systems methodology. In: M Reynolds S Holwell, eds, *Systems approaches to managing change: a practical guide*. London: Springer. 191–242.

Collin C, Wade DT, Davies S, Horne V (1988) The Barthel ADL Index: a reliability study. *International Disability Studies, 10(2)*, 61–63.

Craig P, Dieppe P, Macintyre S, Michie S, Nazareth I, Petticrew M (2008) Developing and evaluating complex interventions: the new Medical Research Council guidance. *BMJ*, *337(7676)*, 979–983.

Craig P, Dieppe P, Macintyre S, Michie S, Nazareth I, Petticrew M (2006) Developing and evaluating complex interventions: new guidance. London: Medical Research Council. Available at: *https://www.mrc.ac.uk/documents/pdf/complex-interventions-guidance/*

Creek J, Ilott I, Cook S, Munday C (2005) Valuing occupational therapy as a complex intervention. *British Journal of Occupational Therapy, 68(6),* 281–284.

Creek J (2003) *Occupational therapy defined as a complex intervention*. London: COT.

Dekkers R (2017) *Applied systems theory,* 2nd ed*.* [ebook] (Partly available online, fully available through purchase or subscription.) Cham [Switzerland]: Springer International. Available at: *https://link.springer.com/book/10.1007%2F978-3-319-57526-1*

Duncan EAS, Paley J, Gail E (2007) Complex interventions and complex systems in occupational therapy. *British Journal of Occupational Therapy*, *70(5),* 199–206.

Fearing VG, Law M, Clark J (1997) An occupational performance process model: fostering client and therapist alliances. *Canadian Journal of Occupational Therapy*, *64(1),* 7–15.

Greenwood-Lee J, Hawe P, Nettel-Aguirre A, Shiell A, Marshall D (2016) Complex intervention modelling should capture the dynamics of adaptation. *BMC Medical Research Methodology, 16(51).* DOI:10.1186/s12874-016-0149-8

Griffiths P, Norman I (2013) Qualitative or quantitative? Developing and evaluating complex interventions: time to end the paradigm war. *International Journal of Nursing Studies, 50(5),* 583–584.

Hammond A (2004) What is the role of the occupational therapist? *Best Practice and Research: Clinical Rheumatology, 18(4),* 491–505.

Hawe P, Shiell A, Riley T (2009) Theorising interventions as events in systems. *American Journal of Community Psychology, 43(3),* 267–276.

Hawe P, Shiell A, Riley T (2004) Complex interventions: how 'out of control' can a randomised controlled trial be? *BMJ, 328(7455)*, 1561–1563.

Hitch D, Pépin G, Stagnitti K (2014) In the footsteps of Wilcock, part two: the interdependent nature of doing, being, becoming, and belonging. *Occupational Therapy in Health Care*, *28(3),* 247–263.

IBM (2015) IBM SPSS statistics for Windows, version 22.0. Armonk, NY: IBM.

Iwama M (2006) *The Kawa model: culturally relevant occupational therapy.* Edinburgh: Churchill Livingstone/Elsevier Press.

Jackson MC (1991) *Systems methodology for the management sciences.* New York: Plenum Press.

Joffe H, Yardley E (2004) Content and thematic analysis. In: DM Marks, E Yardley, eds*, Research methods for clinical and health psychology*. London: Sage. 56–68.

Kellehear A (1993) Rethinking the survey. In: D Colquhoun, A Kellehear, eds, *Health research in practice: political, ethical and methodological issues*. London: Chapman & Hall. 126–137.

Kielhofner, G (1985). *A model of human occupation: theory and application*. Baltimore, MD: Williams and Wilkins.

Lambert R, Harrison D, Watson M (2007). Complexity, occupational therapy, unpredictability and the scientific method: a response to Creek et al. (2005) and Duncan et al. (2007). *British Journal of Occupational Therapy, 70(12),* 534–536.

Law M, Cooper B, Strong S (1996) The Person Environment Occupation model: a transactive approach to occupational performance. *Canadian Journal of Occupational Therapy, 63(1),* 9–23.

Law M, Baptiste S, Carswell A, McColl MA, Potalajko H, Pollock N (2000) *Canadian Occupational Performance Measure.* Ottawa, ON: CAOT Publications ACE.

Lewin R (1999) *Complexity: life at the edge of chaos*. 2nd ed. Chicago, IL: University of Chicago Press.

McLaughlin Gray J (1998) Putting occupation into practice: occupation as ends, occupation as means. *American Journal of Occupational Therapy*, *52(5),* 354–364.

Mitchell M (2009) *Complexity: a guided tour*. Oxford: Oxford University Press.

Medical Research Council (2000) A framework for the development and evaluation of RCTs for complex interventions to improve health. London: MRC.

Moore G, Evans RE, Hawkins J, Littlecott HJ, Turley R (2017) All interventions are complex, but some are more complex than others: using iCAT_SR to assess complexity. Chichester, UK: John Wiley & Sons, Ltd*.* Available at: *http://www.cochranelibrary.com/editorial/10.1002/14651858.ED000122*

Moore G, Audrey S, Barker M, Bond L, Bonell C, Hardeman W, Baird J (2015) Process evaluation of complex interventions: Medical Research Council guidance. *BMJ, 320(1258)*, 1–7.

O'Brien JC, Kielhofner G (2017) The interaction between the person and the environment. In: R. Taylor, ed. *Kielhofner's model of human occupation: theory and application*. 5th ed. Philadelphia, PA: Wolters Kluwer. 24–37.

Petticrew M (2011) When are complex interventions 'complex'? When are simple interventions 'simple'? *The European Journal of Public Health, 21(4),* 397–398.

Polatajko HJ, Mandich A (2004) *Enabling occupation in children: the cognitive orientation to daily occupational performance*. Ottawa, ON: CAOT Publications ACE.

QSR International (2012) NVivo Qualitative Data Analysis Software Version 10. Victoria, AU: QSR International.

Royal College of Occupational Therapists (2017) *Career development framework: guiding principles for occupational therapy*. London: RCOT.

Senge P (1990) *The fifth discipline: the art and practice of the learning organisation.* London: Century Business.

Stevenson A ed (2010) *Oxford dictionary of English.* 3rd ed. Oxford: Oxford University Press.

Strevens M (2017) Ontology, complexity and compositionality. In: M Slater, Z Yudell, eds, *Metaphysics and the philosophy of science*. New York: Oxford University Press. 41–54.

Taylor, R ed (2017) *Kielhofner's model of human occupation: theory and application*. 5th ed. Philadelphia, PA: Wolters Kluwer

Townsend E, Polatajko HJ (2007) *Enabling occupation II: advancing an occupational therapy vision for health, well-being and justice through occupation.* 2nd ed. Ottawa, ON: CAOT Publications ACE.

World Health Organization (WHO) (2016) *International statistical classification of diseases and related health problems*. 10th revision (ICD-10). Geneva: WHO. Available at: *http://apps.who.int/classifications/icd10/browse/2016/en*

World Health Organization (WHO) (2008) *International classification of functioning, disability and health* (ICF). Geneva: WHO.

Wilcock A (2006) *An occupational perspective of health.* Thorofare, NJ: Slack Inc.

Wilcock A, Hocking C (2015) *An occupational perspective of health.* 3rd ed. Thorofare, NJ: Slack Inc.

Yamada T, Taylor R, Kielhofner G (2017) The person-specific concepts of human occupation. In: R Taylor, ed. *Kielhofner's model of human occupation: theory and application*. 5th ed. Philadelphia, PA: Wolters Kluwer. 11–23.

All websites accessed on 15.03.2018.

Appendix A: Literature review reference tables

In the following tables references are numbered for ease of use. Please refer to Appendix B, p.193, for full references.

Table 1: Articles reviewed by type

Type of article	No. included	References
Peer-reviewed – systematic or literature review	13	1, 18, 28, 46, 95, 101, 122, 154, 175, 182, 218, 228, 242
Peer-reviewed – primary research	107	3, 4, 7, 9, 15, 19, 20, 22, 24, 25, 26, 29, 39, 40, 41, 47, 48, 49, 53, 54, 61, 62, 63, 64, 65, 67, 69, 70, 71, 72, 73, 75, 77, 79, 80, 82, 83, 84, 85, 87, 88, 92, 93, 99, 102, 103, 104, 106, 107, 109, 110, 111, 112, 113, 114, 116, 119, 121, 123, 125, 127, 128, 136, 138, 140, 147, 148, 149, 150, 152, 153, 159, 161, 163, 169, 172, 173, 176, 180, 185, 190, 191, 192, 193, 194, 195, 201, 202, 203, 205, 206, 208, 209, 217, 222, 224, 225, 227, 229, 236, 238, 244, 247, 248, 249, 250, 256
Peer-reviewed – other	3	130, 166, 179
Non-peer-reviewed – magazine	133	2, 5, 6, 8, 10, 11, 12, 13, 14, 16, 17, 21, 23, 27, 30, 31, 32, 33, 34, 35, 36, 37, 38, 42, 43, 44, 45, 50, 51, 52, 55, 56, 57, 58, 59, 60, 66, 68, 74, 76, 78, 81, 86, 89, 90, 91, 94, 96, 97, 98, 100, 105, 108, 115, 117, 118, 120, 124, 126, 129, 131, 132, 133, 134, 135, 137, 139, 141, 142, 143, 144, 145, 146, 151, 155, 156, 157, 158, 160, 162, 164, 165, 167, 168, 170, 171, 174, 177, 178, 181, 183, 184, 186, 187, 188, 189, 196, 197, 198, 199, 200, 204, 207, 210, 211, 212, 213, 214, 215, 216, 219, 220, 221, 223, 226, 230, 231, 232, 233, 234, 235, 237, 239, 240, 241, 243, 245, 246, 251, 252, 253, 254, 255

Table 2: Papers by geographic area

Geographic area	No. of papers	References
USA	73	5, 6, 7, 8, 11, 14, 19, 21, 24, 27, 31, 38, 39, 45, 54, 55, 56, 61, 63, 64, 66, 68, 71, 75, 82, 83, 86, 92, 100, 113, 117, 118, 120, 121, 127, 130, 136, 139, 142, 150, 151, 153, 159, 160, 169, 170, 171, 172, 173, 176, 179, 185, 191, 197, 202, 208, 210, 212, 221, 224, 231, 232, 233, 234, 238, 240, 247, 248, 249, 252, 254, 255, 256
UK and Ireland	99	2, 10, 12, 16, 17, 23, 30, 32, 33, 34, 35, 36, 37, 43, 44, 50, 51, 52, 57, 58, 60, 74, 76, 78, 80, 81, 88, 89, 90, 91, 94, 96, 97, 98, 105, 106, 108, 114, 115, 124, 129, 131, 132, 133, 134, 135, 137, 140, 141, 143, 144, 145, 146, 155, 156, 157, 158, 162, 164, 165, 166, 167, 168, 174, 177, 178, 181, 183, 184, 186, 187, 188, 189, 196, 198, 199, 200, 204, 207, 211, 213, 214, 215, 216, 219, 220, 223, 225, 226, 229, 230, 237, 239, 241, 243, 245, 246, 251, 253
South and Central America	2	59, 82
Middle East	4	26, 192, 195, 236
Europe	19	1, 9, 15, 20, 22, 62, 65, 72, 73, 85, 107, 110, 119, 152, 190, 207, 227, 250, 209
Canada	12	3, 41, 42, 67, 69, 102, 125, 170, 197, 201, 222, 235
Australia and New Zealand	30	4, 13, 25, 28, 40, 70, 75, 77, 79, 87, 93, 99, 104, 116, 126, 128, 138, 147, 149, 161, 162, 170, 180, 194, 193, 203, 205, 206, 217, 244
Asia	9	47, 48, 49, 84, 103, 112, 123, 163, 225
Africa	1	53

Table 3: Aims of settings

Aim of setting	No.	References
Occupational performance	50	1, 7, 8, 13, 18, 24, 27, 38, 39, 48, 58, 64, 66, 77, 79, 80, 83, 88, 103, 104, 105, 110, 111, 115, 118, 120, 121, 123, 130, 137, 138, 139, 143, 148, 173, 179, 181, 182, 185, 190, 193, 202, 205, 218, 224, 238, 246, 252, 253, 256
Mental health assessment and treatment	27	10, 17, 22, 23, 25, 43, 72, 87, 108, 135, 143, 145, 157, 158, 160, 162, 165, 187, 198, 199, 207, 210, 219, 223, 238, 245, 253
Life skills	24	37, 39, 49, 50, 56, 58, 66, 70, 107, 121, 122, 130, 133, 135, 137, 142, 143, 168, 173, 206, 221, 236, 239, 252
Physical rehab	22	38, 50, 61, 62, 89, 101, 106, 159, 178, 193, 216, 222, 225, 226, 227, 229, 236, 237, 242, 247, 249, 253
Social integration	21	7, 35, 38, 58, 86, 96, 97, 114, 115, 125, 133, 136, 142, 173, 174, 178, 218, 236, 239, 248, 253
Independent living	17	1, 32, 34, 39, 94, 100, 108, 127, 133, 137, 138, 151, 166, 231, 232, 235, 252
Education	17	8, 15, 26, 56, 68, 82, 99, 102, 107, 109, 126, 142, 161, 184, 254, 255
Participation in society	17	7, 8, 17, 24, 36, 51, 62, 75, 133, 155, 157, 175, 192, 202, 244, 252, 253
Long-term support	14	33, 57, 70, 81, 107, 133, 146, 169, 189, 206, 239, 241, 244, 252
Hand therapy	13	47, 54, 63, 73, 84, 92, 112, 113, 116, 119, 150, 152, 197
Supported discharge, intense rehab	11	21, 33, 49, 57, 94, 124, 131, 132, 206, 220, 243
Safety	11	41, 69, 140, 145, 153, 170, 171, 184, 203, 209, 250
Sensory processing	9	68, 86, 117, 128, 149, 180, 204, 213, 228
Home modifications service	9	4, 11, 41, 78, 90, 134, 151, 212, 235
Family support	8	3, 20, 83, 213, 216, 122, 172, 252
Paediatric service	7	38, 53, 55, 59, 183, 192, 240
Dementia care	6	52, 155, 177, 186, 196, 230
Home care	5	2, 25, 42, 163, 210
Autonomy	5	41, 67, 144, 253, 252
Feeding	4	6, 12, 19, 172
Driving	3	14, 31, 188
Pain management	3	1, 95, 156
Palliative care	2	44, 251

Table 4: Papers listed by medical conditions and diagnosis

Developmental conditions and issues		
Developmental conditions – no other details	2	108, 236
Attention Deficit and Hyperactivity Disorder (ADHD)	4	40, 75, 86, 192
Autism	16	5, 7, 8, 12, 16, 39, 75, 86, 93, 122, 128, 149, 218, 221, 228, 252
Developmental Co-ordination Disorder (DCD)	4	27, 75, 89, 115
Down's syndrome	4	38, 75, 86, 228
Learning difficulties	6	16, 91, 126, 128, 228, 246
Psychiatric, psychological and mental health issues		
Mental illness – no other details	25	10, 17, 23, 49, 58, 72, 87, 99, 135, 145, 155, 157, 158, 160, 162, 167, 187, 189, 198, 200, 201, 207, 210, 245, 253
Affective disorders	3	99, 126, 151
Eating disorders	2	6, 126
Personality disorder	2	141, 223
Schizophrenia	3	22, 49, 207
Stress	2	111, 164
Tourette syndrome	1	66
Neurological condition and issues		
Neurological conditions – no other details	4	16, 216, 227, 237
Brain injuries – no other details	11	18, 19, 32, 49, 110, 133, 164, 175, 178, 193, 248
Cerebral palsy	8	59, 61, 73, 86, 104, 125, 126, 222
Cerebrovascular disease	1	163
Cognitive impairment	4	6, 52, 114, 155
Dementia	10	48, 114, 144, 154, 161, 166, 177, 186, 196, 230
Guillain-Barré syndrome	1	224
Motor neurone disease/ Amyotrophic lateral sclerosis	2	100, 341
Parkinson's disease	2	138, 241

Table 4: Continued

Spinal cord injury	3	98, 226, 229
Stroke	27	9, 14, 20, 24, 35, 50, 63, 84, 94, 101, 109, 111, 112, 113, 123, 138, 143, 147, 152, 154, 159, 174, 188, 241, 242, 247, 249
Physical conditions and medical issues		
Physical conditions – no other details	3	49, 165, 200
Identified as multiple or complex	3	3, 51, 251
Multimorbidity	3	80, 165, 208
Medical conditions – no other details	1	34
Arthritis	2	1, 138
Cancer	3	55, 62, 142
Cardiac	1	181
Cardiovascular	1	103
Dupuytren's contracture	1	92
Mobility restrictions	4	3, 53, 125, 233
Motor control issues	2	7, 113
Musculoskeletal injuries	7	19, 106, 107, 116, 150, 195, 220
Osteoarthritis	2	26, 106
Pre-eclampsia (obstetrics)	1	139
Repetitive strain injury	1	47
Spina bifida	1	125
Spinal injury	3	19, 98, 136
Sensory conditions		
Sensory conditions	1	118
Chronic pain	2	95, 156
Deaf/hearing impairment	2	137, 245
Glaucoma	1	130
Meares-Irlen syndrome or visual stress	1	88
Sensory modulation disorder	2	117, 228
Visual impairment	3	18, 130, 254

Table 5: Other population types by reference

Population	No. of papers	References
Adopted children and families	1	213
Carers	10	25, 42, 79, 94, 120, 122, 136, 142, 199, 241
Children foster care	1	120
Families	9	109, 111, 121, 122, 192, 203, 248, 254, 255
Homeless	1	97
Inappropriate sexual behaviour	1	184
Pre-school children	3	64, 75, 256
Migrants	1	15
New mothers	1	206
Palliative	1	44
Poor readers	1	83
Prison	7	81, 105, 124, 141, 153, 157, 246
Refugees	1	56
School children	7	59, 137, 146, 171, 183, 221, 255
Unemployed	2	116, 129
University students	1	146
Veterans	4	164, 238, 239, 248
Youth leaving foster care	1	169
Occupational therapists	8	28, 29, 41, 67, 140, 179, 180, 250
Other health professionals	3	131, 180, 219
Management team	1	160
Support workers	1	160
Teachers	1	102

Table 6: Objective themes by reference

Objective theme	No. of papers	References
Social integration	36	13, 27, 35, 40, 77, 86, 91, 97, 105, 114, 115, 122, 133, 136, 141, 142, 160, 164, 173, 174, 175, 177, 183, 189, 192, 202, 204, 218, 221, 224, 230, 231, 237, 240, 248, 251
Related to service processes (length of stay, etc.)	42	5, 17, 18, 21, 22, 25, 28, 29, 33, 41, 53, 67, 69, 76, 94, 98, 99, 106, 109, 111, 118, 126, 131, 132, 140, 142, 147, 160, 163, 170, 171, 173, 175, 176, 179, 183, 188, 201, 210, 227, 229, 250
Performance capacity and skill-related improvements	73	1, 9, 12, 13, 16, 26, 27, 28, 35, 36, 45, 50, 52, 54, 55, 63, 86, 89, 92, 95, 96, 97, 98, 104, 113, 115, 116, 117, 119, 124, 128, 139, 141, 142, 149, 150, 152, 153, 154, 160, 164, 165, 174, 178, 182, 186, 189, 192, 193, 196, 199, 200, 204, 205, 208, 210, 211, 216, 218, 221, 222, 223, 225, 228, 230, 235, 238, 240, 247, 249, 251, 251, 254
Independent living	49	9, 11, 13, 14, 19, 20, 21, 26, 31, 32, 39, 41, 44, 45, 48, 60, 70, 76, 81, 85, 97, 100, 108, 116, 130, 131, 132, 137, 138, 142, 145, 155, 159, 160, 166, 169, 174, 190, 201, 209, 210, 217, 221, 229, 232, 233, 235, 243, 251
Health, wellbeing, quality of life	17	8, 38, 70, 105, 114, 121, 130, 146, 165, 173, 176, 190, 198, 218, 230, 239, 241
Health promotion	14	2, 15, 42, 72, 82, 91, 107, 119, 130, 153, 155, 210, 251, 255
Environmental modification	25	3, 4, 10, 17, 30, 36, 59, 66, 78, 79, 80, 97, 100, 110, 118, 134, 151, 160, 165, 190, 198, 201, 203, 214, 240
Education and awareness	15	20, 42, 137, 142, 144, 166, 174, 176, 190, 199, 201, 210, 229, 230, 251
Occupation, activity and routine	85	3, 7, 9, 11, 13, 14, 19, 20, 21, 22, 23, 25, 26, 30, 31, 36, 37, 41, 42, 43, 44, 45, 49, 54, 55, 58, 62, 64, 70, 73, 75, 78, 81, 83, 88, 97, 100, 102, 104, 116, 120, 122, 125, 127, 129, 139, 141, 148, 149, 151, 153, 155, 159, 160, 164, 165, 168, 172, 173, 174, 176, 187, 188, 190, 194, 199, 200, 201, 202, 205, 206, 209, 213, 218, 223, 225, 229, 232, 234, 235, 240, 244, 251, 252, 256

Table 7: Frequency and duration of interventions by reference

Intervention reported by frequency	
2× day or more	176
Daily	61, 179
4× per week	89, 146
3× per week	52
2× per week	50, 103, 142
Once a week	17, 32, 37, 115, 174, 178, 192, 202, 223, 240
Fortnightly, 8 contacts over 4 months	237, 248
12 sessions over 5 months	133, 155
Intervention reported by number of sessions	
20 sessions	195
13 sessions	192
10 sessions	82, 135, 154
7 sessions	96
6 sessions	23
5 sessions	133, 139, 152, 208
1 session	86
Intervention reported by overall timescale	
19 months	224
12 months	247
7 months	55
20 weeks	104
4 months or 16 weeks	71, 107, 161, 247
Up to 3 months or 12 weeks	3, 52, 88, 125, 154, 173, 246
10 weeks	30
9 weeks	93
8 weeks	22, 24, 27, 48, 75, 84, 241
7 weeks	40, 83
6 weeks	26, 38, 80, 97, 112, 113, 121, 193, 238, 239
5 weeks	117, 252
4 weeks	61, 119, 123, 195, 205, 221

Table 7: Continued

2 weeks	222
2 days	31
Interventions reported as variable timeframes	
Variable timeframe	14, 49, 85, 101, 102, 104, 110, 122, 171, 173, 201, 210, 225, 227

Table 8: Intervention content types

Intervention type	References
Specific named programmes comprising multiple techniques	7, 9, 13, 18, 23, 36, 85, 86, 89, 98, 102, 117, 144, 155, 161, 172, 190, 198, 207, 241, 248, 249, 251, 252, 255
Health promotion	97, 107, 121, 135, 142, 146, 154, 162, 207, 211
Virtual environment and information communication technologies	32, 46, 52, 79, 104, 123, 151, 190, 221, 224
Alterations to environments	3, 4, 6, 7, 9, 11, 18, 19, 21, 26, 28, 36, 39, 44, 45, 50, 59, 66, 67, 69, 78, 90, 95, 100, 106, 108, 110, 118, 125, 130, 134, 154, 160, 165, 174, 176, 229, 231, 233, 235, 236,240, 242, 245, 251
Use of and facilitation of engagement with occupation and activity	1, 3, 9, 13, 22, 23, 26, 27, 35, 36, 37, 38, 46, 49, 52, 55, 56, 62, 64, 66, 75, 83, 86, 92, 93, 95, 97, 99, 100, 102, 107, 108, 110, 116, 126, 129, 133, 138, 145, 157, 158, 159, 160, 162, 164, 176, 178, 189, 190, 200, 208, 209, 210, 211, 218, 222, 226, 229, 233, 239, 240, 253, 256
Group-based interventions	2, 17, 25, 30, 31, 37, 51, 57, 59, 96, 97, 99, 105, 114, 115, 119, 133, 135, 136, 141, 145, 160, 162, 174, 176, 186, 189, 190, 210, 211, 216, 218, 221, 223, 226, 238, 239, 240241, 246, 254
Education, coaching and methods to increase knowledge and understanding	3, 7, 9, 14, 18, 22, 24, 25, 26, 31, 39, 40, 47, 48, 55, 64, 66, 70, 75, 82, 89, 93, 95, 99, 106, 110, 111, 113, 116, 125, 137, 142, 148, 173, 176, 190, 219, 221, 224, 229
Skill training and development	2, 10, 24, 27, 36, 37, 43, 49, 50, 54, 55, 56, 64, 73, 80, 91, 93, 95, 98, 99, 100, 102, 105, 109, 110, 112, 127, 135, 142, 143, 160, 176, 184, 189, 190, 195, 198, 207, 210, 229, 241, 251, 256
Training and strategies for cognitive, physical and sensory function	1, 3, 7, 9, 13, 18, 26, 27, 29, 32, 46, 48, 52, 54, 55, 57, 59, 61, 66, 73, 84, 92, 99, 100, 110, 113, 116, 124, 150, 152, 159, 163, 182,190, 210, 213, 229, 230, 247
Collaboration with client's family, carer, teachers, support, education	25, 31, 32, 115, 119, 165, 176, 189, 190, 192, 199, 204, 207, 210, 213, 241, 243, 254
Collaboration with other agencies and staff	3, 6, 7, 8, 14, 28, 75, 81, 99, 131, 239

Table 9: Theories and frameworks

Category	Specific theory or framework	References
Client-/person-/family-centred	No other details	15, 22, 25, 31, 69, 72, 167
	Canadian Model of Client-Centered Enablement	22
	Family-centred practice	111, 170, 173
	Person/client-centred practice	25, 67, 69, 72, 143, 172, 198, 251
Non-occupation-specific models	Allen cognitive disabilities model	153, 160
	International Classification of Functioning, Disability and Health	62, 214, 222
	Individual Placement Support	162, 244
	Neuro-sequential model	120
	Recovery model	97, 153, 155
Non-occupation-specific theories	Ageing theories	70, 103
	Behaviourism	66, 122, 192
	Motivational theory	256
	Relational Frame Theory	139
	Cognitive theories	75, 82, 153, 256
	Lewin's person–environment fit concept	248
	Neurological and neuropsychological theories	12, 68, 112, 117, 120, 146, 207, 219, 256
	Sensory integration	12, 68, 117, 146, 180,207, 219
	Human rights	25, 69
Occupation models	Occupational Therapy Practice Framework	24, 27, 31, 75, 175, 176, 208, 218, 238
	CMOP-E	67, 153, 206, 222
	MOHO	17, 31, 43, 91, 141, 153, 160, 165, 238
	Occupational adaptation model	153
	PEO model	153, 172, 224, 243
	PEOP model	153, 240
Occupational therapy theory	Occupational adaptation	28, 83, 107
	Occupational analysis	25, 121
	Occupation-focused	25, 28, 31, 38, 54, 58, 70, 111, 229
	Occupational therapist competencies	25, 62, 86

Table 10: Facilitators of practice

Category	Specific issue	References
Factors related to therapists and their context	Occupational therapist's attitudes, knowledge and skill	25, 28, 56, 62, 96, 138, 140, 155, 158, 183, 206, 209, 227, 245, 254
	Professional artistry	52, 87, 96, 205, 235
	Occupational therapist's management strategies	52, 54
	Occupational therapist's behaviour	22, 24, 52, 67, 81, 96, 107, 136, 201,
	Occupation-based approaches	54, 96, 110, 114
	Occupational outcomes	114
	Achieving occupational goals	54, 70, 227
	Occupational adaptation	52, 107, 170,
	Occupational engagement	87, 114, 134, 172
	Engagement in activities	3, 16, 22, 27, 54, 56, 72, 113, 225,
	Holism	54
	Collaborative practice	25, 28, 33, 52, 62, 70, 72, 75, 82, 116, 125, 138, 160, 187, 210, 244
	Volunteers	86, 145
	Pragmatics	26, 35, 254
	Timing of referral	28, 62, 164
	Policy	25
	Donation	35
	Attitudes, knowledge and skills	155, 96, 158, 183, 25, 28, 56, 62, 138, 140, 206, 209, 227, 254
	Professional artistry and behaviours	22, 24, 52, 52, 67, 81, 87, 96, 96, 107, 136, 201, 205, 235
	Occupation-based approaches	54, 96, 110, 114
	Occupational outcomes	54, 70, 114, 227
	Occupational adaptation	52, 107, 170
	Occupational engagement	87, 114, 134, 172
	Engagement in activities	16, 22, 54, 72, 114, 225, 239
	Holism	54
	Value of group process and interactions with peers	52, 82, 96, 107, 155, 158, 162, 189, 241
	Timing of referral	28, 62, 164
	Policy and governance	23, 25

Table 10: Continued

Category	Specific issue	References
Wider environments and contexts	Family involvement	125, 240, 248
	Donations	35
	Context	15, 125
	School environment	156, 183
	Natural or close to natural environments	54, 125, 155, 156, 170, 175, 200, 211
	Home environment	50, 170, 248
	Clinic environment	135, 145, 171
Experiences of the person during therapy	Trust	82, 97, 170, 184, 227, 234
	Prior experience	79
	Patient-selected activities/ choices	112, 125, 170
	Patient-led goals	97, 143, 157, 170, 234
	Recognising new opportunities	87
	Inclusion	87, 175, 240
	Enjoyment	52, 79, 82, 125
	Contact with other families	100, 156

Table 11: Obstacles to practice

Category	Specific Issue	References
Client issues	No more specific info	174, 194, 195, 238
	Adherence to therapy	113, 202, 238
	Administration for clients	62
	Client knowledge of diagnosis	2, 213, 170
	Client motivation and concentration	112, 115, 119, 124, 162, 173, 178, 187, 202, 221, 238
	Financial limitations	98, 172, 222, 234
	Family or carer issues	89, 170, 172, 173, 217
Cultural issues	No more specific info	26, 69, 170, 190
	Language discordance	136, 170
Environments	No more specific info	110, 125, 170, 202
	Access to technology	79, 170
	Geographical location	79, 116, 162, 170, 222, 234
Limited research		32, 57, 54, 63, 99, 119, 149, 175, 180, 182, 192, 194, 202, 206, 217, 218, 221, 225, 227, 228, 244
Practice or settings issues	Documentation	41, 170, 227
	Financial accountability	28, 62, 98, 160
	Focus of service	28, 41, 69
	Focus on deficits and functional autonomy	41, 69
	Lack of integrated care	62
	Limitations to client-centred practice	140, 170
	Occupational therapist identity in multidisciplinary teams	28, 29, 41
	Policy	41, 138, 212
	Role incompatibility	28
	Staff resistance to change	35

Table 11: Continued

Category	Specific Issue	References
Pragmatic issues	Limited resources	32, 35, 41, 42, 59, 76, 78, 98, 115, 116, 124, 166, 170, 182, 192, 205, 217, 222, 225, 234, 247
	Time	28, 54, 57, 58, 69, 82, 97, 135, 140, 170, 180, 183, 190, 222
Therapist issues	Alternative models and frameworks	54, 69, 170, 214
	Lack of experience	98, 116, 170, 229
	Occupational therapist's thinking	140
	Power/influence	41, 62, 138

Table 14: Word frequency analysis – nature of change

Word	Number of uses	Similar Words (included in count)
changing	392	change, changed, changes, changing
client	324	client, clients, clients'
improving	265	improve, improved, improvement, improvements, improves, improving
occupations	255	occup, occupation, occupational, occupationally, occupations, occupations'
skills	207	skill, skilled, skills
increased	202	increase, increased, increases, increasing
self	191	self
confidence	177	confidence, confident
function	171	function, functional, functionality, functioning, functions
independently	168	independence, independent, independently
activity	153	active, actively, activities, activity
ability	140	abilities, ability
engaging	132	engage, engaged, engagement, engages, engaging
patient	130	patient, patients, patients'
support	106	support, supported, supporting, supportive, supports
develops	100	develop, developed, developing, development, develops
physical	97	physical, physically
life	96	life
participation	90	participant, participants, participate, participates, participating, participation, participative
learning	83	learn, learning, learns
understanding	82	understand, understanding
individual	81	individual, individuals, individuals'
new	80	new
health	79	health
performance	79	perform, performance, performing
persons	76	person, personal, personalise, personally, persons
enable	74	enable, enabled, enablement, enables, enabling
goals	74	goal, goals

Table 14: Continued

Word	Number of uses	Similar Words (included in count)
motivational	73	motivate, motivated, motivates, motivating, motivation, motivational
able	72	able
socially	72	social, socialise, socialised, socially
living	71	live, lived, lives, living
environment	71	environment, environments
adapt	70	adapt, adaptation, adaptations, adapted, adapting, adaption, adaptive, adapts
manage	69	manage, manageable, managed, management, manages, managing
use	69	use, used, uses, using
works	68	work, worked, working, works
become	63	become, becomes, becoming
level	63	level, levels
meaningful	63	meaningful
achieving	62	achievable, achieve, achieved, achievement, achievements, achieves, achieving
help	62	help, helped, helpful, helping, helps
sense	61	sense
mental	60	mental, mentally
family	59	families, family
tasks	58	task, tasks
way	58	way, ways
wellbeing	55	wellbeing
therapist	53	therapist, therapists, therapists’
needs	52	need, needed, needing, needs
condition	49	condition, conditions
people	49	people
roles	49	role, roles
awareness	48	aware, awareness
well	48	well
maintain	48	maintain, maintained, maintenance, maintaining, maintains

Table 14: Continued

Word	Number of uses	Similar Words (included in count)
may	47	may
feel	46	feel, feeling, feelings, feels
esteem	46	esteem
service	45	service, services
community	44	communicate, communication, community
daily	44	daily
empowered	44	empower, empowered, empowering, empowers
make	43	make, makes, making
therapy	43	therapy
hope	43	hope, hoped, hopeful, hopefully, hopefulness, hoping
better	42	better
identify	42	identified, identifies, identify, identifying
often	42	often
relationship	42	relationship, relationships
interventions	40	intervention, interventions
positively	40	positive, positively, positivity
accepting	39	accept, acceptable, acceptance, accepted, accepting, accepts
setting	38	set, sets, setting, settings
process	37	process, processes, processing
regain	37	regain, regained, regaining, regains
equipment	37	equipment, equipped, equipping
gain	36	gain, gained, gaining, gains
techniques	36	technique, techniques
control	33	control
care	33	care, cared, caring
education	32	educate, educated, educating, education
important	32	importance, important, importantly
mood	32	mood, moods
possibly	32	possibilities, possibility, possible, possibly
therapeutic	32	therapeutic
routines	31	routine, routines

Table 14: Continued

Word	Number of uses	Similar Words (included in count)
building	31	build, building, builds
facilitate	31	facilitate, facilitated, facilitates, facilitating, facilitation, facilitators
take	30	take, takes, taking
depends	30	depend, dependence, dependency, dependent, depending, depends
different	30	difference, differences, different, differently
etc.	30	etc
quality	29	quality
reduced	29	reduce, reduced, reduces, reducing
behaviours	29	behaviour, behavioural, behaviours
knowledge	29	knowledgeable, knowledge
moving	29	move, moved, moves, moving
think	29	think, thinking, thinks
carers	28	carer, carers

Appendix B: Literature review references

1. Aebischer B, Elsig S, Taeymans J (2016) Effectiveness of physical and occupational therapy on pain, function and quality of life in patients with trapeziometacarpal osteoarthritis: a systematic review and meta-analysis. *Hand Therapy, 21(1),* 5–15.

2. Alexander S (2016) Personally written care plans. *Occupational Therapy News, 24(10),* 28–29.

3. Anaby DR, Law MC, Majnemer A, Feldman D (2016) Opening doors to participation of youth with physical disabilities: an intervention study. *Canadian Journal of Occupational Therapy, 83(2)*, 83–90.

4. Aplin T, Jonge D, Gustafsson L (2015) Understanding home modifications impact on clients and their family's experience of home: a qualitative study. *Australian Occupational Therapy Journal, 62(2)*, 123–131.

5. Arbesman M, Stutzbach M, Lieberman D (2015) Keeping current on autism. *OT Practice,* 20(22), 16–17.

6. Arsenault JK, Musgrave JGR (2015) Comfort food. *ASHA Leader, 20(10),* 56–60.

7. Asher A, Nichols J (2016) Collaboration around facilitating emergent literacy: role of occupational therapy. *Journal of Occupational Therapy, Schools, & Early Intervention, 9(1)*, 51–73.

8. Atighechi A (2016) Designing a physical education program for adolescents with autism. *OT Practice, 21(2*), 2–14.

9. Ávila A, Durán M, Peralbo M, Torres G, Saavedra M, Viana IM (2015) Effectiveness of an occupational therapy home programme in Spain for people affected by stroke. *Occupational Therapy International, 22(1),* 1–9.

10. Ayoola-Giwa F (2015) Graffiti: vandalism or art form? *Occupational Therapy News, 23(10),* 34.

11. Bachner S (2015) Easy come, easy go, easy everything in between. *Rehab Management: The Interdisciplinary Journal of Rehabilitation, 28(4)*, 26–31.

12. Bailey T, Moore N, Ferguson T, Fletcher E, Mendelsohn J (2015) Creating an autism-friendly dining experience. *Occupational Therapy News, 23(10),* 35.

13. Baker S (2015) Emerging practice areas: occupational therapy and hippotherapy. *Connections, 12(5),* 14–15.

14. Barbree A, Wolfe SD, Herbst ER (2015) A clinical pre-driving model for young stroke survivors. *OT Practice, 20(13),* 10–14.

15. Barenfeld E, Gustafsson S, Wallin L, Dahlin-Ivanoff S (2015) Understanding the 'black box' of a health promotion program: keys to enable health among older persons aging in the context of migration. *International Journal of Qualitative Studies on Health and Well-being, 10,* 1–10.

16. Bayes V, Donaghue L (2016) Promoting new and different active leisure occupations. *Occupational Therapy News, 26(4)*, 42–43.

17. Beck K, Harkin E (2016) How music matters. *Occupational Therapy News, 24(5),* 40–41.

18. Berger S, Kaldenberg J, Selmane R, Carlo S (2016) Effectiveness of interventions to address visual and visual perceptual impairments to improve occupational performance in adults with traumatic brain injury: a systematic review. *American Journal of Occupational Therapy, 70(3)*, 7003180010p1–7003180010p7.

19. Bernard S (2016) Use of a modified Frazier Water Protocol in critical illness survivors with pulmonary compromise and dysphagia: a pilot study. *American Journal of Occupational Therapy, 70(1)*, 7001350040p1–7001350040p5.

20. Bertilsson A, Von Koch L, Tham K, Johansson U (2015) Client-centred ADL intervention after stroke: significant others' experiences. *Scandinavian Journal of Occupational Therapy, 22(5)*, 377–386.

21. Bierman SN (2016) Helping Kim return home. *OT Practice, 21(16)*, 11–12.

22. Bjørkedal STB, Torsting AMB, Møller T (2016) Rewarding yet demanding: client perspectives on enabling occupations during early stages of recovery from schizophrenia. *Scandinavian Journal of Occupational Therapy, 23(2)*, 97–106.

23. Blackwood J, Gillen A, Gillies B (2015) Sowing the seed of possibility. *Occupational Therapy News, 23(6),* 36–38.

24. Boehm N, Muehlberg H, Stube JE (2015) Managing post-stroke fatigue using telehealth: a case report. *American Journal of Occupational Therapy, 69(6)*, 6906350020p1–6906350020p7.

25. Bourke C, Sanders B, Allchin B, Lentin P, Lang S (2015) Occupational therapy influence on a carer peer support model in a clinical mental health service. *Australian Occupational Therapy Journal, 62(5)*, 299–305.

26. Bozorgi A, Ghamkhar L, Hossein Kahlaee A, Sabouri H (2015) The effectiveness of occupational therapy supervised usage of adaptive devices on functional outcomes and independence after total hip replacement in Iranian elderly: a randomized controlled trial. *Occupational Therapy International*, *23(2),* 143–153.

27. Brammer W, Malshuk E, Robertson L, Rubin B, Rios D, Jirikowic T (2015) Improving children with functional motor skills coordination challenges and confidence. *OT Practice, 20(18)*, 8–12.

28. Britton L, Rosenwax L, McNamara B (2016) Occupational therapy in Australian acute hospitals: a modified practice. *Australian Occupational Therapy Journal, 63(4),* 257–265.

29. Britton L, Rosenwax L, McNamara B (2015) Occupational therapy practice in acute physical hospital settings: evidence from a scoping review. *Australian Occupational Therapy Journal, 62(6),* 370–377.

30. Brown F (2015) Ease into exercise. *Occupational Therapy News, 23(8),* 34–35.

31. Brzuz A (2015) To drive or ride? *OT Practice, 20(13)*, 7–9.

32. Buckle C (2016) Keeping up with technology. *Occupational Therapy News, 24(10)*, 24–26.

33. Bunting J (2016) A new way of communicating. *Occupational Therapy News, 24(10),* 42–43.

34. Burden R, Diaz-Cala A, Davey S, Murphy H, Terzoli C, Teers K (2016) Introducing self-assessment to improve wellbeing. *Occupational Therapy News, 26(05),* 32–33.

35. Burgess E (2015) Growing roots on a stroke rehabilitation ward. *Occupational Therapy News, 23(8),* 26.

36. Burrough M (2016) Occupational therapy support for children and staff in mainstream schools. *Occupational Therapy News, 24(1),* 43.

37. Butler F (2016) Providing independence and responsibility through horticulture. *Occupational Therapy News, 24(6),* 45.

38. Cahill SM, Clone J, Wilson M, Moroni A (2015) Friends, fun, and fitness: a 6-week program for adolescents with Down syndrome. *Developmental Disabilities Special Interest Section Quarterly, 38(2)*, 1–4.

39. Campbell JE, Morgan M, Barnett V, Spreat S (2015) Handheld devices and video modeling to enhance the learning of self-help skills in adolescents with autism spectrum disorder. *OTJR: Occupation, Participation & Health, 35(2)*, 95–100.

40. Cantrill A, Wilkes-Gillan S, Bundy A, Cordier R, Wilson NJ (2015) An eighteen-month follow-up of a pilot parent-delivered play-based intervention to improve the social play skills of children with attention deficit hyperactivity disorder and their playmates. *Australian Occupational Therapy Journal, 62(3)*, 197–207.

41. Carrier A, Freeman A, Levasseur M, Desrosiers J (2015) Standardized referral form: restricting client-centered practice? *Scandinavian Journal of Occupational Therapy, 22(4)*, 283–292.

42. Carrier A, Levasseur M (2015) Involvement of support personnel in occupational therapy home care services in Quebec: methods that comply with regulations and support prevention and health promotion. *Occupational Therapy Now, 17(2)*, 17–18.

43. Carroll H (2016) Exploring and applying evidence-based practice. *Occupational Therapy News, 24(10),* 52–53.

44. Caudren H, Abbey J (2015) Empowering patients and carers. *Occupational Therapy News, 23(6),* 41.

45. Chabot M (2016) Home modifications on a shoestring budget. *OT Practice, 21(16)*, 8–10.

46. Chan V, Xiong C, Colantonio A (2015) Patients with brain tumors: who receives postacute occupational therapy services? *American Journal of Occupational Therapy, 69(2)*, 6902290010p1–6902290010p6.

47. Cheung TWC, Clemson L, O'Loughlin K, Shuttleworth R (2016) Understanding decision-making towards housework among women with upper limb repetitive strain injury. *Australian Occupational Therapy Journal, 63(1)*, 37–46.

48. Cho M, Kim D, Chung J, Park J, You H, Yang Y (2015) Effects of a cognitive enhancement group training program on daily living activities, cognition and depression in the demented elderly. *Journal of Physical Therapy Science,* 27, 681–684.

49. Chuang W, Hwang E, Lee H, Wu S (2015) An in-house prevocational training program for newly discharged psychiatric inpatients: exploring its employment outcomes and the predictive factors. *Occupational Therapy International, 22(2)*, 94–103.

50. Chung C (2016) Alice's story. *Occupational Therapy News, 24(4),* 34–35.

51. Clarke C, Bergson K (2016) Empowerment: a route to occupational engagement. *Occupational Therapy News 24(1),* 37.

52. Cleverley M (2015) The important role OTs can play in research. *Occupational Therapy News, 23(4),* 26–27.

53. Coker-Bolt P, Deluca SC, Ramey SL (2015) Training paediatric therapists to deliver constraint-induced movement therapy (CIMT) in sub-Saharan Africa. *Occupational Therapy International, 22(3)*, 141–151.

54. Colaianni DJ, Provident I, Dibartola LM, Wheeler S (2015) A phenomenology of occupation-based hand therapy. *Australian Occupational Therapy Journal, 62(3),* 177–186.

55. Connelly C (2015) Pediatric oncology clients undergoing stem cell transplant: the impact on occupational performance. *OT Practice, 20(9),* 7–9.

56. Crandall J, Smith YJ (2015) The life skills program. *OT Practice, 20(22)*, 18–20.

57. Cronin H, Dingwall H, Dunne M, Verner A (2016) Getting together for group work. *Occupational Therapy News, 24(8),* 28–30.

58. Croucher A (2015) The word is out. *Occupational Therapy News, 23(5),* 44.

59. Davies S (2016) Starting from scratch. *Occupational Therapy News, 24(2),* 42.

60. Davis S (2016) A therapist in a nurse-led team. *Occupational Therapy News, 24(1),* 31.

61. Deluca SC, Ramey SL, Trucks MR, Wallace DA (2015) Multiple treatments of pediatric constraint-induced movement therapy (pCIMT): a clinical cohort study. *American Journal of Occupational Therapy, 69(6)*, 6906180010p1–6906180010p9.

62. Désiron H, Crutzen R, Godderis L, Hoof E, Rijk A (2016) Bridging health care and the workplace: formulation of a return-to-work intervention for breast cancer patients using an intervention mapping approach. *Journal of Occupational Rehabilitation, 26(3)*, 350–365.

63. Doman CA, Waddell KJ, Bailey RR, Moore JL, Lang CE (2016) Changes in upper-extremity functional capacity and daily performance during outpatient occupational therapy for people with stroke. *American Journal of Occupational Therapy*, *70(3),* 7003290040p1–7003290040p11.

64. Donica DK (2015) Handwriting without tears: general education effectiveness through a consultative approach. *American Journal of Occupational Therapy, 69(6),* 6906180050p1–6906180050p8.

65. Döpp CME, Graff MJL, Teerenstra S, Olde Rikkert MGM, Nijhuis-van der Sanden MW, Vernooij-Dassen MJ (2015) Effectiveness of a training package for implementing a community-based occupational therapy program in dementia: a cluster randomized controlled trial. *Clinical Rehabilitation, 29(10)*, 974–986.

66. Dressel R (2015) Overcoming the urge. *Advance for Occupational Therapy Practitioners, 31(4),* 16–17.

67. Drolet M, Désormeaux-Moreau M (2016) The values of occupational therapy: perceptions of occupational therapists in Quebec. *Scandinavian Journal of Occupational Therapy, 23(4),* 272–285.

68. Durci T, Popovich R (2015) In the community: super sensory adventure program promoting sensory exploration for children in the community. *OT Practice, 20(12)*, 18–20.

69. Durocher E, Kinsella EA, Ells C, Hunt M (2015) Contradictions in client-centred discharge planning: through the lens of relational autonomy. *Scandinavian Journal of Occupational Therapy, 22(4),* 293–301.

70. Eagers J, Franklin RC, Broome K, Yau MK (2016) A review of occupational therapy's contribution to and involvement in the work-to-retirement transition process: an Australian perspective. *Australian Occupational Therapy Journal, 63(4),* 277–292.

71. Eckberg Zylstra S, Pfeiffer B (2016) Effectiveness of a handwriting intervention with at-risk kindergarteners. *American Journal of Occupational Therapy, 70(3),* 7003220020p1–7003220020p8.

72. Eklund M, Leufstadius C (2016) Adding quality to day centre activities for people with psychiatric disabilities: staff perceptions of an intervention. *Scandinavian Journal of Occupational Therapy, 23(1)*, 13–22.

73. Eliasson A (2015) What can be learned from reporting no-treatment effect of distribution of upper limb training? *Developmental Medicine & Child Neurology, 57(6)*, 498–498.

74. El-Khatib F, Nazir S (2015) The recovery tree project. *Occupational Therapy News, 23(3),* 41.

75. Fabrizi SE, Ito MA, Winston K (2016) Effect of occupational therapy-led playgroups in early intervention on child playfulness and caregiver responsiveness: a repeated-measures design. *American Journal of Occupational Therapy, 70(2)*, 700220020p1–700220020p9.

76. Ferguson J (2015) OT: the right position, at the right time, to influence change? *Occupational Therapy News, 23(11),* 40–41.

77. Fulton S, Clohesy D, Wise FM, Woolley K, Lannin N (2016) A goal-directed woodwork group for men in community rehabilitation – a pilot project. *Australian Occupational Therapy Journal, 63(1)*, 29–36.

78. Gaffney J, Trevorrow J (2016) Behind the scenes: raising the profile of occupational therapy. *Occupational Therapy News, 24(1),* 26–27.

79. Gardner K, Bundy A, Dew A, Lynch H, Moore A (2016) Perspectives of rural carers on benefits and barriers of receiving occupational therapy via information and communication technologies. *Australian Occupational Therapy Journal, 63(2)*, 117–122.

80. Garvey J, Connolly D, Boland F, Smith SM (2015) OPTIMAL: an occupational therapy-led self-management support programme for people with multimorbidity in primary care: a randomized controlled trial. *BMC Family Practice, 16(1)*, 1–11.

81. Glassbrook M (2015) Developing a prison assessment service. *Occupational Therapy News, 23(8),* 31.

82. Gontijo DT, Sena EV, Monteiro RJS, Facundes VLD, Fátima CT, Lima LS (2016) Occupational therapy and sexual and reproductive health promotion in adolescence: a case study. *Occupational Therapy International, 23(1)*, 19–28.

83. Grajo L, Candler C (2016) An occupation and participation approach to reading intervention (OPARI) part II: pilot clinical application. *Journal of Occupational Therapy, Schools, & Early Intervention, 9(1),* 86–98.

84. Gudlavalleti ASV, Taimni V, Bhasin A, Srivastava MVP (2015) Comparison of constraint-induced movement therapy and neuromuscular electrical simulation on clinical outcomes in chronic stroke. *Indian Journal of Physiotherapy & Occupational Therapy*, *9(2)*, 182–187.

85. Guidett, S, Ranner M, Tham K, Andersson M, Ytterberg C, Von Koch L (2015) A 'client-centred activities of daily living' intervention for persons with stroke: one-year follow-up of a randomized controlled trial. *Journal of Rehabilitation Medicine, 47(7)*, 605–611.

86 Habovick N (2016) Off the hook: an adaptive fishing program for children with special needs. *OT Practice, 21(2)*, 15–17.

87 Haracz K, Ennals P (2015) Occupational therapy intervention in mental health should be individualised, occupation focussed, promote inclusion and occur in the context of an authentic relationship. *Australian Occupational Therapy Journal, 62(5)*, 365–366.

88. Harries P, Hall R, Ray N, Stein J (2015) Using coloured filters to reduce the symptoms of visual stress in children with reading delay. *Scandinavian Journal of Occupational Therapy, 22(2)*, 153–160.

89. Harrison N, Read I (2015) Supporting children with the CO-OP approach. *Occupational Therapy News, 23(3),* 30–31.

90. Hawes D, Meredith J (2016) All aboard the bathing bus. *Occupational Therapy News, 24(10),* 20–22.

91. Haythorne R (2016) Promoting personhood and citizenship. *Occupational Therapy News, 24(2)*, 34.

92. Heathfield A, Dupre K, Rosel M, Beasley J, Leiras C, Mead M (2016) Range of motion outcomes of an alternative protocol for clostridium histoliticum collagenease injection and occupational therapy. *Journal of Hand Therapy, 29(3)*, 373–374.

93. Henning B, Cordier R, Wilkes-Gillan S, Falkmer T (2016) A pilot play-based intervention to improve the social play interactions of children with autism spectrum disorder and their typically developing playmates. *Australian Occupational Therapy Journal, 63(4*), 223–232.

94. Hepworth, L (2015) Helping to ease the strain for carers of stroke survivors. *Occupational Therapy News, 23(12), 3*0–31.

95. Hesselstrand M, Samuelsson K, Liedberg G (2015) Occupational therapy interventions in chronic pain: a systematic review. *Occupational Therapy International, 22(4),* 183–194.

96. Heywood L, Michel K, Vinter L (2015) Making Hagrid. *Occupational Therapy News, 23(6),* 26–27.

97. Hill J, Morrey S (2016) An enterprising approach to group work. *Occupational Therapy News, 24(7),* 28–30.

98. Hills L (2016) Outreach support for acute spinal cord injury patients. *Occupational Therapy News, 24(10),* 44–45.

99. Hitch D, Taylor M, Pepin G (2015) Occupational therapy with people with depression: using nominal group technique to collate clinician opinion. *Scandinavian Journal of Occupational Therapy, 22(3)*, 216–225.

100. Hocevar, R (2015) Invested in innovation. *Advance for Occupational Therapy Practitioners*, *31(5)*, 8–21.

101. Howlett OA, Lannin NA, Ada L, McKinstry C (2015) Functional electrical stimulation improves activity after stroke: a systematic review with meta-analysis. *Archives of Physical Medicine & Rehabilitation, 96(5),* 934–943.

102. Hui C, Snider L, Couture M (2016) Self-regulation workshop and occupational performance coaching with teachers: a pilot study. *Canadian Journal of Occupational Therapy, 83(2),* 115–125.

103. Imanishi M, Tomohisa H, Higaki K (2016) A narrative approach to home-based occupational therapy can improve the development of grandparenthood and quality of life in the elderly. *New Zealand Journal of Occupational Therapy, 63(2),* 38–44.

104. James S, Ziviani J, Ware RS, Boyd RN (2015) Randomized controlled trial of web-based multimodal therapy for unilateral cerebral palsy to improve occupational performance. *Developmental Medicine & Child Neurology, 57(6),* 530–538.

105. Jamieson L (2016) Building occupational skills in the prison population. *Occupational Therapy News, 24(6),* 14–16.

106. Jepson P, Sands G, Beswick AD, Davos ET, Blom AW, Sackley CM (2016) A feasibility randomised controlled trial of pre-operative occupational therapy to optimise recovery for patients undergoing primary total hip replacement for osteoarthritis (PROOF-THR). *Clinical Rehabilitation, 30(2),* 56–166.

107. Johansson A, Björklund A (2016) The impact of occupational therapy and lifestyle interventions on older persons' health, well-being, and occupational adaptation. *Scandinavian Journal of Occupational Therapy, 23(3),* 207–219.

108. Johnson R, Daly M (2015) 3D printing: the way to independence. *Occupational Therapy News, 23(7),* 38.

109. Kahjoogh MA, Rassafiani M, Dunn W, Hosseini SA, Akbarfahimi N (2016) Occupational performance coaching: a descriptive review of literature. *New Zealand Journal of Occupational Therapy, 63(2),* 45–49.

110. Kassberg A, Prellwitz M, Malinowsky C, Larsson-Lund M (2016) Interventions aimed at improving the ability to use everyday technology in work after brain injury. *Scandinavian Journal of Occupational Therapy, 23(2),* 147–157.

111. Kessler D, Graham F (2015) The use of coaching in occupational therapy: an integrative review. *Australian Occupational Therapy Journal, 62(3),* 160–176.

112. Kim E, Kim K (2015) Effect of purposeful action observation on upper-extremity function in stroke patients. *Journal of Physical Therapy Science, 27(9),* 2867–2869.

113. Kim GJ, Rivera L, Stein J (2015) Combined clinic–home approach for upper limb robotic therapy after stroke: a pilot study. *Archives of Physical Medicine & Rehabilitation, 96(12),* 2243–2248.

114. Kindleysides M, Biglands E (2015) 'Thinking outside the box, and making it too': piloting an occupational therapy group at an open-air museum. *Arts & Health: International Journal for Research, Policy & Practice,* 7*(3),* 271–278.

115. Kingsley F (2016) Meeting children's occupational goals. *Occupational Therapy News,* September, *24(9),* 12–14.

116. Kingston GA, Williams G, Judd J, Gray MA (2015) Hand therapy services for rural and remote residents: results of a survey of Australian occupational therapists and physiotherapists. *Australian Journal of Rural Health, 23(2),* 112–121.

117. Kinnealey M, Riuli V, Smith S (2015) Case study of an adult with sensory modulation disorder. *Sensory Integration Special Interest Section Quarterly, 38(1),* 1–4.

118. Kinney A, Gitlow L (2015) A consumer-centered approach to evaluating assistive technology usability outcomes. *Technology Special Interest Section Quarterly, 25(2),*1–4.

119. Kjeken I, Grotle M, Hagen K, Østerås N (2015) Development of an evidence-based exercise programme for people with hand osteoarthritis. *Scandinavian Journal of Occupational Therapy, 22(2),* 103–116.

120. Klemp R (2015) A Little 'r and r'. *Advance for Occupational Therapy Practitioners, 31(5),* 12–13.

121. Kugel J, Hemberger C, Krpalek D, Javaherdian-Dysinger H (2016) Occupational therapy wellness program: youth and parent perspectives. *American Journal of Occupational Therapy, 70(5),* 7005180010p1–7005180010p8.

122. Kuhaneck MH, Madonna S, Novak A, Pearson E (2015) Effectiveness of interventions for children with Autism Spectrum Disorder and their parents: a systematic review of family outcomes. *American Journal of Occupational Therapy, 69(5),* 6905180040p1–6905180040p14.

123. Kyoung-Hee L (2015) Effects of a virtual reality-based exercise program on functional recovery in stroke patients: part 1. *Journal of Physical Therapy Science, 27,* 1637–1640.

124. Lacey R (2016) The challenge of stroke rehabilitation in a prison environment. *Occupational Therapy News, 24(10)*, 18–19.

125. Law M, Anaby D, Imms C, Teplicky R, Turner L (2015) Improving the participation of youth with physical disabilities in community activities: an interrupted time series design. *Australian Occupational Therapy Journal, 62(2),* 105–115.

126. Layton N (2015) Occupational Therapy Australia scope of practice framework and statement resources: update. *Connections, 12(5),* 6.

127. Leland NE, Fogelberg D, Sleight A, Mallinson T, Vigen C, Blanchard J, Carlson M, Clark F (2016) Napping and nighttime sleep: findings from an occupation-based intervention. *American Journal of Occupational Therapy, 70(4),* 7004270010p1–7004270010p7.

128. Leong HM, Carter M, Stephenson J (2015) Systematic review of sensory integration therapy for individuals with disabilities: single case design studies. *Research in Developmental Disabilities, 12(47),* 334–351.

129. Lewis L (2015) Planning a return to work. *Occupational Therapy News, 23(11),* 39.

130. Livengood HM, Baker NA (2015) The role of occupational therapy in vision rehabilitation of individuals with glaucoma. *Disability & Rehabilitation, 37(13),* 1202–1208.

131. Lochhead A (2015) Collaborative working to reduce hospital admissions. *Occupational Therapy News, 23(12),* 26–27.

132. Lucking A, Shields S (2015) OT in emergency and acute medicine. *Occupational Therapy News, 23(12)*, 33.

133. Marsland J (2016) Managing fatigue levels to achieve vocational goals. *Occupational Therapy News, 24(5),* 43.

134. Martin D (2016) Remap – making things possible. *Occupational Therapy News, 24(9),* 36–37.

135. Martin L, Heneghan C (2016) Time to pause. *Occupational Therapy News, 24(9)*, 28–29.

136. Martinez J, Leland N (2015) Language discordance and patient-centered care in occupational therapy: a case study. *OTJR: Occupation, Participation & Health, 35(2),* 20–128.

137. Massey J, Diedrick L (2016) A collaborative approach to functional therapy. *Occupational Therapy News, 24(6),* 28–30.

138. Maywald A, Stanley M (2015) Prescribing mobility scooters in Australia: occupational therapists' narratives. *Australian Occupational Therapy Journal, 62(2),* 86–92.

139. McCammon S (2015) Applying a mindfulness-based approach in a medical setting: a case example. *Mental Health Special Interest Section Quarterly, 38(1),* 1–3.

140. McCorquodale L, Kinsella EA (2015) Critical reflexivity in client-centred therapeutic relationships. *Scandinavian Journal of Occupational Therapy, 22(4),* 311–317.

141. McDonnell F, Donovan J (2016) OT within an evolving prison environment. *Occupational Therapy News, 24(6),* 18–20.

142. McElroy ME, Schaffner L (2016) The role of OT in an interdisciplinary oncology group for hospitalized patients. *OT Practice, 21(2),* 18–20.

143. McEwen S (2016) Taking a task-based approach with adults. *Occupational Therapy News, 24(5),* 45.

144. McGee S (2015) Beyond assessment and provision. *Occupational Therapy News, 23(7),* 40–41.

145. McLening B (2016) Supporting the transition from hospital to home. *Occupational Therapy News, 24(8),* 27.

146. Meharg S (2015) Student support. *Occupational Therapy News, 23(5),* 42–43.

147. Merchant J, Kitsos G, Ashby S, Kitsos A, Hubbard IJ (2016) Occupational therapy and physiotherapy in acute stroke: do rural patients receive less therapy? *Stroke Research & Treatment.* DOI:10.1155/2016/1582706.

148. Miller Kuhaneck H, Madonna S, Novak A, Pearson E (2015) Effectiveness of interventions for children with autism spectrum disorder and their parents: a systematic review of family outcomes. *American Journal of Occupational Therapy, 69(5),* 6905180040p1–6905180040p14.

149. Mills C, Chapparo C, Hinitt J (2016) The impact of an in-class sensory activity schedule on task performance of children with autism and intellectual disability: a pilot study. *British Journal of Occupational Therapy, 79(9),* 530–539.

150. Mitsukane M, Sekiya N, Himei S, Oyama K (2015) Immediate effects of repetitive wrist extension on grip strength in patients with distal radial fracture. *Archives of Physical Medicine & Rehabilitation, 96(5),* 862–868.

151. Moormann A, Stellato J, Egan B (2015) Time management and smartphone applications: a case study. *Mental Health Special Interest Section Quarterly, 38(2),* 1–4.

152. Mortensen J, Figlewski K, Andersen H (2016) Combined transcranial direct current stimulation and home-based occupational therapy for upper limb motor impairment following intracerebral hemorrhage: a double-blind randomized controlled trial. *Disability & Rehabilitation, 38(7),* 637–643.

153. Muñoz JP, Moreton EM, Sitterly AM (2016) The scope of practice of occupational therapy in US criminal justice settings. *Occupational Therapy International, 23(3),* 241–254.

154. Nagayama H, Tomori K, Ohno K, Takahashi K, Yamauchi K (2016) Cost-effectiveness of occupational therapy in older people: systematic review of randomized controlled trials. *Occupational Therapy International, 23(2),* 103–120.

155. Naseem Dove H (2015) The way to positive lifestyle changes. *Occupational Therapy News, 23(8),* 38–39.

156. Neuman E (2015) Learning to be in control, not controlled. *Occupational Therapy News, 23(4),* 30–31.

157. Newman C, Baker F (2015) Physical activity and occupational change. *Occupational Therapy News, 23(8),* 36–37.

158. Nicol S (2016) Making meaningful beats. *Occupational Therapy News, 23(8),* 34–35.

159. Nilsen D, Gillen G, Arbesman M, Lieberman D (2015) Occupational therapy interventions for adults with stroke. *American Journal of Occupational Therapy, 69(5),* 6905395010p1–6905395010p3.

160. Noyes S (2015) Living in the community with serious mental illness. *OT Practice, 20(21),* 23–25.

161. O'Connor CM, Clemson L, Brodaty H, Gitlin LN, Piguet O, Mioshi E (2016) Enhancing caregivers' understanding of dementia and tailoring activities in frontotemporal dementia: two case studies. *Disability & Rehabilitation, 38(7),* 704–714.

162. O'Hara S (2016) Learning from unforeseen challenges. *Occupational Therapy News, 24(4),* 38–39.

163. Ohura T (2015) Differences between home-visit rehabilitation users and providers in their understanding of the content and subjective effects of rehabilitation practices. *Journal of Physical Therapy Science, 27(6),* 1705–1708.

164. Olney J, Bucklet D, Duncan Anderson J, Oliver L (2015) Supporting the armed forces in returning to employment. *Occupational Therapy News, 23(7),* 26–27.

165. O'Nions C, Lewis H (2015) OT and medically unexplained symptoms. *Occupational Therapy News, 24(4),* 28–29.

166. O'Sullivan G (2016) Occupational therapy: the promise and the paradox. *New Zealand Journal of Occupational Therapy, 63(1),* 28–30.

167. Palmer L (2015) A partnership in recovery. *Occupational Therapy News, 23(9),* 37.

168. Parkinson S (2015) OT: helping children find their inner superhero. *Occupational Therapy News, 23(12),* 43.

169. Paul-Ward A, Lambdin-Pattavina C (2016) New roles for occupational therapy to promote independence among youth aging out of foster care. *American Journal of Occupational Therapy, 70(3),* 7003360010p1–7003360010p5.

170. Pidgeon F (2015) Occupational therapy: what does this look like practised in very remote Indigenous areas? *Rural & Remote Health, 15(2),* 1–7.

171. Piller A, Candler C (2015) Text mining. *OT Practice, 20(20),* 9–12.

172. Pitonyak JS, Mroz TM, Fogelberg D (2015) Expanding client-centred thinking to include social determinants: a practical scenario based on the occupation of breastfeeding. *Scandinavian Journal of Occupational Therapy, 22(4),* 277–282.

173. Pizzi M, Orloff S (2015) Childhood obesity as an emerging area of practice for occupational therapists: a case report. *New Zealand Journal of Occupational Therapy, 62(1),* 29–38.

174. Plumb B (2016) Eating socially: an opportunity for rehabilitation in a stroke unit. *Occupational Therapy News, 24(8),* 32–33.

175. Powell JM, Rich TJ, Wise EK (2016) Effectiveness of occupation- and activity-based interventions to improve everyday activities and social participation for people with traumatic brain injury: a systematic review. *American Journal of Occupational Therapy, 70(3),* 7003180040p1–7003180040p9.

176. Preissner K, Arbesman M, Lieberman D (2016) Occupational therapy interventions for adults with multiple sclerosis. *American Journal of Occupational Therapy, 70(3),* 7003395010p1–7003395010p4.

177. Prescott R (2015) Connecting music, people and memories. *Occupational Therapy News, 23(11),* 32–33.

178. Price R (2016) Creating an age-appropriate therapeutic network. *Occupational Therapy News, 24(9),* 16–17.

179. Proffitt R (2015) Understanding the nature of home exercise programs for persons with neurological disorders. *Archives of Physical Medicine & Rehabilitation, 96(12),* e10–e11.

180. Pumpa LU, Cahill LS, Carey LM (2015) Somatosensory assessment and treatment after stroke: an evidence–practice gap. *Australian Occupational Therapy Journal, 62(2),* 93–104.

181. Quinlan S (2015) Integrating OT into a cardiac rehab service. *Occupational Therapy News, 23(5),* 41.

182. Radomski MV, Anheluk M, Bartzen MP, Zola J (2016) Effectiveness of interventions to address cognitive impairments and improve occupational performance after traumatic brain injury: a systematic review. *American Journal of Occupational Therapy, 70(3),* 7003180050p1–7003180050p9.

183. Read L (2016) A schools-based model of occupational therapy service delivery. *Occupational Therapy News, 24(1),* 28–30.

184. Reade S (2016) A complex and challenging role. *Occupational Therapy News, 24(9),* 40–42.

185. Reynolds S, Lane SJ, Mullen B (2015) Effects of deep pressure stimulation on physiological arousal. *American Journal of Occupational Therapy, 69(3),* 6903350010p1–6903350010p5.

186. Richardson S, Ede J (2015) Reminiscence, rummage and recreation. *Occupational Therapy News, 23(11),* 26–27.

187. Richardson G (2015) Back of the net. *Occupational Therapy News, 23(5),* 34.

188. Rider J, Davis L (2015) Providing fair assessments and relevant information. *Occupational Therapy News, 23(11),* 24–25.

189. Robertson C, Brown J (2015) Recovering motivation. *Occupational Therapy News, 23(11),* 30–31.

190. Rodríguez-Bailón M, Pulido-Navarro MJ, Bravo-Quirós A, Alberto-Cantizano MJ, Rubio-Fernández V, Fernández-Solano AJ (2016) Seeing, judging and … acting! Improving health perception and meaningful occupational participation in older Spanish adults. *Educational Gerontology, 42(8),* 572–584.

191. Roll SC, Gray JM, Frank G, Wolkoff M (2015) Exploring occupational therapists' perceptions of the usefulness of musculoskeletal sonography in upper-extremity rehabilitation. *American Journal of Occupational Therapy, 69(4),* 6904350020p1–6904350020p6.

192. Rosenberg L, Maeir A, Yochman A, Dahan I, Hirsch I (2015) Effectiveness of a cognitive–functional group intervention among preschoolers with attention deficit hyperactivity disorder: a pilot study. *American Journal of Occupational Therapy, 69(3),* 6903220040p1–6903220040p8.

193. Ross LF, Harvey LA, Lannin NA (2016) Strategies for increasing the intensity of upper limb task-specific practice after acquired brain impairment: a secondary analysis from a randomised controlled trial. *British Journal of Occupational Therapy, 79(6),* 353–360.

194. Ross P, Ponsford JL, Di Stefano M, Charlton J, Spitz G (2016) On the road again after traumatic brain injury: driver safety and behaviour following on-road assessment and rehabilitation. *Disability & Rehabilitation, 38(10),* 994–1005.

195. Rostami HR, Khayatzadeh Mahany M, Yarmohammadi N (2015) Feasibility of the modified constraint-induced movement therapy in patients with median and ulnar nerve injuries: a single-subject A-B-A design. *Clinical Rehabilitation, 29(3),* 277–284.

196. Russell M (2016) Oceans of time. *Occupational Therapy News, 24(8),* 25.

197. Safdar S (2015) Wide-awake flexor tendon repair. *OT Practice, 20(8),* 7–16.

198. Saunders L (2016) The best kind of therapy. *Occupational Therapy News, 24(2),* 36–37.

199. Savory S, Kelly H, Townsend S (2015) Supporting families and carers through education and peer support. *Occupational Therapy News, 23(12),* 32–33.

200. Sharp N (2015) Healing with horses. *Occupational Therapy News, 23(7)*, 30–31.

201. Shea C, Jackson N (2015) Client perception of a client-centered and occupation-based intervention for at-risk youth. *Scandinavian Journal of Occupational Therapy, 22(3),* 173–180.

202. Shea C, Siu AMH (2016) Engagement in play activities as a means for youth in detention to acquire life skills. *Occupational Therapy International, 23(3),* 276–286.

203. Sim S, Barr CJ, George S (2015) Comparison of equipment prescriptions in the toilet/bathroom by occupational therapists using home visits and digital photos, for patients in rehabilitation. *Australian Occupational Therapy Journal, 62(2),* 132–140.

204. Simmonds A, Davies E, Allen S (2016) Working in partnership to support the best health outcomes for children. *Occupational Therapy News, 24(1),* 46.

205. Simpson B, McCluskey A, Lannin N, Cordier R (2016) Feasibility of a home-based program to improve handwriting after stroke: a pilot study. *Disability & Rehabilitation, 38(7),* 673–682.

206. Slootjes H, McKinstry C, Kenny A (2016) Maternal role transition: why new mothers need occupational therapists. *Australian Occupational Therapy Journal, 63(2),* 130–133.

207. Smith S (2016) An environment to self-modulate, relax and learn coping strategies. *Occupational Therapy News, 24(1),* 45.

208. Somerville E, Smallfield S, Stark S, Seibert C, Arbesman M, Lieberman D (2016) Occupational therapy home modification assessment and intervention. *American Journal of Occupational Therapy, 70(5),* 7005395010p1–7005395010p3.

209. Spang L, Holmqvist K (2015) Occupational therapy practice in emergency care: occupational therapists' perspectives. *Scandinavian Journal of Occupational Therapy, 22(5),* 345–354.

210. Spence TL, Schwarzschild J, Synovec C (2015) Integrating everyday functional skills into acute mental health settings. *OT Practice, 20(12),* 13–17.

211. Sproule A, Hunter R (2015) The green gym. *Occupational Therapy News, 23(8),* 27.

212. Staver C (2015) Finding the 'right' way to do home modifications. *OT Practice, 20(16),* 15–16.

213. Stephens R (2016) Supporting adoptive families. *Occupational Therapy News, 24(9),* 26–27.

214. Streatfield Y, Haggas S, Wilson K, McAnuff J (2016) Listening for participation. *Occupational Therapy News, 24(1),* 42.

215. Anon. (2016) Supporting community-based mental health. *Occupational Therapy News, 24(1),* 3.

216. Sweetings S (2015) Reach for the stars. *Occupational Therapy News, 23(11),* 27–28.

217. Tan ESZ, Mackenzie L, Travasssaros K, Yeo M, Bryant W (2016) The development of the modified Blaylock tool for occupational therapy referral (MBTOTR): a preliminary evaluation of its utility in acute care. *Disability and Rehabilitation, 38(16),* 1610–1619.

218. Tanner K, Hand BN, O'Toole G, Lane AE (2015) Effectiveness of interventions to improve social participation, play, leisure, and restricted and repetitive behaviors in people with Autism Spectrum Disorder: a systematic review. *American Journal of Occupational Therapy, 69(5),* 6905180010p1–6905180010p12.

219. Taylor F, O'Neill S (2015) A multidisciplinary approach to positive behaviour support. *Occupational Therapy News, 23(4),* 36–37.

220. Taylor S (2015) Patient-centred rehabilitation. *Occupational Therapy News, 23(12),* 35.

221. Thayer K (2015) Text talk. *OT Practice, 20(7),* 11–14.

222. Thompson AME, Chow S, Vey C, Lloyd M (2015) Constraint-induced movement therapy in children aged 5 to 9 years with cerebral palsy: a day camp model. *Pediatric Physical Therapy, 27(1),* 72–80.

223. Tillbrook E (2016) The book club. *Occupational Therapy News, 24(6),* 46.

224. Tomita MR, Buckner K, Saharan S, Persons K, Liao SH (2016) Extended occupational therapy reintegration strategies for a woman with Guillain-Barré syndrome: case report. *American Journal of Occupational Therapy, 70(4),* 7004210010p1–7004210010p7.

225. Tomori K, Nagayama H, Ohno K, Nagatani R, Saito Y, Takahashi K, Higashi T (2015) Comparison of occupation-based and impairment-based occupational therapy for subacute stroke: a randomized controlled feasibility study. *Clinical Rehabilitation, 29(8),* 752–762.

226. Tuffin J (2016) A garden oasis. *Occupational Therapy News, 24(6),* 44.

227. Van de Velde D, Devisch I, De Vriendt P (2016) The client-centred approach as experienced by male neurological rehabilitation clients in occupational therapy: a

qualitative study based on a grounded theory tradition. *Disability & Rehabilitation, 38(16),* 1567–1577.

228. Vargars S, Lucker JR (2016) A quantitative summary of The Listening Program (TLP) efficacy studies: what areas were found to improve by TLP intervention? *Occupational Therapy International, 23(2),* 206–217.

229. Verdonck M, Maye F (2016) Enhancing occupational performance in the virtual context using smart technology. *British Journal of Occupational Therapy, 79(6),* 385–390.

230. Vollero Corry N, Ryan L (2015) The potential of 4D immersive spaces. *Occupational Therapy News, 23(9),* 30–31.

231. Waite A (2015) By design: assistive technology group helps OTs sharpen adaptive equipment skills. *OT Practice, 20(9),* 13–14.

232. Waite A (2015) The ABCs of area agencies on aging. *OT Practice, 20(7),* 19–20.

233. Waite A (2015) Free rides. *OT Practice, 20(18),* 19–21.

234. Waite A (2015) Rural occupational therapy. *OT Practice, 20(13),* 15–18.

235. Waite A (2015) Using the OT brain to implement smart home technology. *OT Practice, 20(16),* 8–11.

236. Waldman-Levi A, Erez AB (2015) Will environmental interventions affect the level of mastery motivation among children with disabilities? A preliminary study. *Occupational Therapy International, 22(1),* 19–27.

237. Ward L (2016) Pets are therapy. *Occupational Therapy News, 24(2),* 29.

238. Wasmuth S, Pritchard K (2016) Theater-based community engagement project for veterans recovering from substance use disorders. *American Journal of Occupational Therapy, 70(4),* 7004250020p1–7004250020p11.

239. Watson L (2016) Supporting resilience and recovery. *Occupational Therapy News, 24(9),* 34–35.

240. Weber L (2015) Healthier eating during rehabilitation. *OT Practice, 20(22),* 8–12.

241. White S (2015) Supporting emotional wellbeing in the community. *Occupational Therapy News, 23(8),* 45.

242. Whitehead L (2016) Constraint-induced movement therapy for hemiparesis following stroke. *American Journal of Nursing, 116(8),* 63.

243. Williams H (2016) On the frontline. *Occupational Therapy News, 24(10),* 30–31.

244. Williams PL, Lloyd C, Waghorn G, Machingura T (2015) Implementing evidence-based practices in supported employment on the Gold Coast for people with severe mental illness. *Australian Occupational Therapy Journal, 10(5),* 316–325.

245. Williamson S (2015) Visual resources in the occupational therapy assessment process. *Occupational Therapy News, 23(6),* 42.

246. Wilson R (2016) And then there was OT. *Occupational Therapy News, 24(6),* 22–23.

247. Winstein C, Wolf S, Dromerick AW (2016) Task-oriented rehabilitation program for stroke—reply. *JAMA: Journal of the American Medical Association, 316(1),* 102.

248. Winter L, Moriarty HJ, Robinson K, Piersol CV, Vause-Earland T, Newhart B … Gitlin LN (2016) Efficacy and acceptability of a home-based, family-inclusive intervention for veterans with TBI: a randomized controlled trial. *Brain Injury, 30(4),* 373–387.

249. Wolf TJ, Polatajko H, Baum C, Rios J, Cirone D, Doherty M, McEwen S (2016) Combined cognitive-strategy and task-specific training affects cognition and upper-extremity function in subacute stroke: an exploratory randomized controlled trial. *American Journal of Occupational Therapy, 70(2),* 7002290010p1–7002290010p10.

250. Wressle E, Samuelsson K (2015) The self-reported use of research in clinical practice: a survey of occupational therapists in Sweden. *Scandinavian Journal of Occupational Therapy, 22(3),* 226–234.

251. Wright D (2015) Shifting the balance of care. *Occupational Therapy News, 23(5),* 32–33.

252. Yonkman J, Kossman M, Thomas K (2016) Cultivating independence through service learning projects. *OT Practice, 21(2),* 8–11.

253. Young S, Rose J (2016) Promoting sustainability through social and therapeutic horticulture. *Occupational Therapy News, 24(3),* 40–41.

254. Zavoda E (2015) The evolution of a low-vision support group. *OT Practice, 20(13),* 19–20.

255. Zeitlin D, Velasco K (2015) A backpack awareness day collaboration. *OT Practice, 20(15),* 9–20.

256. Zylstra SE, Pfeiffer B (2016) Effectiveness of a handwriting intervention with at-risk kindergarteners. *American Journal of Occupational Therapy, 70(3),* 7003220020p1–7003220020p8.

Notes

Occupational therapy and complexity: defining and describing practice

This publication aims to describe and define contemporary occupational therapy, and explores, expands and illustrates the unique complexity of the profession. It is clearly based upon, but goes beyond previous work in this area and sets this within contemporary health and social care contexts. It describes current occupational therapy based on data drawn from reports of, and reflections on, occupational therapy practices; generates a model of contemporary occupational therapy that describes and explains the components; and identifies and explains how occupational therapy aligns with the concept of complex interventions. It also considers and suggests terminology and language to aid with practice, research and other work involving consideration of occupational therapy.

Occupational therapy and complexity: defining and describing practice is an essential reference point for all occupational therapists and students, and provides useful guidance for all working in partnership with occupational therapy.

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Adaptations without delay

A guide to planning and delivering home adaptations differently

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Executive summary

Introduction

The benefits of adapting the home are recognised as an effective way to improve the health and wellbeing of older people, and disabled adults and children. A more accessible home environment can improve independence, reduce risk and reduce reliance on assistance. As the body of evidence demonstrating the benefits of home adaptations grows, so does the recognition that the sooner they are installed, the greater will be the preventative benefits.

Across the UK there continue to be delays in the delivery of minor and major adaptations across all housing tenures. In recognition of this continuing issue, in 2017 the Royal College of Occupational Therapy (RCOT) commissioned the Housing Learning and Improvement Network (Housing LIN) to conduct a UK-wide review of *Minor adaptations without delay* (2006), which was focused on enabling housing associations to provide minor adaptations without the need for an occupational therapy assessment, and to identify whether a new version was required.

Review of current practice

The Housing LIN review was extensive. It involved a review of UK-wide policy and legislation related to the assessment and delivery of adaptations; stakeholder consultation across England, Northern Ireland, Scotland and Wales that involved telephone interviews with managers of occupational therapy services, housing providers, housing associations, home improvement agencies, and care and repair services; a nationwide survey completed by 800 front-line practitioners; and focus groups involving key personnel and organisations from the four UK nations.

The key findings of the review were as follows:

- A common theme in legislation and policy across the UK is the need for a more preventative approach to interventions, including adaptations, for older people, disabled children and adults, to maximise health and wellbeing.
- Waiting for a social care assessment is cited as a key factor in contributing to delays in the delivery of adaptations. Legislation pertaining to the funding of major adaptations has been misinterpreted as being dependent on an occupational therapy assessment.
- Current systems for delivering adaptations need to provide person-centred outcomes through a more integrated and collaborative approach to the assessment, design and installation of adaptations.
- In terms of demand for major adaptations, the most common are showers, stairlifts and ramps, often in situations that are simple and straightforward.
- Typically, the need for an adaptation has been defined by the *type* or *cost* of the solution, rather than the *complexity* of the situation.

- It is recognised that there is a large proportion of people who are not eligible for funding for adaptations who could benefit from better information, advice and guidance on how to get adaptations installed.

Adaptations without delay: a guide

From the review findings it was clear that a radically different approach to addressing the delays in the assessment and delivery of adaptations was required. This new approach sets out a better way of defining adaptations based on *complexity*. It focuses on the role of adaptations as a preventative intervention to support person-centred outcomes using an approach that makes the best use of the skills mix within the workforce.

The *Adaptations without delay* guide provides a fresh new approach. It has been developed in conjunction with those consulted during the review process and the RCOT's steering group. The overall aim of the guide is to reduce delays in the delivery of adaptations by providing tools that support a proportionate response. The guidance also ensures the valued and specialist skills of occupational therapists can be used to work with the growing number of individuals whose circumstances are complex.

The guide sets out the *Adaptations without delay* decision-making framework. The framework outlines the person-centred outcomes that can be achieved from having the home adapted. Workforce and operational factors to support integrated and new ways of working are identified. The framework outlines the different levels of *complexity* of the situation, rather than cost and type of adaptation. The levels of complexity are defined as:

- Universal (simple, low level).
- Targeted (straightforward, moderate).
- Specialist (complex, high risk).

The guide outlines circumstances when occupational therapists need to work closely with those with the technical expertise necessary to establish and develop bespoke adaptations and ensure that the installation is feasible. The guide highlights ways that occupational therapists can add value at a strategic level in the design of services, communication tools, and the provision of training and support for unregulated staff.

Practice examples from across the UK include:

- Training and support to enable support workers, trusted assessors and occupational therapy assistants to assess and make recommendations for major adaptations where the situation is simple and straightforward.
- Triage and duty systems at first point of contact used to identify whether or not the input of an occupational therapist is required to support a more proportionate and timely response.
- Integrated services that have established the right skills mix in the workforce in order to provide a proportionate response to reduce delays in the installation of adaptations.

- Services that recognise the value of occupational therapists' skills by focusing on complex cases.

The guide provides a list of what are considered to be the best examples of technical and design guidance to achieve the most accessible adaptations, as well as design to address the needs of people with sensory and cognitive impairments.

The guide is intended to have the following benefits:

- Ensuring a more responsive service to those needing adaptations.
- Reducing demand on occupational therapy services.
- Providing reasoning for key stakeholders about adaptations that do not need an assessment by an occupational therapist.
- Recognising the expertise of occupational therapists in complex situations where adaptations are required.
- Being applicable in all four UK nations.

Intended audience

The guide and the framework are intended to be used at a practitioner and strategic level by personnel in occupational therapy services, home improvement agencies, care and repair agencies, housing associations and other housing providers, but also by members of the public who need to know when to seek advice from an occupational therapist. It may also be of interest to health and social care commissioners and care practitioners where there is a need for an adaptation to help facilitate someone's care and support at home or reablement.

1 Introduction

There is widespread recognition that some simple changes to the home environment can completely transform the lives of older people, disabled people and children by enabling them to function more easily and safely in their own homes.

> The Equalities and Human Rights Commission found that approximately 1.8 million disabled people require suitable housing and approximately 300,000 do not have the adaptations they need in their existing homes.[1]

A growing body of evidence supports the view that home adaptations can prevent falls, reduce hospital admissions, reduce reliance on care, avoid the need to move into residential care and significantly improve quality of life and wellbeing for individuals, their families and carers.[2] At the same time, the retail market and independent builders are beginning to adapt to consumer-led changes. There is potential for a growing self-funder market across all tenures for equipment and adaptations.

A number of factors (including demographic changes) are therefore increasing demand for home adaptations. Yet across the UK there continue to be significant delays in the delivery of adaptations.[3] The UK Government's recent review of Disabled Facilities Grants (DFGs)[4] in England highlights that there is a pressing need for all services concerned to be able to provide a more timely response to installing adaptations that can deliver better outcomes for the person. In Wales, the Auditor General found that public bodies have a limited understanding of the longer-term benefits of housing adaptations, and there remains significant scope to reform the system to improve equality and wellbeing.[5]

1 Equality and Human Rights Commission (2018) *Housing and disabled people: Britain's hidden crisis.* [s. l.]: Equality and Human Rights Commission. Available at: *https://www.equalityhumanrights.com/sites/default/files/housing-and-disabled-people-britains-hidden-crisis-main-report_0.pdf* Accessed on 16.11.18.

2 Centre for Ageing Better (2017) *Room to improve: the role of home adaptations in improving later life.* [London]: Centre for Ageing Better. Available at: *https://www.ageing-better.org.uk/publications/room-improve-role-home-adaptations-improving-later-life* Accessed on 09.11.19.

3 Equality and Human Rights Commission (2018) *Housing and disabled people: Britain's hidden crisis.* [s. l.]: Equality and Human Rights Commission. Available at: *https://www.equalityhumanrights.com/sites/default/files/housing-and-disabled-people-britains-hidden-crisis-main-report_0.pdf* Accessed on 16.11.18.

4 Mackintosh S, Smith P, Garrett H, Davidson M, Morgan G, Russell R (2018) *Disabled Facilities Grant (DFG) and other adaptations reviews*: *external review*. Main report. Bristol: University of the West of England. Available at: *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/762920/Independent_Review_of_the_Disabled_Facilities_Grant.pdf* Accessed on 12.03.19.

5 Auditor General for Wales (2018) *Housing adaptations*. Cardiff: Wales Audit Office. Available at: *http://www.audit.wales/system/files/publications/housing-adaptations-2018-english.pdf* Accessed on 12.03.19.

Whether based in housing, health or social care, occupational therapists have an established role in carrying out assessments and making recommendations for adaptations, partly driven by statutory obligations. Their specialist expertise is invaluable in contributing to finding the best solutions to support older and disabled people in their own homes. However, there is a significant proportion of situations that are simple and straightforward which may not require specialist occupational therapy assessment or interventions. This is particularly the case where the timely installation of an adaptation or a piece of equipment prevents or delays the development of more acute health and social care needs.

Purpose of this guide

HOW TO USE THIS GUIDE

This guide will enable you:

- **To reduce delays** by avoiding service design and delivery based on cost and type of adaptation.
- **To make more effective use** of occupational therapists by understanding the workforce skills and operational considerations required to deliver adaptations.
- **To reduce delays** where legislation and the role of occupational therapists has been misinterpreted.
- **To understand the type of situations** where an occupational therapist does not need to be involved in the assessment for an adaptation.
- **To develop or redesign service delivery models** based on person-centred and preventative outcomes.
- **To understand what level of home adaptation** service and help you might offer.
- **To ensure your organisation takes a safe and person-centred approach** to providing adaptations to older and disabled people.

The primary purpose of this guide is to address delays in the delivery of all types of adaptations (minor and major) across all tenures that occur when people receive a disproportionate response to their need for an adaptation. Delays in installing adaptations can increase the risk of health and social care needs developing or increasing. A person waiting for an occupational therapy assessment where the situation and need for an adaptation is relatively simple and straightforward should therefore be avoided.

The core principles underlying this guide are that the person is central to the process and that the preventative benefits of adaptations are maximised. The aim is to enable all services concerned with adaptations to provide a more proportionate and timely response, reducing delays in installation of adaptations and alleviating the likelihood of an unplanned hospital admission or an unwanted move to residential or nursing care. *The intention is that the widespread skills and knowledge of all professionals involved in the adaptation process are put to best effect*.

Intended audience

Adaptations without delay is intended to be used by practitioners and organisations across the UK who may be contacted by disabled and older people and their families who are seeking advice or support with home adaptations, including:

- Occupational therapists in health, social care and housing settings.
- Occupational therapists in independent practice.
- Housing association housing managers and officers, surveyors and property staff.
- Local authority housing managers and officers, surveyors and property staff.
- Care and repair agency technical staff and case workers.
- Handyperson services staff.
- Home improvement agency technical staff and case worker (England).
- Health and social care commissioners and practitioners in local authorities and the NHS.
- Members of Integrated Joint Boards (Scotland).
- Members of Regional Partnership Boards (Wales).
- Members of Health and Wellbeing Boards (England).
- Environmental health officers/grants officers.
- Voluntary organisations' housing staff/home visitors.
- Organisations delivering training on the assessment and delivery of adaptations.
- Individuals and their families who need to know about how to get adaptations installed.

The role of this guide for different audiences

Housing providers

Adaptations without delay builds on the previous publication *Minor adaptations without delay* (2006), which provided a rationale to support housing associations to provide minor adaptations without an occupational therapy assessment. Rather than providing a fixed range of minor adaptations, this guide will help housing providers consider how to provide a wider range of adaptations to their tenants without the direct involvement of an occupational therapist.

Local authority housing services, home improvement agencies and care and repair agencies

It provides a framework for considering the most appropriate response to a person's need for an adaptation. Based on the complexity of the situation, the framework will help those currently delivering adaptations to address the skills mix and operational considerations needed to deliver a wider range of adaptations without the direct involvement of an occupational therapist.

Occupational therapists

It provides tools to help occupational therapists articulate the value of their role in the adaptation process. By highlighting how their specialist skills and knowledge contribute to the adaptation process, the guide and framework helps to identify the circumstances when occupational therapists can be most effective in individual cases, at an operational level and in the strategic planning of services.

Health and social care commissioners and practitioners with responsibility for improving the delivery of adaptations

It highlights that delays in providing adaptations are often a result of the fragmented approach to the assessment, funding and installation of adaptations. Better integration of housing, health and social care provides an opportunity to consider how adaptations can be delivered without delay. It also sets out an overview of the *Adaptations without delay* framework (Section 3), providing those with strategic responsibility for integration or commissioning with an understanding of how the care and support of individuals with different needs can be addressed through different types of adaptation interventions to achieve improved person-centred outcomes.

Retailers, product suppliers and independent builders

Older and disabled people are becoming less reliant on, or are being signposted away from, statutory services. To adapt their home, many older and disabled people are directly purchasing products or employing builders. It is therefore vital that this sector provides safe and person-centred services. The framework can help guide retailers, product suppliers and independent contractors to understand when they need to consult with an occupational therapist for support to design and install the right solution.

Members of the public

While the guidance in this publication is focused towards those assessing and delivering adaptations, members of the public will also find the publication useful. A better understanding of how adaptations can help, and what kind of service they need to address the type of problem they might have, will help them to get an adaptation installed without delays.

2 Why *Adaptations without delay*?

DID YOU KNOW?

Preventing or reducing delays in people receiving adaptations can:

- Help people stay well at home for longer.
- Give people choice and control over their health and wellbeing.
- Help people have access to the wider community.
- Prevent or reduce the risk of falls.
- Reduce the need for formal care, informal care and residential care.
- Avoid unnecessary hospital admission.

In 2018, the Royal College of Occupational Therapy (RCOT) commissioned the Housing Learning and Improvement Network (Housing LIN) to conduct a review of the *Minor adaptations without delay* (2006) publication. This publication provided guidance to support housing associations to provide minor adaptations without the need to refer for an occupational therapy assessment. The review considered whether the guide needed to be updated, and if so, how it could be made applicable to stakeholders across the UK. The review method and findings are summarised in Annexe 2.

What the review found

The Housing LIN review found consistent policy themes and approaches across all four UK nations that are relevant to the provision of adaptations:

- Health and social care policy across all four nations supports a 'person-centred' or 'citizen-centred' approach. With regard to minor adaptations, this appears to support the policy of self-assessment and identification of own needs.
- Minor adaptations have a central role in the prevention 'agenda', including the reduction of falls, delaying admission to hospital, supporting re-ablement and recovery at home by enabling discharge from hospital or preventing a readmission.
- The process for delivering minor adaptations is done through a combination of integrated community equipment services, home improvement agencies/care and repair agencies, and by housing associations, with health, social care, housing professionals or older people referring into these services. However, in England, Scotland and Wales local authorities appear to take different approaches to how services for minor adaptations are accessed and provided.
- There is potential for better use of resources through a recognition that occupational therapists do not need to assess for adaptations that are required to resolve 'simple issues'. However, there appears to be relatively little guidance on defining the difference between simple issues and complex situations that need the expertise of an occupational therapist.

Across the UK, at both a strategic and practitioner level, the review found that:

- The greatest demand is for adaptations such as showers, stairlifts and ramps, which are often classed as major adaptations but can often be simple and straightforward.
- There continue to be delays for people who can self-direct their own care and wish to adapt their homes but are having to wait for a social care assessment from the occupational therapy service.
- There is a concern that delay in providing adaptations is potentially reducing the benefits of adaptations as a preventative intervention, for example impacting on their recovery or rehabilitation.
- With appropriate training and supervision, support workers, occupational therapy assistants and trusted assessors in many areas are carrying out assessments for shower adaptations, community equipment, assistive technology, stairlifts and ramps where the situation is simple and straightforward.
- In some areas the skills, knowledge and experience of occupational therapists are being used at a strategic level to develop policies, design guidance, triaging tools and training to ensure the right level of assessment and skills mix is used to make best use of local housing stock for existing/prospective residents, deliver tailored adaptations, improve the quality of the home environment and reduce delays.

What constrains providing adaptations without delay?

DID YOU KNOW?

The review found that barriers to delivering adaptations included:

1. Misinterpretation of legislation pertaining to the funding of adaptations.
2. A lack of research and evidence-based best practice guidance on the role of occupational therapists in the home adaptation process.
3. The assumption that if an adaptation is 'major' it is complex and must involve an occupational therapist.

At the strategic, operational and practitioner levels the review found that stakeholders want to address the delays in delivering adaptations, but they also identified barriers to change. The three main barriers were:

1. A misinterpretation of legislation (pertaining to eligibility for the funding of adaptations) has led to the assumption that a request for a major adaptation should be accompanied by an assessment and recommendation from an occupational therapist.
2. A lack of published guidance is preventing teams wanting to provide a wider range of adaptations, without the direct involvement of an occupational therapist, from developing the policies and procedures that would help with the risk management of this change.

3. Allowing the cost and type of adaptation to define the complexity of a case is preventing occupational therapists from concentrating their specialist skills on working with individuals whose circumstances are most complex and where they would have the greatest impact on the individual's health and wellbeing.

To reduce delays caused by the barriers identified by stakeholders, it was evident that a new type of guide was required in place of *Minor adaptations without delay*. Moving away from a prescribed list of adaptations and technical guidance, this guide introduces a framework to support the delivery of adaptations without delay.

This framework defines adaptations based on both the complexity of the situation and the type of structural alteration to the home. Based on person-centred outcomes, the framework identifies different levels of intervention, and what health and social care needs can be met by having the home adapted. There is also guidance on workforce and operational considerations required for the different levels of intervention.

3 *Adaptations without delay*: a framework for decision making

GETTING STARTED: What you need to know

- The framework describes three levels of home adaptations interventions: universal, targeted, specialist.
- There is a description of the person-centred outcomes expected at each level of intervention.
- The level (or type) of intervention is based on the person's care and support needs and the potential type of solution required.
- The framework includes three tables describing the nature of complexity at each level of intervention and identifies the workforce and operational requirements to deliver that level of intervention.

The design of the framework has been influenced by the widely recognised and influential Balanced System® of improving integrated care services for children[6] and the Comprehensive Model for Personalised Care.[7] Both these models link person-centred outcomes with the level of intervention that best addresses the health and care needs of the person. Using this approach ensures people receive a proportionate level of assessment and response to their needs while reducing unnecessary delays as well as demand for specialist practitioners and services.

To overcome the barrier that occupational therapists need to be involved in the assessment of *all* major adaptation because major adaptations have typically been defined as complex, the *Adaptations without delay* framework adopts a definition of adaptations[8] that considers the types of solutions alongside the complexity of the situation in four key areas:

1. The person, their priorities and needs.
2. The nature of the activities the person is having difficulty performing.
3. The environmental barriers to independence (physical, social etc.).
4. The types of solutions required.

6 See *https://www.thebalancedsystem.org*.
7 [NHS England] [2018] *Comprehensive personalised care model*. [London]: [NHS England.] Available at: *https://www.england.nhs.uk/wp-content/uploads/2019/02/comprehensive-model-of-personalised-care.pdf* Accessed on 12.03.19.
8 Ainsworth E, de Jonge D (2018) Minor modifications: it's not as simple as 'do it yourself' (DIY). In: E Ainsworth, D de Jonge, eds. *An occupational therapist's guide to home modification practice*. 2nd ed. Thorofare, NJ: Slack. 381–388.

This approach to defining adaptations recognises that a simple grab rail may be the solution to a complex situation. Conversely, a shower adaptation can be a solution to a simple problem. In the first scenario, the person benefits from the assessment skills of the occupational therapist who will consider a range of other factors that may impact on the safety and wellbeing of the individual and their situation. In the second scenario, the person benefits from the design and installation skills of a technical officer and builder.

The four types of adaptations are described in Table 1.

Table 1 Categories of adaptations (adapted from the framework for home modification service delivery[9])

Type of adaptation	Description
1. Simple situation requiring a simple adaptation or readily available off-the-shelf/retail solution.	Installation of this type of adaptation requires minimal disruption to the structure or fabric of the home and/or is a readily available off-the-shelf/retail solution.
2. Simple situation requiring a standard structural solution.	Installation of this type of adaptation impacts on one or two aspects of the home environment, involving structural changes but with minimal disruption. The adaptations may involve reconfiguration of the space, but this can be achieved through standard building alterations or installation techniques.
3. Complex situation requiring a non-structural solution.	A person has one or more complex key area of need (see above) which requires the non-structural solution to be customised for the person.
4. Complex situation requiring a specialised structural solution.	A person has one or more complex key area of need (see above) requiring a specialised structural solution. This type of adaptation requires substantial structural changes to the home environment. The solution will involve reconfiguration of the spatial layout and/or installation of specialist fixtures and fittings, such as height-adjustable baths.

9 Ainsworth E, de Jonge D (2018) Minor modifications: it's not as simple as 'do it yourself' (DIY). In: E Ainsworth, D de Jonge, eds. *An occupational therapist's guide to home modification practice*. 2nd ed. Thorofare, NJ: Slack. 381–388.

The *Adaptations without delay* framework: overview

Figure 1 provides an overview of the framework, illustrating the link between the complexity of the health and care need and the type of intervention that best addresses the person-centred outcome. The levels of intervention are divided into *universal, targeted* and *specialist* types of solution. A person's health and care needs are not fixed and will change over time; for this reason, it is important that this is considered each time a person approaches a service for support.

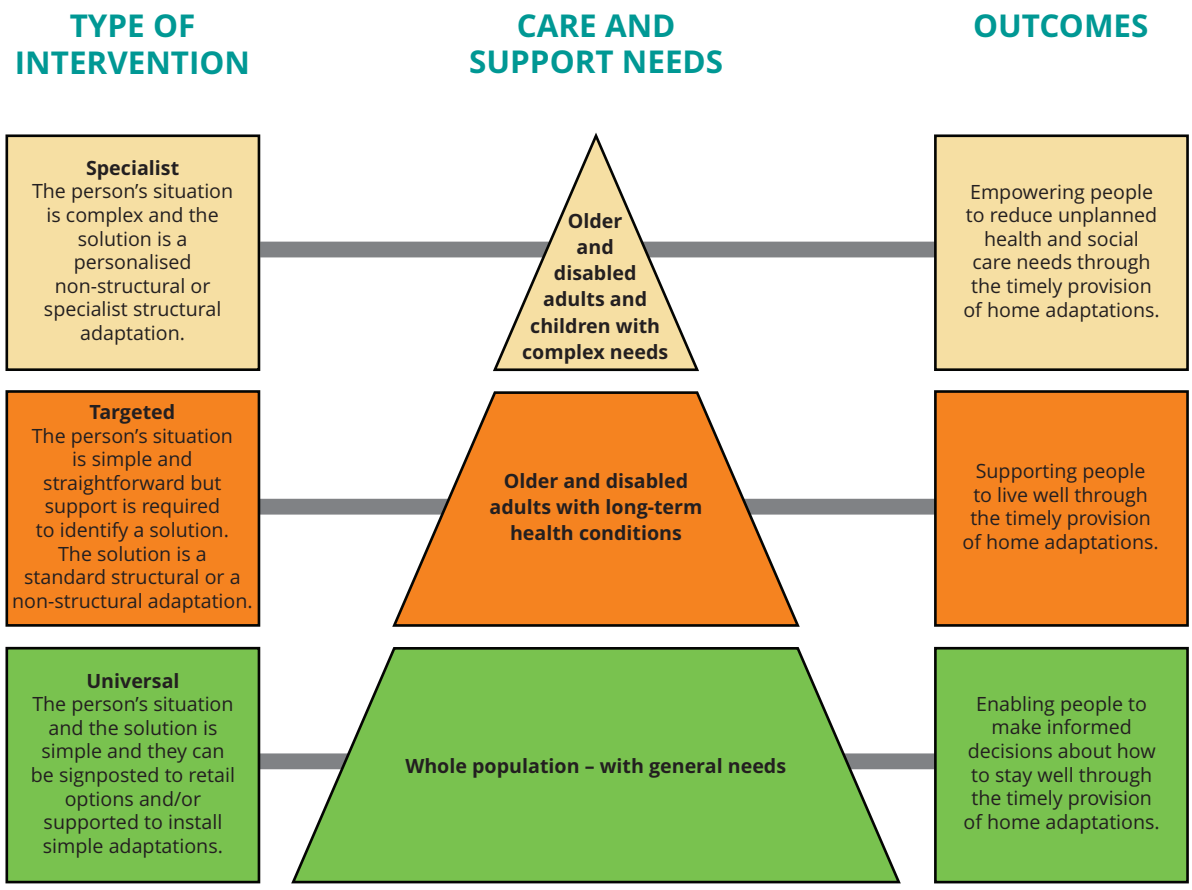

Figure 1 The *Adaptations without delay* framework

The purpose of the framework

The framework provides a holistic guide to the assessment and delivery of adaptations that supports positive risk taking for those who wish to explore different ways of working. It avoids disproportionate use of specialist occupational therapy services and offers a definition of adaptations that focuses on the outcomes for the person, rather than the funding mechanisms for the type of solution that is being installed.

The framework takes a person-centred approach that ensures the level of intervention is proportionate to the person's housing, health and social care needs. The framework:

- Outlines the circumstances when the needs and the solution are both simple and straightforward, and direct input by an occupational therapist may not be required.
- Provides a better understanding of the role of occupational therapists in the assessment, recommendation and design of adaptations, based on the complexity of the situation, rather than the type or cost of the adaptation.
- Outlines the appropriate level of workforce skills and governance required to meet demand and improve the delivery of an extended range of adaptations.

Using the framework to support decisions about the level of intervention required

This section explains how the framework detailed in the following tables can be used to understand the difference in complexity between *universal, targeted* and *specialist* types of intervention, the workforce skills and the operational and governance issues that need to be addressed at each level.

Universal types of intervention and services enable people with low levels of needs to make informed decisions about how to stay well through the timely provision of home adaptations. The solution is simple and they or their carer can be signposted to retail options and/or supported to install simple adaptations.

> Rita is struggling to get on and off her toilet. She contacts the local handyperson scheme to discuss her difficulties and arrangements are made to install a grab rail beside the toilet.

Targeted types of intervention and services enable older or disabled people with long-term health conditions to maintain their personal dignity, reduce risks and live well in their own homes through the timely provision of adaptations. The person's situation is simple and straightforward, but support is required to identify the most appropriate solution. The solution could be universal, but is likely to be a non-structural adaptation or standard structural solution.

> Robert was provided with bathing equipment several years ago, but he is struggling to use the equipment. He is visited at home by a member of a Home Improvement Agency. Through a discussion with Robert and an assessment of his difficulties, it is identified that the installation of a wet room will help him to remain independent with his personal care routine.

Specialist types of interventions and services empower people with complex health and social care needs to maintain their personal dignity, and reduce unplanned health and social service care needs through the timely provision of home adaptations. Due to the complexity of the situation it is likely the solution will be a personalised non-structural or specialist structural adaptation.

Helen has multiple sclerosis and is finding a range of activities of daily living difficult to perform. Her abilities change from day to day. She wants advice on how to make changes to her home so that she can maintain her personal dignity, wellbeing and independence. An occupational therapist visits Helen at home. The occupational therapist works with Helen in the home environment and identifies the barriers in the home impacting on Helen. As part of understanding what type of adaptations Helen will require, the occupational therapist arranges for her to visit a demonstration centre. At the demonstration centre Helen is able to try different products and to look at options for adapting her home. Using the information from the assessment and visit to the demonstration centre, the occupational therapist visits Helen at home with a technical officer from the local authority housing team, who suggests several potential solutions. The occupational therapist works together with Helen to agree on the best long-term solution, and with this information an application for funding is made.

The following tables for each level of intervention provide detailed information about factors contributing to complexity at that level. Each table sets out the staff skills and operational factors that need to be considered to provide each level of intervention to achieve the best personal outcomes.

KEY LEARNING: Benefits of using the *Adaptations without delay* framework

The framework provides a structure for considering how current practice or future service design can be improved to deliver adaptations without delay by:

- Providing a more proportionate response based on level of need and the complexity of the person's situation and type of solution required.
- Establishing a workforce with the appropriate skills mix.
- Acting as a guide to retailers and product manufacturers as to when members of the public may require a more targeted or specialist level of intervention.
- Helping members of the public understand the level of intervention or type of service they need to adapt their home.

Table 2 *Adaptations without delay*: UNIVERSAL level of intervention

NATURE OF COMPLEXITY	WORKFORCE SKILLS	OPERATIONAL CONSIDERATIONS
Health condition is: • Predictable. • Stable. • No recent deterioration in health or wellbeing. **The need is related to:** • Reducing or preventing risk. • Enabling a person to maintain performance of basic activities of daily living. • Person and/or family can communicate and make decisions about their needs and the solution. **Complexity of the anticipated adaptations** • Person and/or family can communicate and make decisions about type of solution required. • The adaptation(s) being installed is an off-the-shelf solution and does not need specialising to meet the person's need. • It is anticipated the solution will be simple and intuitive to use and will not require any specialist training or support to use. • Person will require no or only minimal support to use the adaptation(s).	**Staff with:** • Knowledge and understanding of how health conditions and the ageing/ developmental processes impact on the performance of simple everyday activities. • Knowledge and understanding of how to arrange the installation of a range of off-the-shelf adaptations that reduce / prevent risk or enable a person to perform basic activities of daily living. • Ability to signpost appropriately to local services including retail and handyperson services that can assist with installation of simple off-the-shelf adaptations. • An understanding of the circumstances when a person requires **targeted** or **specialist** input, including when it is appropriate to consult an occupational therapist.	**Accessing service** • First contact triage tool to identify if it is a targeted case. **Delivery of service** • Agreed policies, procedures and system for the delivery of adaptations provided without an occupational therapy assessment. • Agreed criteria for when to refer to targeted or specialist services or when to consult with an occupational therapist. • Agreed training and competency levels for non-occupational therapy staff who will facilitate process. • Agreed best practice guidance on the installation of off-the-shelf products. • Simple and transparent processes for procurement and installation of adaptations. • Partnership agreements between social care, health and housing agencies, housing associations, home improvement agencies and care and repair involved in the delivery of adaptations. • Effective review processes following installation of the adaptation.

Table 3 *Adaptations without delay*: TARGETED level of intervention

NATURE OF COMPLEXITY	WORKFORCE SKILLS	OPERATIONAL CONSIDERATIONS
Health condition is: • Predictable. • Stable. • No recent deterioration in health or wellbeing. **The need is related to:** • Reducing or prevent risk. • Enabling a person to maintain performance of basic activities of daily living. • Person and/or family can communicate and make decisions about their needs. • A visit is required to identify solution. **Complexity of the anticipated adaptations** • Person and/or family can communicate and make decisions about their needs. • The adaptation(s) being installed is simple and readily available, and if a structural solution (e.g. bathroom adaptation) it does not need specialising to meet the person's need. • It is anticipated the solution will be simple and intuitive to use and will not require any specialist training or support to use. • Person will require no or only minimal support to use the adaptation(s).	**Staff with:** • Ability to take a person-centred approach to identifying priorities, needs and preferences. • Knowledge and understanding of how health conditions and the ageing/ developmental processes impact on the performance of simple everyday activities. • Knowledge and understanding of how to identify hazards and barriers to independence within the home environment. • Knowledge and understanding of how to identify and recommend a range of off-the-shelf and standard structural adaptations (e.g. stairlifts/shower adaptions) that reduce/prevent risk or enable a person to perform basic activities of daily living. • Ability to select and use appropriate documentation to procure adaptations appropriate to identified needs. • An understanding of when the complexity of the situation requires **specialist** input and when it is appropriate to consult an occupational therapist.	**Accessing service** • First contact triage tool to identify if it is a targeted case. **Delivery of service** • Agreed criteria for delegation. • Agreed policies, procedures and system for the assessment and delivery of adaptations provided without an occupational therapy assessment. • Agreed criteria for when to refer to specialist services or when to consult with an occupational therapist. • Agreed training and competency levels for non-occupational therapy staff who will conduct home visits. • Tools to support effective communication. • Agreed design standards and installation best practice for standard structural adaptations. • Agreed best practice guidance on the installation of off-the-shelf products. • Partnership agreements between social care, health and housing agencies, housing associations, home improvement agencies and care and repair involved in the delivery of adaptations. • Simple and transparent processes for procurement. • Effective review processes following installation of the adaptation.

Table 4 *Adaptations without delay*: SPECIALIST level of intervention

NATURE OF COMPLEXITY	WORKFORCE SKILLS	OPERATIONAL CONSIDERATIONS
Health condition is: • Unpredictable. • Changeable/fluctuating. • Including cognitive impairment. • Combined with physical/sensory/ cognitive impairments. • Associated with being neuro-divergent. **Need is related to:** • Changing needs over time (child to adult). • Reducing or preventing risk. • A sudden change in health, independence and/or safety impacting on the identify and roles of the person and/or carer. • Safeguarding issues identified. • Advocacy needs during the assessment process. • Advocacy needs to make decisions about design of adaption. • Carers using adaptations as part of care package. **Complexity of the anticipated adaptations** • Several areas of home need adaptation. • The adaptation will need to accommodate the use of specialist equipment. • Installing adaptations could impact significantly on other members of the household. • Solution is non-structural or a specialised structural solution and requires both occupational therapy and technical involvement.	**Staff with:** • Ability to take a person-centred approach to identifying priorities, needs and preferences. • Knowledge and understanding of how health conditions and the ageing/ developmental processes impact on the performance of simple everyday activities. • Knowledge and understanding of how to identify and recommend a range of off-the-shelf and standard structural adaptations (e.g. stairlifts/shower adaptions) that reduce /prevent risk or enable a person to perform basic activities of daily living. • Knowledge and understanding of how to select a range of interventions, including reablement, activity adaptation, energy conservation, moving and handling, advice and support for families and carers. • Ability to effectively communicate the details of bespoke adaptations and liaise with technical officers to find the best solutions appropriate to needs. • Knowledge and understanding of when an occupational therapy specialist assessment is not needed and it is appropriate to delegate assessment to targeted or universal input.	**Accessing service** • Effective triaging tool to identify complexity of situation. • Consider access to short-term solutions (i.e. equipment) while longer-term solutions are considered. **Delivery of service** • Person-centred process bringing together the assessment, design, procurement and installation of complex specialised structural solutions. • Integrated teams and/or joint working arrangements between occupational therapy and housing technical expertise. • Clear delegation of roles in relation to the adaptation process and who considers design requirements, writes technical specifications, designs technical solutions and supports procurement of the adaptation. • Effective and efficient procurement processes. • Effective review processes following installation of the adaptation.

4 How to use the *Adaptations without delay* framework in practice to improve delivery of adaptations

Introduction

Successful delivery of home adaptations is reliant on knowledge and understanding of what works best for the person and their situation. In practice, people need timely advice about what they might need, how they can get it and who can help them. This section considers how the *Adaptations without delay* framework can be used to achieve the above.

In this section you will learn how to use the framework:

- To provide a proportionate response.
- To support the development of a workforce with appropriate knowledge and skills.
- If you are builder, retailer or product manufacturer and want a guide as to when a person may require a more targeted or specialist level of intervention.
- If you are a member of the public and want to understand the level of intervention or type of service you need to adapt your home.

How to use the framework to provide a proportionate response

Key message for achieving proportionate response

Getting the right response at the first point of contact, followed by signposting people to the right type of service (universal, targeted, specialist) reduces delays and the likelihood of people waiting on lists for assessments they do not require.

Signposting at first point of contact: At the first point of contact identifying and signposting people to the type of intervention/service they require reduces delays. The ***nature of complexity columns*** in the intervention tables (Tables 2–4, Section 3) can be used to support the development of tools to identify the type of intervention a person requires (based on the person's health condition, the nature of the need and the complexity of the anticipated adaptation).

Communicating the level of service delivery: Delays can be prevented when people are directed to a service that can best meet their needs. Services (including the retail sector) can use the ***overview of the framework*** and the ***four categories of adaptations*** (Section 3, Table 1) to benchmark the level of intervention/service they currently provide. This information can then be used to communicate what level of intervention a service is able to provide.

Supporting service development or redesign: Services can increase the range of adaptations they provide without an occupational therapy assessment if they address the workforce skills/knowledge and operational issues that arise when an occupational therapist is not directly involved in the process. The ***workforce skills and operational considerations column*** of each intervention table (Tables 2–4, Section 3) can act as audit questions to identify these gaps and issues, helping to support service development or redesign.

Strategic planning and oversight of adaptation services: A key recommendation from reports on the delivery of adaptations is the need to improve the strategic planning of services that deliver adaptations. The ***overview of the framework*** can be used to map and understand current assessment and delivery mechanisms in a locality. This information identifies gaps in provision, where improvement in pathways to access adaptations can be achieved and opportunities for integrated working or joining up of services.

Across the UK a range of cross-sector forums exist to enable continual improvement in the delivery of adaptations. In Wales this work is done by the Housing Adaptations Steering Group; in Northern Ireland by the Joint Adaptations Steering Group; across England the Home Adaptations Consortium champions quality of provision; in Scotland the Accessible Housing Group, which is a sub-group of the Scottish Government's Joint Housing Delivery Planning Group, involves a wide range of stakeholders and has a role in contributing to policy development, including on adaptations. The Scottish Housing Network is a membership organisation which runs a forum focusing on adaptations and mainly involves a number of local authorities and some Registered Social Landlords (the Scottish Government are invited to attend).

Example: Strategic planning – establishing integrated housing support teams

Organisation: The Lightbulb Project

Location: Leicestershire

Services: Housing support locality teams in each district council area. Targeted, proactive approach, including via GPs and other health/care professionals such as those in integrated locality teams.

- Early assessment and triage of housing issues at key points of entry.
- Hub-and-spoke model – integrated locality teams delivering minor and major adaptations, and housing-related support, advice and information.

Skills mix:

- Housing Support Co-ordinators (HSCs) and Technical Officer.
- Occupational therapists remain in Leicestershire County Council employment.

Method/process:

- Occupational therapists assess and recommend complex major adaptations and mentor/support HSCs (who are also trusted assessors) to complete less complex work.
- Housing specialists in a separate Hospital Enablement team identify housing-related barriers to discharge.

Impact and outcomes:

- Delivery costs, including Hospital Housing team approximately £1 million per annum against a potential £2 million per annum saving to health and social care reduced admissions/delays in transfers of care.
- Projected savings on DFG delivery costs through more efficient processes and staffing efficiencies.

Further information:

https://www.housinglin.org.uk/Topics/type/The-Lightbulb-Project-Switched-on-to-integration-in-Leicestershire

Example: Integrated service delivery

Organisation: Care & Repair Rapid Response Adaptations Service (RRAP)

Location: All Wales via 13 Care & Repair Agencies, Care & Repair Cymru and partners in statutory services – Health, Social Care and Housing.

Services:

- Very quick, responsive, small adaptations costing up to £350.
- Non-means-tested and available to all homeowners and private tenants aged 60+.

Skills mix:

- Care & Repair case workers, technical officers and handypersons.
- Hospital-based Care & Repair case workers.

Method/process:

- Referrals accepted from social care, housing, primary and secondary care health professionals, as well as direct requests from clients and their carers.

- Referrals can be community- or hospital-based, delivering quick solutions that prevent falls, reduce hospital admissions, assist independent living, or speed up safe transfers of care and patient flow within hospitals.

Impact and outcomes:

- Around 18,000 rapid response adaptations completed annually.
- Delivery times range from same day/immediate to eight days.
- Early engagement between hospital staff, patients and Care & Repair and consideration of housing needs at hospital discharge planning, combined with immediate practical solutions through RRAP programme improves patient flow at hospitals, and saves bed days.
- Care & Repair partnerships with occupational therapists, social care, health and housing provides quicker small adaptations in communities, outside DFG processes.
- Estimated that every £1 spent on RRAP saves £7.50 for the public purse.

How to use the framework to establish a workforce with the appropriate skills mix

Key message for establishing a workforce with the appropriate skills mix

The framework places older and disabled people at the centre of a process that ensures they receive the right level of assessment from a workforce that has the right level of skill and knowledge to assess and recommend adaptations.

Developing mechanisms for allocating cases: Delays are reduced when cases are allocated to the worker/practitioner who has the appropriate skills to manage the case to achieve the best person-centred outcome. For example, if a person's presenting situation is relatively straightforward, an occupational therapist does not need to be allocated a case where the anticipated adaptation is a standard structural solution, such as a bathroom adaptation or stairlift. The ***workforce skills column*** in the intervention tables (Tables 2–4, Section 3) can be used to support the development of mechanisms for allocating cases based on the *skills and knowledge* required to manage the case effectively.

Developing robust policies and procedures: Robust policies and procedures ensure workers/practitioners work within their scope of practice and are used appropriately to assess and deliver adaptations. This approach is particularly important when an occupational therapist is *not* involved in the assessment and recommendation of adaptations. The ***operational considerations column*** in the intervention tables (Tables 2–4, Section 3) indicates the policies and procedures that need to be developed and implemented at each level of intervention.

Example: Establishing agreed levels of responsibilities for making recommendations

Organisation: Royal Borough of Greenwich Occupational Therapy Service

Services: Occupational Therapy Service

Method/process: Guidance on scope of responsibility for Occupational Therapy Assistant Assessment Officers (OTA AO).

- Outlines criteria for when cases need to be referred back to an occupational therapist if they appear to become more complex.
- With regard to the RCOT code of ethics and professional conduct in relation to delegation.
- In line with agreed levels of professional competence outlined in the RCOT Career Development Framework.
- OTA AOs can assess and recommend simple level-access showers, stairlifts, half steps, hand rails, ramps, door widening, lever taps, window winders.

Factors where occupational therapy input and authorisation are required include:

- Safeguarding.
- Moving and handling.
- Clients with progressive, neurological and complex conditions.
- All children's cases.
- Complex social situations.
- Specialist and bespoke equipment needs.

Impact and outcomes:

- Reduces demand on occupational therapy assessments for major adaptations.
- Support for unregulated staff to assess and recommend adaptations when the situation is simple and to know when they need to seek specialist advice.

Developing and maintaining workforce skills and competencies: The ***workforce skills column*** in the intervention tables (Tables 2–4, Section 3) should be used to audit current staff for the appropriate level of skills and knowledge to assess and recommend adaptations for each level of intervention. If gaps in knowledge and skills are identified appropriate training can be provided. Where a service intends to extend the range of adaptations provided without an occupational therapy assessment then the workforce skills column will identify the skills and knowledge a worker will require to work safely and appropriately.

Example: Workforce training

Organisation: Housing Solutions Change Programme (Scotland) (developed by ihub Healthcare Improvement Scotland)

Services: Training a range of sector staff who may come into contact with people in their own homes, for example nurses, housing officers, podiatrists, occupational therapists and voluntary sector agencies.

Skills mix: Involves health, housing, social care and third-sector staff within local Health and Social Care Partnership areas across Scotland

Method/process: Training modules delivered by local training pairs (occupational therapist and a housing colleague) with an emphasis on early intervention, simple solutions, exploration of rehousing opportunities and personal outcomes. Partnership and an integrated approach are advocated to deliver better outcomes.

Module 1 promotes the value of 'early housing conversations' for any professionals visiting people at home to make use of opportunities for preventative interventions.

Module 2 provides a range of housing, health and social care staff with the skills to assess and commission straightforward adaptations where appropriate.

Module 3 trains non-social care occupational therapists to assess for and commission major adaptations.

Impact and outcomes:

- A wider range of staff are able to intervene earlier and enable forward planning.
- Enables a better use of skilled occupational therapists.

Developing interprofessional collaboration and practice for complex cases:
Delays occur when there is ineffective collaboration between occupational therapy and housing teams. Where occupational therapy and housing teams are not integrated, the framework and categories of adaptations can be used to support and encourage collaborative working practices. This approach is particularly important for complex cases where interprofessional collaboration and communication is essential during the assessment and design of the adaptations. Where integration of teams is being considered, the framework and tables are a starting point to consider the skills mix and operational issues that need to be addressed to provide a range of solutions to a population with diverse needs.

Getting the message across: effective communication

Effective communication between the staff carrying out assessments and the technical staff responsible for design and installation of adaptations is essential to ensure that completed adaptations are fit for purpose. It is important to provide staff with communication tools to make it as easy as possible to complete requests, make recommendations and explain the reasoning for key requirements.

In many areas around the UK standardised templates, which can be edited easily, are being used for simple straightforward adaptations. This ensures that good standards in relation to minimum space requirements, dimensions and key facilities are always included while being easily understood by technical staff.

Example: Adaptations Design Communication ToolKit

Organisation: Northern Ireland Housing Executive

Services:

- A published toolkit (including a list of adaptations that can be installed without an occupational therapy assessment).
- Evidence-based designs standards that can be used to help older and disabled people visualise the proposed adaptation.
- Standardised digital forms for applying for adaptations.
- Standardised digital formats for specifying adaptations.

Method/process:

- Published toolkit used to show older and disabled people designs of standardised adaptations.
- Electronic forms used to send information between occupational therapists and housing team.

Impact and outcomes:

- Improved older and disabled people's understanding of what adaptations will be installed.
- Improved interagency working and communication.
- Where standard solution can be installed, this has reduced need for joint visits.

Further information:

https://m.nihe.gov.uk/adaptations_design_communications_toolkit.pdf

How to use the framework if you are a builder, retailer or product manufacturer

Key message for builders, retailers and product manufacturers

Builders, retailers and product manufacturers are increasingly playing an important role in assessing, recommending and installing adaptations for people who are paying for their own adaptations. For the public to have confidence in this sector, it is important that builders, retailers and product manufacturers demonstrate they are implementing safe and person-centred practices.

Knowing when to consult with an occupational therapist: When assessing, recommending or installing adaptations it is important that builders, retailers and product manufacturers have the appropriate knowledge and skills to deliver this type of service to older and disabled people. The ***overall framework and intervention tables*** (Tables 2–4, Section 3) will help this sector to understand what level of intervention they can deliver safely and effectively, and when they need to draw on the expertise of occupational therapists.

Example: Supporting decisions on when to refer for occupational therapist assessment

A checklist used in Trusted Assessor Training

Method/process: An example of this is given in the Disabled Living Foundation training questionnaire:

How do I know when to refer on to an occupational therapist?

It can be difficult, especially when you first start working in the role of a Trusted Assessor, to know when you are able to provide a safe solution and when you are not. A simple way of deciding this is to ask the following questions:

- Does the customer have more than two conditions that are impacting on their ability to complete the chosen task?
- Does the customer's condition change significantly from day to day or is their condition likely to change significantly within the next year?
- Does the customer lack capacity to make decisions and/or are they unable to follow instructions?
- Is the environment complex and difficult to adapt?
- Is the solution outside standard and simple options available to you?
- Has the person lost the ability to transfer from one seat to another?
- Does a Trusted Assessor solution impact others' health, development or independence within the environment?

- Are there other areas that the customer is struggling with in the same environment that a Trusted Assessor solution wouldn't solve safely?

If the answer is yes to any of these questions then you should seek help from an occupational therapist.

Further information:

https://www.dlf.org.uk

Collaborative opportunities with independent occupational therapists: There are a growing number of older and disabled people who require a targeted or specialist level of intervention/service but who are self-funding. There is an opportunity for independent occupational therapists and building professionals to collaborate to meet this demand. The ***overall framework, intervention tables and categories of adaptations*** (Tables 2–4, Section 3) can provide a foundation and structure to develop business partnerships between independent occupational therapists and builders interested in providing a service to this population of older and disabled people.

Product suppliers and manufacturers' role in the delivery of specialist interventions: Sourcing, researching and analysing the cost–benefits of products comprise an important part of assessing and recommending adaptations. This process can be lengthy if workers/practitioners do not have easy access to product information. Product manufacturers and suppliers can play an important role in reducing delays in the adaptations process by making the following information available:

- How the product can be used to improve functional performance.
- What issues the product can/cannot address.
- Cost–benefit analysis of a product.
- Case study examples of how the product has been used in the real world.

How to use the framework if you are a member of the public

Key message to members of the public who want to use the framework to understand the level of intervention or type of service they need to adapt their home

The framework and supporting tables help you to understand the type of advice or support you or your family member need to adapt the home. Understanding this information will help you to make informed decisions about which services can provide the best solutions for your situation.

Identifying the type of intervention/service you or a family member need to adapt the home: Delays are avoided when people know the type of adaptation or service that will provide them or their family member with the best outcome to address

the issues they are having in and around the home. The ***nature of complexity columns*** in the intervention tables (Tables 2–4, Section 3) can be used by people to understand the type of service and category of adaptation they are likely to require for each level of intervention. As discussed under *signposting at first point of contact* (above), communicating this information helps direct people to the service that best addresses their needs.

Example: Guided advice and support on daily living for older and disabled people and children

AskSARA is an online interactive self-help tool that guides users through a number of simple questions about their abilities and environment, and provides impartial advice and information on products and equipment to suit their needs.

Further information:

https://asksara.dlf.org.uk

Self-funding and checking the quality of a service: If you are self-funding an adaptation, it is important to know that the builder or company has the right skills to be able to recommend and install the adaptation. It is also important to know whether you will benefit from the input of an occupational therapist, who can assess the person and the home environment and then identify and recommend solutions. The workforce skills column for each level of intervention can be used as a checklist to ensure a builder has the right skills and knowledge to recommend and install the adaptation; in addition it will indicate whether you will require input from an occupational therapist.

Example: One-stop shop enabling self-referral across tenure

Organisation: Borders Care and Repair commissioned by Eildon Housing in partnership with Scottish Borders Council Housing Strategy

Services:

- Help and advice on housing repairs, improvements and adaptations.
- Scope: older people and people with disabilities living in the Scottish Borders, who are owner occupiers or living in privately or socially rented accommodation.

Method/process:

- One-stop shop for adaptations.
- Options appraisal templates to support decisions.
- Occupational therapy input on complex and high-cost cases.

Impact and outcomes:

- A consistent and equitable adaptation service to all people in the Borders regardless of tenure.

- Enabling people to self-refer for assessment and adaptations.
- Reduced waiting times.

Further information:

https://www.scotborders.gov.uk/info/20070/care_at_home/520/care_and_repair_service

Annexe 1
Sources of design guidance

This section provides links to a range of useful sources of guidance, tools and relevant resources that can be used when considering the design of inclusive and accessible home adaptations. It includes links to guidance about factors to consider in designing for:

- Adaptations.
- Inclusive and accessible housing.
- Cognitive impairments.
- Visual impairments.

It is important when making recommendations for adaptations that practitioners are aware of their respective responsibilities in relation to *The Construction (Design and Management) Regulations 2015* (CDM 2015).[10] Services are advised to consult these when developing any operational guidance for their staff.

Adaptations

The aim of home adaptations is to make it easier and safer for people to access and use their own homes. There will be specific factors to consider for each individual, their priorities and needs, and aspects particular to their home environment. The following evidence-based guidance on space requirements and layouts provides useful baselines from which to develop bespoke adaptations.

Northern Ireland Housing Executive

Adaptations design communications toolkit is published by Northern Ireland Housing Executive and developed through close work and interagency working with disabled people, occupational therapists, housing designers and the Northern Ireland Federation of Housing Associations.

This toolkit provides detailed recommendations on space requirements and positioning to support the design of bespoke home adaptations. A useful tool to appraise room layouts, it provides evidence-based, consistent and equitable housing adaptation design standards for all housing tenures:

- Design formats that help visualise proposed housing adaptations and depict how people with mobility difficulties and carers use the space are included.

10 Health and Safety Executive (2015) *Managing health and safety in construction: Construction (Design and Management) Regulations 2015.* [London]: Stationery Office. Available at: *http://www.hse.gov.uk/pUbns/priced/l153.pdf* Accessed on 12.03.19.

- Standardised and robust occupational therapy formats for housing adaptations recommendations, financial governance, specifications and follow-up communications to all housing providers.

https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/adaptations_design_communications_toolkit.pdf

Muscular Dystrophy UK

Adaptations manual: for children and adults with muscle wasting conditions, revised for Muscular Dystrophy UK by occupational therapists who work closely with families living with muscle-wasting conditions, includes examples and practical information about what is available to families, as well as an outline of the process of making adaptations to their homes.

https://www.musculardystrophyuk.org/about-muscle-wasting-conditions/information-factsheets/equipment-and-adaptations/adaptations-manual/

Disabled Living Foundation

The Disabled Living Foundation produces a number of factsheets for the public, written and peer-reviewed by experienced occupational therapists, on factors to consider when selecting daily living equipment and adaptations. These include:

- Choosing and fitting grab rails.
- Choosing equipment for getting up and down stairs.

https://www.dlf.org.uk/content/factsheets-groups

Foundations

The national body for home improvement agencies in England provides useful guidance on the factors to consider when designing different types of home adaptations including:

- Ramp design.
- Shower adaptations.
- Kitchen adaptations.

https://www.foundations.uk.com

Care and Repair England

This national charitable organisation, set up to improve the homes and living conditions of older people, offers a range of useful resources on repairs and adaptations.

http://careandrepair-england.org.uk

Care and Repair Cymru

The national body for care and repair in Wales, whose vision is a Wales where all older people can live independently in warm, safe and accessible homes.

https://www.careandrepair.org.uk

Care and Repair Scotland

This body offers independent advice and assistance to help older and disabled homeowners repair, improve or adapt their homes.

http://www.careandrepairscotland.co.uk

Design Council

The Design Council's purpose is to make life better by design. They are an independent charity whose vision is a world where the role and value of design is recognised as a fundamental value, enabling happier, healthier and safer lives for all. Their current Spark programme is focused on home innovation and looking to turn bright ideas into products that transform the experience of getting around, remembering things and doing daily tasks to enable more independent living.

https://www.designcouncil.org.uk/what-we-do/accelerator/design-council-spark

Dunhill Medical Trust

The Dunhill Medical Trust not only funds the very best of the UK's academic and clinical research into understanding the mechanisms of ageing and treating age-related diseases and frailty, they also support community-based organisations that are working to enhance the lives of those who need extra support in later life. They have recently announced a new research programme that will address the evidence gap on adaptations and assistive technology to enable safer, independent living with dignity.

https://dunhillmedical.org.uk/2018/09/03/expert-in-the-future-of-housing-for-an-ageing-population-take-a-look-at-our-latest-call-for-proposals/

Inclusive and accessible housing

There are a number of resources available to support the design, build and retrofitting of inclusive and accessible housing. The core intention is to create homes that are flexible and adaptable to meet a range of needs.

Housing Learning and Improvement Network

The Housing Learning and Improvement Network (Housing LIN) brings together housing, health and social care professionals in England, Wales and Scotland to exemplify innovative housing solutions for an ageing population.

Occupational therapists: helping to get the housing design right is a collection of links to resources to support inclusive and accessible housing design.

https://www.housinglin.org.uk/Topics/browse/Design-building/occupational-therapy

An occupational therapist's access checklist: a practical tool is a quick reference checklist to existing regulations and best practice guidance on inclusive and accessible housing design, covering minimum requirements to more generous provision. Key aspects of the home are included, from access and approach to internal layouts.

https://www.housinglin.org.uk/Topics/type/An-Occupational-Therapists-Access-Checklist-a-practical-Tool

Royal Institute of British Architects

The Royal Institute of British Architects is a global professional membership body driving excellence in architecture. It supports its members to deliver better buildings and places, stronger communities and a sustainable environment.

The third edition of the *Wheelchair housing design guide* (2018) provides advice and design considerations to support the delivery of good-quality wheelchair-accessible housing. It details how to meet and exceed the minimum requirements laid out in *The building regulations: approved document M: volume 1: dwellings: category 3: wheelchair accessible* (ADM4(3)).[11] It was produced by contributors from the Royal Institute of British Architects, Centre for Accessible Environments and the Royal College of Occupational Therapists Specialist Section – Housing, along with input from a cross-section of experts including building control, architects, developers and other housing professionals. It includes:

- Clear cross-references to ADM4(3).
- Technical diagrams illustrating design details.
- Simple-to-follow guidance on best practice and technical provisions.

https://www.habinteg.org.uk/whdg3

Age-friendly housing: future design for older people (Park and Porteus 2018) sets out how we should approach the design of future housing for an ageing population. It looks at how well-designed, accessible and adaptable buildings can facilitate the provision of care, support, independence and wellbeing, and also includes a section on adaptation and refurbishment.

https://www.ribabookshops.com/item/age-friendly-housing-future-design-for-older-people/91915

11 Great Britain. HM Government (2015) *The building regulations: approved document M: access to and use of buildings: volume 1: dwellings*. [Newcastle Upon Tyne]: NBS. Available at: *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/540330/BR_PDF_AD_M1_2015_with_2016_amendments_V3.pdf* Accessed on 13.03.19.

Royal College of Occupational Therapists Specialist Section – Housing (RCOTSS-H)

RCOTSS-H provides a forum for occupational therapists with an interest in housing, inclusive design and accessible home environments. It works closely with other organisations and professionals to advocate for improved standards of housing for older and disabled people.

https://www.rcot.co.uk/about-us/specialist-sections/housing-rcot-ss

Centre for Ageing Better

The Centre for Ageing Better is a charity, funded by an endowment from the National Lottery Community Fund, working to create a society where everyone enjoys a good later life. Their Safe and Accessible Homes programme of work seeks to ensure new homes are future-proofed and that there is a diversity of suitable homes, that current homes are adapted, and better information is available for people approaching later life.

https://www.ageing-better.org.uk/our-work/safe-accessible-homes

Centre for Accessible Environments

The Centre for Accessible Environments is a leading authority on inclusive design. It provides consultancy, training and research. It also has a selection of free publications and others for sale on building design and management to meet all user needs, including disabled and older people.

https://cae.org.uk/

Cognitive impairments

The design of the environment can have a significant impact on the abilities of people with cognitive and neuro-diverse impairments to make sense of their surroundings and support independence. This may include people living with dementia, learning disability or autistic spectrum disorders. The following provide some guidance on the factors to consider.

Beyond Accessibility

Beyond Accessibility is a team of therapists that specialises in how people live in the home environment.

99 ideas to make homes easier, safer, and more enjoyable for families with children on the autism spectrum by Paige Hays (2017) provides ideas and recommendations specific to designing home areas for families with members who have ASD.

http://beyondaccessibility.com/homes-autism-spectrum-disorder

The Challenging Behaviour Foundation

The Challenging Behaviour Foundation (CBF) is a charity for people with severe learning disabilities who display behaviour described as challenging. CBF provides information and resources to enable families to work with others to plan proactively for personalised housing for their relative.

https://www.challengingbehaviour.org.uk

Helen Hamlyn

The Helen Hamlyn Centre for Design at the Royal College of Art undertakes design research and projects with industry that will contribute to improving people's lives.

Living in the community: housing design for adults with autism (Brand 2010) details the findings from a research partnership between the Kingswood Trust and Helen Hamlyn, with a particular focus on housing providers, architects and designers involved in the design, refurbishment and development of residential accommodation for adults with autism.

https://www.rca.ac.uk/documents/390/Living_in_the_Community.pdf

Centre for Excellence in Universal Design: National Disability Authority

The Centre for Excellence in Universal Design is dedicated to enabling the design of environments that can be accessed, understood and used regardless of age, size and ability.

Universal Design guidelines: dementia friendly dwellings for people with dementia, their families and carers was published in 2015 by the National Disability Authority in Northern Ireland to inform those who commission, design, build, provide and occupy dwellings. The Universal Design dementia-friendly approach aims to help people to remain living at home and in their community independently and safely for as long as possible.

http://universaldesign.ie

Dementia Services Development Centre (DSDC), University of Stirling

The DSDC is an international centre of knowledge and expertise dedicated to improving the lives of people with dementia. It draws on research and practice from across the world to provide a comprehensive, up-to-date resource on all aspects of dementia.

https://dementia.stir.ac.uk/about-dsdc

Visual impairment

Attention to levels and location of lighting and tonal contrast can have a significant impact on the ability of people with sight loss to find their way around, and help to make it easier and safer to carry out everyday activities.

Housing Learning and Improvement Network

A comprehensive range of information on design and lighting for people with sight loss is available on dedicated pages.

https://www.housinglin.org.uk/Topics/browse/sight-loss-home-the-built-environment/

Thomas Pocklington Trust

Thomas Pocklington Trust is a national charity dedicated to delivering positive change for people with sight loss. The Trust funds research to support independent living and identify barriers and opportunities in areas such as employment, housing and technology.

Making an entrance: colour, contrast and design of entrances to homes of people with sight loss (2013)

http://pocklington-trust.org.uk/wp-content/uploads/2016/02/Check-List.pdf

Lighting in and around the home: a guide to better lighting for people with sight loss (2018)

http://www.pocklington-trust.org.uk/project/lighting-around-home-guide-better-lighting-people-sight-loss

Good practice in the design of homes and living spaces for people with dementia and sight loss (Greasley-Adams et al. 2011; jointly produced by Thomas Pocklington Trust and DSDC)

http://dementia.stir.ac.uk/design/good-practice-design-dementia-and-sight-loss

Royal National Institute of Blind People

RNIB is one of the UK's leading sight loss charities and the largest community of blind and partially sighted people. They have a dedicated webpage that provides useful information for people who are losing their sight or have a sight problem. It explains the types of improvements, repairs or adaptations that may be needed to help people with sight loss live independently.

https://www.rnib.org.uk/information-everyday-living-home-and-leisure/adapting-your-home

Annexe 2
Review method and findings

The Royal College of Occupational Therapists (RCOT) commissioned a team from the Housing Learning and Improvement Network (Housing LIN), which included occupational therapists, to:

- Determine whether there was still a need for *Minor adaptations without delay* publication, Part 1.
- Determine whether there was still a need for *Minor adaptations without delay* publication, Part 2 (Technical Specifications).
- Ensure that a revised version of *Minor adaptations without delay* was produced that would be valued by key stakeholders in all four UK nations and representative of occupational therapy practice.
- Raise the profile of the assessment process of occupational therapists in preventative adaptations and demonstrate when their expertise is required.

The original version of *Minor adaptations without delay* (MAWD), which was published in 2006, was jointly commissioned by the College of Occupational Therapists and the former Housing Corporation. The guidance was in two parts:

- Part 1: A practical guide for housing associations, which included a list of minor adaptations that do not require an occupational therapy assessment and outlined the criteria for good practice in the delivery.
- Part 2: Technical Specifications, which provided guidance on the installation of a selection of minor adaptations.

The primary aim of MAWD was to enable more timely delivery of minor adaptations for tenants of housing associations.

The review of MAWD, undertaken during 2018, involved:

- A desktop review of current policy, legislation, guidance and key research of relevance to the delivery and benefits of home adaptations across the four UK nations.
- Primary research, which involved:
  - Interviews with 31 professional stakeholders (January to April 2018).
  - An online survey aimed at front-line practitioners that generated over 800 responses.
  - Discussion groups with stakeholders in all four UK nations (May/June 2018).

Interviews were conducted with:

- Occupational therapy managers.
- Occupational therapy policy leads in the four UK nations.
- Housing associations.
- National bodies for home improvement agencies.
- Care and repair organisations.
- Royal College of Occupational Therapists Specialist Section – Housing leads in the four UK nations.

Focus group meetings were subsequently held in all four UK nations, which included groups in Scotland, Northern Ireland and Wales, a practitioner consultation meeting in Manchester, and a presentation at the Home Adaptations Consortium, England. The consultation also included a joint meeting as part of the Disabled Facilities Grant Review in England.

The purpose of this primary research was to:

- Assess the extent to which the original MAWD publication achieved its aims.
- Across the four nations, identify the common issues affecting the process of providing (minor) adaptations.
- Elicit the gaps stakeholders identified in the original publication.
- Identify the content and resources required in a new *Adaptations without delay* guide.

Findings in relation to the extent to which MAWD has achieved its aims included:

- For the housing associations MAWD was targeted at, it has been and continues to be a valuable resource (but some housing associations are unaware of MAWD).
- Occupational therapy managers have used it as a negotiation tool with housing associations in relation to their role and remit.
- MAWD has been used to develop Adaptations Agreements between local authorities and housing associations.
- MAWD is mentioned in a number of reports and guidance documents outside of England.

However, the review of MAWD also found that:

- In practice some housing associations are still referring to occupational therapy teams.
- Occupational therapists want to work in creative ways (beyond working with housing associations), but MAWD does not provide reassurance or guidance on how to do this.
- The process of providing (minor) adaptations without an occupational therapy assessment has not generally been broadened to apply across tenure.

Findings in relation to the common issues across the four UK nations about the process of providing adaptations included:

- There continue to be delays in the delivery of minor adaptations for people in private tenures.
- There continue to be delays in the delivery of major adaptations across tenure.
- Some housing associations are not providing minor adaptations without an occupational therapy assessment.
- Across the four UK nations, adaptations are defined by type (minor/major) and cost rather than being defined by the complexity of the individual's circumstances (i.e. related to their needs and home environment).
- There are varying levels of skills and competence among individuals signposting at first points of contact in housing, health, social care and the private sector.
- There continues to be a lack of information for individuals about adaptations: how to decide what they might need, when to consult an occupational therapist, what funding is available and who can carry out the work.

Findings in relation to the gaps stakeholders identified in the original publication included:

- MAWD does not provide sufficient guidance on the criteria for when and why an occupational therapist is or is not needed.
- The existing guidance is primarily focused on housing associations and their tenants.
- The existing guidance is paper-based; an online version is now required.
- The existing guidance is less applicable to Northern Ireland, Scotland and Wales than to England.

Findings in relation to the content and resources required in a new *Adaptations without delay* guide included:

- A framework for decision making that is based on the complexity of the 'case' in relation to adaptations.
- A reasoning framework for when an occupational therapist *is not* needed.
- In both cases (above), guidance about when an occupational therapy assessment is not required for recommending different types of adaptations.
- A definition of minor and major adaptations that is not based on cost.
- Updated examples of good practice in the delivery of adaptations.
- Recommended training/competencies, particularly for non-occupational therapists who may be able to recommend adaptations.
- A guide that is applicable across all four UK nations.

The discussion groups specifically identified the disproportionate use of specialist (i.e. occupational therapist) skills in relation to the assessment for and provision of adaptations as an issue that this new guide should address.

This review identified an ongoing need for practical guidance in relation to the assessment for and provision of adaptations more generally, beyond existing categorisations of 'minor' and 'major' adaptations, across all tenures. The review identified a need for this guide to provide a framework for decision making about adaptations based on the level and degree of *complexity* rather than more traditional minor/major adaptation and cost-based definitions.

About the authors

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Rachel is an occupational therapist, lecturer and researcher based at the University of Salford. With 18 years' experience of working in adult health and social care, she has been directly involved in the assessment and delivery of home adaptations in several local authorities. Since 2011, her research has focused on the home adaptations process in the UK, particularly the role of occupational therapists in this process.

Marney Walker DipCOT, BA, MA

Marney Walker is an independent occupational therapist with 25 years' experience in housing and social care. She specialises in advising on the design of inclusive and accessible housing and adaptations. She has an MA in Design Research for Disability and has taught at master's level. She hosts a web page of resources on the Housing LIN Design Hub, is an Inclusive Design Assessor for the Civic Trust and a member of the Access Association.

Ian Copeman BSc, MSc

Ian leads the Housing LIN's programme of research and commercial consultancy. He has previously worked as a local authority commissioner of housing and care services, for housing associations and for voluntary sector organisations that support people with disabilities.

He has an extensive track record of undertaking research projects in housing and care in relation to older and disabled people. His recent projects with a high public profile include working in a consortium with Ipsos MORI on the Department of Work and Pensions and the Department of Communities and Local Government Supported Accommodation Review across England, Scotland and Wales. He is the author of the National Housing Federation's *Home from hospital* report and the Local Government Association's *Housing our ageing population* report.

He has previously been a trustee of a charity that provides housing advice and support for people with learning disabilities and their families.

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The Housing LIN's free knowledge- and information-sharing activities, along with its consultancy business, provide market insight and intelligence on the latest funding, research, policy and practice to inspire better housing and care choices.

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Royal College of Occupational Therapists

Occupational therapy with people with learning disabilities

June 2009

College of Occupational Therapists
Specialist Section
People with Learning Disabilities

This leaflet highlights key points from research undertaken by the College of Occupational Therapists Specialist Section – People with Learning Disabilities. Occupational therapists who work with people with learning disabilities were initially audited against current standards (OTPLD 2003) and then discussed their practice in focus groups. Paid carers of people with learning disabilities were also interviewed to gain their perspective.

A report containing full details of findings including the views of these carers and recommendations for practice, will be published in autumn 2009.

The findings are summarised into seven themes:

Occupational therapists have a unique role

- Occupational therapists are passionate about working with people with learning disabilities often staying for a long time in the field where a lack of set protocols or pathways allows them to be innovative. Using core occupational therapy skills which focus on independence, they have a more practical role than other professionals in their teams concentrating on *doing* activity *with* people.

- Occupational therapists bring a unique understanding of occupation to their teams. They support others to focus on meaningful activity, the quality of occupational lives and the environment in its widest sense. Their role is particularly important with people whose lives lack meaningful occupation or who are occupationally deprived and supports the key priorities of learning disability policy in the UK Governments (For example Department of Health 2009, Scottish Executive 2000).

- As adaptable, flexible and creative problem solvers, occupational therapists provide a perspective that "moves things forward". Use of activity analysis supports this problem solving approach and enables adaptation of activity to meet an individual's needs. Occupational therapists have a particular ability to work with people who are difficult to engage, for example due to limited motivation and this is a key reason for occupational therapy involvement. A main component of occupational therapy practice involves working in a person-centred way, supporting people to make informed decisions and enabling them to set their own goals. This underpins participation in Person-Centred Planning.

Occupational therapists carry out independent occupational assessments

- Occupational therapy assessments uniquely ascertain the impact of someone's learning disability on their occupational performance, highlighting how the learning disability affects their life and engagement in occupations that are important to them. Increasing numbers of referrals are being received for assessment to pinpoint strengths and identify support needs. Information from these assessments is used to evidence the need for and design of support packages.

- Through direct observation of occupational performance in a real environment and not merely accepting what is said "at face value", occupational therapists are able to provide a real understanding of the strengths and needs of people with learning disabilities. They provide an *independent* assessment of an individual's needs (something that carers seem to particularly value), allowing them to be very specific about what a person can and cannot do as well as the amount and type of support they need.

- Occupational therapists use a wide variety of assessment tools some of which are standardised. Additional assessment tools and outcome measures need to be developed particularly for people with severe and profound learning disabilities for whom existing assessments do not sufficiently indicate change.

Occupational therapy interventions support the rights of people with learning disabilities

- Occupational therapy outcomes link closely with the wider policy priorities of promoting the rights of people with learning disabilities including supporting them to live more independently, being in control of their lives and included in society. Occupational therapists may for example support people with learning disabilities who are parents or enable people to gain work skills to access paid or unpaid employment. Involvement is particularly important when an individual is at a time of transition in their life, for example becoming an adult or moving home.

- Occupational therapists may work with an individual over a long period of time, often in a consultative role making recommendations for carers and families to carry out with the person. Variation in abilities, staffing levels, turnover and motivation amongst paid carers may require occupational therapists to be pragmatic in the recommendations they make. Paid carers are very positive about the input that occupational therapists provide but suggest that they need recommendations to be both realistic and easy to follow.

- In some teams, work with people with profound and multiple learning disabilities and others with complex health needs is prioritised above skills development work. This may include:
  - Meeting an individual's sensory needs, such as completing sensory integration assessments and recommending "sensory diets"
  - Addressing the amount of meaningful occupation in someone's life as an alternative means of looking at why their behaviour may be challenging to others.

Recognition of the occupational therapy role

- Occupational therapists have a skilled and meaningful role which adds "core value" by joint working with other colleagues, service users and carers.
- Occupational therapists working with people with learning disabilities acknowledge the importance and need for evidence-based practice which would enable them to provide colleagues, services users and carers with more robust information about service user outcomes.
- Some occupational therapists feel that their work is not always well-recognised and therefore they need to be confident and assertive about their role.

Developing the skills to work with people with learning disabilities

- Occupational therapists would like to see more specific content on working with people with learning disabilities in pre-registration occupational therapy courses. Good feedback from students is received who undertake placements in this area but more placements need to be offered. Lack of placements together with the paucity of fixed or rotational posts for newly qualified occupational therapists in learning disabilities impacts on recruitment.
- There is very little post-registration training specific to both learning disabilities and occupational therapy. Resources to pay for training varies and therapists in Scotland and Northern Ireland are hampered by long travelling distances to training venues.
- Occupational therapists highly value networking with each other as a means of developing skills and knowledge, for example via the College of Occupational Therapists Specialist Section-People with Learning Disabilities and through locality special interest groups.

Challenges to occupational therapy practice

- Occupational therapists would like more resources to meet the identified needs and improve the lives of people with learning disabilities. Occupational therapy recommendations for support packages of care can be insufficiently funded resulting in crisis responses.
- In some teams occupational therapists feel under increased pressure to take on extended roles in care management. This impacts on the amount of time available for specialist work and may lead to a conflict of interest or compromise the independence of their assessments.
- Targets, for example related to waiting lists, create pressure to continuously expand caseloads. They focus attention on quantity of referrals rather than quality of service and make long-term occupational therapy difficult. This appears currently to be a particular issue for occupational therapists in Northern Ireland.

Occupational therapy with people with learning disabilities

June 2009

College of Occupational Therapists
Specialist Section
People with Learning Disabilities

Promoting access to mainstream health and social care

- Occupational therapists agree that people with learning disabilities and their families need to access mainstream health and social care and should not have all their needs met by learning disability services (Department of Health 2009, Welsh Assembly Government 2004, OTPLD 2003). Some services have established clearly defined occupational therapy roles focusing on specialist input but not all have developed consistently especially around meeting needs related to physical disability of people with learning disabilities. Different health and social care structures across the four countries in the UK place varying amounts of emphasis on the dominance of equipment and adaptations for the occupational therapy role.

- Occupational therapy staff have had success in enabling access to mainstream occupational therapy services by being persistent and assertive with fellow colleagues. Time previously spent on adaptations and equipment provision can now be spent on specialist learning disability related expertise and recognises that occupational therapists cannot be expected to keep up to date on all areas of occupational therapy practice. Working in partnership and having a consultative role with mainstream colleagues ensures that an individual gets the benefit of both areas of expertise whilst developing therapists' knowledge and skills. Some therapists have developed formal protocols with other occupational therapy services to clarify their respective roles.

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References
Department of Health (2009) Valuing People Now. London: Department of Health
National Association of Occupational Therapists working with People with Learning Disabilities (OTPLD) (2003) Occupational therapy with people with learning disabilities: Principles for education and practice. London: College of Occupational Therapists
Scottish Executive (2000) The same as you? A review of services for people with learning disabilities. Edinburgh: Scottish Executive
Welsh Assembly Government (2004) Learning disability strategy: Guidance on service principles and service responsibilities. Cardiff: Welsh Assembly Government

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Look out for the full report containing: a detailed analysis of these findings; and recommendations for practice
Available for COT Specialist Section – People with Learning Disabilities members to download for free in autumn 2009!

www.COT.org.uk

The College of Occupational Therapists is the professional body for occupational therapy

Practice Briefing

College of Occupational Therapists

Safe use of Weighted Blankets

Publication Date: October 2011
Lead Group: Professional Practice
Country Relevance: United Kingdom

1. Introduction

This briefing has been developed by the College of Occupational Therapists in consultation with the Sensory Integration Network (UK and Ireland) and with members of the College of Occupational Therapists Specialist Section for Children, Young People and Families. It aims to provide guidance for occupational therapists that use and/or recommend weighted blankets for their clients. This briefing does not offer support or otherwise for the use of Sensory Integration as an intervention, for use of weighted blankets as part of Sensory Integration treatment or incorporating sensory needs into daily routine. It does however aim to inform those using weighted blankets (or covers) as part of an occupational therapy programme, using Sensory Integration as a tool to achieve sensory regulation to support engagement and occupational performance.

1.1 Background

In Canada in 2008, 9-year-old Gabriel Poirier 'died of suffocation under a weighted blanket in which he had been rolled by his teacher at the special school he attended'. He was left without supervision for 20 minutes and the instructions given to the special education worker and teacher by the occupational therapist were not followed (OEQ 2008).

1.2 Sensory Integration

The use of equipment such as weighted blankets has developed from the theories and practice of Sensory Integration (SI). SI was defined by Jean Ayres, its founder, as 'the neurological process that organises sensation from one's own body and from the environment and makes it possible to use the body effectively within the environment' (Ayres 1970). SI offers a theory of brain behaviour relationship, a model of assessment and a model of intervention. A dysfunction in an individual's sensory integration (DSI), or sensory processing disorder (SPD), as it is often known, may be the cause of difficulties for children who find themselves unable to easily learn new skills, to pay attention, to co-ordinate movements or to cope with social participation. Intervention may be direct, meeting the recent criteria for fidelity (Parham et al 2007), or indirect, taking a consultative approach, reframing behaviours and developing new strategies (Bundy 2002). Schaaf and Smith Rowley (2006) identify the need to incorporate sensory needs into daily routine.

Neuroscience literature identifies the use of active sensory experiences to enhance sensory regulation as a basis for learning, brain maturation and neural organisation. Deep pressure touch externally supplied is passive application of a sensory stimulus, whereas self-initiated movement against resistance or weight provides active sensory rich experience. Passive application of sensory stimulation is rarely justified unless the clinician uses extreme caution and care (Dahl Reeves 2001).

1.3 Weighted blankets

Weighted blankets, also referred to as weighted covers, can be used for children, young people and adults with sensory processing difficulties to assist with self-calming and sensory regulation.

The rationale for the use of weighted blankets is linked to the impact of deep pressure touch on arousal (Lane 2002). Weighted blankets offer deep pressure touch to the body giving a feeling of being hugged,

held or cuddled (Grandin 1992). Some limited evidence regarding the beneficial effects of weighted blankets is available (Mullen 2008)[1], but this was undertaken with healthy adults so cannot be generalised to apply to children with or without disabilities or to adults with learning disabilities. However, there is significant anecdotal evidence from occupational therapists, parents and teachers of the calming effects of sensory 'tools' including weighted blankets.

Touch receptors in the skin are activated when stimulus are applied and then when stimuli are removed. When stimuli are applied and left in place there is a diminishing response or adaptation over time. Therefore it is thought that weighted items are most effective over shorter periods of time when the client is not moving and for longer periods of use only when the client is moving. When the client is moving/active or providing some resistance there is an increase in active proprioception rather than the more passive pathway of deep pressure touch.

Weighted blankets can be a useful tool but will not be the sole solution for meeting client's sensory needs; there are alternative methods that can assist with self-calming which could be trialled first and always used in the event of any safety concerns. For further suggestions see Schaaf and Smith Rowley (2006, chapter 13). One of the components of SI is to tap the client's inner drive and support client activity. It is important that sensory activities are not imposed.

2. Safe use of weighted blankets as part of direct occupational therapy intervention

The use of weighted blankets can be part of an occupational therapy treatment or used to incorporate sensory needs into daily routine (Schaaf and Smith Rowley 2006). The assessment of need and subsequent clinical reasoning will determine which is appropriate.

2.1 Assessment

Occupational therapists should undertake a comprehensive assessment of their client and be able to justify the use of any chosen treatment approach.

Assessment should include:

- Occupational and functional abilities and needs in the relevant contexts;
- Health condition and physical strength, size and weight;
- Relevant risk assessments (see Contraindications 2.2);
- Sensory processing.

2.2 Contraindications

The occupational therapist should determine if their client's health contradicts in any way the use of the blanket, with reference to any condition including :

- Respiratory problems (consider use below the torso);
- Cardiac problems;
- Epilepsy (ensure epilepsy is controlled);
- Serious hypotonia;
- Skin problems, including certain allergies;

[1] Mullen et al (2008) evaluated the safety and effectiveness of a weighted blanket with 32 volunteer adults. The results of this study showed that the use of weighted blankets did not generally cause unsafe physiological reaction. The authors therefore concluded that weighted blankets were safe. They found 33% of the sample group demonstrated lower electro-dermal activity (EDA) and 63% had a demonstrated reduced anxiety. In a self-reporting questionnaire, 78% reported that they felt more relaxed when using the blanket than without it. The group also showed some physiological change and reported reduction in anxiety when lying down without the weighted blanket, to the point that the authors acknowledge the beneficial effect of lying down (in a quiet room).

- Circulatory problems (OEQ 2008);
- They should also assess whether the client is unable to remove blanket independently.

2.3 Record keeping

Please refer to *Record Keeping* (COT 2010) and College of Occupational Therapists, *Professional Standards for Occupational Therapy Practice*, (COT 2011, section 6), for full details of standards regarding record keeping.

As with all occupational therapy practice, all contacts, advice and interventions must be recorded. 'If it is not included, it has not been done, has not been considered or was not said.' (Lynch 2009 p50). Your records should provide a comprehensive and accurate account of service plan and provision (COT 2011, Section 6). It is also required that consent for the specific intervention is detailed including the form in which the consent was given and by whom.

2.4 Consent

Please refer to the *Professional Standards for Occupational Therapy Practice* (COT 2011, section 3) for full details regarding consent.

Consent to generic occupational therapy input is not sufficient. Occupational therapists should also ensure that the client is fully informed about the specific nature of the interventions relevant to them.

2.5 Impaired capacity

Occupational therapy staff should be aware of the correct legal approach to take when obtaining consent is difficult or not possible.

Adults - For adults with impaired capacity, the occupational therapist needs to ensure that they always act in the best interests of the client. (COT 2011, section 3).

Children and young people - A child must also consent to the use of the weighted blanket if possible, even though they are a minor.

Review

The success of the intervention will be judged by a client's responses and reactions and so it is important to listen to the information your client is providing. Use of any programme should be part of identified goals and outcomes reviewed at agreed intervals and documented clearly in client notes.

3. Safe use of weighted blankets - checklist

3.1 Weighted blankets can be a safety risk in not used correctly

Recommendations for safe use:

- The client's head and neck must not be covered.
- The client's vital signs should be observable at all times.
- The client must not be rolled in the blanket; it should be placed over them. If in a bed it should not be draped over the sides of the bed (see use at night time/ for sleeping (see 4.5).
- The client must be able to remove the blanket or get free of the blanket by themselves. When trying out a weighted blanket for the first time, ensure clients are able to physically manoeuvre the blanket with confidence. Remind the client using the blanket that they can take it off at any time, if it feels uncomfortable, too hot or heavy etc.

- The client must be supervised at all times when under the blanket. When it is used for the first time or as part of a direct occupational therapy treatment this must be by a therapist able to interpret the user's reaction and response, in order to ensure it is the right tool to meet the needs of the client.
- When a blanket is given as part of a sensory diet the care giver must receive training for that specific client and understand the safety guidelines (see section 4).
- The weighted blanket must never be used as a restraint.
- Manufacturer's instructions on the recommended use of the equipment should be followed as a minimum standard. All non-compliant use should be justifiable. Many manufacturers provide limited guidance and it is likely that the recommendations provided will be superseded by the checklist above. None the less if guidelines are provided they should be followed.

3.2 Observations during use

Watch for any negative reactions shown by the client when under the blanket. These could include:

- Difficulty breathing
- Nausea
- Increase in temperature
- Any behavioral or physical reactions demonstrating the client's discomfort or anxiety

3.3 Assessing safe weight

At the time of writing, there is no evidence specifying the required weight of a weighted blanket in relation to the client's body size and weight. However, good practice suggests that the blanket should be as light weight as possible, while still achieving any agreed outcomes.

The Ordre des Ergotherapeutes du Quebec (OEQ) state the weight and size of the blanket should correspond to the client's physical features and recommend a ration of 10% of the client's weight as the blanket's maximum weight. For example:

- 100 pound person should use a blanket that is no more than 10 pounds in weight.
- Clients who weigh around 40 pounds should use a 4 blanket that weighs four pounds or less
- A 9 pound blanket is for clients who weigh 90 pounds or more (6st 6 lb) (OEQ 2008).

Weighted blankets should be individually recommended on a client by client basis. This should be particularly stressed in a school environment to ensure that blankets are not swapped between varying children.

3.4 Duration of use

Guidelines from OEQ and the State of Quebec Coroner state the blanket is to be used for no longer than 20 minutes (unless there are exceptional reasons). The reasons for this are not given. This would prohibit lengthy night time use. If the blanket is used for longer periods, close justification must be recorded and close observation is recommended. (See 4.5 – night time use and sleeping).

3.5 Fabrication

There is no evidence about use of materials and size, but common sense indicates attention should be given to the client's size, any health needs, e.g. allergies, and the environment where the blanket will be used. Personal considerations might also need to be factored in e.g. they may prefer a smaller or lighter blanket.

4. Guidance for the safe use of weighted blankets as part of an occupational therapy programme given to parents, teachers or other care givers

Weighted blankets are often used to incorporate sensory needs into a daily routine.

4.1 Assessment

Assessment will be very similar to that undertaken for direct occupational therapy intervention and should include:

- Occupational and functional abilities and needs;
- Health condition and physical strength, size and weight;
- Relevant risk assessments;
- Sensory processing;
- Carer's abilities and needs;
- Environmental factors.

4.2 Provision

The occupational therapist should demonstrate in person, explain the safety checklist and ask the care giver to sign an agreement of demonstration and checklist. This process should then be fully documented in the client notes. The provision of a weighted blanket is to be documented as part of the client's goals and interventions with a planned time for review (COT 2011).

When demonstrating the use of a weighted blanket occupational therapists should communicate effectively so that everyone who uses a weighted blanket is aware of and agree to follow the safety guidelines above and the intervention plan designed for the client.

Occupational Therapists should:

- Provide training to users of weighted blankets based on the checklist for safe use and the client's individual needs and circumstances.
- Provide the above checklist information verbally during demonstration and in written form.
- Provide written information regarding:
    1. General guidance for the safe use of weighted blankets.
    2. Specific information and instructions for individual clients linked to their intervention / care plans.
    3. Instructions to follow if any problems arise e.g. remove the blanket and stop using, contact emergency help if the client experiences breathing difficulties, or contact the occupational therapist if the client has any behavioural difficulties.
- Ideally regular training and follow-up should be provided in order to maintain continued, up-to-date knowledge and skills both about the use of weighted blankets and in relation to meeting individual client's needs. If this is not possible or inconsistent with department models, occupational therapists should assure themselves that those using the blanket are aware to contact the occupational therapist should an individual's needs change or a review of the blanket is required.

4.3 Review

Weighted blankets are an item of equipment, used within the framework of an intervention or care plan in order to meet specific objectives. These objectives should ideally be regularly reviewed in order to evaluate outcomes and in particular, the continued benefits and use of a weighted blanket (see 4.2).

4.4 Learning to use a weighted blanket more independently

Older children/adults may benefit from being encouraged to use their weighted blanket as and when they require it as a self-calming strategy and, in the longer term, a coping strategy.

In these situations a risk assessment should be undertaken covering the guidance above, particularly with respect to the client's ability to:

- move around under the blanket;
- be able to remove the blanket independently; and
- be able to understand and follow guidance for safe use and to self supervise their health needs.

4.5 Use of weighted blankets at night and for sleeping

Given the maximum duration for use guidelines issues by the Canadian Coroner (20 minutes), occupational therapists are advised not to recommend blankets for prolonged use. The advice also states that users should be supervised so this would preclude extensive use at night. Parents/carers may choose to ignore this advice. Occupational therapists are advised to explain the risks and contraindications to parents if they are aware they are acting against this advice and to document this discussion thoroughly.

Before considering brief use of a weighted blanket at night, ensure all other alternatives have been explored first. If a weighted blanket is to be used at night or for sleeping during the day, a risk assessment is recommended and, as well as the guidance above, further consideration should be given to the following:

- It is important that the client can move around by themselves under the weighted blanket and be able to remove the blanket easily.
- Always remind the client that they can remove the blanket at any time if it is feeling too heavy or hot.
- It is recommended that the blanket should be removed once the client has fallen asleep so that it is not in place all night.
- Ensure the blanket fits on the top of the mattress without hanging over the sides of the bed.
- The blanket should only be used under supervision and if parents/carers plan to use without supervision at night it is recommended that carers check on the client while they are sleeping.

4.6 Looking after a Weighted Blanket

Always follow the manufacturer's instructions for using and caring for weighted blankets.
Every time it is used, check it for damage such as loose stitching or ripped seams. If it is damaged, stop using it until it is repaired or replaced.

5. Issuing guidance when a weighted blanket has been purchased independently

If a weighted blanket has been purchased for use at home or school without the recommendation of an occupational therapist it is good practice to advise on safe use, particularly if there is an open duty of care for that client. The above information should form a basis for this. However, the full duties above only apply if the blanket has been issued by an occupational therapist or specifically recommended.

Acknowledgement

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References:

Alberta College of Occupational Therapists Adhoc Task Force (2009) Commentary on l'Ordre des ergothérapeutes du Québec's Position Statement on Use of Weighted Covers. Available at: http://www.acot.ca/files/Commentary_Weighted_Blankets_c_Append.pdf

Accessed on 17.10.11.

Ayres AJ (2005) *Sensory integration and the child: 25th anniversary edition*. CA, Los Angeles: Western Psychological Services.

Bundy AC (2002) Using sensory integration theory in schools: sensory integration and consultation. In: Bundy AC, Lane SJ, Murray EA, eds. *Sensory integration: theory and practice.* 2nd ed. Philadelphia: FA Davies. 309-332.

College of Occupational Therapists (2010) *Record keeping.* 2nd ed. London: COT.

College of Occupational Therapists (2011) *Professional standards for occupational therapy practice.* London: COT. Available at: http://www.cot.co.uk/standards-ethics/professional-standards-occupational-therapy-practice Accessed on 09.11.11.

Dahl Reeves G (2001) From neuron to behavior: regulation, arousal and attention as important substrates for the process of sensory integration. In: Smith Roley S, Blanche EI, Schaaf RC, eds. *Understanding the nature of sensory integration with diverse populations.* TX, San Antonio: Therapy Skill Builders. 89-108.

Grandin T (1992) Calming effects of deep touch pressure in patients with autistic disorder, college students, and animals. *Journal of Child and Adolescent Psychopharmacology, 2(1),* 63-72.

Lane SJ (2002) Structure and function of the sensory systems. In: Bundy AC, Lane SJ, Murray EA, eds. *Sensory integration: theory and practice.* 2nd ed. Philadelphia: FA Davies. 35-70.

Lane SJ (2002) Sensory modulation. In: Bundy AC, Lane SJ, Murray EA, eds. *Sensory integration: theory and practice.* 2nd ed. Philadelphia: FA Davies. 101-122.

Lynch J (2009) *Health records in courts*. Oxford: Radcliffe Publishing Ltd.

Mullen B, Champagne T, Krishnamurty S, Dickson, D, Gao R (2008) Exploring the safety and therapeutic effects of deep pressure stimulation using a weighted blanket. *Occupational Therapy in Mental Health, 24(1),* 65-89.

Parham LD, Cohn ES, Spitzer S, Koomar JA, Miller LJ, Burke JP, Brett-Green B, Mailloux Z, May-Benson TA, Smith Roley S, Schaaf RC, Schoen SA, Summers CA (2007) Fidelity in sensory integration intervention research. *American Journal of Occupational Therapy, 61(2),* 216-227.

Ordre des erothérapeutes du Québec (2008) OEQ Position Statement on the use of Weighted Blankets. Montreal: OEQ.

Schaaf RA, Smith Roley S (2006) SI: *Applying clinical reasoning to practice with diverse populations.* TX, Austin: Pro-Ed.

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College of Occupational Therapists

COT/BAOT Briefings

Quality Briefing: Measuring Outcomes

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Country Relevance: UK wide

1. Introduction

This Briefing paper covers background information and broad principles for good practice regarding measuring the outcomes following occupational therapy intervention. It also signposts relevant resources and information available.

2. What are occupational therapy outcomes?

Outcomes are the end result of intervention or action, or lack of it, on an individual or on a population group. They are the changes that occur that may be attributed, to some degree, to the intervention (or lack of it).

An outcome measure is a tool to measure or quantify this change. An initial assessment provides the baseline against which a later measurement can be compared when considering the outcome for the service user. Many tools are rated by the care professional, but increasingly service users are the raters, e.g. Patient Rated Outcome Measures (PROMs), see section 7 below.

Outcome measures may be standardised, meaning that they have a constant application procedure and scoring system.

Examples of outcomes that can be measured include:

- improvements in health or quality of life;
- improvements in function or level of independence;
- attainment of intervention goals;
- service user satisfaction; and
- system changes such as reduced hospital length of stay, waiting lists, and readmission rates.

Whilst implementing a care plan occupational therapists focus on achievement of the individual goals for the individual person, rather than the overall expected outcomes. Some goals may concern the service user's ability to complete tasks and activities, rather than looking at overall performance and participation.

As the care plan nears completion, the focus often shifts from the achievement of individual goals to the overall outcomes concerning that person's occupational performance and participation. For convenience, outcomes are often measured at the point when interventions have just been completed. However, the point at which outcomes for the service user are best measured may be months after last contact with the occupational therapist. This delay

allows time for the service user to optimise the benefits they achieve from occupational therapy interventions.

The occupational therapist will also be concerned with measuring outcomes for secondary purposes such as service management, service commissioning, information for central government (Central returns), clinical audit and clinical research.

3. The purpose of outcome measurement

Outcome measurement can demonstrate the effectiveness of intervention for individual service users or population groups, guiding further decision-making and/or intervention. The use of outcome measures, especially standardised measures, allows occupational therapists to build up and use a body of evidence for occupational therapy.

Standardised tools tend to be better recognised by those in other professions. They can help improve the sharing and understanding of information in multidisciplinary teams and between teams when more than one service is involved. The routine use of standardised tools also underpins the credibility of information and reports provided to local managers and service commissioners. Some examples are given below.

A recent trend is the development of national data sets that include outcome data, for example the recording and central aggregation of outcomes as part of the Improving Access to Psychological Therapies (IAPT) programme[1].

4. Identifying realistic aims of intervention

Health and social care services are provided to people with diverse conditions and individual circumstances. Consequently there is a variety of overall aims relevant to different individuals. For example:

Rehabilitation - to restore personal autonomy in those aspects of daily living considered most relevant by patients or service users and their family carers (Sinclair and Dickinson, 1998).
Habilitation - To achieve new levels of performance and participation, e.g. people with learning disabilities.
Reablement - to help people accommodate their illness or condition by learning or relearning the skills necessary for daily living (DH, 2007).
Adaptation – to adjust to a lower level of performance and participation, e.g. some people with neurological conditions.
Prevention – to minimise the risk of deterioration or harm, e.g. joint protection for people with arthritis.
Stabilisation – trying to maintain functioning or slow down expected deterioration, e.g. COPD.
Palliative – to improve the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support to from diagnosis to the end of life and bereavement (WHO[2]).

The above aims are not mutually exclusive. 'Reablement' and 'Rehabilitation' overlap, and may be used with different care groups. For example, home care reablement[3] is more

[1] http://www.iapt.nhs.uk/services/measuring-outcomes
[2] From the World Health Organisation, see: http://www.who.int/cancer/palliative/en/

focussed on people who need to accommodate to their condition or illness, rather than to get better.

There are other frameworks for categorising the overall aims of care and intervention, which are broadly similar to the framework set out above. For example:

- The Department of Health (DH) has published guidance on implementing Care Planning in electronic care record systems, 'Care Planning Content Technical Guidance October 2012 Technical Preview Release' (DH, 2012). This includes '*Procedure intents'* (Appendix 5, page 33), e.g. Prophylactic treatment, Curative – procedure; Adjuvant; Neo-adjuvant; Supportive – procedure; Adjunct; Adaptation; Rehabilitation; and Habilitation.

- 'Occupation for Health', Ann Wilcock (COT, 2001), e.g. Adaptation following disability and handicap; Rehabilitation; Habilitation; Restoration of Health; Prevention of Illness; and Promotion of health.

The aim provides the overall context for evaluating the effectiveness of interventions. Someone with a deteriorating condition, such as Alzheimer's disease, may expect some improvement in functioning and quality of life when first receiving health and care services. Once their situation and care package has been optimised then a more realistic aim will be to stabilise their level of functioning, or perhaps even to minimise the rate of deterioration as the illness progresses.

Individual goals should contribute to the overall aim, and wherever possible be: Specific, Measurable, Agreed, Realistic and Timed (SMART). Interventions are often chosen to collectively contribute to the achievement of the current set of goals. In some instances there may be a single intervention for each specific goal.

5. Standardised outcome measures

A 'standardised' outcome measure (as for standardised assessment tools) has a set, unchanging procedure that must be used when carried out, as well as a consistent system for scoring. This ensures minimal variation in the way it is carried out at different times and by different testers. The scoring system may also have been normatively standardised, meaning that the test has been used with a very large group of similar people, giving an average score or range of expected scores that the tester and the service user can use to compare with their own results. Standardised tests have known levels of reliability, validity, and utility, which ensure that therapists can select and use them appropriately and with confidence in the results.

6. The selection and use of outcome measures

Practitioners need to select an outcome measure that is appropriate for the specific identified measurement purpose. There isn't and probably never will be a 'one size fits all' outcome measure for all fields of practice. This reflects the breadth of occupational therapy intervention and the diversity of service users' circumstances and needs. Several outcome measures may be needed to provide comprehensive relevant information about the outcomes for each individual service user.

Before selecting outcome measures practitioners need to consider the following:

[3] 'Home Care Reablement' is a recent term used by DH, to describe some home care services that complement intermediate care services. See: http://www.csed.dh.gov.uk/homeCareReablement/

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- Existing data collection requirements for service commissioning, information required by central government and national agencies, and for local clinical audits.
- National guidance on assessment and outcome measurement in each area of practice, e.g. people with Dementia, Diabetes, 'Falls', and COPD.
- What do they want to measure – is there a tool that will do this precisely?
- Is the tool suitable for the service user's condition, needs, setting, culture and background?
- Is the tool reliable and valid?
- Is the outcome measure sensitive enough to change in the individual?
- What training is required to use the outcome measure?
- Does the outcome measure require the use of particular equipment or a specific environment?
- Is the outcome measure easy to use in practice?
- Will the introduction of the outcome measure into the service be practicable?
- Are the results meaningful and useful/usable?

There are books and other resources that provide key details of the main assessment tools and outcome measures used in health and social care services, or that can help practitioners to choose appropriate tools for their service. Some are listed below in 'Further reading'.

When it is difficult to find an outcome measure that meets precise local requirements it is tempting to adapt a published tool or to develop a 'home grown' one based on local experience. This can be very appealing and can appear to provide a quick solution. It may be relatively easy to implement, and have an acceptable degree of face validity, i.e. the outcome measure appears to measure what it says it measures.

However, the process of developing a standardised outcome measure usually takes several years, and requires a major research project with significant resources. So, a locally developed outcome measure is unlikely to have been standardised and cannot be relied on to be sufficiently valid or reliable. Practitioners should explicitly state when their results are derived from a locally developed tool to ensure those results can be interpreted correctly by the service user and other professionals.

The introduction of an outcome measure into routine clinical practice should be considered very carefully, be part of the organisation's business plans, and have the full support of senior management.

Outcome measures may require the practitioner to complete training before using the tool, and possibly regular refresher training. The training can be seen as a valid part of continuing professional and service development, if it is going to meet the requirements of the service or the needs of the service-user.

Some published tools have pre-printed forms to use. Practitioners need to ensure that they use these according to any copyright and licensing conditions given.

The results of an outcome measure must be recorded appropriately and comprehensively, then stored as part of the service-user's care records. Please refer to College of

Occupational Therapists *Professional standards for occupational therapy practice*[4], and the College's *Guidance: Record Keeping* (2010), with regards to assessment, evaluation and record keeping.

With the increasing use of electronic care records, and the inclusion of standardised tools as part of the records, the outcomes of intervention may become easier to collect and analyse. There are country-specific development programmes to design and implement electronic care records in England, Northern Ireland, Scotland and Wales.

Ideally, each assessment or outcome measure tool will have a corresponding electronic template designed into every electronic care record system. Each template will have been designed to accurately mirror existing data collection methods, such as paper forms. Correctly designed templates will ensure that assessment data can be accurately recorded in the individual electronic care record whilst retaining the full meaning of that assessment data. The assessment information can then be viewed, analysed and used for individual clinical care, and for management reporting, clinical audit and research purposes.

7. Groups of outcome measures

Some national developments in outcome measurement have produced measures that are often referred to collectively, e.g. PROMs and Social Care outcomes.

Patient Reported Outcome Measures in England

Patient Reported Outcome Measures (PROMs) are a record of the quality and effectiveness of care as perceived by patients themselves. In England, the roll out of PROMs started in 2009 with the collection and reporting of PROMS for four conditions, namely:

- hip replacements
- knee replacements
- hernia
- varicose veins

Further information is available from the Health and Social Care Information Centre, at: http://www.ic.nhs.uk/proms

(Accessed, 20/10/2012)

Social Care Outcomes

In England, the development and implementation of care outcomes is covered by the Adult Social Care Outcomes Framework (DH, 2012). The ASCOF document:

- describes the principles for the way in which the ASCOF should be used, and its relationship with local outcome measurement
- sets out the detail for each of the domains in the ASCOF, including the specific measures agreed for 2012-13
- outlines details of the next steps for future development of the outcomes-based approach and improvements to the ASCOF over coming years

http://www.dh.gov.uk/health/2012/03/adult-social-care-outcomes-framework/

[4] College of Occupational Therapists (2011) *Professional standards for occupational therapy practice.* London: COT.

(Accessed, 20/10/2012).

The social care outcomes include a number of key concepts that are relevant to occupational therapists' concern with occupational performance and participation, e.g.

- Proportion of people who use services who have control over their daily lives
- Proportion of (client group) in paid employment
- Proportion of (client group) who live independently
- Proportion of (client group) who were still at home 91 days after discharge

These, and some other newly reported outcomes, reflect the shift away from measuring processes and the efficiency of care services, and towards measuring the relative gain for service users and the overall effectiveness of care services.

8. Commonly used outcome measures

The following are a number of assessments and outcome measures commonly used by occupational therapists.

- ***Assessment of Motor and Process Skills (AMPS)***

AMPS is a standardised, observational assessment that offers occupational therapists a unique approach to the problem of how to conceptualise and assess occupational performance. When the practitioner uses the AMPS, he or she is able to simultaneously evaluate a person's overall ability to perform domestic or instrumental activities of daily living and the quality of a person's motor and process skills. Occupational therapists are required to complete a course in order to administer AMPS. More information is available from:
http://www.ampsintl.com/

(Accessed 20/10/2012)

- ***Australian Therapy Outcome Measures (AusTOMs).***

These tools are designed for use by physiotherapists, occupational therapists and speech pathologists, to measure the outcomes of their services in terms of patient functioning. The AusTOMs for Occupational Therapy scales were developed by Australian occupational therapy practitioners through focus groups, a mail out survey, and ongoing feedback during training and pilot data collection. Consumer groups also had input into the development of all of the AusTOMs scales. More information is available from:
http://www.latrobe.edu.au/austoms/

(Accessed 20/10/2012)

A review of the AusTOMs was published in the International Journal for Quality in Health Care Online: Therapy outcome measures for allied health practitioners in Australia: the AusTOMs
Perry et al. *Int J Qual Health Care.*2004; 16: 285-291.

Unsworth C (2005) Measuring Outcomes using the Australian Therapy Outcome Measures for Occupational Therapy (AusTOMs - OT): Data Description and Tool Sensitivity. British Journal of Occupational Therapy, 68(8), 354-366

- ***Canadian Occupational Performance Measure (COPM)***

COPM is an individualised, client-centred measure designed for use by occupational therapists to detect change in a client's self-perception of **occupational performance** over time. It is designed as an outcome measure for use with clients with a variety of disabilities

and across all developmental stages. The COPM is standardised in that there are specific instructions and methods for administering and scoring the test.
More information is available from: http://www.caot.ca/copm/

(Accessed 20/10/2012)

- ***EQ-5D***

The EQ-5D is a widely adopted standardised outcome measure, developed by the Euroqol group. The EQ-5D covers five dimensions (5D) namely: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. The EQ-5D includes both functioning in daily living activities and symptoms, which has contributed to its usefulness as a general measure of outcome.

There are several versions of EQ-5D, and different scoring systems. For example, the EQ-5D-3L has three levels of severity: '*No problems; some or moderate problems; and extreme problems'*. Whereas the EQ-5D-5L has five levels of severity: '*No problems; slight problems; moderate problems; severe problems; and extreme problems'*.
Further information is available on the Euroqol website, at: http://www.euroqol.org/

(Accessed 20/10/2012)

- ***Health of the Nation Outcome Scales (HoNOS)***

HoNOS, developed by the Royal College of Psychiatrists, comprises 12 simple scales to measure the health and social functioning of people with severe mental illness. They are designed for repeated use, as clinical outcome measures and training is required for those who wish to administer the outcome scales. There is a range of scales for different groups of people:

  - HoNOS for working age adults
  - HoNOS65+ for older adults
  - HoNOSCA for children and adolescents
  - HoNOS-Secure for use in health and social care settings secure psychiatric, prison health care and related forensic services, including those based in the community)
  - HoNOS-LD for learning disabilities
  - HoNOS-ABI for acquired brain injury.

More information is available from the Royal College of Psychiatrists web site:
http://www.rcpsych.ac.uk/quality/honos/whatishonos.aspx

(Accessed 20/10/2012)

- ***MOHO (Model of Human Occupation) Assessments***

More than 20 assessments have been developed based upon the MOHO model. MOHO seeks to explain how occupation is motivated, patterned, and performed. The model aims to understand occupation and problems of occupation that occur in terms of its primary concepts of volition, habituation, performance capacity and environmental context.
More information is available from: http://www.moho.uic.edu/

(Accessed 20/10/2012)

QALYs

Quality-adjusted life years (QALYS) are a standard and internationally recognised method to compare different treatments or interventions and measure their clinical effectiveness. A QALY measures how many extra months or years of life of a reasonable quality an individual might gain as a result of a specified treatment, intervention or care package. This is

particularly important when considering treatment options for people with long term conditions. For further information, see:
http://www.nice.org.uk/newsroom/features/measuringeffectivenessandcosteffectivenesstheqaly.jsp
(Accessed 20/10/2012)

9. Further reading

Asher I E ed (2007). *Occupational therapy assessment tools: an annotated index.* 3rd ed. Bethesda, MD: AOTA Press.

Clarke C, Sealey-Lapeš C, Kotsch L (2001) *Outcome measures- information pack for occupational therapy*. London: College of Occupational Therapists. [Out of print].

College of Occupational Therapists (2011) *Professional standards for occupational therapy practice (2011).* London: COT. Available at:
http://www.baot.co.uk/professionalstandards
(Accessed on 8 November 2012)

College of Occupational Therapists (2010) *Record keeping*. 2nd ed. London: COT.

Corr S, Siddons L (2005) An introduction to the selection of outcome measures. *British Journal of Occupational Therapy, 68(5),* 202-206

Department of Health (2007) *Homecare Re-ablement: Discussion document*. London: DH. Available from:
http://www.csed.dh.gov.uk/homeCareReablement/supportAndRoll/Docs/
(Accessed on 8 November 2012)

Department of Health (2012) *Care Planning Content Technical Guidance October 2012 Technical Preview Release (minor review including minor table changes).* London: DH. Available from:
http://www.uktcregistration.nss.cfh.nhs.uk/trud3/user/guest/group/0/home
(Accessed on 7 November 2012)

Enderby, P, John, A, Petheram, B (2006) *Therapy outcome measures for rehabilitation professionals: speech and language therapy, physiotherapy, occupational therapy*. 2nd ed. Chichester: John Wiley.

Finch E, Canadian Physiotherapy Association (2002) *Physical rehabilitation outcomes measures: a guide to enhanced clinical decision-making.* 2nd ed. Hamilton Ont.: BC Decker.

Health and Social Care Information Centre (2011) *Provisional Monthly Patient Reported Outcome Measures (PROMs) in England: A guide to PROMs methodology*. Leeds: NHS. Available at:
http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=1295
(Accessed on 4 October 2012)

Laver Fawcett A (2007) *Principles of assessment and outcome measurement for occupational therapists and physiotherapists: theory, skills and application.* Chichester: John Wiley.

Law M, McColl MA (2010) *Interventions, effects, and outcomes in occupational therapy: adults and older adults.* Thorofare, NJ: Slack Incorporated.

Perry A, Morris M, Unsworth C, Duckett S, Skeat J, Dodd K, Taylor N, Reilly K (2004) Therapy outcome measures for allied health practitioners in Australia: the AusTOMs. *Int J Qual Health Care. 16 (4),* 285-291.

Roberts Albert R, Yeager Kenneth R eds (2004) *Evidence-based practice manual: research and outcome measures in health and human services*. New York: Oxford University Press.

Salter K, Jutai JW, Teasell R, Foley NC, Bitensky J (2005) Issues for selection of outcome measures in stroke rehabilitation: ICF Body Functions. *Disability and Rehabilitation*, *27(4),* 191-207.

Sinclair A, Dickinson E (1998) *Effective practice in rehabilitation: the evidence of systematic reviews.* London: Kings Fund.

Slade A, Fear J, Tennant A (2004) Predicting outcome for older people in a hospital setting: which scales are appropriate? *International Journal of therapy and Rehabilitation*, *11(1),* 25-30.

Unsworth C (2005) Measuring outcomes using the Australian Therapy Outcome Measures for Occupational Therapy (AusTOMs - OT): data description and tool sensitivity. *British Journal of Occupational Therapy, 68(8),* 354-366.

Wilcock A (2001) *Occupation for health volume 1: a journey from prescription to self health. London*: British Association and College of Occupational Therapists.

World Health Organisation (2012) *Palliative care.* Geneva. WHO. Available at: http://www.who.int/cancer/palliative/en/

(Accessed 13/11/2012)

10. Useful resources

College of Occupational Therapists Library

The library has a growing collection of assessments/outcome measures and a number of textbooks on assessments/outcome measures, which are available for reference only. *For information on specific assessments please contact the COT library (*library@cot.co.uk) *or browse the library catalogue, which is available via the COT web site, at:* www.cot.org.uk

Accessed 20/10/2012

Framework for Measuring Impact ...

The Framework for measuring impact aims to help practitioners to:

> *'... demonstrate the effectiveness of your practice, the efficiency of your service, and the degree of person centred care that you are providing'.*

The website includes descriptions of a number of measures, including: CARE measure, Picker Questionnaire, Patient Experience Questionnaire, EQ-5D, SF-36, and MYMOP2.
http://www.measuringimpact.org/home

(Accessed 20/10/2012)

Practice Briefing

College of Occupational Therapists

Eight core principles for occupational therapists working with people with learning disabilities

Publication Date: March 2013
Lead Group: Practice
Country Relevance: United Kingdom

Introduction

General principles for working with adults with learning disabilities have existed for many years and are based on the concept that people with learning disabilities should be enabled to live normal, everyday lives. This fundamental principle led to the creation of a guiding set of requirements for occupational therapy practice called *Occupational therapy services for adults with learning disabilities: principles for Education and Practice* (OTPLD 2003).

Research commissioned by the College of Occupational therapists (COT) and its Specialist Section – People with Learning Disabilities (COTSS–PLD) audited against these principles and through country wide interviews, analysed and documented current occupational therapy practice. The resulting report was called *Occupational therapy and people with learning disabilities: findings from a research study* (Lillywhite and Haines 2010).

This briefing aims to incorporate the original principles for education and practice into eight new principles from the research study. The document that contains the original principles has been withdrawn and is superseded by this briefing. The eight principles need to be considered alongside both the COT and the Health and Care Professions Council standards and ethics as common topics are covered such as assessment, intervention, evaluation and supervision (COT 2010, COT 2011, HCPC 2007, HCPC 2008). All links were accessed on 22nd January 2013.

Background

Principles to guide the practice of professionals and service providers who work with adults with learning disabilities are outlined in learning disability policy documents from each of the four countries of the United Kingdom (Lillywhite and Haines 2010). All the policy papers emphasise the importance of equal rights, independence, self- determination and inclusion for adults with learning disabilities.

These principles exist to improve the lives of people with learning disabilities who are amongst the most socially isolated and vulnerable groups in society. They are less likely to have a job, own their own home and often experience occupational
deprivation. They are more likely to die at an earlier age than the rest of the population and they are likely to experience higher incidents of heart and respiratory problems, sensory impairment, epilepsy, diabetes, mental health problems and dementia (Department of Health 2009).

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Recent policy drivers have emphasised the importance of meeting the needs of people with autism, profound and multiple learning disabilities and challenging behaviour (DH 2010a, DH 2010b, DH 2012).

Principles from *Occupational therapy and people with learning disabilities. Findings from a research study* (Lillywhite and Haines 2010).
The research findings formed eight themes which have led to the creation of the new principles. Any relevant COT resources are listed below each principle:

- **Principle 1 – Occupational therapists should provide a unique occupational role and perspective.**
  The unique role and perspective of occupational therapists who work with adults with learning disabilities should be to focus on meaningful occupation, activity and enabling independence. Occupational therapy services should be for people whose primary reason for referral relates to the effect of their learning disability upon their occupational performance. Occupational therapists should practice in a person centred manner which includes working in partnership with the person with learning disabilities, considering the person's interests and motivators, using individualised communication and facilitating choice. Occupational therapy training which encompasses occupational therapy models of practice, physical, mental and social aspects of health will enable use of this broad skill set when working in this area. Occupational therapists should also bring an understanding of the problems of occupational deprivation and imbalance for adults with learning disabilities. The occupational therapy role needs to include the use of activity analysis and consideration of environmental factors.

  Occupational therapy evidence fact sheet: the importance of occupational therapy to people with learning disabilities
  http://www.cot.co.uk/sites/default/files/commissioning_ot/public/ot-evidence-learning-disabilities.pdf

- **Principle 2 – Occupational therapists should assess the impact of the person's learning disability on their occupational performance.**
  Occupational therapy assessments should focus on the impact of the person's learning disability on their occupational performance using occupational therapy practice models. The assessment should include direct observation in real environments and information gathering from all relevant sources. The assessment should lead to an understanding of the person's strengths and needs to enable the occupational therapist to advocate for the right support package.

  Standardised assessments need to be used where possible. A list of the most commonly used standardised assessments is available in the research report (Lillywhite and Haines 2010). Occupational therapists may also use a range of non-standardised assessments where appropriate. Occupational therapists need to be able to respond to increased demand for assessments for activities of daily living, risk, capacity and vocational skills.

  Self-assessment toolkit for occupational therapists to audit practice against research recommendations
  http://www.cot.co.uk/cotss-people-learning-disabilities/resources

- **Principle 3 – Occupational therapists should offer interventions to people with learning disabilities that focus on engagement in occupation and enabling independence.**
  People with learning disabilities need to be enabled to have choice and influence over their occupational therapy intervention. Occupational therapy interventions should be of an appropriate length of time to enable engagement with the service user and development of their independent living skills. Occupational therapists use a wide variety of interventions to work with both people with mild learning disabilities and those with complex needs. Broad categories and approaches of intervention can include: environmental adaptation; sensory integration; skill

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development for activities of daily living; leisure; education; employment and parenting. Occupational therapists can also use their knowledge of occupation and sensory integration theory to offer interventions to those whose behaviour is described as challenging or distressed. Occupational therapy interventions are particularly valued during times of transition, for example moving from one environment to another or moving from child to adult services.

- **Principle 4 – Occupational therapists should work collaboratively with others to meet the needs of people with learning disabilities.**
  Occupational therapists should work in partnership with others and offer a consultancy role to colleagues, family, support workers and mainstream services. Occupational therapists need to provide recommendations for managers and support workers to follow that are achievable and in an accessible format. These can be written in negotiation with managers/support staff and support staff should be involved in session planning and reviewing progress. Occupational therapists also need to provide training to support staff about the importance of occupation and activity and how to support a person to be more engaged. Occupational therapists must develop working relationships with mainstream health and social care services so people with learning disabilities can access and receive appropriate generic services as is their right. Protocols need to be developed so service users are clear who provides what part of services.

- **Principle 5 – Occupational therapists should measure the outcomes of occupational therapy interventions for people with learning disabilities.**
  When measuring the outcomes of interventions, occupational therapists should consider the views of the person with a learning disability, family carer and support worker regarding what the outcome will be and if it has been achieved. Good relationships with everybody involved in the care of the person with a learning disability should be developed as this will improve outcomes. Being able to measure whether the aims set at the beginning of the intervention have been achieved is a valid method to demonstrate impact. Occupational therapists need to develop ways to show subtle changes in quality of life and improvements in the environment, especially for service users with complex needs.

  COT Briefing 153- Measuring outcomes
  http://www.cot.co.uk/briefings/briefing-153-measuring-outcomes-2012

- **Principle 6 – Occupational therapists should promote recognition of occupational therapy with people with learning disabilities.**
  Occupational therapists need to be confident and assertive in their role to ensure managers and government agencies understand the contribution and added value the profession brings. Developing protocols, marketing information, written referral criteria, regular attendance at multidisciplinary meetings and representation on forums can assist this. Using appropriate terminology in verbal feedback and written reports can enhance others' understanding of this by showing the complexity of clinical reasoning. Care must be taken, however, to reduce scientific language when producing accessible information. Occupational therapists should contribute to developing the evidence base of effectiveness of occupational therapy interventions as this will increase recognition. There is a need to find opportunities to read the literature, to network in order to learn from case studies, to share resources and publish work.

  Research and development strategic vision and action plan for occupational therapists working with people with learning disabilities
  http://www.cot.co.uk/cotss-people-learning-disabilities/research

- **Principle 7 – Occupational therapists need to creatively respond to the impact of health and social care policy on occupational therapy with people with learning disabilities.**

  Occupational therapists will need to think creatively to respond to the opportunities and challenges presented by health and social care policy. The aims of national learning disability

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policy fit well with the aims of the profession in terms of promoting independence. The policy drive is also to enable access to mainstream services which can give occupational therapists the opportunity to develop a specialist learning disability role and carry out less provision of adaptations/equipment for physical health needs. Competing demands such as lack of resources and targets impact on services and mean occupational therapists need to be more creative about how they provide services.

Supporting Practice –Evidence and Resources (SPEaR). People with learning disabilities.
http://www.cot.co.uk/supporting-practice/learning-disabilities

- **Principle 8 – Occupational therapists need to develop the skills to work with adults with learning disabilities.**

  Pre-registration training needs to ensure up-to-date content about the role of the occupational therapist with adults with learning disabilities is an integral part of the course. Occupational therapists in practice need to find ways to offer more student placements in learning disability services which could include sharing students across services. Post-registration learning is important and occupational therapists need to seek opportunities to develop their skills and find resources for training. It is vital to ensure appropriate clinical supervision is sourced particularly for those who work alone. It is also vital that opportunities to network and share skills, resources and experience are utilized such as COTSS–PLD locality groups and internet/email/social media.

  Higher education resource pack and top tips for students
  http://www.cot.co.uk/cotss-people-learning-disabilities/resources

References:

College of Occupational Therapists (2010) *Code of ethics and professional conduct.* London: COT.

College of Occupational Therapists (2011) *Professional Standards for Occupational therapy practice.* London: COT.

Department of Health (2009) *Valuing people now. A new three year strategy for people with learning disabilities.* London: DH.

Department of Health (2010a) *Fulfilling and rewarding lives: a strategy for individuals with autism in England.* London: DH.

Department of Health (2010b) *Raising our sights: services for adults with profound intellectual and multiple disabilities.* London: DH.

Department of Health (2012) *Transforming care: A national response to Winterbourne View hospital. Final report.* London: DH.

Health and Care Professions Council (2007) *Standards of proficiency: occupational therapists.* London: HCPC.

Health and Care Professions Council (2008) *Standards of conduct, performance and ethics.* London: HCPC.

Lillywhite A, Haines D (2010) *Occupational therapy and people with learning disabilities: findings from a research study.* London: College of Occupational Therapists.

OTPLD (2003) *Occupational therapy services for adults with learning disabilities: principles for education and practice.* London: College of Occupational Therapists.

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A resource about Occupational Therapy with People with Learning Disabilities

Introduction

Occupational Therapy is a profession founded on the belief that occupation is essential to good health and wellbeing (Keilhofner 2007, Creek, 2003). Occupational deprivation affects both physical and psychological health. This can be a particular problem for people with learning disabilities who are more likely to experience social isolation, dependence on others to plan and complete activities and poor access to services (Department of Health, 2001)

People with learning disabilities are more likely than the rest of the population to experience a range of health conditions such as mental health problems, cardio vascular problems, and sensory impairment. As such, our multi-dimensional training puts Occupational Therapists in a prime position to consider the range of difficulties that people with Learning Disabilities might experience.

Occupational Therapists have a key role in helping people with learning disabilities to access occupation; adapting activity, equipment, environment or materials in the places where they live and work. They have specific skills in activity analysis, assessment of function, collaborative goal setting, evaluation and an understanding of the relevance and role of occupation in health and well being (COT 2007).

The most commonly used definition of learning disability internationally is that of the World Health Organisation.

> A condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, i.e. cognitive, language, motor, and social abilities. (WHO, ICD - 10 version 2010)

The diagnosis will depend on the overall assessment of intellectual functioning by a skilled practitioner. Degrees of impairment are conventionally estimated by standardized intelligence tests supplemented by assessing social adaptation. Intellectual abilities and social adaptation may change over time, and may improve as a result of training and rehabilitation (ICD -10, version 2010).

There is evidence that people with learning disabilities are amongst the most socially isolated and vulnerable groups in society. They are less likely to have jobs (DoH 2009a), less likely to own their own home and often rely on others for day to day support (DoH 2009b). People with learning disabilities are more likely to experience occupational deprivation and social isolation (Stancliffe et al 2007).

They are also at a significantly increased risk of a range of health problems and are more likely to die at an earlier age than the rest of the population (DoH 2007), experiencing a higher incidence of heart and respiratory problems, sensory impairment, epilepsy, diabetes, mental health problems and dementia (Gustavson et al 2005). In light of government drivers promoting the rights of people with learning disabilities to access mainstream services, it is probable that Occupational

Therapists specialising in any field of practice will at some point in their career work with someone with a learning disability.

This paper will consider best practice for both Occupational Therapists working in mainstream services and those specialising in learning disabilities.

Background and context

The four countries of the United Kingdom each have policies or visions for meeting the needs of people with learning disabilities. Occupational Therapy is provided within the context of these policies. Although the emphasis and language used varies slightly in each country, the overall direction is similar.

In England, the *Valuing people* White Paper (DoH 2001) and *Valuing people now* (DoH 2009) focus on rights, independence, control and inclusion with specific reference to addressing needs related to health, housing, work, education and relationships.

In Scotland, *The same as you?* (Scottish Executive 2000) is committed to improving the quality of life of people with learning disabilities, it focuses on importance of social inclusion, equality, fairness and the opportunity for continuous learning. The paper provides information for people about their needs and places people with learning disabilities at the centre of decision making about their care.

In Northern Ireland, *Equal lives* (Department of Health, Social Services and Public Safety Northern Ireland, 2005) bases its recommendations on the five key values of citizenship, social inclusion, empowerment, working together and individual services.

In Wales, *Fulfilling the promises* (National Assembly for Wales Learning Disability Advisory Group 2001) provides a statement on policy and practice (Welsh Assembly Government 2007) based on the principle that people with a learning disability are full citizens, equal in status and value to others of the same age. They have the right to live healthy, productive and independent lives and to decide everyday issues and life-defining matters for themselves. Fulfilling the promises highlights the need for people with learning disabilities to live their lives fully, have support within their community and to have access to general and specialist services.

Occupational Therapists working in mainstream services

Despite a commitment by the respective governments to ensure better access to mainstream services (DoH 2001, Scottish Executive 2000, DHSSPSNI, 2005 and Welsh Assembly Government, 2007) it is well documented that people with a learning disability receive poorer standards of care in mainstream services (Mencap, 2007, Michael, 2008 and Mencap, 2012) due to poor communication, assumptions about quality of life and a lack of understanding by healthcare professionals about their needs (Mencap 2007). Diagnostic overshadowing is thought to contribute significantly to health inequalities for people with learning disabilities and refers to the tendency of professionals to interpret the reporting of symptoms and pain

behaviours to a learning disability or mental health problem (Disability Rights Commission 2007).

Valuing People Now (DoH, 2009) stresses the rights of people with learning disabilities to access mainstream healthcare and *Fulfilling and rewarding lives* (DoH, 2010 p.6) states that people with autism should be able to "depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents."

Occupational Therapists working in both mainstream and specialist services need skills and knowledge to work with people with learning disabilities. The College of Occupational Therapy and College of Occupational Therapy Specialist Section – People with Learning Disabilities have been actively involved in the development of the 'Mencap – getting it right' charter (Mencap 2008) which highlights key activities that ensure equal treatment in mainstream health and social care services. Of these nine activities the following are most significant to Occupational Therapy practice:

- All staff should understand and apply the principles of mental capacity laws.
- Staff should receive ongoing learning disability awareness training
- Staff should listen to, respect and involve families and carers
- Staff should offer practical support and information to families and carers
- Staff should provide information that is accessible for people with a learning disability

Occupational Therapists should offer the same range of assessments and interventions offered to other service users. By law they have an obligation to make reasonable adjustments to ensure an equal opportunity to benefit from the treatment (Great Britain Parliament, 2010, Equality Act).

The following bullet point's offer suggested adjustments:

- Establish the best way to communicate with the person. Mencap (2010) offer the following guidance:
    - Pay attention to facial expressions.
    - Notice gestures and body language.
    - Try pointing to pictures.
    - Try signing.
    - Keep information simple and brief.
    - Avoid using jargon.
    - Avoid abstract concepts as many people with learning disabilities, particularly those with autism have a literal understanding of language, Concepts such as emotions may also be difficult as these do not have concrete meaning.

- Longer appointment times as many people with learning disabilities require more time than most to express their needs and process information (Martin et al 1997, Melville et al 2006).

- Flexible appointment times. Many people with learning disabilities (especially those with autism) find waiting very difficult. In hospital or outpatient settings it may be helpful to offer the first appointment of the day to avoid delays(Brown et al 2012, Brown and Guvenir 2009).

- Assessments of everyday activities should be done in context as many people with learning disabilities have difficulties with generalisation. Replicate the home environment as closely as possible if not assessing at home, use familiar objects and familiar routines as much as possible and assess at the time that person would normally be doing that activity. Things we take for granted may be difficult to comprehend for someone with a learning disability: a commode may just look like another chair to a person with a learning disability; they may not be able to understand that this is the same as the toilet they use at home (Morton-Cooper 2004).

- Use the knowledge and skills of staff or family who can show you how to best communicate and engage with the person (Mencap 2010).

- Seek advice from services, particularly your local Community Learning Disability Team.

Occupational Therapists specialising in learning disabilities:

The College of Occupational Therapy and The College of Occupational Therapist Specialist Section – People with Learning disabilities commissioned a comprehensive research project in the unique role of Occupational Therapy and people with learning disabilities (Lillywhite and Haines, 2010). It can be accessed from http://www.cot.co.uk/publication/books-z-listing/occupational-therapy-and-people-learning-disabilities-findings-research).

Occupational Therapists specialising in the field of learning disabilities have both a clinical and consultancy role (Lillywhite and Haines, 2010).

The Clinical role:

Occupational Therapists have a key role in the assessment and treatment of people with complex needs (people with profound and multiple disabilities, autism, dual diagnosis and behaviour that challenges), those with sensory processing needs, those in transition (moving house, moving from children's service to adult services or adult services into older persons services), those who are becoming parents and in vocational rehabilitation (Lillywhite and Haines. 2010).
Occupational Therapists also have an important contribution described within a range of recent government drivers such as:

- Rewarding and Fulfilling Lives (DoH 2010a) highlights the needs of people with autism to be supported to participate in day to day meaningful activities, in their communities and access employment.

- Raising our sights (DoH 2010b) discusses people with profound and multiple learning disabilities stating the need for highly individualised packages of support and It highlights the importance of accessing assistive technology that enables them to have greater control over their lives.
- Services for people with learning disability and challenging behaviour or mental health needs – (Mansell Report) (DoH 2007) recommendations better day opportunities and environments with staff sufficiently skilled to support people with challenging behaviour and engage them in meaningful activities

Specialist assessment:

Learning Disability Occupational Therapists have a significant role in assessing the impact of an individual's learning disability on their occupational performance i.e. how it affects their life and engagement in the occupations that are important to them.

Occupational Therapists use a wide range of assessments tools in order to gain a broad understanding of a person's needs. These tools include standardised assessments which are robust and provide measurable outcomes.

Assessments should be carried out in a range of naturalistic settings relevant to the individual's life (e.g home, day services, work, college etc...) matched with information from a range of sources such as direct observation, liaison with service user, staff and families Assessments should also include the use of standardised assessments to ensure clarity and objectivity. Assessment can inform services on the support or placement most appropriate for the individual or about the support required to complete daily activities which are relevant and meaningful to the person. This may in turn promote self-esteem and a sense of control, reducing challenging behaviour and promoting skill development.

Lillywhite and Haines found that the main standardised assessments used by Occupational Therapists with people with learning disabilities are:

- The Assessment of Motor and Process Skills (Fisher, 2010)
- The Canadian Occupational Performance Measure (Law et al, 1994);
- Assessments from the Model of Human Occupation (Kielhofner, 2007) i.e The Model of Human Occupation Screening Tool (Parkinson *et al,* 2006), the Volitional Questionnaire (De las Heras *et a,l* 2007), the Occupational Self Assessment (Baron *et al,* 2006) and the Occupational Circumstances Assessment Interview and Rating Scale (Forsyth *et al,* 2005).
- The Pool Activity Level Instrument for Occupational Profiling (Pool, 2007).

Many Occupational Therapists specialising in learning disabilities also undertake post-registration training in sensory integration enabling them to use standardised assessments from within that theoretical framework e.g. The Sensory Integration

Inventory – Revised for Individuals with Developmental Disabilities (Reisman and Hanschu, 1992),

Despite a desire to use these standardised assessments Lillywhite and Haines (2010) found that they were only used for 29% of referrals. This is often due to the complexity of service user need and difficulties with communication. Standardised assessments adapted to be more accessible and applicable to people with learning disabilities (Lillywhite and Haines, 2010, Blount, 2008) are sometimes used and there have been attempts to standardise adapted versions of tools. Examples include activities of daily living or interest checklists, using visual cues such as photos or symbols (Lillywhite and Haines, 2010).

Occupational Therapists are also key contributors in risk assessments (Lillywhite and Haines, 2010).

Specialist treatment and intervention:

Central to intervention is the presumption that the individual should be enabled as much as possible to lead the process, being involved in and taking control over their own Occupational Therapy interventions. Best practice dictates that information about occupational goals is provided in an accessible format (Lillywhite and Haines, 2010).

Learning disability Occupational Therapists should offer a range of interventions including:

- Skills development via 1:1 work (Kottorp et al, 2003), groups (Hallgren and Kottorp 2005) or consultation for those who support the person with a learning disability.
- Development of support profiles which help others to grade activities appropriate to an individual's skills and needs as well as guidance on ways to set up the environment to promote opportunities for engagement (Beadle-Brown et al, 2008, *Stancliffe et al*, 2007).
- Environmental adaption to include the physical environment, sensory and social environment (SIGN 2007).
- Support to develop a range of meaningful occupations, facilitating motivation and promoting choice and control through activity**.** Offering choice and control can reduce challenging behaviour (DoH, 2012) and encourage more passive individuals to take a more active role in their lives (Koritsas et al 2008, Stancliffe *et al.* 2007).
- Work rehabilitation and development of vocational skills (Robertson and Emerson 2006, Winstow and Schneider 2003, Jenkins 2002).
- Developing structures and routines: to create a sense of control and predictability in the day helps orientate people to time and support independence (Jones, 2004).
- Sensory integration therapy**:** Evidence suggests that Sensory Integration Therapy programs can reduce challenging behaviour and self-stimulatory

behaviour (Reisman, 1993), improve interaction with the environment (Green et al, 2003) and improve a person's attention and performance in daily activities (Urwin, 2004).

- Supporting service users to make positive choices about their occupation and listening to service users preferences regardless of communication needs and level of learning disability (Joyce and Shuttleworth, 2001).

The consultation role

Consultation to support staff and families:

Developing a good working relationship with key members of staff who have particular interests or skills can increase the likelihood of recommendations being followed (Emerson et al 2012). Building rapport can take time and may involve educating and encouraging support workers to work in a more occupational or enabling way, requiring long term work to support attitudinal change. Occupational therapists must consider how knowledge is shared across the *whole* team as collaborative working with other members of the multi disciplinary team is vital (Emerson et al 2012, Dobson 2002). Lillywhite and Haines(2010) found that written recommendations in an accessible format clarify the key points discussed and that support workers "emphasise the importance of occupational therapists keeping recommendations down to a minimum". They value involvement in decisions on the format of recommendations transferrable to a whole staff group. This may mean looking beyond written guidelines and recommendations and giving support workers alternative tools, including visual materials such as DVDs (Dunn et al 2006).

Consultation to mainstream services:

Occupational Therapists who specialise in learning disabilities will be involved in consultation with those working in a range of mainstream settings. This will involve supporting colleagues in adapting their practice and communication to ensure the best possible outcome for the person with a learning disability. It may involve advocating on behalf of the person with a learning disability. There are no nationally agreed standards in relation to this role; agreements are made on a local basis.

The consultative role also extends beyond fellow Occupational Therapists to include advocating for people with learning disabilities in support to access services in the community e.g. transport, education and employment opportunities.

Measuring outcomes and auditing good practice

Outcome measures:

Measuring outcomes can be challenging when working with people with learning disabilities. Occupational therapists are required to comply with the *Mental Capacity Act 2005* (Great Britain. Parliament 2005) enabling people to make choices and set their own goals to improve their quality of life. Documenting and reviewing whether intervention goals have been achieved is an important way of demonstrating outcomes. There is a lack of standardised tools that can be used to measure outcomes in relation to people with profound and multiple learning disabilities

therefore detailed observational recording and goal reviewing are essential. Tools with a greater focus on the environment, sensitive enough to measure change in this group of people would be beneficial (Lillywhite and Haines, 2010).

Service user feedback:

The perspective of the person with a learning disability, family carers and support workers on what the outcome should be and whether it has been achieved is particularly important, for example their satisfaction with their own occupational performance (Lillywhite and Haines, 2010). When gaining feedback from service users with learning disabilities much care must be taken. Ball and Shanks (2012) explored how Occupational Therapists specialising in learning disabilities gain feedback. They found that the majority of participants used informal interviews and only just over half considered issues of suggestibility and susceptibility to bias. They offer some suggested ways to increase the reliability of service user feedback. These include:

- Use of tools such as talking mats, cue cards, photographs or the use of multimedia such as DVD's.
- Use of independent interviewers who use photos of the subject of the feedback.
- Clear standardised organisational processes which offer a structure by which to gather and use feedback.

They also recognise the need for more research in to the best ways of gaining feedback, particularly for those with profound and multiple learning disabilities.

Audit tools:

The College of Occupational Therapists Specialist Section –People with Learning Disabilities have produced an audit tool to help specialist Occupational Therapists evaluate their practice. The tool is available at http://www.cot.co.uk/news/cotss-people-learning-disabilities/OT-audit-tool - check

Training issues for Occupational Therapists when working with people with learning disabilities

Whilst it would be impossible to discuss all the possible training opportunities available and appropriate for Occupational Therapists working with people with learning disabilities, this section will describe some of the most relevant.

Undergraduate training:

Despite recommendations in Healthcare for All (Michael, 2008) there is great variation in the amount of undergraduate Occupational Therapy education about the needs of people with learning disabilities (Lillywhite and Haines2010) The College of Occupational Therapists Specialist Section- People with Learning Disabilities has produced the 'Higher education resource pack' (see resources) in an attempt to to support educators.

Mainstream Occupational Therapists:

The Mental Capacity Act (Great Britain. Parliament, 2005).

It is vital that all professionals understand that no one can give consent on behalf of an adult with learning disabilities. There may be a need to adapt information to facilitate capacity and there is a clear process for assessing best interests should a person lack capacity. The act is clear that capacity to consent is situation specific.

The principles of the Act are:

- **Presumption of capacity** (section 1(2) MCA). Every adult has the right to make their own decisions if they have the capacity to do so.
- **Maximising decision making capacity** (section 1(3) MCA). People should receive support to help them make their own decisions.
- **Right to make unwise decisions** (section 1(4) MCA). People have the right to make decisions that others might think are unwise.
- **Best interests** (section 1(5) MCA). Any act done for, or any decision made on behalf of, someone who lacks capacity must be in their best interests.
- **Least restrictive option** (section 1(6) MCA). Any act done for, or any decision made on behalf of, someone who lacks capacity should be the least restrictive option possible

Autism awareness training

The Autism Strategy (DoH 2010) states that all health care professionals should have a basic awareness of the needs of people with autism. There are a range of independent and local organisations able to provide this. Occupational therapists should seek advice from their managers or local community learning disability team.

Specific training for Occupational Therapists specialising in Learning Disabilities:

Assessment of Motor and Process Skills:

The Assessment of Motor and Process Skills (AMPS) (Fisher 2010) is the standardised assessment that is reported by Lillywhite and Haines (2010) as the most used by occupational therapists with people with learning disabilities. To practice AMPS assessments the Occupational Therapist must complete a 5 day training course and be calibrated by AMPS international.

Sensory Integration

The College of Occupational Therapists have produced a briefing paper on the use of sensory integration (COT/BAOT Briefing 70, reviewed 2008).
Sensory Integration is not part of core Occupational Therapy training therefore those wishing to do so must undertake recognised and appropriate training to use this in their work. They do so as extended scope practitioners (COT/BAOT Briefing 14 Extended Scope Practice). The Sensory Integration Global Network and the Sensory

Integration Network (UK) state appropriate levels of training required and stress that competencies in the application of sensory integration theory and skills learned must be maintained. The Network suggests two years of development of clinical experience, mentorship, supervision, ongoing study and guidance for those newly trained and peer support thereafter as a check and balance for best practice.

(*It should be noted that sensory integration therapy is not covered by The British Association of Occupational Therapists indemnity insurance. But would normally be covered by the employers insurance providing appropriate training and supervision is undertaken.)*

Communication techniques

Intensive Interaction
Intensive interaction is an inter-professional approach to communication with children and adults who have severe learning disabilities and/or autism and who are still at an early stage of communication development. Training course information is available on the Intensive Interaction webpage http://www.intensiveinteraction.co.uk/. For an Occupational Therapy based approach, the work of Phoebe Caldwell can be found on: http://www.phoebecaldwell.co.uk/links.html

Supervision, mentoring and locality groups

As with any other area of Occupational Therapy it is important that individuals source appropriate supervision. COT Briefing 55 states that the kind of supervision needed will depend upon the role and level of experience of the practitioner and should be sought from a practitioner with a higher level of knowledge, skills and experience in the same field.

The College of Occupational Therapists Specialist Section – People with Learning Disabilities support local special interest groups who can offer a source of support and advice, involvement in these groups is seen as a valuable continuing professional development exercise.

Research

There remains limited, but growing, published research evidence to support clinical practice. There is a particular need for evidence on the effectiveness of occupational therapy interventions and regarding assessments and outcome measures.

The College of Occupational Therapists Specialist Section – People with Learning Disabilities Strategic Vision and Action Plan for occupational therapists working with people with learning disabilities (2012) gives suggested areas for research. It outlines support for research and evidence based practice. The specialist section also provides support to members who wish to undertake research (COT Briefing 88).

COT/BAOT Briefings and COTSS-PLD resources:

http://www.cot.co.uk/briefings/briefings

Briefing 51: Management of disturbed and violent behaviour (December 2005)
Briefing 55: Management Briefing: Supervision (Revised May 2010)
Briefing 60: Mental Capacity Act 2005 (Revised August 2011)
Briefing 70: Occupational Therapists and Sensory Integration (September 2006)
Briefing 88: Responding to research enquiries: information for specialist sections (Revised September 2011)

Higher Education Resource pack: http://www.cot.co.uk/cotss-people-learning-disabilities/resources

Occupational Therapy Fact Sheet: The importance of occupational therapy to people with Learning Disabilities
http://www.cot.co.uk/sites/default/files/commissioning_ot/public/ot-evidence-learning-disabilities.pdf

Self assessment toolkit: http://www.cot.co.uk/news/cotss-people-learning-disabilities/OT-audit-tool

Strategic Vision and Action Plan for occupational therapists working with people with learning disabilities (2012): http://www.cot.co.uk/cotss-people-learning-disabilities/research

Tips for students: http://www.cot.co.uk/cotss-people-learning-disabilities/resources

SPEaR: http://www.cot.co.uk/supporting-practice/learning-disabilities

Useful websites/ resources:

www.easyhealth.org.uk

www.easyinfo.co.uk

www.plainenglish.co.uk/atoz.pdf

http://www.bildservices.org.uk

www.**mencap**.org.uk (getting it right leaflet and charter)

http://www.pamis.org.uk/

http://www.pmldlink.org.uk/

http://www.pmldnetwork.org/

http://www.intensiveinteraction.co.uk/.

http://www.phoebecaldwell.co.uk/links.html

CAF directory of specific conditions and rare disorders: http://www.cafamily.org.uk/

Challenging Behaviour National Strategy Group Charter:
(Challenging Behaviour Foundation website)
http://www.thecbf.org.uk/campaigns/campaigns.htm

References:

Ball and Shanks (2012) *Gaining feedback from people with learning disabilities* British Journal of Occupational Therapy. BJOT. 75 (10), pp. 471-477(7).

Baron K, Kielhofner G, Iyenger A, Goldhammer V, Wolenski, J (2006) *Occupational self assessment (OSA)*. Chicago, IL: University of Illinois at Chicago

Beadle-Brown J, Hutchinson A, Whelton B (2008) *A better life: the implementation and effect of person-centred active support in the Avenues Trust* Tizard Learning Disability Review 13 (4) 15-24

Blount J (2008) *The Use Of Occupationally Focused Assessment Tools: The Practice Of Occupational Therapists Working With Adults With Learning Disabilities In The UK* College of Occupational Therapist Specialist Section- People with Learning Disabilities (2) 1 pg 8- 17

Brown FJ, Cooper K, Diebel T (2012) *Access to mainstream health services: a case study of the difficulties faced by a child with learning disabilities* Journal of Learning Disabilities

Brown FJ, Guvenir J (2009) *The Experiences of Children with Learning Disabilities, Their Carers and Staff during a Hospital Admission* British Journal of Learning Disabilities 37 (2) 110-115

Creek (2003) *Occupational therapy as a complex intervention.* London: College of Occupational Therapists College of Occupational Therapists

De las Heras CG, Geist R, Kielhofner G, Li Y (2007) *The volitional questionnaire*. Chicago, IL: University of Illinois at Chicago.

Department of Health (2001) *Valuing people: a new strategy for learning disability for the 21st century.* London: Department of Health.

Department of Health (2007) *Services for people with learning disability and challenging behaviour or mental health needs (revised edition).* London: Department of Health.

Department of Health (2009a) *Valuing employment now*. London: Department of Health.

Department of Health (2009b) *Valuing people now*. London: Department of Health.

Department of Health (2010a) *Fulfilling and rewarding lives: a strategy for individuals with autism in England* Department of Health: London

Department of Health (2010b) *Raising our Sights; services* for adults with profound intellectual and multiple disabilities Department of Health: London

Department of Health (2012) *Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report Available at: https://www.wp.dh.gov.uk/publications/files/2012/12/final-report.pdf. Accessed 17.12.2012*

Department of Health, Social Services and Public Safety Northern Ireland (2005) *Equal lives: review of policy and services for people with a learning disability in Northern Ireland*. Belfast: Department of Health, Social Services and Public Safety.

Disability Rights commission (2007) *Equal treatment: closing the gap. A formal investigation into the physical health inequalities experienced by people with learning disabilities and/or mental health problems* Stratford upon Avon: Disability Rights Commission.

Dobson S, Upadhyaya S, Stanley S (2002) *Using an interdisciplinary approach to training to develop the quality of communication with adults with profound learning disabilities by care staff* International Journal of Language and Communication Disorders 37 (1) 41-57

Dunn A Kroese B Thomas G McGarry A Drew P (2006) *'Are you allowed to say that' using video materials to provide accessible information about psychology services* British Journal of Learning Disabilities 34 215-219

Emerson E, Hatton C, Gone R, Caine A, Bromley J (2012) *Clinical psychology and people with intellectual disability 2nd edition* Oxford: Wiley publishing

Fisher A (2010) *Assessment of motor and process skills. 7*th ed. Fort Collins, CO: Three Star Press.

Forsyth K, Deshpande S, Kielhofner G, Henriksson C, Haglund L, Olson L, Skinner S, Kulkarni S (2005) *The occupational circumstances assessment interview and rating scale (OCAIRS)*. Chicago, IL: University of Illinois at Chicago.

Goodman J, Hurst J, Locke C, eds (2008) *Occupational therapy for people with learning disabilities: a practical guide*. London: Churchill Livingstone.
Great Britain. Parliament (2005) Mental Capacity Act 2005. Available from http://www.legislation.gov.uk/ukpga/2005/9/contents. Accessed 17.12.2012.

Great Britain. Parliament (2010). *Equality Act* Available at; http://www.legislation.gov.uk/ukpga/2010/15 accessed on 1.12.2012

Green D., Beaton L., Moore D., Warren L., Wick V., Sanford E., Santosh P., (2003) Clinical incidence of sensory integration difficulties in adults with learning disabilities and illustration of management BJOT 66 (10) 454

Gustavson, Umb-Carlsson, Sonnander (2005) *A follow up study of mortality, health conditions and associated disabilities of people with intellectual disabilities in a Swedish County* Journal of intellectual disability research 49 905-914

Lillywhite A, Haines D (2010) *Occupational Therapy and People with Learning Disabilities: findings from a research study* London: College of Occupational Therapists

Jenkins R (2002) *Value of employment to people with learning disabilities* British Journal of Nursing 11 (1) 38-44

Jones, E. (2004) 'Active support', Occupational Therapists in Learning Disabilities Conference, Cardiff, Wales.

Joyce T, Shuttleworth L (2001) *From engagement to participation: how do we bridge the gap?* British Journal of Learning Disabilities 29 63-71

Kielhofner G (2007) *Model of human occupation: theory and application.* 4th ed. Kingsley.

Koritsas S, Iacono T, Hamilton D, Leighton D (2008) *The effect of active support training on engagement, opportunities for choice, challenging behaviour and support needs.* Journal of Intellectual & Developmental Disability 33 (3) 247-256

Kottorp A, Hallgren M, Bernspang B, Fisher A (2003) *Client-Centred Occupational Therapy for Persons with Mental Retardation: Implementation of an Intervention Programme in Activities of Daily Living Tasks* Scandinavian Journal of Occupational Therapy 10 (2) 51-60

Law M, Baptiste S, Carswell A, McColl MA, Polatajko H, Pollock N (1994) *Canadian occupational performance measure.* 2nd ed. Toronto, ON: CAOT Publications Ace.

Martin, Roy, Wells (1997) *Health gain through health checks: improving access to primary care for people with intellectual disability* Journal of intellectual disability research 41 401-408

Melville C, Cooper S-A, Morrison J, Finlayson J, Allan L, Robinson N, Burns E, Martin G (2006) *The outcome of an intervention study to reduce the barriers experienced by people with intellectual disabilities accessing primary health care service* Journal of intellectual disability research 50 (1) 11-17

Mencap (2007). Death by *indifference*. Mencap

Mencap (2010) *Getting it right charter.* London: Mencap

Mencap (2012) Death by *indifference*: 74 deaths and counting
A progress report 5 years on. Mencap. Available from
http://www.mencap.org.uk/74deaths accessed on 17.12.2012.

Michael J (2008) *Healthcare for all: report of the independent inquiry into access to healthcare for people with learning disabilities*. Department of Health. Available from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_106126.pdf . accessed on 17.12.2012.

Morton-Cooper A. (2004) *Health care and the autism spectrum: a guide for health professionals, patients and carers*. London: Jessica Kingsley

National Assembly for Wales Learning Disability Advisory Group (2001) *Fulfilling the promises*: *proposal for a framework for services for people with a learning disability.*

National Association of Occupational Therapists Working with People with Learning Disabilities (OTPLD) (2003) *Occupational therapy services for adults with learning disabilities.* (Principles for Education and Practice). London: College of Occupational Therapists.

Parkinson S, Forsyth K, Kielhofner G (2006) *The model of human occupation screening tool (MOHOST)*. Chicago, IL: University of Illinois at Chicago. Philadelphia, PA: Lippincott Williams & Wilkins

Pool J (2007) *The Pool activity level instrument for occupational profi ling: a practical resource for carers of people with cognitive impairment.* 3rd ed. London: Jessica

Reisman J, Hanschu B (1992) *The sensory integration inventory: revised for individuals with developmental disabilities*. Hugo, MN: PDP Press Inc.

Reisman JE (1993) Using a sensory integrative approach to treat self-injurious behaviour in an adult with profound mental retardation. *American Journal of Occupational Therapy, 47,* 403-11.

Robertson J, Emerson E (2006) A systematic review of the comparative benefits and costs of models of providing residential and vocational supports to adults with autistic spectrum disorder. NAS: Lancaster University

Scottish Executive (2000) *The same as you? A review of services for people with learning disabilities.* Edinburgh: Scottish Executive.

Sensory integration global network; Guidelines for competency in the application of sensory integration theory http://www.siglobalnetwork.org/guidelines.pdf [accesses January 2012]

SIGN (2007) *Assessment, diagnosis and clinical interventions for children and young people with autistic spectrum disorders* Scottish Intercollegiate Guidelines Network: Edinburgh

Stancliffe RJ Harman AD, Toogood S, McVilly K (2007) *Australian Implementation and Evaluation of Active Support* Journal of Applied Research in Intellectual Disabilities 30 (3) 211- 227

Urwin R., Ballinger C., (2005) Effectiveness of sensory integration therapy to improve functional behaviour in adults with learning disabilities,: five single-case experimental designs 68 (2) 56

Welsh Assembly Government (2007) *Learning disability strategy: section 7 guidance on service principles and service responsibilities.* Cardiff: Welsh Assembly Government

Winstow R, Schneider J (2003) *User views on supported employment and social inclusion: a qualitative study of 30 people in work* British Journal of Learning Disabilities 31 166-174

WHO (1996) International Classification of Disease -10 Guide for Mental retardation World Health Organisation: Geneva
Available on http://www.who.int/classifications/icd/en/ accessed on the 17.12.2012.

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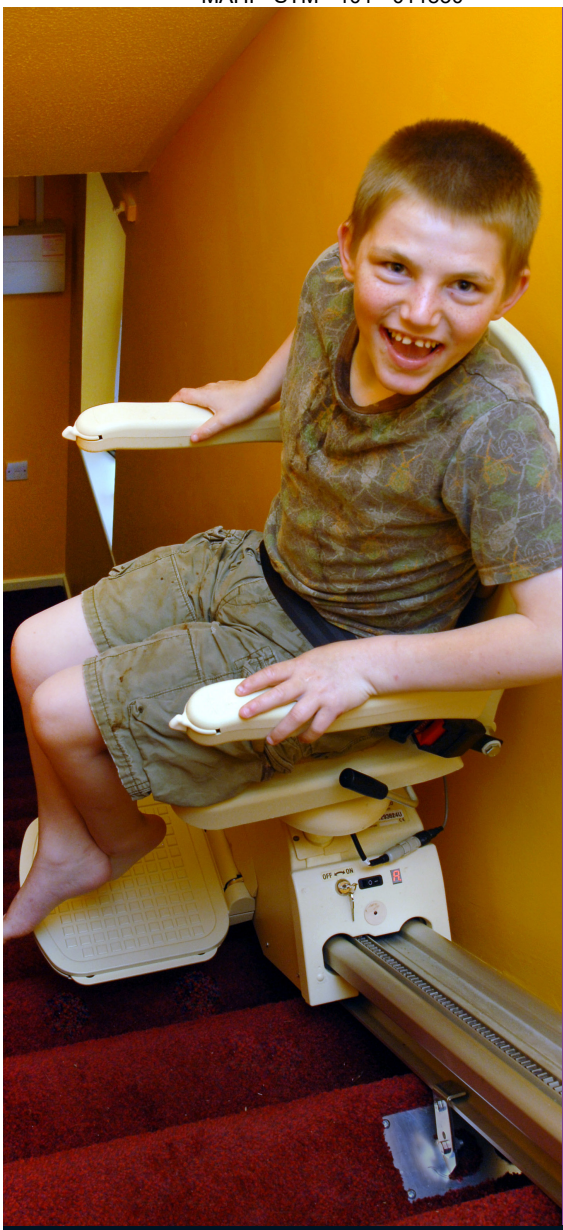


Occupational therapy and **SOCIAL HOUSING**

Occupational therapy
Helping people to live life their way

Occupational therapists can support social housing providers

Occupational therapists can support housing associations and social landlords to provide efficient and cost effective housing solutions for their older, disabled and vulnerable tenants. The unique skills of an occupational therapist can help housing associations to:

- Identify appropriate alterations to enable tenants to remain in their home
- Select suitable tenants for an empty adapted property
- Ensure that adaptations will be appropriate for a tenant's long term needs

Assuring a good match for a property

Finding the right tenant for an existing adapted property can be a challenge. An occupational therapist can help by using their clinical expertise to match a tenant's current and long term needs to an adapted property. An in-house occupational therapist's unique insight of the needs of your tenants and knowledge of the available housing stock will ensure the adapted property is allocated effectively.

"At Teign Housing, our allocation of property is more efficient because we have an occupational therapist working alongside and advising us"

Clare Beach, Neighbourhood Services Manager
Teign Housing

Supporting tenants to remain in their homes for longer

There is evidence which states that installing the right equipment and fitting the appropriate adaptations can enable vulnerable tenants to remain in their homes for up to five years longer.* An occupational therapist can assess a tenant's ability to manage everyday activities and, if necessary, will recommend solutions to enable the tenant to continue to remain there by providing advice, which could include door ways being widened, or installing ramps for easier access. The occupational therapist will also liaise with the appropriate agencies to help secure funding for any adaptations and specialist equipment, should this be needed.

**Adaptations Working Group, Final Report (November 2012), Scottish Government*

Working with architects and builders

Occupational therapists work with architects and builders to support and instigate inclusive design, particularly in new-build properties. An in-house occupational therapist can work with your development team to optimise interior design and build for mainstream accommodation to meet the requirements of tenants who have a range of complex needs and disabilities. Designs that include the advice and expertise of an occupational therapist may avoid the need for further property adaptations later on.

Addressing the complex needs of tenants

Occupational therapists possess the clinical knowledge to assess and anticipate both the current and potential future needs of tenants. They can assess applicants with a wide range of medical conditions and identify how accommodation can be adapted to meet their ongoing long term needs.

Occupational therapists will also make safeguarding suggestions and identify preventative measures, for example, recommending bariatric equipment or telecare aids, to enable tenants to retain their dignity, their independence, and making them feel safe in their own home.

Making a positive contribution to your organisation

Occupational therapists can enhance the services you offer to your tenants and can improve the economic viability of your business. They have the clinical skills to assess your tenants' needs and possess the appropriate knowledge to advise on your building programmes.

They can help your tenants to apply for funding, and enable your business to make the best use of your housing stock. Employing an occupational therapist will contribute to cost effective and efficient housing solutions enabling your organisation to retain tenants and avoid the inconvenience and expense of having void properties in your portfolio.

"Having our own occupational therapist in Westward has led to a more efficient and cost effective service to our tenants"

Nigel Barnard, Director of Operations
Westward Housing Group

COT.org.uk

Accessing occupational therapy services

Your tenant can be assessed by an occupational therapist by asking their local social care department for a referral. Tenants can also arrange for an occupational therapy assessment via their GP, nurse or social worker.

Employing an occupational therapist

You will benefit from employing an occupational therapist or entering into a secondment arrangement with local community occupational therapy services. According to the Chartered Institute of Housing*, organisations who have employed occupational therapists have reported more effective and appropriate use of their adapted housing stock. Occupational therapists have also made a valuable contribution to supporting these organisations when planning future housing developments.

**How to… make effective use of adapted properties, Chartered Institute of Housing, January 2014*

If you are considering employing an occupational therapist, you will find a sample job description and person specification at www.haffot.org.uk. HAFFOT is a group of occupational therapists working for or on behalf of housing associations.

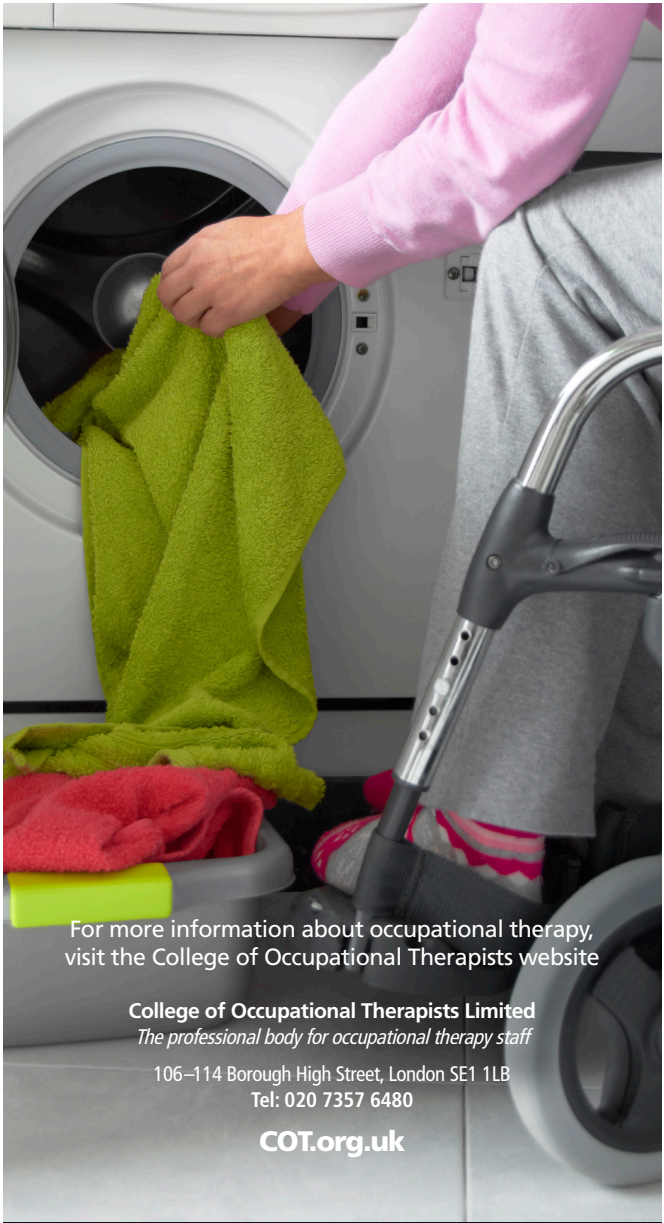
For more information about how occupational therapy can support housing associations visit:

COT.org.uk/housing associations

To find an independent occupational therapist, visit the College of Occupational Therapists website:

COT.org.uk/find-otfind-occupational-therapist

For leisure, learning, living or working
Occupational therapy
Helping people to live life their way



Research Briefing

College of Occupational Therapists

Evidence-based / Evidence-informed Practice

Published: September 2015
Lead Group: Education and Research
Country relevance: UK wide

Introduction

Occupational therapy should be underpinned by evidence-based practice. This is reflected in the required competencies of occupational therapists stated within the Health and Care Professions Council's *standards of proficiency for occupational therapists* (Health and Care Professions Council 2013) and the College of Occupational Therapists' *Code of Ethics and Professional Conduct* (College of Occupational Therapists 2015 pp32-35) and *Professional Standards for Occupational Therapy Practice* (College of Occupational Therapists 2011).

A systematic review of published research identified that whilst occupational therapists generally held positive attitudes towards evidence-based practice, there were barriers to implementation (Upton et al 2014). These included workload and time pressures, organisational barriers, and perceived lack of training, knowledge, skills and personal motivation. This briefing provides guidance on some of the key elements of evidence-based practice and the resources available from the College to support occupational therapy staff.

1. More than research

Evidence-based practice (EBP) has its origins in medicine, but it has evolved as a concept which fully recognises that it is not 'just research' (Sackett et al 2000). EBP takes into account the integration of the best available research evidence, together with the practitioner's clinical expertise and the service user's values and goals, as represented in the model below (Figure 1).

Figure 1

Links between evidenced-based, evidence-informed and values-based practice

The term *evidence-informed practice* is now increasingly being used within health and social care. Whilst various models of evidence-informed practice exist, they tend to conceptualise clinical expertise as being informed by the best available research, as well as contextual factors such as: service user preferences and actions; clinical state and circumstances; and, sometimes, healthcare resources. Such models therefore share common theoretical features with models of evidence-based practice, particularly in terms of the integration of best evidence with the service user context. However, it has been suggested that evidence-informed practice is perhaps a more appropriate term for such processes of integrating evidence and contextual factors, particularly as the amount of valid evidence available can vary and its use can be inexact (Shlonsky and Mildon 2014).

Values-based practice is an approach to working with complex and conflicting values in healthcare (Fulford 2008, Warwick Medical School 2013) that supports balanced decision making between clinicians and service users (Peile and Fulford 2015). It has been identified that this approach is complimentary to, and can be used in partnership with, evidence-based practice to inform clinical decision making and to promote care that is both science-based and person-centred (Fulford 2008, Peile and Fulford 2015).

For clarity, and in recognition of the terminology used within much of the reference material, this briefing will predominantly use the term evidence-based practice.

2. Making sense of the evidence

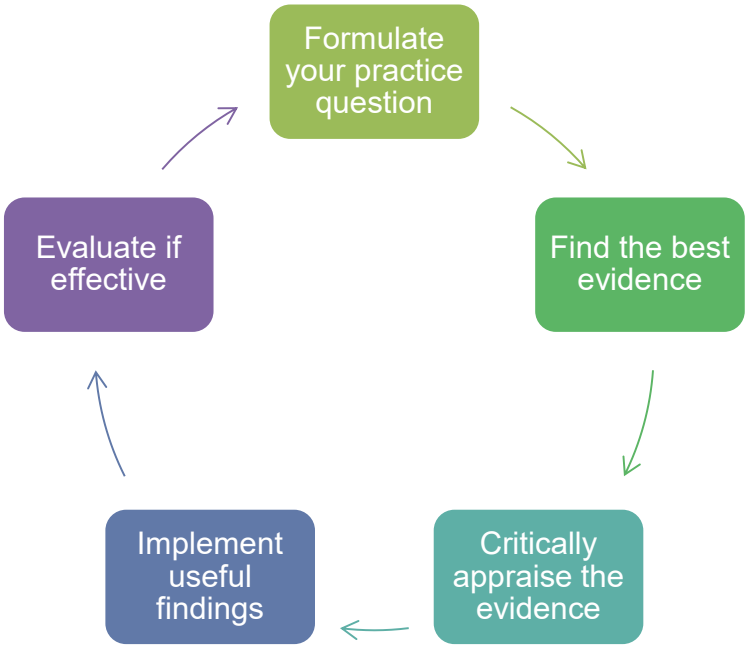
If a therapist uses their clinical experience and well-thought through reasoning (enhanced by the routine use of standardised assessments and outcome measures) and affords due consideration to the individual perspectives of service users, they would be addressing two of the key components of evidence-based practice outlined in Figure 1. It is research evidence, and its application, which is often viewed as the stumbling point. This section will therefore focus on this aspect of evidence-based practice.

The Health and Care Professions Council (HCPC) requires that occupational therapists should 'be aware of the principles and applications of scientific enquiry, including the evaluation of treatment efficacy and the research process' (Health and Care Professions Council 2013 p13) whilst COT's *Code of Ethics and Professional Conduct* requires that you are able 'to access and understand and critically evaluate research and its outcomes, incorporating it into your practice where appropriate' (College of Occupational Therapists 2015 p37). It is therefore important to consider how you can meet these standards.

Firstly, it is useful to remind yourself that evidence-based practice is not in itself a single entity or, necessarily, a linear one. Bannigan (2007) identified five stages:

- Formulating a clear, clinical question.
- Finding the best evidence in the literature to answer the question.
- Critically appraising that evidence for its clinical usefulness and validity.
- Implementing useful findings in practice.
- Evaluating the effectiveness of the new way of working.

These stages can usefully be seen within a cyclical process:



Like all things that appear complex, breaking down 'evidence-based practice' into smaller bite-sized pieces makes it feel more manageable.

A. Formulate your practice question

Be clear about the topic for which you require evidence, its purpose and why it is important. Thinking of it in terms of a practice question can help to make the identification of the appropriate evidence less complicated.

Using the PICO methodology (Richardson et al 1995) can assist in drilling down the specific area of practice you really need to examine:

- The **P**atient (service user), **P**opulation or **P**roblem/circumstance.
- The **I**ntervention under investigation or action.
- The **C**omparison, which is an alternative intervention or action.
- The desired **O**utcome.

This approach can be helpful and provide you with the basic terms you will need in your search for evidence.

B. Find the best evidence

The main sources of research evidence are best found via a thorough literature search.

Identify the search terms: search terms can include the service user group or problem (e.g. older adults, stroke); the intervention (e.g. constraint induced movement therapy); and the outcomes (e.g. occupational engagement). In order to find the widest range of literature on the topic, alternative terms should be suggested for each of these concepts (e.g. older people, older persons, elderly). It is also important to

consider whether there may be variations in spelling, such as between English and American words (e.g. paediatric/pediatric). Most librarians will be able to offer help with identifying and combining search terms.

Search the databases: your search terms are used to interrogate one or more databases. Some databases are free to the internet user, such as PUBMED, OTseeker and the Cochrane database. Others, which can only be accessed by subscribers, include Allied and Complementary Medicine (AMED), Cumulative Index to Nursing and Allied Health Literature (CINAHL), PSYCINFO and Social Policy and Practice. OTDBASE is a specialist subscription database of abstracts from occupational therapy journals. An NHS or university librarian will advise on what databases are available to you. To carry out an exhaustive search, it is necessary to cover as many relevant databases as possible.

Select papers and obtain the literature: a database search may bring up thousands of references so it is important to have clear inclusion/exclusion criteria for selecting papers to review. Important considerations when setting such criteria can include: the relevance of the paper to the question, the type of research, and the quality of the research. For example, the decision may be taken to only include reports of randomised controlled trials (RCT) or systematic reviews that include at least one RCT, or to exclude studies that occurred before a certain year.

Some databases give online access to full text journal articles while others provide only an abstract. Selected papers can be obtained from a specialist library or via interlibrary loans. A librarian can advise.

Information can also be found in grey literature and professional magazines (such as OTnews). Whilst these can provide valuable perspectives and examples of practice, they are not usually research-based and have not been peer reviewed. They cannot, therefore, be assumed to offer robust evidence and you would need to be very cautious about the context in which you use any information from these publications. Similar care would need to be employed when considering whether to use general information obtained from websites (as opposed to peer reviewed ejournals available on a website).

C. Critically appraise the evidence

Once you have tracked down relevant articles, you will need to appraise the evidence. Published research in professional journals will, in the main, have been peer reviewed, but you still need to critically review the strengths and limitations of the evidence and consider whether the findings can be generalised to your area of practice. Critical appraisal can provide an excellent continuing professional development activity either alone, or with colleagues in a journal club.

Frameworks for critically appraising different types of research are available. For example, the following websites provide guidance information and templates/tools to help structure your appraisal:

- The Critical Appraisals Skills Programme (CASP)
  http://www.casp-uk.net/
- McMaster University's Occupational Therapy Evidence-Based Practice Research Group
  http://srs-mcmaster.ca/research/evidence-based-practice-research-group
- Centre for Evidence-based Medicine
  http://www.cebm.net/index.aspx?o=1157

When considering different types of evidence, practitioners need to be aware that research designs vary in terms of their robustness and the risk of error and bias in their results. Various hierarchies of evidence are available and these traditionally reflect the highest levels of evidence as systematic reviews and randomised controlled trials. In terms of the nature of occupational therapy research and evidence, sources of information and evidence accessed will often need to be as inclusive as possible.

The final stages of appraising the evidence involve asking if the findings answer the clinical question and using clinical judgement to decide if they are likely to be clinically important.

D. Implement useful findings

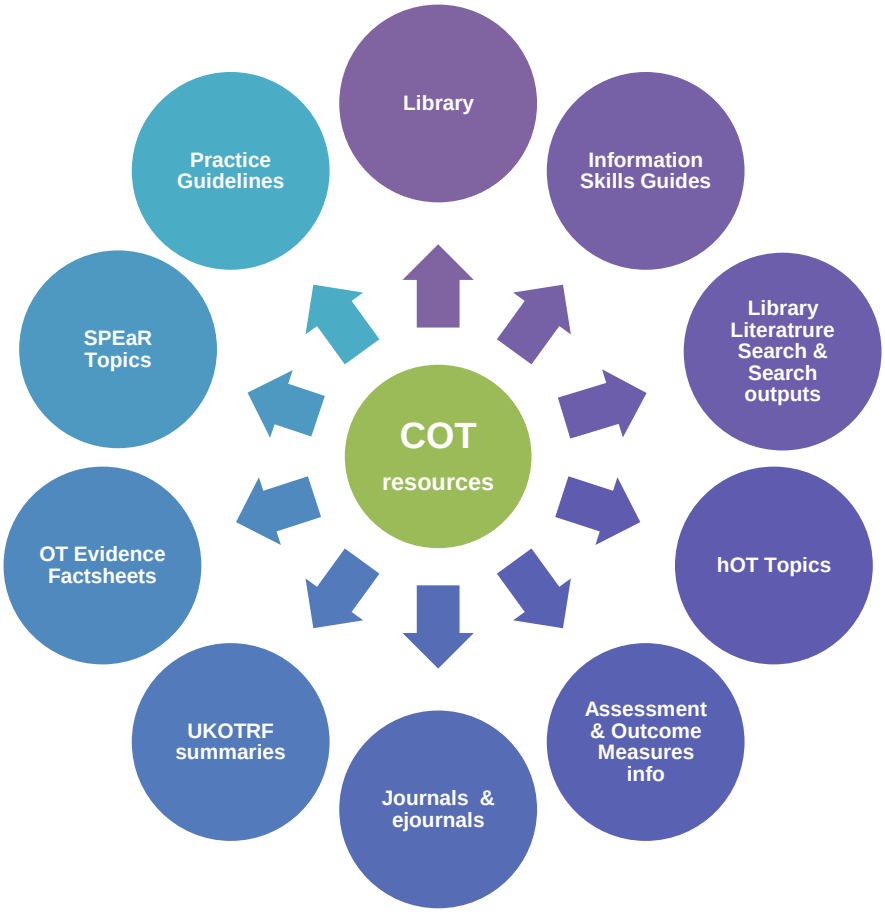
A review of the evidence may lead to identification of findings that support your current practice. Alternatively, it could lead you to consider whether you need to make changes to your practice. A decision to make any changes should ideally be based on a body of evidence, and not made in isolation from your own expertise and experience, the individual service user's needs and the environment in which you practice. Risks and benefits need to be considered, and any decision should be made in consultation with/with the support of managers, service users, multidisciplinary team members and commissioners, as appropriate.

E. Evaluate if effective

If you find evidence that is both robust and meaningful, and you have determined the potential benefits and risks of implementing change to your area of practice, then don't forget to evaluate the impact of that change to close the loop. Very much like the occupational therapy process, this may need to lead to 're-assessment' of the situation and so the cycle begins again.

3. COT Evidence-based practice resources

COT has a number of resources to support evidence-based practice, available to members of the British Association of Occupational Therapists (BAOT).



COT Library

When it comes to searching for the evidence, there is a lot of useful information on the Library and Publications pages of the BAOT/COT website: http://www.cot.co.uk/cot-library/cot-library .

The COT library houses a unique specialist collection of materials and resources to support the work and study of BAOT members, including reference books/ebooks, journals/ejournals and donated PhD theses as well as offering access to a range of databases (further information on databases and theses is provided in Section 4 of this document).

The COT library team can support members in tracking down what information is available on a particular topic, and obtain copies of articles through their document supply service.

Information Skills guides: the library team have produced a number of information skills guides, including guides to literature searching and using particular databases. These can be accessed at: https://www.cot.co.uk/cot-library/information-skills.

Literature Searches and Literature Search outputs: the library team can carry out literature searches for BAOT members: http://www.cot.co.uk/cot-library/library-literature-search (please note, this service is not available to those who are undertaking award-bearing courses who should refer to their university library). The results of some previous literature searches carried out by COT library staff are available on the *literature search outputs* page: https://www.cot.co.uk/cot-library/literature-search-outputs.

hOT Topics: an extensive collection of hOT Topics are available. These provide a useful starting point and overview of key readings related to a particular subject, including articles, books and selected websites. They cover a variety of subjects, ranging from areas of practice (e.g. vocational rehabilitation; palliative care), specific conditions (e.g. autism spectrum disorder) and other topics of interest (e.g. risk management): http://www.cot.co.uk/hot-topics/hot-topics.

Assessments and Outcome Measures library pages: the Assessment and Outcomes Measures web pages are another useful library resource for supporting evidence-based practice. They provide information about selecting and using assessments/outcomes measures and will signpost you to some key resources. Access them at: https://www.cot.co.uk/cot-library/assessments-and-outcome-measures.

Journals and ejournals: in addition to the journals held in the COT library, a wealth of electronic journals are available to BAOT members via the Library and Publications tab of the BAOT/COT website. This member benefit widens your exposure to international research and evidence. Ejournals available include:

- British Journal of Occupational Therapy (BJOT), the official journal of the College of Occupational Therapists.
- American Journal of Occupational Therapy.
- Australian Occupational Therapy Journal.
- Canadian Journal of Occupational Therapy.
- An extensive range of other health and social care journals, including occupational therapy specific titles.

All ejournals can be accessed at: http://www.cot.co.uk/journals-ejournals/journals-ejournals. This web page also contains information about signing up for Table of Contents (TOC) alerts (or you can sign up to TOC alerts via individual journal websites). TOC email alerts enable you to keep up to date with new journal articles being published as soon as they become available online. When you receive a TOC alert a useful starting point can be to review the abstracts and key messages to see if an article may provide details of evidence which is relevant to your area of practice.

Research Briefing

College of Occupational Therapists

UKOTRF Projects: Summaries of Key Findings

The United Kingdom Occupational Therapy Research Foundation (UKOTRF) is a division of the College of Occupational Therapists. UKOTRF supports research that will build the evidence-base for occupational therapy and increase research capacity within the profession. It has a role in raising awareness of the valuable contribution of occupation to people's health and wellbeing.

A summary of the key findings for each completed UKOTRF funded project (including, where known, journal publication references) can be accessed at: https://www.cot.co.uk/uk-ot-research-foundation-ukotrf/funded-project-outputs-0

All funded projects are required to provide a final project report, a hard copy of which will be placed in the COT library for reference by members six months after the project has been signed off by COT.

Occupational Therapy Evidence Fact Sheets

Occupational therapy evidence factsheets provide concise information about a particular topic (e.g. developmental coordination disorder, falls management, hand therapy, reablement). The target audience is commissioners. The factsheets provide key facts, examples of key benefits/cost benefits and related reference points: http://www.cot.co.uk/occupational-therapy-evidence-fact-sheets.

Practice guidelines

COT has published a number of practice guidelines in conjunction with COT specialist sections. Practice guidelines outline the nature and level of intervention that is considered best practice for specific conditions in specific populations. COT received NICE Accreditation in January 2013 (valid for five years) for the process it uses to produce its practice guidelines.

The use of a robust process, which draws on available evidence to develop recommendations for practice, ensures that the practice guidelines are a good hallmark to demonstrate and implement evidence-based practice.

Practice guidelines available include the following:

- Hand and wrist orthoses for adults with rheumatological conditions (2015).
- Occupational therapy in the prevention and management of falls in adults (2015).
- Splinting for the prevention and correction of contractures in adults with neurological dysfunction (2015).
- Occupational therapists' use of occupation focused practice in secure hospitals (2012).
- Occupational therapy for adults undergoing total hip replacement (2012).

All guidelines published since 2011 are supported by a quick reference guide, audit tool and continuing professional development session.

If there is a guideline relevant to your service, then it is recommended that you carry out an audit against the recommendations and identify any action you might need to take.

Access the guidelines at: http://www.cot.co.uk/practice-guidelines/cot-practice-guidelines.

SPEaR Topics (*Supporting Practice: Evidence and Resources*)

There are numerous SPEaR topics available on the COT website. The SPEaR topics are an online signposting resource and include topics related to particular conditions (e.g. dementia), areas of practice (e.g. housing) and topics relevant to occupational therapy practice (e.g. age friendly environments, public health). There are also SPEaR topics on *Outcomes* and on *Research and evidence-informed practice*.

SPEaR topics direct members towards some key information on a particular topic by providing links to relevant web sites or documents. Links are usually to information that is freely accessible and in the public domain, or to professional journals accessible via the COT ejournal collection.
All topics can be accessed via: https://www.cot.co.uk/supporting-practice/evidence-and-resources.

4. Sources of evidence

There are many sources of evidence available. The information below provides examples of some of those commonly used, although it is by no means intended to be a definitive list.

BMJ Clinical Evidence

A database of high-quality, rigorously developed systematic overviews assessing the benefits and harms of treatments, and a suite of evidence-based medicine (EBM) resources and training materials: http://clinicalevidence.bmj.com

Cochrane Library

The Cochrane Libary includes the following databases:

- Cochrane Database of Systematic Reviews (CDSR).
- Database of Abstracts of Reviews of Effects (DARE).
- Cochrane Central Register of Controlled Trials (CENTRAL).
- Health Technology Assessment Database (HTA).
- NHS Economic Evaluation Database (EED).
- Cochrane Methodology Register (CMR).

Available at: http://www.thecochranelibrary.com

COT Library and Information Service

The COT Library provides access for members to the principal allied health databases. These include the following databases for which COT holds a subscription:

- AMED (Allied and Complementary Medicine).
- CINAHL (Cumulative Index to Nursing and Allied Health Literature).
- HMIC (Health Management Information Consortium).
- MEDLINE (the U.S. National Library of Medicine's digital archive of life sciences journal literature.).
- PSYCINFO (psychology and related disciplines).
- Social Policy and Practice (social policy, public health, social services, and mental and community health).
- OTDBASE – (international occupational therapy journal literature).
- OTSearch (the catalogue and database of the American Occupational Therapy Association).

Members would need to visit the library to access these databases. However, COT librarians would be able to use the subscription databases, in addition to databases that are publically available on the internet such as the Cochrane Library and OTSeeker, to carry out literature searches for members. Please refer to section 3 of this document for more information regarding literature searches.

In addition to providing access to principal databases, the COT library houses an extensive collection of over 7000 reference books, holds print copies of over 50 key occupational therapy / occupational therapy relevant journals and has a collection of over 650 unpublished UK Master's and doctoral theses and reports. Find out more: http://www.cot.co.uk/cot-library/cot-library.

Europe PubMed Central

A free online digital archive of full-text, peer reviewed research publications, based on PubMed Central: http://europepmc.org.

Evidence-Based Occupational Therapy web portal

The Evidence-Based Occupational Therapy web portal is funded by the Canadian Occupational Therapy Association and McMaster University and is endorsed by the World Federation of Occupational Therapists. It provides strategies, knowledge and resources to aid occupational therapists in finding out about and using evidence: http://www.otevidence.info.

National Elf Service

The National Elf Service is a collection of evidence-based websites, owned and managed by Minervation Ltd, which aim to help busy health and social care professionals keep up to date with the latest research. It is intended that the sites will present high quality research, critically appraise it, and ask subject experts to summarise it in simple and clear blogs. There are numerous 'elf' sites, including the: Commissioning Elf Learning Disabilities Elf, Mental Elf, and Musculoskeletal Elf.

Find out more and access the separate Elf websites at: http://www.nationalelfservice.net/.

NICE Evidence Search

NICE Evidence Search provides free access to a health and social care information web portal that allows users to search multiple sources simultaneously and gives access to specialist collections covering a wide range of conditions, topics and health populations. This includes the Quality, Innovation, Productivity and Prevention (QIPP) resource: https://www.evidence.nhs.uk.

OTseeker

OTseeker is a database of abstracts of systematic reviews and randomised controlled trials relevant to occupational therapy. The validity and interpretability of the trials has, in most cases, been critically appraised: http://www.otseeker.com.

Occupational Therapy Critically Appraised Topics (CATS)

CATS gives access to short summaries of evidence on particular topics or clinical questions: http://www.otcats.com.

Social Care Online

A product of the Social Care Institute for Excellence, this website is a free database of social care information and research. It includes listings of research briefings, reports, government documents, journal articles, events and websites. Available at: http://www.scie-socialcareonline.org.uk.

Trip Database

The Trip Database is a gateway to evidence-based healthcare resources, updated monthly: http://www.tripdatabase.com.

References

Bannigan K (2007) Making sense of research utilisation. In: J Creek, A Lawson-Porter, eds. *Contemporary issues in occupational therapy: reasoning and reflection.* John Wiley: Chichester. 189-216.

College of Occupational Therapists (2015) *Code of ethics and professional conduct.* London: COT. Available at: *https://www.cot.co.uk/sites/default/files/publications/public/CODE-OF-ETHICS-2015.pdf*

College of Occupational Therapists (2011) *Professional standards for occupational therapy practice.* London: COT. Available at: *https://www.cot.co.uk/standards-ethics/professional-standards-occupational-therapy-practice*

Fulford KWM (2008) Values-based practice: a new partner to evidence-based practice and a first for psychiatry? *Mens Sana Monographs, 6(1),* 10–21. Available at: *http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3190543/*

Health and Care Professions Council (2013) *Standards of proficiency: occupational therapists.* London: HCPC. Available at: *http://www.hpc-uk.org/publications/standards/index.asp?id=45*

Peile E, Fulford KWM (2015) Values-based practice: translating values and evidence into good clinical care. *International Journal of Therapy and Rehabilitation, 22 (7),* 306-307. doi: http://dx.doi.org/10.12968/ijtr.2015.22.7.306

Richardson WS, Wilson MC, Nishikawa J, Hayward RS (1995) The well-built clinical question: a key to evidence-based decisions. *ACP Journal Club, 123(3),* A12-A13.

Sackett DL, Straus SE, Richardson WS, Rosenberg W, Haynes RB (2000) *Evidence based medicine: how to practice and teach EBM.* 2nd ed. London: Churchill Livingstone.

Shlonsky A, Mildon R (2014) Methological pluralism in the age of evidence-informed practice and policy. *Scandinavian Journal of Public Health, 42(13, Supplement),* 18-27. Available at*: http://sjp.sagepub.com/content/42/13_suppl/18.full*

Upton D, Stephens D, Williams B, Scurlock-Evans L (2014) Occupational therapists' attitudes, knowledge, and implementation of evidence-based practice: a systematic review of published research. *British Journal of Occupational Therapy, 77(1),* 24-38.

Warwick Medical school (2013) *What is values-based practice?* Coventry: University of Warwick, Warwick Medical School. Available at: *http://www2.warwick.ac.uk/fac/med/study/research/vbp/about/*

All websites in the references were accessed on 02.09.15 unless otherwise indicated.

Need further information or advice?

Contact: COT Research and Development Team
Email: [redacted] or Tel: 020 7450 2363

Briefing

Royal College of Occupational Therapists

Safe use of Weighted Blankets (for Children and Adults)

Published: 2019 (Updated)

Lead Group: Professional Practice

Country relevance: UK wide

1. Introduction

This briefing has been developed by the Royal College of Occupational Therapists in consultation with the Sensory Integration Network (UK and Ireland) and with members of the Royal College of Occupational Therapists Specialist Section for Children, Young People and Families. It aims to provide guidance for occupational therapists that use and/or recommend weighted blankets for their clients. This briefing does not offer support or otherwise for the use of Sensory Integration as an intervention, for use of weighted blankets as part of Sensory Integration treatment or incorporating sensory needs into daily routine. It does however aim to inform those using weighted blankets (or covers) as part of an occupational therapy programme, using Sensory Integration as a tool to achieve sensory regulation to support engagement and occupational performance.

1.1 Background

In Canada in 2008, 9-year-old Gabriel Poirier 'died of suffocation under a weighted blanket in which he had been rolled by his teacher at the special school he attended'. He was left without supervision for 20 minutes and the instructions given to the special education worker and teacher by the occupational therapist were not followed (OEQ 2008).

1.2 Sensory Integration

The use of equipment such as weighted blankets has developed from the theories and practice of Sensory Integration (SI). SI was defined by Jean Ayres, its founder, as 'the neurological process that organises sensation from one's own body and from the environment and makes it possible to use the body effectively within the environment' (Ayres 1970). SI offers a theory of brain behaviour relationship, a model of assessment and a model of intervention. A dysfunction in an individual's sensory integration (DSI), or sensory processing disorder (SPD), as it is often known, may be the cause of difficulties for children who find themselves unable to easily learn new skills, to pay attention, to co-ordinate movements or to cope with social participation. Intervention may be direct, meeting the recent criteria for fidelity (Parham et al 2007), or indirect, taking a consultative approach, reframing behaviours and developing new strategies (Bundy 2002). Schaaf and Smith Rowley (2006) identify the need to incorporate sensory needs into daily routine.

Neuroscience literature identifies the use of active sensory experiences to enhance sensory regulation as a basis for learning, brain maturation and neural organisation. Deep pressure touch externally supplied is passive application of a sensory stimulus, whereas self-initiated movement against resistance or weight provides active sensory rich experience. Passive application of sensory stimulation is rarely justified unless the clinician uses extreme caution and care (Dahl Reeves 2001).

1.3 Weighted blankets

Weighted blankets, also referred to as weighted covers, can be used for children, young people and adults with sensory processing difficulties to assist with self-calming and sensory regulation.

The rationale for the use of weighted blankets is linked to the impact of deep pressure touch on arousal (Lane 2002). Weighted blankets offer deep pressure touch to the body giving a feeling of being hugged, held or cuddled (Grandin 1992). Some limited evidence regarding the beneficial effects of weighted blankets is available (Mullen 2008)[1], but this was undertaken with healthy adults so cannot be generalised to apply to children with or without disabilities or to adults with learning disabilities. However, there is significant anecdotal evidence from occupational therapists, parents and teachers of the calming effects of sensory 'tools' including weighted blankets.

Touch receptors in the skin are activated when stimulus are applied and then when stimuli are removed. When stimuli are applied and left in place there is a diminishing response or adaptation over time. Therefore it is thought that weighted items are most effective over shorter periods of time when the client is not moving and for longer periods of use only when the client is moving. When the client is moving/active or providing some resistance there is an increase in active proprioception rather than the more passive pathway of deep pressure touch.

Weighted blankets can be a useful tool but will not be the sole solution for meeting client's sensory needs; there are alternative methods that can assist with self-calming which could be trialled first and always used in the event of any safety concerns. For further suggestions see Schaaf and Smith Rowley (2006, chapter 13). One of the components of SI is to tap the client's inner drive and support client activity. It is important that sensory activities are not imposed.

2. Safe use of weighted blankets as part of direct occupational therapy intervention

The use of weighted blankets can be part of an occupational therapy treatment or used to incorporate sensory needs into daily routine (Schaaf and Smith Rowley 2006). The assessment of need and subsequent clinical reasoning will determine which is appropriate.

2.1 Assessment

Occupational therapists should undertake a comprehensive assessment of their client and be able to justify the use of any chosen treatment approach.

Assessment should include:

- Occupational and functional abilities and needs in the relevant contexts;
- Health condition and physical strength, size and weight;
- Relevant risk assessments (see Contraindications 2.2);
- Sensory processing.

2.2 Contraindications

The occupational therapist should determine if their client's health contradicts in any way the use of the blanket, with reference to any condition including :

[1] Mullen et al (2008) evaluated the safety and effectiveness of a weighted blanket with 32 volunteer adults. The results of this study showed that the use of weighted blankets did not generally cause unsafe physiological reaction. The authors therefore concluded that weighted blankets were safe. They found 33% of the sample group demonstrated lower electro-dermal activity (EDA) and 63% had a demonstrated reduced anxiety. In a self-reporting questionnaire, 78% reported that they felt more relaxed when using the blanket than without it. The group also showed some physiological change and reported reduction in anxiety when lying down without the weighted blanket, to the point that the authors acknowledge the beneficial effect of lying down (in a quiet room).

- Respiratory problems (consider use below the torso);
- Cardiac problems;
- Epilepsy (ensure epilepsy is controlled);
- Serious hypotonia;
- Skin problems, including certain allergies;
- Circulatory problems (OEQ 2008);
- They should also assess whether the client is unable to remove blanket independently.

2.3 Record keeping

Please refer to *Keeping Records* (RCOT 2018) and College of Occupational Therapists, *Professional Standards for Occupational Therapy Practice*, (COT 2017, section 7), for full details of standards regarding record keeping.

As with all occupational therapy practice, all contacts, advice and interventions must be recorded. 'If it is not included, it has not been done, has not been considered or was not said.' (Lynch 2009 p50). Your records should provide a comprehensive and accurate account of service plan and provision (COT 2017, Section 7). It is also required that consent for the specific intervention is detailed including the form in which the consent was given and by whom.

2.4 Consent

Please refer to the *Code of Ethics and Professional Conduct* (2015) for full details regarding consent.

Consent to generic occupational therapy input is not sufficient. Occupational therapists should also ensure that the client is fully informed about the specific nature of the interventions relevant to them.

2.5 Impaired capacity

Occupational therapy staff should be aware of the correct legal approach to take when obtaining consent is difficult or not possible.

Adults - For adults with impaired capacity, the occupational therapist needs to ensure that they always act in the best interests of the client. (COT 2015).

Children and young people - A child must also consent to the use of the weighted blanket if possible, even though they are a minor.

Review

The success of the intervention will be judged by a client's responses and reactions and so it is important to listen to the information your client is providing. Use of any programme should be part of identified goals and outcomes reviewed at agreed intervals and documented clearly in client notes.

3. Safe use of weighted blankets - checklist

3.1 Weighted blankets can be a safety risk in not used correctly

Recommendations for safe use:

- The client's head and neck must not be covered.
- The client's vital signs should be observable at all times.

- The client must not be rolled in the blanket; it should be placed over them. If in a bed it should not be draped over the sides of the bed (see use at night time/ for sleeping (see 4.5).
- The client must be able to remove the blanket or get free of the blanket by themselves. When trying out a weighted blanket for the first time, ensure clients are able to physically manoeuvre the blanket with confidence. Remind the client using the blanket that they can take it off at any time, if it feels uncomfortable, too hot or heavy etc.
- The client must be supervised at all times when under the blanket. When it is used for the first time or as part of a direct occupational therapy treatment this must be by a therapist able to interpret the user's reaction and response, in order to ensure it is the right tool to meet the needs of the client.
- When a blanket is given as part of a sensory diet the care giver must receive training for that specific client and understand the safety guidelines (see section 4).
- The weighted blanket must never be used as a restraint.
- Manufacturer's instructions on the recommended use of the equipment should be followed as a minimum standard. All non-compliant use should be justifiable. Many manufacturers provide limited guidance and it is likely that the recommendations provided will be superseded by the checklist above. None the less if guidelines are provided they should be followed.

3.2 Observations during use

Watch for any negative reactions shown by the client when under the blanket. These could include:

- Difficulty breathing
- Nausea
- Increase in temperature
- Any behavioral or physical reactions demonstrating the client's discomfort or anxiety

3.3 Assessing safe weight

At the time of writing, there is no evidence specifying the required weight of a weighted blanket in relation to the client's body size and weight. However, good practice suggests that the blanket should be as light weight as possible, while still achieving any agreed outcomes.

The Ordre des Ergotherapeutes du Quebec (OEQ) state the weight and size of the blanket should correspond to the client's physical features and recommend a ratio of 10% of the client's weight as the blanket's maximum weight. For example:

- 100 pound person should use a blanket that is no more than 10 pounds in weight.
- Clients who weigh around 40 pounds should use a 4 blanket that weighs four pounds or less
- A 9 pound blanket is for clients who weigh 90 pounds or more (6st 6 lb) (OEQ 2008).

Weighted blankets should be individually recommended on a client by client basis. This should be particularly stressed in a school environment to ensure that blankets are not swapped between varying children.

3.4 Duration of use

Guidelines from OEQ and the State of Quebec Coroner state the blanket is to be used for no longer than 20 minutes (unless there are exceptional reasons). The reasons for this are not given. This would prohibit lengthy night time use. If the blanket is used for longer periods, close justification must be recorded and close observation is recommended. (See 4.5 – night time use and sleeping).

3.5 Fabrication

There is no evidence about use of materials and size, but common sense indicates attention should be given to the client's size, any health needs, e.g. allergies, and the environment where the blanket will be used. Personal considerations might also need to be factored in e.g. they may prefer a smaller or lighter blanket.

4. Guidance for the safe use of weighted blankets as part of an occupational therapy programme given to parents, teachers or other care givers

Weighted blankets are often used to incorporate sensory needs into a daily routine.

4.1 Assessment

Assessment will be very similar to that undertaken for direct occupational therapy intervention and should include:

- Occupational and functional abilities and needs;
- Health condition and physical strength, size and weight;
- Relevant risk assessments;
- Sensory processing;
- Carer's abilities and needs;
- Environmental factors.

4.2 Provision

The occupational therapist should demonstrate in person, explain the safety checklist and ask the care giver to sign an agreement of demonstration and checklist. This process should then be fully documented in the client notes. The provision of a weighted blanket is to be documented as part of the client's goals and interventions with a planned time for review (COT 2017).

When demonstrating the use of a weighted blanket occupational therapists should communicate effectively so that everyone who uses a weighted blanket is aware of and agree to follow the safety guidelines above and the intervention plan designed for the client.

Occupational Therapists should:

- Provide training to users of weighted blankets based on the checklist for safe use and the client's individual needs and circumstances.
- Provide the above checklist information verbally during demonstration and in written form.
- Provide written information regarding:
    1. General guidance for the safe use of weighted blankets.
    2. Specific information and instructions for individual clients linked to their intervention / care plans.
    3. Instructions to follow if any problems arise e.g. remove the blanket and stop using, contact emergency help if the client experiences breathing difficulties, or contact the occupational therapist if the client has any behavioural difficulties.
- Ideally regular training and follow-up should be provided in order to maintain continued, up-to-date knowledge and skills both about the use of weighted blankets and in relation to meeting individual client's needs. If this is not possible or inconsistent with department models, occupational therapists should assure themselves that those using the blanket are aware to contact the occupational therapist should an individual's needs change or a review of the blanket is required.

4.3 Review

Weighted blankets are an item of equipment, used within the framework of an intervention or care plan in order to meet specific objectives. These objectives should ideally be regularly reviewed in order to evaluate outcomes and in particular, the continued benefits and use of a weighted blanket (see 4.2).

4.4 Learning to use a weighted blanket more independently

Older children/adults may benefit from being encouraged to use their weighted blanket as and when they require it as a self-calming strategy and, in the longer term, a coping strategy.

In these situations a risk assessment should be undertaken covering the guidance above, particularly with respect to the client's ability to:

- move around under the blanket;
- be able to remove the blanket independently; and
- be able to understand and follow guidance for safe use and to self supervise their health needs.

4.5 Use of weighted blankets at night and for sleeping

Given the maximum duration for use guidelines issues by the Canadian Coroner (20 minutes), occupational therapists are advised not to recommend blankets for prolonged use. The advice also states that users should be supervised so this would preclude extensive use at night. Parents/carers may choose to ignore this advice. Occupational therapists are advised to explain the risks and contraindications to parents if they are aware they are acting against this advice and to document this discussion thoroughly.

Before considering brief use of a weighted blanket at night, ensure all other alternatives have been explored first. If a weighted blanket is to be used at night or for sleeping during the day, a risk assessment is recommended and, as well as the guidance above, further consideration should be given to the following:

- It is important that the client can move around by themselves under the weighted blanket and be able to remove the blanket easily.
- Always remind the client that they can remove the blanket at any time if it is feeling too heavy or hot.
- It is recommended that the blanket should be removed once the client has fallen asleep so that it is not in place all night.
- Ensure the blanket fits on the top of the mattress without hanging over the sides of the bed.
- The blanket should only be used under supervision and if parents/carers plan to use without supervision at night it is recommended that carers check on the client while they are sleeping.

4.6 Looking after a Weighted Blanket

Always follow the manufacturer's instructions for using and caring for weighted blankets.
Every time it is used, check it for damage such as loose stitching or ripped seams. If it is damaged, stop using it until it is repaired or replaced.

5. Issuing guidance when a weighted blanket has been purchased independently

If a weighted blanket has been purchased for use at home or school without the recommendation of an occupational therapist it is good practice to advise on safe use, particularly if there is an open duty of care for that client. The above information should form a basis for this. However, the full duties above only apply if the blanket has been issued by an occupational therapist or specifically recommended.

Acknowledgement

The Royal College of Occupational Therapists would like to thank the Sensory Integration Network (UK and Ireland) Directors Group for their contribution to the development of this briefing.

References:

Alberta College of Occupational Therapists Adhoc Task Force (2009) Commentary on l'Ordre des ergothérapeutes du Québec's Position Statement on Use of Weighted Covers.

Ayres AJ (2005) *Sensory integration and the child: 25th anniversary edition*. CA, Los Angeles: Western Psychological Services.

Bundy AC (2002) Using sensory integration theory in schools: sensory integration and consultation. In: Bundy AC, Lane SJ, Murray EA, eds. *Sensory integration: theory and practice.* 2nd ed. Philadelphia: FA Davies. 309-332.

Royal College of Occupational Therapists (2018) *Keeping Records.* 4th ed. London: RCOT. Available at https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/keeping-records Accessed 31.01.19

COT (2015) Code of Ethics and Professional Conduct. London: COT. https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/rcot-standards-and-ethics

College of Occupational Therapists (2017) *Professional standards for occupational therapy practice.* London: COT. Available at https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/rcot-standards-and-ethics Accessed on 31.01.19.

Dahl Reeves G (2001) From neuron to behavior: regulation, arousal and attention as important substrates for the process of sensory integration. In: Smith Roley S, Blanche EI, Schaaf RC, eds. *Understanding the nature of sensory integration with diverse populations.* TX, San Antonio: Therapy Skill Builders. 89-108.

Grandin T (1992) Calming effects of deep touch pressure in patients with autistic disorder, college students, and animals. *Journal of Child and Adolescent Psychopharmacology, 2(1),* 63-72.

Lane SJ (2002) Structure and function of the sensory systems. In: Bundy AC, Lane SJ, Murray EA, eds. *Sensory integration: theory and practice.* 2nd ed. Philadelphia: FA Davies. 35-70.

Lane SJ (2002) Sensory modulation. In: Bundy AC, Lane SJ, Murray EA, eds. *Sensory integration: theory and practice.* 2nd ed. Philadelphia: FA Davies. 101-122.

Lynch J (2009) *Health records in courts*. Oxford: Radcliffe Publishing Ltd.

Mullen B, Champagne T, Krishnamurty S, Dickson, D, Gao R (2008) Exploring the safety and therapeutic effects of deep pressure stimulation using a weighted blanket. *Occupational Therapy in Mental Health, 24(1),* 65-89.

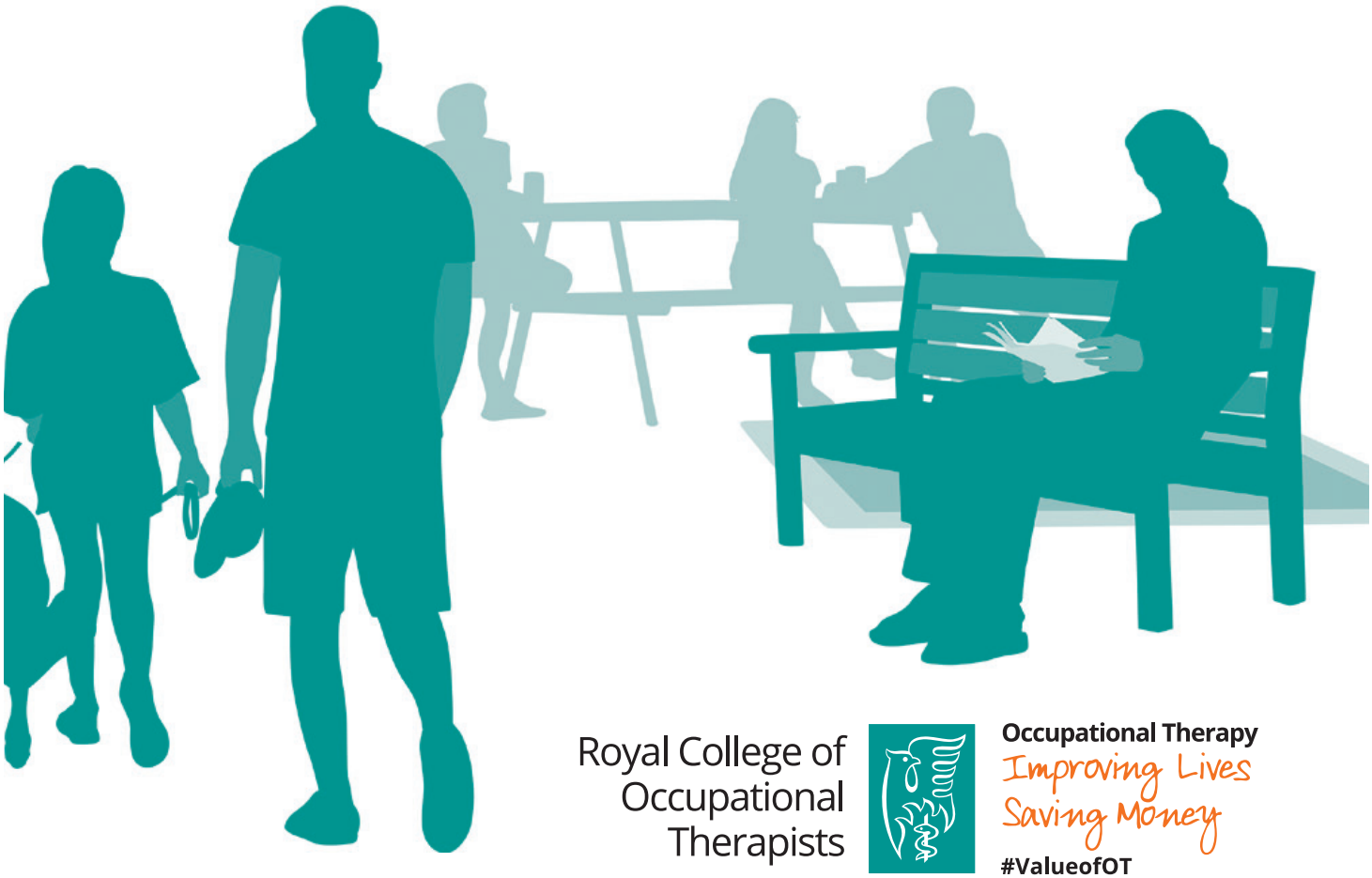
Parham LD, Cohn ES, Spitzer S, Koomar JA, Miller LJ, Burke JP, Brett-Green B, Mailloux Z, May-Benson TA, Smith Roley S, Schaaf RC, Schoen SA, Summers CA (2007) Fidelity in sensory integration intervention research. *American Journal of Occupational Therapy, 61(2),* 216-227.

Ordre des erothérapeutes du Québec (2008) OEQ Position Statement on the use of Weighted Blankets. Montreal: OEQ.

Schaaf RA, Smith Roley S (2006) SI: *Applying clinical reasoning to practice with diverse populations.* TX, Austin: Pro-Ed.

Leading fulfilled lives

Occupational therapy supporting people with learning disabilities



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Leading fulfilled lives

Occupational therapy supporting people with learning disabilities

The right of all people, regardless of their abilities, to have opportunities to participate in a full range of everyday activities (occupations) within their community is recognised by the United Nations.[i] This right underpins the whole concept of occupational therapy philosophy and practice.

People with learning disabilities face particular challenges in fulfilling this expectation, whether developing social relationships[ii], gaining paid employment[iii] or taking part in their communities. To help them manage a range of situations, occupational therapists tailor and adapt their approach to support people with learning disabilities to:

- **Lead fulfilled lives** by developing skills for daily living, accessing education, work and taking part in family and cultural life, leisure and sport.
- **Transition through the key stages in a life course** – for example, from childhood to adulthood, moving from residential care to community support, ageing and end of life.

In order for people with learning disabilities to have a good quality of life and for services to be able to meet demand, there needs to be more focus on early intervention, prevention and management, at a universal, targeted and specialist level of health and social care.

By 2030, the life expectancy for people with a learning disability is projected to increase by 164% to 80 years of age[iv]. Medical advances and measures to tackle discrimination have led to life expectancy catching up with the general population, but this increase means more people living with multi-morbidities.[v]

The Royal College of Occupational Therapists (RCOT) argues that to ensure people can live well with complex morbidities, service provision must be reshaped in order to optimise multidisciplinary working. This action is given a further sense of urgency with the reported 40% drop since 2010 in specialist learning disabilities nurses[vi] and fewer pre-registration nursing students[vii]. This means commissioning services to:

- Centre on supporting people to access and participate in education, work and mainstream community resources.
- Clear access points for mainstream services to specialist expertise and guidance.
- Create strong working partnerships across sectors to ensure people with learning disabilities are able to maintain their health and wellbeing through healthy occupations.

Capitalising on the occupational therapy workforce

Occupational therapists work with people to develop an all-round understanding of their skills and abilities to perform daily activities (occupations) in the home, at school, in work or in the community.

Occupations involve the integration and use of sensory, motor, cognitive, perceptual, emotional and social skills and abilities. By assessing these skills and examining where the person will be functioning (for example, their home, school or workplace), occupational therapists can help people develop skills, modify the activity or the environment to create the best person/environment/occupation fit. Put simply, the best outcome for the person.

This report makes recommendations for effective use of the occupational therapy workforce in order to enhance the life opportunities for people with learning disabilities.

Recommendations – Services should deploy occupational therapy expertise to:

1. Ensure participation within communities is a core activity in service commissioning and delivery.
2. Support people with learning disabilities to live fully integrated lives within communities.
3. Create packages of care and support to enable people to get the right care in the right place.

Universal service example: Sport for Confidence

Sport for Confidence supports people with learning disabilities to access opportunities to engage in an inclusive sport and physical activity programme. The model involves an occupational therapist and a specialist sports coach working in a leisure centre. The occupational therapist advises on adapting and grading the activities and programme for adults with learning disabilities and works closely with the leisure centre staff, coaches and community learning disabilities teams.

Impact: 50 groups per week over eight locations. Over 300 people a week are being offered a choice of 15 different sports and activities. People with learning disabilities can access different programmes ranging from fully supported, therapy-led groups to mainstream activities.

1 **All** people with learning disabilities can participate in healthy occupations

HOW

Ensure participation within communities is a core activity in service commissioning and delivery.

Recent legislation, such as the Care Act in England[viii] and Social Services and Wellbeing Act (Wales)[ix], has directed care and support services to listen to and understand the needs of people with learning disabilities and to work with them to achieve their own wellbeing outcomes. Further initiatives such as the 'stopping over-medication of people with a learning disability, autism or both with psychotropic medicines' (STOMP) campaign support the move away from a medicalised model of care[x]. It is widely recognised, however, that there is a need for on-going work, in particular supporting access to employment and lifelong learning, improving access to health services and integration into local communities.

A fundamental principle of occupational therapy is to enable participation in society. Key occupations for participation are, among others, education, employment, sports and leisure.

The difference occupational therapy makes:
As well as working with individuals, occupational therapists can support community integration by advising and training families, care providers, community and education providers and employers.

Occupational therapists understand the changing interaction between the person and their environment, and utilising their skills will help to ensure communities are more inclusive and sensitive to everyone's needs.

Key components for delivering the recommendation

Position occupational therapists to:

- Develop wider partnerships to create access to opportunities in education, work and leisure.
- Provide advice and training to families and service providers.
- Create clear access points for partners and service providers to utilise advice and guidance from occupational therapists.

Fatima and Jamila's Story

Sisters Fatima and Jamila moved with their family to the UK at the age of 12 and were not known to services. They were referred to occupational therapy by their GP as they were not attending college and withdrawing from family life. The sisters wanted to be seen by the occupational therapist together. The assessment led to:

Accessing the community. For opportunities to mix with other people, the sisters decided they would like to attend an art class and the gym. The occupational therapist supported them to attend an annual health check at their GP's and advocated for Gym on prescription as the GP had not identified physical fitness as a priority. A benefits application was made to fund these activities, as well as a bus pass.

Safeguarding. The occupational therapist identified concerns over potential radicalisation through internet use and made referrals for Safeguarding and the National Crime Agency Prevent programme. Working jointly alongside the local Police Prevent Team risks were identified.

Concerns were raised over the sisters' behaviour at College resulting in their exclusion. The occupational therapist worked alongside the local Police Prevent team and college tutors to support their re-engagement at college.

Fatima and Jamila also disclosed information suggesting on-line sextortion, posting of pornographic material and stalking. The occupational therapist supported them to report this to the Police and consequently the Porn Hotline.

Advice and guidance. The occupational therapist provided advice and information to the police on how to make their training accessible to people with learning disabilities so that the twins could be taught how to stay safe online.

IMPACT

With support in place Fatima and Jamila are attending a College course, going to the gym and swimming sessions on a weekly basis, and their social media activity has reduced. They are seeing a psychologist for help to manage anger and the Prevent team are no longer involved.

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2 People with learning disabilities are supported to manage changes throughout life

HOW **Support people with learning disabilities to live fully integrated lives within communities.**

Being and taking part in the community should happen throughout a person's life. Their role, and what they do in the community, will vary depending on the stage of a person's life and their interests. For example, integrating a child or young person into the community may focus on home, school, and leisure, while integrating an adult into the community may focus on home management, employment, leisure, and social or religious activities.

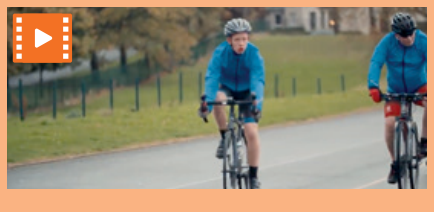
There are key stages in the life of someone with a learning disability where significant adjustment might be needed, and this may involve professional help. These stages include the transition from childhood to adulthood, the death or ill health of a carer, and ageing.

The difference occupational therapy makes:
Occupational therapists review peoples' aspirations, abilities and needs at key points of transition throughout their life. A stepped approach provides:

- one off advice and guidance;
- targeted training to care staff and families;
- a tailored one to one approach for people with more complex needs or situation.

Occupational therapy expertise needs to be available and accessible across sectors and delivered in the relevant environment. For example: in school or higher education institutes, through vocational support services, in sports and leisure centres or older people's extra care housing or care homes.

Alistair's story demonstrates the effectiveness of occupational therapy in helping a person with learning disabilities achieve their chosen goals and reach their full potential.



View the film here **https://bit.ly/2WVmmF5**

Tracey's Story

Tracey is 62 with a global learning disability. Tracey lived with her mother, did not attend school and was cared for like a child. When Tracey's mother died she moved in with her aunt. She continued to live a very sheltered and dependent life. When the aunt died her son inherited responsibility for Tracey.

Managing risk. A referral was made to the Learning Disabilities Service to help manage a very vulnerable and potential safeguarding situation. The family felt Tracey should be in care or have 24-hour support in a home of her own. The cost of a 24-hour support care package was calculated at **£1,354** per week, which equates to an annual cost to the Local Authority of **£70,408.**

Taking an assets based approach. An occupational therapy assessment was completed and the occupational therapist recommended two days at the local authority centre with an individualised care plan to prompt independence and 21 hours per week to support with reading letters, paying bills and shopping. Tracey moved into a warden assisted bungalow and a graded treatment plan was delivered by the occupational therapist.

IMPACT

Tracey learnt the skills to look after herself and her home independently. Road safety/travel training and the local learning centre supported Tracey to gain paid employment in a kitchen for five hours per week and travel there independently.

Saving money for the public purse
The cost of occupational therapy involvement was **£516** (12 hours at £43 per hour). Housing and the care plan costs **£33,436** per annum saving the Local Authority **£36,972** each year.

Key components for delivering the recommendation are to:

- Take an assets based approach.
- Balance risk and choice – taking into account the meaning and value of the occupation to the person when assessing risk.
- Keep people with learning disabilities connected with their communities, family and friends.

Occupational Therapy | Improving Lives Saving Money

3 People with complex needs and behaviours are supported close to home

HOW Create packages of care and support to enable people to get the right care in the right place.

Research shows that people living in residential institutions experience occupational deprivation (a lack of meaningful occupations and routine).[xi] Understanding the impact of this deprivation is important when considering people's behaviours, particularly if these are challenging.

Approximately 1,827 people in the UK are inpatients in learning disability units.[xii, xiii, xiv, xv] Each country has targets to reduce the number of inpatient beds and provide more support in local communities.

The difference occupational therapy makes: Occupational therapists assess a person's needs and advise on activities they can do that will improve and support their wellbeing. They identify a range of activities for the person to take part in, and encourage them. This is a tailored, personalised approach[xvi] that can lead people, as well as their family and their care staff, to learn new skills and find what's right for them.

In addition, occupational therapists recommend what type of support is needed, how best to work with the person, how to prompt and encourage, or how to set up the environment around them.

For people with complex behaviours, occupational therapists can advise on the therapeutic use of activities to help regulate emotions. Adopting therapeutic activities as part of an overall package of strategies can reduce the need for psychotropic medication.

Key components for delivering the recommendation:

Use occupational therapists:

- as an alternative or as part of a positive behaviour support approach to cater for people's needs.
- to train and advise formal carers to take up a personalised approach to care.
- to identify suitable housing and support.

Ian's Story

Ian had served a prison term and was living in a specialist forensic rehabilitation unit **outside his home county**. He was referred to the Learning Disability Team for discharge back into the community.

Ian was inactive for most of the day and did not engage with the programme of activities on the unit. He was taking medication for his **extreme anxiety** and being frequently physically restrained. Following an assessment by the occupational therapist, Ian was supported by the team's technical instructors to start **engaging with activities** that he was interested in.

Designing support around Ian's needs. MENCAP staff had been commissioned to provide community support. The occupational therapist advised on a gradual community integration programme based on Ian's goals. Having identified activities, that helped Ian with his anxiety, the occupational therapist requested his medication be reviewed and reduced. The occupational therapist, also, assessed for **suitable housing**.

Training to embed personalised care. The occupational therapist and technical instructor staff remained involved throughout the transition process and provided regular sessional work both in Ian's home and community, advising MENCAP staff on resources and daily activities.

Ian has been discharged to a rented property **near to his mother's nursing home**. He is supported by MENCAP with 24-hour care provision which includes an 8-hour sleep-in and further 1:1 support.

IMPACT

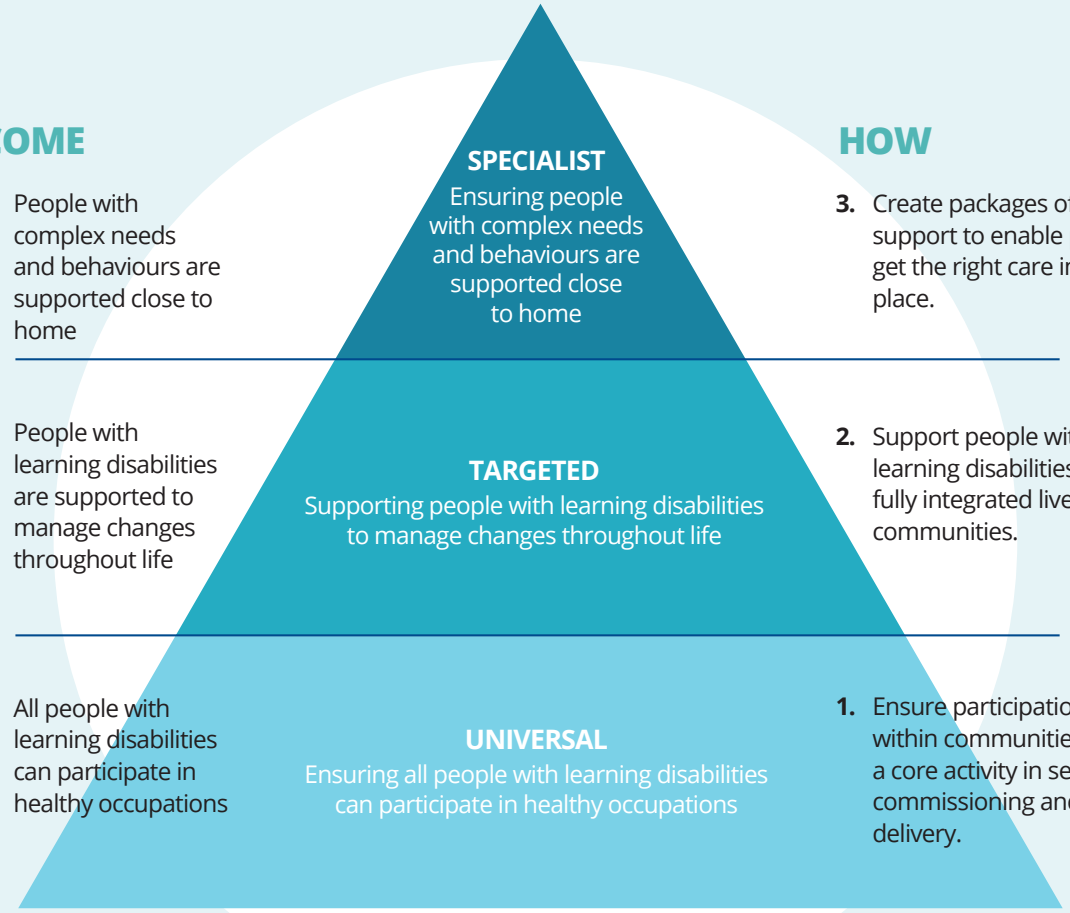
Ian is taking **less medication** and has **improved mobility**. He has more control over his anxiety, resulting in **reduced use of restraint**.

Ian attends church and prayer meetings, visits his mother and goes shopping. Ian cooks his own meals with **minimal support** and is supported with laundry, cleaning and gardening. He continues to **expand his experiences** and has recently been on a church holiday.

Leading fulfilled lives

Occupational therapy supporting people with learning disabilities

To achieve the three recommendations contained within this report, services should deploy occupational therapy expertise so that...



The full list of references for this report is available at ***www.rcot.co.uk/improvinglives/reports***.

The RCOT Occupational Therapy Improving Lives, Saving Money campaign's overarching recommendations are:

To empower people to manage their health and wellbeing occupational therapists should be deployed across the health and care system to:

- **Intervene** early within primary care
- **Embed** personalised care through training and supervising others
- **Develop** wider partnerships to further innovation
- **Expand** therapy-led services

Find out more: www.rcotimprovinglives.com

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References

[i] United Nations, Department of Economic and Social Affairs (2006) *Convention on the rights of persons with disabilities*. Available at: *https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html*

[ii] Verdonschot MML, de Witte LP, Reichrath E, Buntinx WHE, Curfs LMG (2009) Community participation of people with an intellectual disability: a review of empirical findings. *Journal of Intellectual Disability Research*, 53, 303-318. doi:10.1111/j.1365-2788.2008.01144.x

[iii] Department of Health (2017) *Local support for people with a learning disability*. London: National Audit Office.

[iv] Emerson E, Hatton C (2011) *Estimating future need for social care among adults with learning disabilities in England: an update*. Durham: Improving Health and Lives Learning Disability Observatory.

[v] NHS Scotland (2017) *People with learning disabilities in Scotland: 2017 health needs assessment update report*. Edinburgh: Scotland.

[vi] Royal College of Nursing (2018) Learning disability care facing crisis. London: RCN. Available at: *https://www.rcn.org.uk/news-and-events/news/learning-disability-care-facing-crisis*

[vii] Nursing Times (2018) *Exclusive: half of learning disabilities nursing courses 'considering closure'*. London: Nursing Times. Available at: *https://www.nursingtimes.net/news/education/exclusive-half-of-learning-disability-nursing-courses-considering-closure/7024425.article*

[viii] Great Britain.Parliament (2014) *Care Act 2014*. London: Stationary Office.

[ix] Welsh Government (2014) *Social Services and Wellbeing (Wales) Act (2014)*. Cardiff: Welsh Government.

[x] VODG (2017) STOMP Campaign. Available at: *https://www.vodg.org.uk/campaigns/stompcampaign/*

[xi] Galvin D, Wilding C, Whiteford G (2011) Utopian visions/dystopian realities: exploring practice and taking action to enable human rights and occupational justice in a hospital context. *Australian Occupational Therapy Journal*, 58(5), 378–385.

Perkes D, Whiteford G, Charlesworth G, Weekes G, Jones K, Brindle S, Hoare L, Todd E, Mililani R (2015) Occupation-focused practice in justice health and forensic mental health: using a practice-based enquiry approach. *World Federation of Occupational Therapists Bulletin*, 71, 101–107, doi:10.1080/14473828.2015.1103464

Smith HC (2005) 'Feel the fear and do it anyway': meeting the occupational needs of refugees and people seeking asylum. *British Journal of Occupational Therapy*, vol. 68(10), 474-476.

Uemura J-I, Hoshino A, Igarashi G, Nishio S (2018) Changes in activity: experience of new admissions to a long-term care facility. *Physical & Occupational Therapy in Geriatrics*, 36(2/3), 221-233.

Whalley Hammell K, Iwama M (2012) Well-being and occupational rights: an imperative for critical occupational therapy. *Scandinavian Journal of Occupational Therapy*, 19(5), 385-394.

Whiteford, G (2000) Occupational deprivation: global challenge in the new millennium. *British Journal of Occupational Therapy*, 63(5), 200-204.

Whiteford GE (2005) Understanding the occupational deprivation of refugees: a case study from Kosovo. *Canadian Journal of Occupational Therapy*, 72(2), 78-88.

[xii] NHS Digital (2016) *Mental health and learning disabilities statistics*. London: NHS England.

[xiii] Welsh Government (2018) *Patients in mental health hospitals and units*. Cardiff: Welsh Government.

[xiv] Department of Health Northern Ireland (2018) *Mental health and learning disability inpatients 2017/18*. Belfast: Department of Health.

[xv] Scottish Government (2017) *Inpatient census*, 2017. Edinburgh: Scottish Government.

[xvi] Royal College of Occupational Therapists (2019) Making personalised care a reality: the role of occupational therapy. London: RCOT. Available at: *http://cotimprovinglives.com/making-personalised-care-a-reality-the-role-of-occupational-therapy/*