

Allied Health Professions' Office of Queensland

Occupational Therapy Learner Guide

Conduct group sessions for individual client outcomes

April 2017

Occupational Therapy Learner Guide – Conduct group sessions for individual client outcomes

Published by the State of Queensland (Queensland Health), April 2017



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Acknowledgement

The Allied Health Professions' Office of Queensland wishes to acknowledge the Queensland Health Allied Health Clinicians who have contributed to the development of these learning support materials. In alphabetical order:

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INTRODUCTION

Welcome to Learner Guide: *Conduct group sessions for individual client outcomes*.

Learner Guide Structure

This Learner Guide has been developed specifically for Allied Health Assistants to provide the skills and knowledge required to receive and respond to rehabilitation programs developed by Allied Health Professionals

This Learner Guide contains information and activities relating to key topics to enhance learning opportunities. The guide is broken up into three topic areas with sub-topics for each. These are as follows:

Organisation Requirements:

- Policies and procedures relevant to conducting group sessions
- Legal and ethical requirements for allied health assistance work
- Record keeping practices including confidentiality requirements

Group Processes:

- Group dynamics and the factors that affect group behaviour
- Group roles
- Group learning

Service Provision:

- Service delivery model
- Client care model
- Scope of practice

Each topic includes sub-topics which cover the essential knowledge from the unit of competency. You will be asked to complete the activities in each topic to support your learning. These activities address the essential skills from the unit of competency and will be part of your assessment.

Throughout the guide, you will be given the opportunity to work through a number of activities, which will reinforce your learning and help you improve your communication and organisation skills, manual handling skills and ability to apply therapeutic exercise practices. Take time to reflect during the module on how you may be able to apply your new knowledge and skills in your role as an allied health assistant.

Learning requirements

It is important that you have an allied health workplace supervisor who has agreed to support in your study. Regular clinical supervision during the course of your study should also assist you to stay “on track”, provide opportunities for your supervisor to monitor your progress, provide encouragement, and to check that you understand the information in the learning materials. This will be particularly important if you are having any specific learning difficulties.

Self-Completion Checklist

The Self Completion Checklist outlines the underpinning knowledge and skills contained in each of the topics for the unit of competency you will be assessed against. You will be asked to review the list and place a tick in the box if you feel you have covered this information in each section and if you feel ready to undertake further assessment. If you have any questions about this checklist, ask your supervisor.

Recognition for Prior Learning

If you subsequently enrol in the Certificate IV in Allied Health Assistance you may be able to undertake recognition assessment for the study that you have done. To enable you to gain recognition for the learning you have undertaken in this Learner Guide, it will be necessary for you to complete the Assessment Guide associated with this unit of competency. The assessment activities in this Assessment Guide must be signed off by an **occupational therapist**. Copies (Word version) of the Assessment Guide can be obtained by contacting the Allied Health Professions' Office of Queensland via e-mail AH_CETU@health.qld.gov.au



Please Note

Due to the varied environments in which allied health assistance is carried out, the terms ‘patient’ and ‘client’ are used interchangeably throughout this resource. Please use your organisation’s preferred term when performing your duties.

Symbols

The following symbols are used throughout this Learner Guide.



Important Points – this will include information that is most relevant to you; statistics, specific information or examples applicable to the workplace.



Activities – these will require you to reflect on information and workplace requirements, talk with other learners, and participate in a role play or other simulated workplace task. You may use the space provided in the Learner Guide to write down a draft response. Record your final answer in the Assessment Guide.



Further Information – this will include information that may help you refer to other topics, complete activities, locate websites and resources or direct you to additional information located in the appendices.



Case Studies – these will include situations or problems for you to work through either on your own or as a group. They may be used as a framework for exploration of a particular topic.



Research – this refers to information that will assist you complete activities or assessment tasks, or additional research you may choose to undertake in your own time.

LEARNING OUTCOMES

As an Allied Health Assistant assisting with the rehabilitation of clients you will be required to perform the following tasks.

1. Plan for group sessions by:
 - Obtaining information about the purpose of group sessions from an Allied Health Professional
 - Obtaining information about the desired individual client outcomes (which may include, client care plan, rehabilitation plans, case notes, skilled observation approaches or Allied Health Professional instructions)
 - Identifying requirements outside scope of role and responsibilities as defined by the organisation and discuss with an Allied Health Professional
 - Identifying and confirm impact of the program's contribution to the clients' overall care plan
 - Determining client availability (which may include strategies such as face to face, telephone, written or flyer) according to organisation protocols
 - Determining client appropriateness according to client profile

2. Assist with the development of a rehabilitation program by:
 - Planning group activities that are consistent with client needs and recognise physical abilities and limitations of each client
 - Planning group activities consistent with the clients' interests, preferences and beliefs
 - Planning group activities with consideration of the clients' pace and timing requirements
 - Planning group activities according to the size and composition of the group
 - Planning group session to maximise the involvement of all group members
 - Establishing a balance between tasks to be accomplished and the group process
 - Identifying possible risk to successful group activities and adjust plan to minimise risk
 - Confirming group session plan with Allied Health Professional
 - Gathering and/or preparing materials and equipment required for the group session and check for safety and suitability

3. Conduct group activity by:
 - Arranging the environment to encourage full participation by all group members
 - Seeking agreement on the purpose, process and intended outcomes of the group activity with the group
 - Discussing the group activity with the group to encourage participation
 - Working with the group to establish ground rules if appropriate

- Providing each group member with the necessary information, materials and support to participate in the group activity
 - Ensuring that the manner, level and pace of communication is appropriate for each group member
 - Communicating with clients in a manner most likely to promote co-operation, dignity and self-esteem and encourage participation
 - Using group skills (which may include eliciting views and addressing individual needs in groups, dealing with issues of power, influence and authority in group or interpreting non-verbal communication) to ensure the involvement of all group members
 - Identifying potential conflict (which may include non-participation and withdrawal, personal comments and attacks, raised voices or agitation) within the group and manage to ensure ongoing involvement of individuals in group activities
 - Monitoring individual client progress and provide constructive feedback to individual group member
 - Following process and directions to evaluate outcomes of the group session
4. Clean and store equipment and materials by
- Cleaning equipment and materials according to manufacturer’s requirements
 - Storing equipment and materials according to manufacturer’s requirements and organisation protocols
 - Reporting equipment faults to appropriate person
5. Document client information by:
- Using accepted protocols to document information relating to the rehabilitation program in line with organisation requirements
 - Providing regular feedback to the client’s care team
 - Using appropriate terminology to document symptomatic expression of identified problems related to the rehabilitation program

LEARNING TOPICS

The table below outlines the relationship between the topics presented in this Learner Guide and the Essential Knowledge required for completion of the unit of competency.

Topics	Essential Knowledge
Organisation Requirements	<ul style="list-style-type: none"> • Legal and organisation requirements on equity, diversity, discrimination, rights, confidentiality and sharing information when supporting a client to develop and maintain skills. • A working knowledge or record keeping practices and procedures in relation to conducting groups for individual client outcomes • OHS policies and procedures that relate to the Allied Health Assistant's role in conducting group sessions • Supervisory and reporting protocols of the organisation
Group Processes	<ul style="list-style-type: none"> • Principles of group dynamics • Nature of group learning • Factors that affect behaviour in groups • Understanding of group roles, leadership and facilitatory techniques
Service Provision	<ul style="list-style-type: none"> • Understanding of role within a care team and when and how to provide feedback about the client.

CONTENT

1. Organisation Requirements

This topic covers information about:

- Policies and Procedures
- Legal and Ethical Requirements
- Record Keeping

Activities in this topic address the following essential skills:

- Use planning skills
- Manage individual client outcomes in a group setting
- Apply group skills, including:
 - Identifying and managing issues of equality of opportunity and non-discriminatory practices in group activities
 - Eliciting views and addressing individual needs in groups
 - Putting groups at ease
 - Managing different individual styles within a group
 - Interpreting non-verbal communication
 - Gauging the appropriateness of language for individuals in a group
 - Balancing the needs of the task with the group process
 - Dealing with issues of power, influence and authority in group
- Work under direct and indirect supervision
- Communicate effectively with clients in a therapeutic/treatment relationship
- Communicate effectively with supervisors and co-workers
- Work within a multi-disciplinary team
- Use time management, personal organisation skills and establishing priorities
- Undertake evaluation processes

1.1 Policies and Procedures

Within all health settings, there are many documents that outline set standards of behaviour and formalised ways of doing things. These should guide actions of staff within that setting. These may be in the form of written policies, procedures, codes of conduct or codes of ethics.

These documents exist to make sure high standards of behaviour, safety and consistent ways of doing things are maintained. They help protect both clients and staff from questionable conduct, and support provision of efficient, effective, consistent health care. Basic knowledge of relevant policies and procedures is essential, as these documents underpin work behaviours in a health setting.

Queensland Health policies and procedures are managed in the following way:

Policy	A statement of intent to achieve a particular outcome
Policy Implementation Standard	Defines the parameters, including responsibilities and accountabilities, of implementing the policy.
Procedure	Agreed set of practices, generally sequential, to support the consistency and quality of an activity or service in more than one work unit.
Workplace Instruction	Procedures, protocols and guidelines which apply only to staff within a particular work unit.

The most current state-wide policies and procedures are located on the Queensland Health Intranet site. Current district and work unit policies, procedures and work instructions will be managed on the District intranet site or local shared drive. It is important you ensure you have access to these.

You will need to be familiar with policies and procedures that address the following:

1. Supervisory and reporting protocols
2. Occupational health and safety
3. Infection control
4. Legal and organisational requirements
5. Quality assurance, best practice and accreditation standards
6. Codes of practice for work in occupational therapy

Queensland Health Policies

Queensland Health policies should always be aligned with Queensland Health's 'strategic direction'. They should be in line with the state and federal legislation on the same matter and be easily accessible for those required to implement the policies (Queensland Health, 2015). On an employee level, we must apply Queensland Health policies and guidelines to our work to ensure we are providing client care that is of a high standard, safe, and accessible to all.



You do not need to be aware of all of Queensland Health's policies. However, you should have an awareness of and understanding of specific Queensland Health policies that apply to your role.

To find out more about the Department of Health's policy framework:

<https://www.health.qld.gov.au/system-governance/policies-standards/types/default.asp>

The following policies include some that you should consider when conducting your work as an Allied Health Assistant. Please note this is not an exhaustive list. There will be additional policies relevant to your particular workplace.

- Work Health and Safety Policy (July 2014)
- Anti-discrimination and vilification Policy (November 2016)
- Orientation, Induction and Mandatory Training Policy (November 2016)
- Workplace Equity and Harassment Officers Policy (May 2010)
- Performance and Development Policy (June 2014)



You should discuss with your supervisor or line manager which additional Queensland Health Policies (not listed above) are relevant to your particular workplace.

Supervisory and Reporting Protocols

Supervision refers to instructing, advising, and monitoring another person in order to ensure safe and effective performance in carrying out the duties of their position. You will be responsible for reporting to the Allied Health Professional and providing supervision to less experienced Allied Health Assistants. To successfully achieve this, you will need to identify your organisations policies that outline how to complete this in relation to your role and boundaries.

Supervision can be direct with face to face contact or indirect, such as via electronic communications e.g. telephone and videoconferencing. The method and frequency of your supervision will be determined by other factors including:

- your experience
- task maturity
- your non-clinical skill development
- your organisation's reporting protocols on client treatment programs and progress

With your supervisor, you need to identify at what level you require direct or indirect supervision for what activities. A Performance Appraisal and Development plan (PAD) may be used by your supervisor to formally document your performance expectations, ensuring feedback and guidance and a way of jointly identifying your learning and developmental needs and activities.

Performance Appraisal and Development (PAD)

This is a process to be completed by all Queensland Health staff, which involves setting goals for improving work performance and progressing career paths. This is intended to benefit both staff and the organisation. Your PAD is usually completed once a year with a six monthly review of the goals that you set.

There is a clear process and structure for employees participating in a PAD including the use of standardised forms. Participating in PAD ensures:

- clear performance expectations for employees
- feedback and guidance on performance – both positive and negative
- joint identification of learning and developmental needs and activities

In addition, your PAD can be used to identify areas of work you would like to improve or develop. You and your manager can develop a plan about how to achieve your goal. For example, you may wish to improve your knowledge of wheelchair maintenance. In your PAD, you can record this as a goal and work out with your manager how you can learn more e.g. work-shadow another staff member or attend a workshop on the topic.

This plan is designed to be used for longer term career planning as well as short term needs. For example, perhaps you wish to work in an acute ward setting. Your manager may then plan with you how you can work towards that goal while still working in your current position.

Goals need to be relevant to your employer and their business of health care. Your manager may use your PAD to identify and discuss areas they require you to work on, including if parts of any of your work performance that may be a concern (Queensland Health, 2014).

Quality Assurance

Queensland Health has a set of policies, processes, and accountabilities that are aimed at improving client safety and the quality, effectiveness and dependability of its services. It does not replace, but is additional to, the professional self-regulation and individual accountability for clinical judgement that are an essential part of healthcare (Queensland Health, 2007).

Quality is a continuous process and you will find yourself participating in and leading quality activities within your department and unit. The guiding principles of quality are:

- respect for people
- client satisfaction
- improvement through change (plan, do, check, act quality cycle)
- management by fact
- teamwork

(Queensland Health State wide Occupational Therapy Clinical Education Program, 2007)



For more information on continuous quality improvement, see <http://qheps.health.qld.gov.au/cqld/quality-safety/quality-improvement.htm>

Accreditation

At an organisational level, all Queensland Health services must participate in a periodic accreditation process. The National Safety and Quality Health Service (NSQHS) Standards were developed by the Australian Commission on Safety and Quality in Health Care to drive the implementation of safety and quality systems and improve the quality of health care in Australia. The 10 NSQHS Standards provide a nationally consistent statement about the level of care consumers can expect from health service organisations.

In September 2011, Health Ministers endorsed the NSQHS Standards and a national accreditation scheme. This has created a national safety and quality accreditation scheme for health service organisations. <https://www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards/>

The primary aim of the National Safety and Quality Health Service (NSQHS) Standards are to protect the public from harm and to improve the quality of health service provision.



The National Safety and Quality Health Service Standards are clearly outlined on the following website.

<http://qheps.health.qld.gov.au/psu/safetyandquality/standards/default.htm>

Review the standards and highlight those standards that you believe will apply to you in your workplace setting.

Best Practice

Best practice is a term used 'in referring to procedures which are believed to result in the most efficient provision of a product or service' (Canadian Association of Occupational Therapists, 2009). Other terms such as evidenced-based practice may also be used in this area. In the healthcare setting, you will be required to ensure your clinical practices are based on current best practice. Ways of achieving this include:

- reviewing the literature
- participating in ongoing professional development

At an organisational level, all Queensland Health services must participate in a periodic accreditation process. Most clinical settings in which Allied Health Assistants (AHAs) operate are required to comply with standards defined by the National Safety and Quality Health Service Standards (NSQHS).



On an employee level, you must apply Queensland Health policies and procedures to ensure that you provide client care that is of a high standard, safe, and accessible to all.

Queensland Health is committed to providing a safe working environment for all staff, clients, visitors, students and volunteers. The following Queensland Health documents outline how this is achieved:

- Work health and safety policy statement (Queensland Health 2015, http://qheps.health.qld.gov.au/safety/safety_topics/p_statement/unsigned.pdf, viewed 13 February 2017,)
- Work health and safety policy (Queensland Health, 2014, https://www.health.qld.gov.au/_data/assets/pdf_file/0034/395764/gh-pol-401.pdf viewed 13 February 2017)

Under the Code of Conduct for the Queensland Public Service (2010) and the Queensland Workplace Health and Safety Act 2011, you have a duty of care to ensure the health and safety of yourself, colleagues, clients and members of the public. Many of the activities you carry out at work have the potential to cause harm. It is important to follow correct occupational health and safety (OHS) policies and procedures to prevent or minimise workplace injuries and harm.

Whilst delivering a client's program, it is your responsibility to put in practice these OHS policies and procedures such as:

- ensuring that the equipment, materials and environment used during programs is cleaned, correctly set up, maintained and stored appropriately
- ensuring correct client handling techniques are used when moving, positioning and transferring clients
- reporting all injuries, incidents and unsafe conditions or work practices appropriately
- reporting equipment faults to appropriate person



The Queensland Health OHS online learning packages will provide you with a summary of the Queensland Health's OHS strategic plan, policies and integrated safety management systems. These packages form part of your orientation to Queensland Health.

<http://qheps.health.qld.gov.au/safety/elearning.htm>



Activity 2 - The Quality Cycle

You have been ordering stock for the work area now for a few months, and you have some ideas about how you may be able to do this more efficiently. You think it will save time and make re-ordering easier to track. You may find it helpful to refer to the following quality cycle.

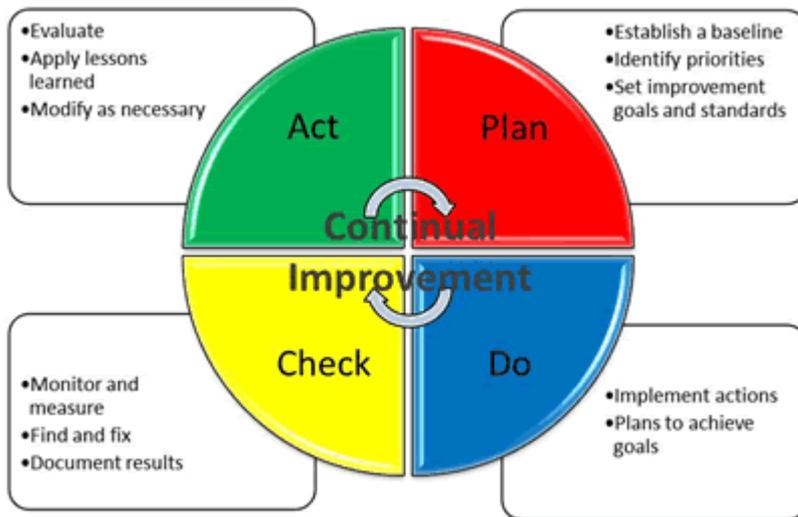


Figure 2 Quality Cycle (Queensland Health, 2017)
<http://gheps.health.qld.gov.au/darlingdowns/html/quality-safety/quality.htm>

Answer the following question. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

How do you go about doing this?

Activity continues on the next page

Infection Control

In addition to the above policies, in your role as an Allied Health Assistant you are expected to stick to infection control procedures and take responsibility for ensuring your safety as well as the safety of others.

You should have developed an understanding of infection control principles whilst completing the following units for the Certificate IV in Allied Health Assistance:

- HLTIN301C Comply with infection control policies and procedures (pre-requisite unit)
- HLTIN403C Implement and monitor infection control policy and procedures (core unit)

'Infection control practices aim to prevent infection transmission by limiting the exposure of susceptible people (hosts) to micro-organisms (agents) that may cause infection.' (Queensland Health, 2008).



The Centre for Healthcare Related Infection Surveillance and Prevention (CHRISP) is the state-wide service for Queensland Health to assist with healthcare related infection. Further information is available at:

<http://www.health.qld.gov.au/chrisp/>

Infection control policies and procedures provide the foundation for a safe health care environment for staff and clients. You will need to identify and apply the policies and procedures that relate to your role including:

- standard and additional precautions
- employee health issues e.g. immunisation
- infection surveillance
- environmental issues
- reprocessing of reusable medical and surgical equipment
- equipment and product purchases
- waste management
- building and refurbishment
- food safety
- laundry management



Many clients with infectious conditions may not be aware that they are a threat to others. Reading clients' notes comprehensively and communicating with Allied Health Professionals will assist you to prepare for group sessions that may include clients with infection precautions.

In some cases a client may not be appropriate to participate in group-based activities until clearance is provided by a medical officer.

Before seeing clients with an infection, seek further information from your supervisor or the infection control nurse. Participation in some activities like kitchen tasks may be inappropriate until the client is cleared of any possible infection risk.



Activity 3 - Infection Control Precautions

Refer to The Centre for Healthcare Related Infection Surveillance and Prevention (CHRISP) intranet site at <http://www.health.qld.gov.au/chrisp/> and answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. Identify 8 standard precautions that you would need to follow to limit the transmission of infectious diseases?

2. Identify how you would identify if a client has an infectious disease (i.e. what notifications would be in place) and provide example of what additional precautions may be in place.

1.2 Legal and Ethical Requirements

The policies and procedures in Section 1.1 exist to ensure Queensland Health employees follow a high standard of behaviour, safety and clinical skills.

Most Queensland Health (QH) policies and procedures are based on Australian or Queensland Government legislation or law. Some of the legislation that applies to your role as an Allied Health Assistant may include:

- Right to Information Act 2009
- Public Service Act 2008
- Building and Fire Safety Regulation 2008
- Public Health Act 2005
- Environmental Protection Act 1994
- Environmental Protection (Waste Management) Policy 2000
- Environmental Protection (Waste Management) Regulation 2000
- Disaster Management Act 2003
- Workers Compensation and Rehabilitation Act 2003
- Public Records Act 2002
- Crime and Misconduct Act 2001
- Industrial Relations Act 1999
- Work Health and Safety Act 2011
- Public Sector Ethics Act 1994
- Whistle blowers Protection Act 1994
- Anti-Discrimination Act 1991
- Public Safety Preservation Act 1986
- Health Practitioners (Professional Standards) Act 1999
- Therapeutic Goods Act 1989



Outlined below is a summary of some of the legal documents that are relevant to you as an Allied Health Assistant. It is recommended that you familiarise yourself with these documents as they apply to your organisation.

Anti-discrimination Act (1991)

Queensland Health's policies and procedures support an inclusive workplace that is free from unlawful discrimination, where all individuals are accepted and valued. This means an individual's cultural beliefs, ethnicity, religion and sexual preference are respected accepted and valued. The Anti Discrimination Act 1991 prohibits discrimination.

Clients who you will assist with rehabilitation include those from diverse backgrounds, religion, impairments and medical history, ethnicity, age and sexuality. The Human Rights and Equal Opportunities Commission Act describes discrimination as conduct which excludes or disadvantages a person based on their; race, colour, sex, religion, political opinion, national extraction or social origin. The Anti-Discrimination Act also prohibits discrimination against people based on their age, marital status, parental status, pregnancy and breastfeeding, impairment and disability, or sexual preference.



The term discrimination includes both direct and indirect discrimination. An example of direct discrimination would be choosing to spend less time working with a particular client in the group because their heavily accented language is difficult to understand. Indirect discrimination would be if you planned a group which required all clients to remove headwear. This places a rule with which a minority group (religious groups who wear veils and etc) may not be able to comply.



For a full copy of the Anti Discrimination Act 1991 refer to The State of Queensland, Office of the Queensland Parliamentary Counsel, Queensland Legislation Website:

<http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/A/AntiDiscrimA91.pdf>

Equal Employment Opportunity

Queensland Health (QH) is committed to providing a safe and equitable work environment. QH recognises that Equal Employment Opportunity (EEO) is achieved by identifying and eliminating all forms of discrimination in recruitment, selection, training, development, human resource practices and conditions of employment.

All employees are entitled to:

- be treated with fairness and respect
- work in a place free from all forms of harassment and discrimination
- have access to, and compete equitably for recruitment, selection, promotion and transfer opportunities
- have access to relevant training and development opportunities
- have all workplace grievances addressed promptly by their supervisor or other appropriate personnel and
- choose and pursue their own career path

(Queensland Health, 2009)

Privacy Act (1988)

The Privacy Act states that as a Queensland Health employee, you should only collect personal information that is directly required for the healthcare needs of clients. At commencement of most Queensland Health services, clients are provided with an overview of their rights under the Privacy Act (1988) and are asked to sign a consent form to enable Queensland Health to record and disclose health information.

Clients **DO NOT** have to provide consent to disclose personal or health information to other parties. If a client does sign the consent form, under the Privacy Act, they are able to retract their consent by providing their request in writing.

According to the Act, personal information or health information should only be used for the purpose of providing high quality healthcare. 'Health Information' means information or an opinion about a client's health or disability, or their expressed wishes about future health services. For example, in a group setting you should not discuss a client's opinion on organ donation. Also, this type of information is not limited to written information; it also includes photographs, pictures or case study information.

Right to Information Act (2009)

The Queensland Government is committed to giving the community greater access to information. The Right to Information reforms strengthen the community's right to access government-held information, unless releasing the information would be contrary to the public interest. Medical records departments will be able to direct you to an officer who deals with requests for copies of or information from medical records.



Do not show medical records to a client without first seeking further advice from your local medical records department.



Activity 4 – Scenario

Read the following scenario and answer the related questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

You are co-facilitating a group of ten clients interested in quitting smoking. After the group, one of the clients, Anthony, approaches you asking for clients' contact numbers. He explains that he is interested in starting a coffee group to help support each other through the difficult process of quitting smoking.

1. Are you able to give Anthony the contact details of the other group members? If 'yes', why? If 'no', why not?

2. How could you assist Anthony to get in contact with the other group members?

Therapeutic Goods Act (1989)

This provides for a national system of control over sales of therapeutic goods in Australia. Manufacturers may have to supply data supporting quality, safety and efficacy of the item (Therapeutic Goods Administration, 2009).

Most legal requirements focus on meeting standards set by legislation and policies. Allied health professionals working in Queensland are required to maintain state or national registration to practice. The Board sets standards of practice including adhering to professional codes of conduct and investigates any allegations of malpractice.

Public Sector Ethics Act (1994)

This Act (along with other Acts) underpins the Code of Conduct for the Queensland Public Service. The Act states that as a Queensland Health employee, you must uphold state and federal laws and carry out your work faithfully and impartially. It also states that you are responsible for operating at work honestly, fairly, and with regard to the rights and obligations to clients and colleagues.

Work Health and Safety Act (2011)

As an employer, Queensland Health has a legal obligation to ensure the workplace health and safety of employees and visitors. Employees have legal obligation to comply with their employer's reasonable instructions, including instructions for workplace health and safety, and not to wilfully place at risk the workplace health and safety of any other person.

Occupational Health and Safety (OHS) is a legislative requirement about keeping people safe in the workplace. Queensland is governed by the Queensland Government Work Health and Safety Act 2011.

One of the main objectives of this Act is "to secure the health and safety of workers and workplaces by protecting workers and other persons against harm to their health, safety and welfare through the elimination or minimisation of risks arising from work or from particular types of substances or plant." (Queensland Government, 2016, Work Health and Safety Act, viewed 13 February 2017, <https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/W/WorkHSA11.pdf>)



For a full copy of the Workplace Health and Safety Act 2011 refer to The State of Queensland, Office of the Queensland Parliamentary Counsel, Queensland Legislation Website:

<https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/W/WorkHSA11.pdf>

Some client sessions you will be involved in won't appear to have a high risk of injury to you, your colleagues or your clients (e.g. education sessions on returning to driving post stroke). Others will be easily identified as potentially 'risky' situations (e.g. skill retraining groups). Safety risks can include a range of things including:

- incorrect use of equipment
- out of date testing and tagging of electrical appliances
- clients who are impulsive
- unfamiliarity with evacuation procedures or client handling issues

As an Allied Health Assistant, part of your role description will be to ensure clients receive healthcare in a safe, supportive environment. This includes taking responsibility for learning how to correctly operate, care for, and service therapy aids and equipment. You may also be expected to educate less experienced Allied Health Assistants about correct procedures.



Queensland Health (2010) outlines client handling as:

'...any workplace activity where a person or their body part is physically moved, handled, repositioned or supported'. Specifically, client handling tasks are those activities requiring the use of force by a worker to hold, support, reposition or transfer (lift, lower, carry, push, pull or slide) a person.

Queensland Health employees are expected to adhere to 'No Lift Principles', which are summarised as:

- the manual lifting of a client's weight is eliminated in all but exceptional or life threatening situations (such as evacuating for a fire)
- individual clients are assessed for their client handling needs at the start of service or admission
- clients should be prompted to participate and assist in client handling tasks where possible
- where clients are unable to assist, client handling equipment should be used
- all workers involved in direct client care are trained and assessed as competent in the use of client handling activities relevant to their work
- appropriate quantities of client handling equipment that is compatible with the work environment and tasks performed is provided, used and maintained

When assisting with the rehabilitation of clients you should consider what type of equipment or aids might be required. This might occur in the form of a 'Falls Risk Assessment' or liaison with the Allied Health Professional (AHP).

As an Allied Health Assistant, workplace health and safety applies to your day to day duties in terms of making sure you are careful and use techniques with tasks such as manual handling of clients and equipment. Another example would be labelling and removing any dangerous or broken equipment so it will not be re-used.



Find out who is the nominated workplace health and safety officer in your area – they will conduct regular audits to identify any risks in the workplace. In your work area, there should also be a register with information (Material Safety Data Sheets or MSDS) on any hazardous substances found in your area.



Visit the Queensland Health OHS online learning packages at <http://qheps.health.qld.gov.au/safety/elearning.htm>. These packages will provide you with a summary of the Queensland Health's OHS strategic plan, policies and integrated safety management systems. These packages form part of your orientation to Queensland Health.

Incidents and 'Near-Misses'

All Queensland Health facilities will have a system for reporting injuries, risks and incidents that could have or nearly happened. Examples that require reporting include the following:

- client falls or nearly falls
- staff injury or near injury at work or on the way to work

All incidents are recorded and reviewed by managers. When necessary, they are investigated by a multi-disciplinary team, usually led by the client safety officer for your district. There will be specific forms or paperwork that need to be filled out. If required, they will be able to link you to your workplace rehabilitation officer.

Any concerns or incidents must be reported to your senior staff and the senior staff member in the area where the incident occurred, as soon as possible. This is done whether staff, clients or visitors are involved or may have been involved in the incident (Queensland Health, 2009).



If yourself or a colleague are injured or have a 'near miss', seek medical help as required then report the incident immediately to your supervisor.



Reporting requirements and record keeping practices will be covered in topic 1.3 'Record Keeping'

Codes of Ethics and Codes of Conduct

Allied health professionals generally have their own profession-specific guidelines and expectations of behaviour. This often takes the form of a published code of ethics or code of conduct within which members of that profession will work.

Codes of ethics are usually based around the principles of:

- doing no harm
- acting in the best interests of the client
- setting aside your own personal values and beliefs when working with clients
- maintaining access for all to services

Codes of conduct may set out expectations such as:

- maintaining up-to-date knowledge
- maintaining the good standing of the profession
- respecting confidentiality

Occupational therapists (OT's) are required to maintain registration with the Registration Board to practice. The Board sets standards of practice including adhering to professional codes of conduct and investigates any allegations of malpractice.

Australian Association of Occupational Therapists states that 'the ethos of the occupational therapy profession and its practice requires its members to discharge their duties and responsibilities, at all times, in a manner which professionally, ethically, and morally compromises no individual with whom they have professional contact, irrespective of that person's position, situation or condition in society. The Code of Ethics is founded on the bio-ethical principles of beneficence, non-maleficence, honesty, veracity, confidentiality, justice, respect, and autonomy'(Australian Association of Occupational Therapists, 2001, p. 2).

The Occupational Therapy Code of Ethics is intended to act as clear guidance to all Occupational Therapists in their professional practice. It does not replace the principles and procedures adopted by the employers, relevant legislation nor other rights within society (Australian Association of Occupational Therapists, 2001).

These documents also help guide the OT's clinical decision-making at times when morals and values may make it unclear as to what is 'best' for a client. They help clarify between a personal opinion and a clinical decision.

The Code of Conduct for the Queensland Public Service reflects the principles of integrity and impartiality, promoting the public good, commitment to the system of

government, accountability and transparency. As an Allied Health Assistant, you need to be aware of this code and abide by it when working in a Queensland Health facility.

The Code of Conduct for the Queensland Public Service was developed in line with the government's commitment and in consultation with agencies, employees and industrial representatives. The Code was designed to be relevant for all public sector agencies and their employees and reflects the amended ethics principles and values contained in the Public Sector Ethics Act 1994.

(Public Service Commission, 2010)



Further information regarding the Code of Conduct can be found at:

<http://gheps.health.qld.gov.au/hr/codeofconduct/home.htm>



Other standards that Occupational Therapists must comply with regarding in-home modification are the Australian Standards. Information about the Australian Standards for ramps can be found on:

<https://www.legislation.gov.au/Details/F2011C00214>

1.3 Record Keeping

The Public Records Act 2002 defines a 'record' as recorded information created or received by an entity in the transaction of business or the conduct of affairs that provides evidence of the business or affairs and includes:

- a) anything on which there is writing or
- b) anything on which there are marks, figures, symbols or holes having meanings for persons, including persons qualified to interpret them or
- c) anything from which sounds, images or writings can be reproduced with or without the aid of anything else or
- d) a map, plan, drawing or photograph

(The State of Queensland, 2002)



Therefore, everything you record in the course of seeing a client is considered a public record.

As an Allied Health Assistant, you have an important role in ensuring client records comply with legal and organisational requirements. Medical records should be complete, concise and accurate notes, which act as a permanent, continuous record of client care (Queensland Health, 2007).

Record keeping includes, but is not limited to, documenting progress notes. When you conduct group sessions, additional record keeping considerations may also include:

- secure storage of client files
- correct filing of notes, correspondence and reports within medical files
- electronic client information (emails, reports and etc)
- maintaining your individual clinical statistics



Depending upon your workplace, most health service districts will have their own policy on documentation in client files. Some districts may even offer information sessions on clinical documentation. Your district health information manager can provide you with specific standards for various forms of documentation.

High quality documentation is important for all health services. Every Queensland Health employee must maintain high quality documentation standards to ensure the best outcome for client outcomes and medico-legal accuracy (Queensland Health, 2008).

Accurate documentation of client care is a legal requirement of clinical practice (Queensland Health, 2008). In your role you will be expected to take responsibility for, or at least contribute to, a wide range of documentation including:

- assessment forms
- progress notes
- care plans
- treatment plans
- referral documentation
- handover summaries
- case conference information
- discharge summaries

At different times you will need to use the above documentation formats to provide regular feedback to your colleagues, other Queensland Health services, and external agencies. For example, if you are the sole facilitator for a group session, you must use a reliable and accurate method of reporting back to the supervising Allied Health Professional. The type of information you must provide to the Allied Health Professional includes, but is not limited to:

- significant changes to a client's physical presentation or health condition
- changes in a client's functional status
- client deviation from an activity or task prescribed by Allied Health Professional
- client motivation and overall participation in rehabilitation and overall treatment plan
- any incidents (falls, seizures and etc) or 'near misses'
- potential for onward referral within your team or external agencies
- any additional information related to the treatment and healthcare



The only information documented in the client chart should correspond directly to their healthcare. This is consistent with the Privacy Act 1988.

There are a number of record keeping practices applicable to you. These may include:

- documenting in a client's medical record and case notes
- documentation on a client's individual treatment plan and client care plan
- the Allied Health Professional's instructions

Documenting in the Client's Medical Record

Within Queensland Health, a client's clinical record (sometimes called the medical record or chart) has traditionally been the key way for capturing all clinical information relating to delivery of care to a client. The Queensland Health position statement on clinical records outlines Queensland Health's use of the clinical record.



For further information please refer to QHEPS Document 'Records Management for Administrative, Clinical and Functional Records'. This is located on the Queensland Health Intranet.

http://qheps.health.qld.gov.au/srmt/policy/rescinded_pol_rm_2012.pdf

The purpose of the medical record is to provide a:

- Record of continuity and evaluation of care
- Communication tool amongst team members
- Teaching tool
- Research and audits tool
- Medico-legal document
- Tool to evaluate the quality of care

(Staunton & Whyburn, 1997)

High Quality Documentation

The principles that promote the development of high quality documentation include:

- **Objective and accurate:** Factual evidence of the care given.
- **Concise:** Straight to the point and relevant.
- **Relevant:** Appropriate and includes evidence of the care given.
- **Complete:** Contains all aspects of care, the client's needs and provides evidence care has been given.
- **Timely:** The entry is made as soon as possible after an event of care. Recording the time of the event is important.
- **Legible:** All team members must be able to read your notes.
- **Informed consent:** must be obtained and documented.

(Queensland Health Occupational Therapy Clinical Education Program, 2007)

Documentation Standards

Standards in the development of documentation include:

- completion in black ball point pen
- each new page has the client's label on it
- don't make entries on behalf of another person

- date and time of the entry, your designation, signature and printed surname
- consider confidentiality and accessibility i.e. don't leave chart lying around
- no blank spaces left in entries
- hospital approved abbreviations only
- medical terminology used only if sure of exact meaning
- check name on medical record cover and on individual sheets before making an entry



For further information on documentation, refer to 'Guidelines for allied health assistants documenting in health records' at:

<http://qheps.health.qld.gov.au/alliedhealth/docs/aha/ahadocguide.pdf>

Format

You may be required to document your sessions in the medical chart or individual treatment plan. There will be specific guidelines relating to this in each individual workplace. Using a format will help you to identify what is important to document in relation to your diagnostic and therapeutic programs/treatments.

One widely used structure for documenting in the client's notes is the SOAP format.

S = Subjective information or what the client reports

O = Objective information or what you see

A = Assessment of how the client's going

P = Plan

For example: Mrs B has a goal of improved socialisation. Mrs B has presented to her therapy session for which the plan had been to attend a coffee shop and purchase a cup of coffee.

S	Mrs B reports she is 'anxious' about going to the coffee shop.
O	Mrs B has presented to therapy on time wearing appropriate clothing for the visit to the coffee shop as was asked at the previous therapy session. Provided reassurance that Mrs B would be accompanied by the Allied Health Assistant.
A	Mrs B independently ordered her coffee. Mrs B was observed to manage her anxiety by squeezing her therapy ball. Mrs B required assistance to manage her money.
P1	Continue with graded socialisation activities.
P2	Assess money skills.

After conducting a group session, you will need to enter a progress note for each individual attendee. The progress note should include appropriate medical terminology, district-approved abbreviations, and concise, objective information.



Case Study: Mrs Anderson

If Mrs Anderson attended your class for upper limb therapy and 'nodded off' several times during the 40 minute session, you might record the following entry in your progress notes:

'Mrs Anderson appeared to experience fatigue; falling asleep on three occasions during this morning's 40 minute class'.

Documentation on a client's Individual Treatment Plan (ITP)/Client Care Plan

Once the Allied Health Professional has assessed a client, they will formulate an individual treatment plan (or something of a similar name).

This document:

- outlines the client's goals
- progressively records the treatment the client receives
- is often specific to each workplace
- provides the OT's instructions

You will need to document each occasion of service on this form. Once completed, this form is filed in the client's medical records. This plan may require you to provide a treatment program to address the clients function limitations.

Common standards exist across all medical systems and facilities for writing in medical records. This ensures clear communication between the team, promoting the best client care and opportunities for evaluation of the care provided. The style of writing you need to use is formal, objective and to the point and as such you will come across a number of common abbreviations.



Ask your supervisor or medical records department for an accepted abbreviation guide available for your facility.

Standardised Assessment

Depending upon your workplace, you may be required to conduct standardised client assessments, from an approved list. A 'standardised assessment' is an assessment that is administered and scored in a consistent or standard way (Pedretti, 2001).

When you conduct these assessments, you must follow the administration guidelines (the Allied Health Professional should be able to assist locating these for individual assessments). Often there are a set of questions, in a set order, which are designed to enable consistent scoring and interpretation of scores. The questions must be recited exactly as indicated on the assessment. Deviation from the administration guidelines may render the assessment results invalid.

After you conduct a standardised assessment with a client, you must provide these results to the Allied Health Professional who will analyse and interpret the client's score(s). When entering a progress note in the client's file, you must record that liaison with the Allied Health Professional has taken place.



Remember when you are documenting information in client notes that under the Right to Information Act 2009, individuals may apply to Queensland Health for access to their files. There is a formal procedure for this to take place. You should **never** provide this information to clients or other persons unless approved by your supervisor.



In the rehabilitation setting where clients may be seen every day for therapy, it may be common practice to document at the end of the week. For example, a summary of the week's session; dates when the client was seen, and any significant information or comments on progress would be included.

Discharge summaries, home visit reports, and assessment forms may be filed on completion rather than recording a daily update. A note in the chart to refer to a certain form for details is required to ensure the rest of the team are aware that the report exists and are able to find it (Princess Alexandra Hospital, 2007).



Activity 7 - Documentation

Read the following case study and complete the relevant chart entry for the case study. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

It may be useful to refer to 'Guidelines for allied health assistants documenting in health records' at

<http://gheps.health.qld.gov.au/alliedhealth/docs/aha/ahadocguide.pdf> and 'Post Traumatic Amnesia Assessment' at

http://gheps.health.qld.gov.au/cairns/docs/ot_post_traum_ames2019.pdf



Case Study: Documentation

You have been asked to undertake daily Post Traumatic Amnesia Assessment (PTA) on Cooper who is a 23-year-old male. Cooper is now 3 days post motor bike accident where he lost consciousness at the scene. His PTA score has been 10/12 for the last 2 days.

When you see Cooper, he is able to name the OT who had seen him, although he reports still being unable to remember the accident. Cooper appears to be distracted when visitors entered the room and requires re-direction to continue. His PTA score today was 11/12 (orientation was 7/7, recall 4/5).

Please complete a relevant chart entry for Cooper.

More space is provided on the next page

Confidentiality of Client's Records

The use, storage of and access to a client's medical record are subject to clear guidelines by every hospital and health organisation. Part 7 of the Hospital and Health Boards Act 2011 identifies that "there is a strict duty of confidentiality imposed on the Department of Health and HHS staff in relation to the protection of confidential information. Where health information has been collected in the context of providing a health service, use and disclosure is governed by the duty of confidentiality in the HHB Act." https://www.health.qld.gov.au/_data/assets/pdf_file/0027/439164/doh-privacy-plan.pdf

Allied health assistants should follow guidelines related to the use, storage of, and access to health records. Consider the following:

- where you leave charts in the clinical and non-clinical areas
- are they accessible to passers-by including clients, visitors, and other staff who do not require access to them?
- if a client/other body requests access to their/an individual's medical record refer them to the medical records department



Further information about privacy and confidentiality can be found on:

<https://www.health.qld.gov.au/global/privacy>

Storage

When assisting with the rehabilitation of clients you will often need to refer to individual client files. These files should not be accessible or visible to others. Failure to store client information appropriately is in breach of the Privacy Act 1988. This also includes transfer of client notes between rooms and facilities. If you need to leave the room where a client is waiting, client files should be secured in a lockable cabinet or case.



Case Study

You are required to conduct a group activity for clients to learn basic cooking skills. The kitchen where you are instructed to conduct the group is a short drive from where your office is based. You realise that you need to take several client's files with you to conduct the session. In order to comply with legal and organisational requirements, you use a lockable briefcase from your office to transfer the files.

Filing

It can sometimes be a confusing when you need to file the various documents in a client's file. Each health service district will however have its own 'form filing guide'. Nevertheless, there are some standard rules that you will need to follow:

- documents should be filed in reverse chronological order (most recent on top)
- all documents should be clearly labelled with the client's name, client number, date of birth and contact details
- do not use 'post it' notes or 'unauthorised' forms in the file
- any relevant documents to the client's healthcare that have not been approved by your district's forms committee must be filed in the correspondence section of notes

Electronic Information

This can include e-mails, client reports (saved electronically) and fax messages. If a client prefers to correspond via email rather than on the telephone, be mindful that you should **avoid sending confidential information by e-mail**. This also includes correspondence between health and external services. If you unlawfully forward confidential information, you and the organisation can be held legally responsible.

All fax correspondence should have a 'fax cover sheet' and all emails must include your name and job title. Queensland Health automatically adds a disclaimer on fax cover sheets and beneath your signature on e-mails. You should also ensure you do not use e-mail for critically urgent communication.



Activity 8 - Managing Confidential Information

Answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. What is the name of the Act which outlines specific statutory requirements for staff of government health authorities and which government department administers the act?

2. What are the obligations of employees under this Act regarding confidentiality?

Activity continues on the next page



Activity 8 - Managing Confidential Information (continued)

3. List five occasions when you may disclose client information under the Act.

1.

2.

3.

4.

5.

Key Points

- Organisational policies and principles exist to communicate the requirements, responsibilities and accountabilities you have as an employee
- It is your responsibility to implement these in all work practices
- Six key areas arise:
 1. Supervisory and reporting requirements
 2. Occupational Health and Safety
 3. Infection Control
 4. Legal and organisational requirements
 5. Quality assurance, best practice and accreditation standards
 6. Codes of practice for work in Occupational Therapy
- Queensland Health's core policies and procedures will help guide you on how to work within relevant state or national legislations. The Queensland Health specific documents will help to translate what this legislation means for you and your workplace
- You must report any accidents or incidents or near-misses to your supervisor or line manager
- If a client is under infection control restrictions, check carefully before involving them in rehabilitation activities
- Record keeping is a legal requirement that is integral to recording and communicating a client's participation in a treatment program
- Record keeping facilitates treatment planning and communication

2. Group Processes

This topic covers information about:

- Group dynamics
- Group roles
- Group learning

Activities in this topic cover the following essential skills:

- Use planning skills
- Manage individual client outcomes in a group setting
- Apply group skills, including:
 - Identifying and managing issues of equality of opportunity and non-discriminatory practices in group activities
 - Eliciting views and addressing individual needs in groups
 - Putting groups at ease
 - Managing different individual styles within a group
 - Interpreting non-verbal communication
 - Gauging the appropriateness of language for individuals in a group
 - Balancing the needs of the task with the group process
 - Dealing with issues of power, influence and authority in group
- Undertake evaluation processes

2.1 Group Dynamics

A group is a collection of people who define themselves as a group and whose attitudes and behaviours are governed by the norms of the group (Vaughan & Hogg, 1995).

Understanding what group dynamics means, will enable you to improve the efficacy of the groups you facilitate. Group dynamics describes how individuals develop into a group and how they interact with one another in the group (Egger et al, 2005).

This means that as well as describing how your clients will behave and communicate with you and other group members, it will dictate how group roles are developed. For example, if one client is always 'driving' the group and dominating group discussion, they may inadvertently become the 'group leader'.



Johnson & Johnson (1991), state that 'People join groups in order to achieve goals they are unable to achieve by themselves'.

This opinion re-enforces why group dynamics are so important. No matter what type of group you are facilitating, clients will be forced to interrelate with one another in some way. This might be either directly or indirectly.

The success of your group and individual client outcomes are largely influenced by group dynamics. Group dynamics will differ depending upon the type of group session you are helping to facilitate. Types of group sessions may include:

- Social Skills Training (e.g. preparing clients to return to work after brain injury)
- Creative Work Groups (e.g. practicing relaxation techniques to reduce stress)
- Health Related Groups (e.g. teaching clients principles of energy conservation)
- Health Promotion Groups (e.g. smoking cessation programs)
- Support Groups (e.g. carer education for supporting clients with dementia)
- Functional Task-based Groups (e.g. relearning basic cooking skills)
- Rehabilitation/Therapy Groups (e.g. client's relearning how to use their upper limb post stroke).
- Wellness Groups (e.g. Mental Health support groups)
- Paediatric Groups (e.g. infant health and wellness programs)



C.

A Summary of Group Methods in Health Promotion can be found in Appendix

Regardless of the format of the group you are facilitating you will need to pay attention to the non-verbal messages that clients communicate to you. Body language, gestures and facial expressions can provide important clues about what a group member is thinking or feeling. You may use this feedback to adapt your session to meet individual client needs. This should be done under supervision of the Allied Health Professional.



Before investigating ways to promote positive group dynamics, you first need to consider why a group is formed. Questions you may ask yourself include:

- Were the clients 'told' to attend or did they volunteer?
- What is the individual client's goal?
- How motivated are they to participate?
- How able are they to participate?
- What is your goal or the AHP's goal?

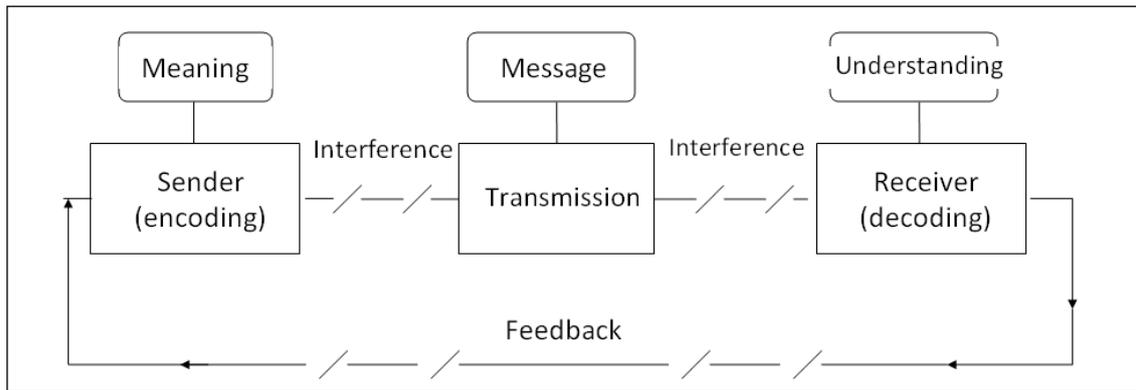


Figure 3 Communication Model. Toseland and Rivas, 2008.

Toseland & Rivas (2008) state the four basic principles for promoting positive group dynamics are:

- communication and interaction patterns
- cohesion
- social integration and influence
- group culture

Communication and Interaction Patterns

In group settings, three forms of communication are commonly used:

1. verbal communication
2. non-verbal communication
3. written communication

Although you will not be expected to be an expert in communication techniques, it can be very helpful to understand 'effective' communication.

The Toseland and Rivas (2008) model, above, depicts how effective communication is reliant upon the message given, the way it is perceived by the recipient, and the presence of 'speed bumps' or interference, along the way. 'Interference' can present in such forms as environmental distractions, language barriers, cultural interpretation, and speech, hearing, and visual impairment.

Therefore, when working in groups, you should consider physical or sensory impairments that may impair communication. Refer to Appendix B for hints on ways to adapt communication for clients with hearing or vision impairment.

The Toseland and Rivas (2009) model of communication also suggests that even when delivering lecture-style education sessions, you should promote 'two-way' communication between yourself and clients.

Cohesion

Toseland and Rivas (2009) describe cohesion as the sense of unity within a group. They also claim that cohesion is the clients' reasons for wanting to be part of the group and how they perform in the group. When facilitating a group, you should promote a high level of open interaction.

One idea is to utilise an 'ice-breaker' activity where clients spend a minute or so telling the group their name and what they hope to get from the group. Helping individual clients identify their needs and a high level of open interaction promotes cohesiveness (Toseland and Rivas, 2009).



Case Study

You are facilitating an upper limb group with six clients. Each client has specific measurable goals set for their performance in the group, and completes tasks to reach these goals within the group. By promoting group members to openly encourage and support each other's progress, the group has developed a strong sense of cohesiveness. They feel they are all working toward a common goal – to use their upper limb again. The group's strong cohesion is one of the contributing factors to 100% attendance rate for group members.

Social Integration and Influence

Toseland and Rivas (2009) describe this as how group members fit together and are accepted in a group. How a client identifies themselves will impact on how they are perceived within the group. When facilitating groups, you can promote a 'safe forum' for client's participation by setting some 'ground rules' at the start of the group.

Group Culture

The group culture can affect group dynamics and interaction. Groups that include clients from diverse cultural backgrounds or life experiences can affect how group members interact and the efficacy of the group. For example, a group member who identifies as being from an Indian background may feel that they have little in common with all other group members. By ensuring you include the group member equally in activities and acknowledging their individual cultural needs, you can prevent them from feeling isolated or alienated from the group (Toseland and Rivas, 2009).



Once a healthy group culture has developed, individual members will feel secure to participate fully. A culture that emphasises values of self-determination, openness, fairness, and diversity of opinion can do much to facilitate the achievement of group and individual goals (Toseland and Rivas, 2009).



Activity 9 – Case Study

You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

Working on your own, read the scenario below and answer the questions that follow. Share your responses with the group.



Case Study

You have been assigned to facilitate a Health Promotion group and this is the first time you have facilitated this program. You have been given a specific health promotion program to follow with clear guidelines relating to activities and including the information you can communicate and disseminate. The members of the group include Jon, Brandi, Ross, Martin and Lisa.

Brandi and Ross appear to have an existing relationship. They are both quite extroverted and have begun what you perceive to be a struggle for 'air time' talking over the top of each other. Martin is reluctant to speak up in the group, but you notice that he sometimes mumbles under his breath when John is speaking. Jon has a very strong accent which makes him difficult to understand. Lisa does not make eye contact with other members, has positioned herself so that her body is turned away from the rest of the group, and she has her hand bag on her shoulder. She has not engaged with the other members

1. As the facilitator what is your first job with this group?

Activity continues on the next page



Activity 9 – Case Study (continued)

2. How would you address the issue of cohesion with this group?

3. How would you describe the group's communication and interaction style?

4. How would you enhance the group culture of this group?

Activity continues on the next page

Motivating and Encouraging Client Participation in Therapy

What helps:

- buddy up/group work; having others to work with can make it a lot more fun
- having motivating, realistic, achievable goals
- record keeping or tracking of progress towards goals. Point out any small improvements or a good effort as you notice them
- explain what you're going to do and why
- keep activities meaningful, interesting and age appropriate
- listen to their story or objections; if they don't want to participate, try to find out why
- keep a positive attitude towards your work and the people around; smile, make encouraging comments, use gentle touch as appropriate, and pay attention to clients' work
- keep a positive environment to work in e.g. try music, encourage joking and laughing
- allow balance of rest and work i.e. let people take a short break for rest, food or toileting as needed
- allow some choice in activity as able e.g. order of activities
- allow people to make mistakes at times and give them the opportunity to fix a mistake themselves (if safe to do so)
- involve family and/or significant others in therapy sessions; ask them to provide sincere positive feedback for a person's efforts

(Pedretti, 2001)

Empowering Clients

AHA's form a partnership based on the achievement of an agreed goal. For example, the goal may be to improve handwriting to enable the child to participate in classroom activities.

In forming an effective partnership it is essential that all members are aware of their rights and responsibilities to ensure the outcomes of the service are safe, equitable, efficient, respectful and effective for everyone. It is important that you ensure the client understands their rights and responsibilities on your first contact with them.

Providing the client with their rights and responsibilities is an important step in empowering them to become an active member of the partnership. This will maximise their participation within the developmental program.

Things you can do to support the rights of your client when delivering a developmental program include:

- encourage independence
- allow the client to decide who they want with them

- allow the client to wear their own clothes if they don't restrict your care of them
- allow the client to choose a male or female Allied Health Assistant if available
- allow the client to ask questions in regards to their care
- allow the client to take part in decisions
- provide easy-to-understand information about the client's treatment, including risks and other choices
- the right to a second opinion
- the right to give a compliment or make a complaint
- the right to have personal information kept private and confidential

You will also have expectations of your client during the course of your developmental program. These may include:

- the client needs to give you as much information as they can about their health
- the client needs to follow your instructions
- the client needs to tell you about any changes to their condition
- the client needs to be on time for appointments and let your health service know if they want to cancel, or if they change their contact details
- to provide respect to all people met in the course of their service provision this includes no harassment, discrimination, physical or verbal abuse
- to respect the confidentiality and privacy of others in the healthcare setting



Activity 10 – Promoting Client Participation

You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. Identity five ways in which you can promote client understanding, choice, control and engagement in their own health and wellbeing when conducting group sessions.

2. What would you do if a group member doesn't turn up for a session? Provide evidence of what you would use to support your actions, for example policies, client information etc.

Activity continues on the next page

2.2 Group Roles

As mentioned in the previous topic, group dynamics and group roles are largely interrelated. Understanding group roles also requires that you understand your role within the group.

Dr Meredith Belbin (2009) defines a team role as 'A tendency to behave, contribute and interrelate with others in a particular way'. Some group roles will be pre-determined by the type of group (such as facilitator or presenter) and others will 'drift into various roles' depending on their interest, motivation and skills (Johnson and Johnson, 1991).

Often in the early stages of a group, clients will differ in their willingness to assume a particular role. For example, you will find that some clients will sit back and wait to be encouraged to participate. Other clients will tend to 'jump in' and require little encouragement. The varied reasons that affect a person's tendency to behave in a particular way can depend on many factors including:

- their level of confidence
- their level of comfort or trust of other group members
- familiarity with other group members
- previous experience of group work and or receiving health services
- their psycho-emotional state (depression, anxiety, grief, etc.)

When group conflict or poor group outcomes occur, this may be attributable to clients developing group roles. Gillard, (2000, p.4) states that 'many problems in groups emerge because of role similarity or lack of any member fulfilling a particular role'.



Case Study: Group Roles

You are facilitating a functional skills (cooking) class with the AHP and four clients (Amanda, Jason, Kate and Michelle). The session comes to end and the AHP asks the group what they would like to cook next session. Amanda often responds quickly in group discussion and volunteers to the group that she would like to cook lasagne. Jason immediately retorts that Amanda got to choose the last two occasions and that he would like to decide this time. This conflict may have occurred for a number of reasons including that they are attempting to operate in the same role 'group decision-maker/leader'.

The role characteristics that clients will display in group interaction will depend upon the situation, and the size and type of the group. The roles of individuals may also evolve or change throughout various stages of the group.



Every member of a group plays a certain role within that group. Some roles relate to the task aspect of the group, while others promote social interaction. A third set of roles are self-centred and can be destructive for the group.



You may wish to look into further information on group roles:

http://www.mindtools.com/pages/article/newTMM_85.htm

Assuming a role within a group creates expectations from other group members. For example, if you are conducting a therapy group where clients rotate between 'stations' in a gym, group members may expect you to assume several roles, including:

- time-keeper
- director
- motivator
- problem-solver

In the early stages, clarifying your role to the group can help prevent deviation from what clients can expect from you. Recognising and providing positive feedback to clients about the roles you have identified in the group, may lead to increased feelings of empowerment and ability to continue on with positive group outcomes after the formal group sessions come to an end.



A potential conflict when you are facilitating groups is when a client misinterprets your role as a health care provider. Societal norms have taught many people to follow the 'medical model' where someone else should be responsible for 'fixing' them. Stritzke et al, (2009), highlights that it is imperative for you to effectively communicate that change is the client's responsibility and choice. You are simply providing them with the 'ingredients' for making changes and improvements.

As stated above, the composition of group roles will depend on many factors. Unlike 'Team Work', the groups you facilitate do not have to have a particular 'recipe' of group roles. That is, there will not always be one leader, one problem solver, one listener, etc.

However, in most group situations you will be expected to be 'facilitator or co-facilitator'. In collaboration with the AHP, you may be required to:

- put group members and groups at ease
- interpret non-verbal communication
- elicit views and address individuals needs in groups
- balance the needs of the task with the group process
- manage different individual styles within a group
- identify and manage issues of equal opportunity and non-discriminatory practices in groups
- deal with issues of power, influence and authority



Activity 11 - Case Study

Please answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

This activity builds upon the case study in Activity 10.



Case Study: John

The group has been running for a few weeks and the group members have taken on different roles.

Brandi appears to be making the decisions on behalf of the group and often influences the direction that the group takes. Ross commonly resists new suggestions or ideas, which will bring the group to a stand-still. Martin often cracks jokes especially during times of tension or stress. Lisa is engaging in group discussion however she is highly emotional and frequently breaks down and cries. At these moments Lisa will disclose personal information about her past which is important to her but not necessarily related to the group discussion or group goal. In response to Lisa's disclosure, Jon will more often than not move forward and comfort Lisa and encourage her self-disclosure.

1. List the roles that the group members are displaying.

Activity continues on the next page

2.3 Group Facilitation

Performing the role of facilitator, or co-facilitator, for a group of clients is an important role in assisting clients to achieve positive health outcomes. Your specific duties will depend on your individual workplace and client group. Meeting with the AHP to clarify the expectations of the AHA role and the purpose of conducting the group will assist you to be an 'effective' facilitator.

For example, does the AHP expect you to manage your time equally between group participants, or will you be expected to spend more time with a particular client who has higher needs; high falls risk, poor communication skills etc.?



Meeting with the AHP early in the process will also enable you to obtain useful information about the desired individual client outcomes. Another strategy to familiarise yourself with individual group members is to review documentation such as progress notes, client care plans, rehabilitation plans, and other forms specific to your service.

There are three main stages for conducting groups as an AHA:

1. Planning
2. Facilitation/Leadership
3. Evaluation

These three stages are not always interdependent of each other. Good practice as a group facilitator would promote a cyclical approach to these steps (Egger et al, 1997).

Planning

As mentioned above, planning for a successful group includes first liaising with the supervising AHP. Once the group objective and individual client information has been identified by the AHP, part of your role in the planning process may include contacting clients (via phone, letter, or face-to-face) to invite them to attend the group.

Depending upon local service requirements, this might also be an opportune time to explain to the client the aim of conducting the group (e.g. to provide support to quit smoking) and establish any specific needs of the clients (e.g. No transport available, cultural needs, visual or hearing impaired, etc).



Many health services will have a specific process to follow to identify possible risks for clients or for health care workers. These tools can include but are not limited to:

- Client Alerts forms
- Falls Risk Assessments
- Medical Clearance from a relevant medical practitioner
- Mental Health Risk Assessment.

When planning the group session, you should also consider the following:

- principles of group dynamics, group roles, and group learning
- physical environment
- group size
- organisational and legal requirements

Some of these topics have already been discussed in detail in the above sections. Those that have not are briefly summarised below:

Physical Environment – is an essential component of risk management and items such as electrical equipment, sharp objects and accessibility to exits needs consideration for group safety. This includes considering how you utilise physical space and the equipment and materials that may be required. The physical environment can affect group interaction patterns (Johnson and Johnson, 1991). For example, groups who are positioned in a circle have greater ability to communicate with each other than if they were seated in rows.

Group Size – this includes planning the number of group participants for optimal group size. For example, a health promotion group to assist clients to quit smoking will likely have a larger group size than a 'carer support' group. You should also consider that large groups may also lack opportunity for all group members to participate (Johnson and Johnson, 1991).

Group Learning – this may include consideration of both individual learning styles (experiential (learning by doing), theoretical, etc.) as well as how individuals learn within a group experience. Basic techniques to optimise group learning include:

- varying the format or process
- preparing audiovisuals to accompany your main points
- speaking slowly and clearly
- revisiting important points at the end of the session

(Egger et al, 2005).

For example, small group work, within a larger group, to 'break up' a lecture style presentation.



When planning to facilitate a group without direct supervision from an AHP, you should always try to expect the unexpected. If a client deviates from the structured program, inform the client/group that you will seek guidance from the AHP and let them know ASAP.

Facilitation/Leadership

Effective preparation for a group session will enable you to concentrate on your facilitation skills. Reflection on these skills is essential and may influence whether the group is a 'success' or a 'failure'. Johnson and Johnson (1991), state that; 'The effectiveness of our groups depends both on our knowledge of group dynamics and on our ability to behave effectively within groups'.

Egger et al (1997) state that group facilitator tools largely consist of highly developed interpersonal skills, effective observation and a working knowledge of group dynamics.

Suggestions for effective facilitation are highlighted by Egger et al (1997):

- ensure adequate time has been allowed for all activities
- clarify the rules and directions for the session or activity as clearly and simply as possible
- encourage all group members to participate in the process of group interactions
- demonstrate a high level of sensitivity, patience and negotiating skills and promote group members to do the same. This will also facilitate cooperation, tolerance and empowerment within the group
- ensure you listen, hear and respond to other people's ideas
- highlight and celebrate individual and group successes to achieving goals or desired outcomes
- assist the group, and individuals, to develop their own solutions to problems that arise
- ensure general group processes and structured exercises run as smoothly as possible, and are in line with the learning goals of individuals and the group as a whole



Free (2007) adds that as the facilitator, it is vital to highlight to the group that 'Individual work is essential'. Attending a one hour group on managing stress effectively will not automatically lead to improvement in a client's stress levels. The more individual work that clients' participate in, the more likely they are to benefit from the group program.

Despite whether you have prepared for and facilitated a group perfectly, you will inevitably come across challenging situations in group work. These can often include conflict between group members and may require you to deal with issues of power and authority. Egger et al (1997) explain that conflict is '... a likely and normal aspect of any group process'.

They indicate how to manage these situations:

- try to conciliate power struggles and re-focus the group's energies on achieving its goal(s)
- ensure that some people do not 'take over' the group
- acknowledge anger and conflict within the group and decide how best to deal with the situation. Depending upon the situation, the issue may be best dealt with in open forum amongst the group, or it may be better to take a break and to spend some time with the person or people who are feeling upset
- when things are very difficult, 'CALL A BREAK!' or introduce a new activity

Evaluation

The third stage you should participate in as part of group work is the evaluation process. Benjamin et al (1997) describe evaluation as 'a tool to ensure that we are providing the best possible service'. Evaluation can be undertaken in a number of ways and involves reviewing what you did, how well it worked and how you might improve next time (Benjamin et al, 1997). As part of this process you may also request group participants complete a 'feedback questionnaire'.

Setting ground rules helps the sessions to run smoothly so that the time is used to the best benefit of all. To make the best use of group time allow everyone an equal chance to take part in class activities and discussions.

- Avoid negative talk
- Be supportive
- Provide equal time
- Confidentiality – if a client volunteers personal information in a group setting they are doing so voluntarily.

(Free, 2007)



Activity 12 – Group Process Part A

Read the below characteristics of an effective and ineffective group, taken from Johnson & Johnson (1991) 'Joining Together: Group Theory and Group Skills' and answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. Discuss how you, as a facilitator, could promote the following effective characteristics of a group.

Characteristic	Promotion
Respect	
Effective communication (two ways)	
Goals that are clarified	
Supportive and welcoming	
Participation and leadership are distributed among all group members	
Individuality is endorsed	
Members evaluate the effectiveness of the group and decide how to improve its functioning	

Activity continues on the next page

Key Points

- Understanding what group dynamics mean will enable you to improve the efficacy of the groups you facilitate.
- The success of your group and individual client outcomes are largely influenced by group dynamics.
- Four basic principles for promoting positive group dynamics are:
 1. Communication and interaction patterns
 2. Cohesion
 3. Social integration and influence
 4. Group culture
- Understanding group roles also requires that you understand your role within the group.
- The role characteristics that clients will display in group interaction will depend upon the situation, and the size and type of the group.
- Recognising and providing positive feedback to clients about the roles you have identified in the group, may lead to increased feelings of empowerment and ability to continue on with positive group outcomes after the formal group sessions come to an end.
- Meeting with the AHP to clarify the expectations of the AHA role and the purpose of conducting the group will assist you to be an 'effective' facilitator
- There are three main stages for conducting groups as an AHA:
 1. Planning
 2. Facilitation/Leadership
 3. Evaluation

3. Service Provision

This topic covers information about:

- Service Delivery Model
- Client Care Model
- Scope of Practice

Activities in this topic cover the following essential skills:

- Work under direct and indirect supervision
- Communicate effectively with clients in a therapeutic/treatment relationship
- Communicate effectively with supervisors and co-workers
- Work within a multi-disciplinary team
- Time management, personal organisation skills and establishing priorities

3.1 Service Delivery Model

The way in which you deliver a service to clients will differ between health settings and service areas. As an AHA assisting Occupational Therapists (OTs) or other Allied Health Professionals (AHPs) to facilitate group sessions, you will be expected to have a basic understanding of general principles of rehabilitation service provision:

- clinical pathways
- continuum of care
- administering specific assessments and treatments

Clinical Pathways

Your work setting (e.g. hospital, community, nursing home, etc.); will determine if there are 'clinical pathways' that affect the care you should provide to clients. Clinical pathways are a standard set of guidelines for managing a particular 'client group'.

Queensland Health develops and endorses clinical pathways so that, as healthcare providers, we can provide a consistent and coordinated approach to healthcare, regardless of where in Queensland a client receives the service. For example, every client that is scheduled for a Total Knee Replacement should be managed according to the 'Total Knee Arthroplasty Clinical Pathway'. This clinical pathway ensures Medical, Nursing, Physiotherapy, Pharmacy and Occupational Therapy staff involved adhere to core standards of care.



For further information on clinical pathways, please refer to <http://qheps.health.qld.gov.au/cairns/docs/sw229.pdf>. Review the Occupational Therapy requirements and discuss with an AHP how you may be involved in adhering to these requirements in a group setting.

Continuum of Care

When a client first accesses health services right up until the time they no longer require any services, can be thought of as 'a journey'. This is often referred to as the 'continuum of care' and the service you provide is often only one part, or stage, of their journey. Realising that clients are people, and not just a client in a hospital, is an important part of understanding the 'Health Continuum Model'.



Refer to <https://www.health.qld.gov.au/stayonyourfeet/toolkits> for an example of the Health Continuum Model for addressing falls prevention for older people.

The importance of understanding the health continuum that clients travel upon includes when a client may require assistance from another health service or agency. As an AHA, part of your role will be to identify when a client might be appropriate for an alternative or concurrent service. The important thing to remember is that onward referral to other members of the team or other health services must be done with authorisation from the AHP.

Administering specific assessments and treatments

The Allied Health Professions' Office of Queensland has developed the Allied health assistant framework describing key accountabilities for AHAs. This document highlights that the role of the AHA within a multi-disciplinary team may include: 'Provide a defined range of specialised clinical screening assessments for clients with complex needs, as delegated and allowed by testing guidelines and legislation.'

When working with individual clients in a group setting, this may include providing individual assessments from a defined list. The supervising AHP must provide you with direction on which assessments are suitable and ethical for you to conduct. Examples of such assessments include: Home Environment screen and the Malnutrition Screening tool.



Activity 13 – Scenario

Read the scenario below and answer the question that follows. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

During a physical rehabilitation group, one of the attendees complains that she is having difficulty doing her home exercise program due to urinary leakage issues.

1. Working within a continuum of care what is the first thing you would do to address this client's complaint?

2. What are the steps involved when referring a client to another services?

3. What other team members would you need to include in this referral?

Activity continues on the next page



Activity 13 – Scenario (continued)

4. What (if anything) would you need to include about this referral in the client's file notes?

3.2 Client Care Model

In most circumstances you will be provided with the content to present to a group of clients. However it is a combination of content and process that will form the way you provide client care during group sessions. Additionally, the service you provide must be in line with the model(s) of care that your service adheres to.

Queensland Health (2000) defines a model of care as; ‘...a multifaceted concept, which broadly defines the way health services are delivered’. It often describes what service will be delivered, how, by whom, and where the service will be delivered. For example, the ‘Rehabilitation Unit Model of Care’ for The Prince Charles Hospital, outlines the service that clients and their family can expect from the Rehabilitation Unit.

A model of care may describe:

- what services are provided
- who provides the service (which workforces)
- when the services is provided
- how the service is provided

(Queensland Health, 2000)

There are many theories and concepts that drive the general approaches a team will take to rehabilitation. Some are concepts which cross all allied health professions and relate to the idea of rehabilitation in general. Each profession will have their own models and theories from which they work, which is the basis for the differences between the professions and their approach to solving a problem (Pedretti, 1996).



Often, you will operate in a service that follows multiple models of care. Specific model(s) will differ between work settings, so remember to ask the supervising Allied Health Professional to clarify which models are used.

Rehabilitation Model

This model emphasises working with a person on their ability to live and work with remaining capabilities. A client will be assisted to learn how to work around or compensate for physical, cognitive and perceptual limitations. The focus is on performance areas or occupations such as self-care, leisure and work. There will be less attention to the components that are used to complete performance such as thinking skills or physical abilities.

Using this model, a therapist will work on minimising barriers to role performance such as the physical environment or equipment design. An example of this would be changing the kitchen bench height so a person in a wheelchair can reach to do the cooking. This approach is often used in combination with other models, for example, a biomechanical model. It is always important to consider the potential for improvement in a person's abilities. A biomechanical model would look at a person's physical abilities and how to improve them. For most clients, restoration of sensorimotor, cognitive and psychosocial functions is required to improve function.

Occupational Therapy Models of Practice

There are a number of different Occupational Therapy models of care, and again, the specific model used will differ between service areas. Some of the models are: The Occupational Performance Model (Australia), The Model of Human Occupation (MOHO) and the Canadian Model of Occupational Performance (COPM).

One thing that all of these models have in common is that they view the health of a client as being influenced by many factors including; environment (physical, social and cultural), personal skills and abilities (cognitive, physical, emotional and spiritual) and the task which they aim to perform.

Occupational Therapy models focus on the interaction and balance between the many factors that affect a person's ability to complete a task or perform their chosen 'occupation'. Occupations are often grouped into self maintenance, leisure and work. Self maintenance refers to daily living tasks such as paying bills, managing money, using the telephone, getting around and etc. (Christiansen, Baum & Bass-Hauge, 2005).

Leisure consists of things people do for pleasure including hobbies, sports and reading. Work or productive occupations covers paid or volunteer work, and may include tasks like driving, typing, and communicating with other people.

The models may vary in their view of exactly how the different aspects of people's lives can interact. Aspects of life that are acknowledged in most models include:

- the environment (physical, cultural, social and time)
- the person's abilities, skills or life stage (cognitive, physical, emotional and spiritual)
- the task or occupation (self care, productivity and leisure activities)

All these parts of a person's life interact with each other and a problem in one area can affect all other areas of a person's life. For example, being in pain can mean a person becomes depressed. They may then not bother showering or grooming themselves as

well as usual. This can affect relationships with other people, performance at work, or motivation to participate in hobbies.

Similar frameworks are used to analyse a person's performance of their occupation or a task, to identify problem areas such as why someone can't pick up a cup. Your analysis of the situation may include exploring the following ideas:

- is it because they don't want to pick up a cup and drink independently?
- if they are ill, does their cultural background tell them that their family should be doing that for them?
- are they too weak to pick up the cup or can they not see well enough to reach it?



The framework will then be used to plan how to improve performance of a specific task or skills (Pedretti, 1996; Polatajko & Townsend, 2007).

Client-Centred

Client-centred practice involves a partnership between you and your client, which promotes client participation in decisions regarding the service they receive (Community Services and Health Industry Skills Council, 2009). It has an important role in group work as it encourages clients to work towards goals which they have themselves identified.



Ideas for employing a client-centred approach to engage clients in a group setting may include asking individual participants about their interests, skills or previous experiences.

When you conduct groups that adhere to the client-centred approach, clients will feel in control of their health care and motivated to participate to their full potential (Community Services and Health Industry Skills Council, 2009).

Goal-Directed

As mentioned above, Queensland Health promotes client participation in all facets of their healthcare including goal setting. By assisting clients to set goals, you will need to consider whether the goal is SMART:

Specific – clearly set out and includes the who, what, when, where and why

Measurable – so that you and the client are able to monitor and track their progress

Attainable/Attractive – within likely reach and appealing to the client

Realistic – the client is willing and able to work towards

Time-based – a time-frame for the client to achieve the goal

The Interaction of Models

As most healthcare services will employ more than one model of care, you will need to understand how models of care link up with one another. The model below shows an example of how several models of care overlap with each other to shape the service that clients receive.

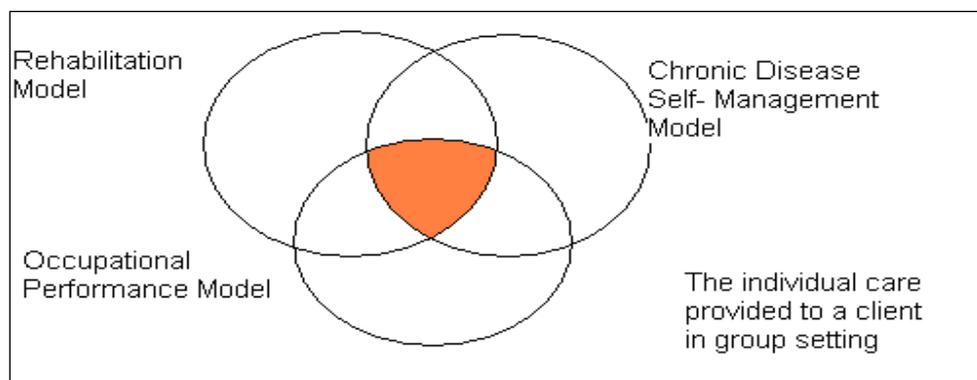


Figure 4 Interaction of Models

It is important note that the models are not always equally aligned. In some services, one model might be more central than others.



Some additional models of care that you may encounter in group work include:

- Case management model
- Slow stream rehabilitation
- Allied health assistant model (still in draft form at present)



Activity 14 – Scenario

Read the scenario below and answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

Michael, Renee and Daniel have been referred to the relaxation/stress management group that you facilitate with the Occupational Therapist.

1. Working within a client centred approach explain in detail what strategies you would use to ensure that the group sessions are as client centred as possible.

During the session Michael complains that he is struggling with motivation and commitment to his treatment. He explains he is feeling lost and confused about his treatment.

2. How would you assist Michael with the issue that he raised with you?

3.3 Scope of Practice

Scope of practice is the range of responsibility, e.g. types of clients, duties and practice guidelines that determine the boundaries within which an Allied Health Assistant works. All care delivered by an Allied Health Assistant needs to be within that individual's scope of practice.

The activity should be an activity that the Allied Health Assistant is trained, competent and authorised to perform. All delegated tasks must be appropriate for the Allied Health Assistant's role description and responsibilities. It is the responsibility of the Allied Health Assistant to inform the Allied Health Professional if they feel a task is outside their scope of practice.

As an Allied Health Assistant, your role will be varied depending on which profession/s you are assigned to assist. In general, the Allied Health Professional will assess the client and design programs for you to carry out. Clarifying exactly what is and isn't your job may take a little while to work through when you first start. Your job description and the instructions of staff should give you a clear idea. However, in rehabilitation, there is often no clear end to how much can be done for a client, which can cause confusion and stress for staff. There is often a lot that can or should be done for a person but limited time to do it in.

A clear timetable or schedule and checking in regularly with your supervisor/s can help you to manage your time. Learning to politely but assertively say 'no' may be necessary at times, particularly if you have a number of different supervisors to work with. An explanation of why you don't have time such as having other commitments, and an offer to negotiate another time or way to complete the task is usually helpful.

The ability to work efficiently and learning to prioritise the most important tasks is often the key to succeed in an Allied Health Assistant position.

Tasks you may be expected to do:

- arrange for clients to complete checklists or help them fill out self-report type assessments and forms
- complete administration tasks such as filling out equipment application forms
- prepare for and run individual or group therapy sessions, with program designed by Allied Health Professional
- make minor changes to therapy programs as required or with guidance from Allied Health Professional

- feedback on client condition or success of therapy sessions to Allied Health Professional
- order and maintain equipment, supplies and tidy work areas
- complete ADL re-training activities with clients
- monitor client progress in therapy programs
- accompany therapists on and assist with home visits
- apply assistive aids to clients
- arrange for equipment prescribed by Allied Health Professional
- provide education to clients and families, including practicing client care with them e.g. dressing and transfers
- attend department meetings and in-house training sessions
- contribute to department quality improvement activities

Queensland Health's Public Patients Charter

The Australian Charter of Healthcare Rights booklet will assist you with outlining to the client both of your rights and responsibilities. You will need to ensure your client has received a copy of the brochure and understands their rights and responsibilities at the start of their treatment program.



Copies of The Australian Charter of Healthcare Rights can be found on:

<https://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/>

Ensure your client has received a copy and understands their rights and responsibilities.

Queensland Health (2008) Models of Care draft role description outlines that the purpose of the Allied Health Assistant is to '...contribute to patient care by providing clinical support tasks delegated under the direct or indirect supervision of an AHP'. This explanation of the Allied Health Assistant role highlights some important issues regarding the Allied Health Assistant scope of practice:

- delegation
- supervision
- role within the health care team
- personal organisational skills

Delegation

Working alongside Occupational Therapists (OT) to assist clients to achieve their individual outcomes, will include the OT delegating tasks to you. When delegation occurs, both Allied Health Assistants and Allied Health Professional have responsibilities. The table below summarises some of these responsibilities.

AHA Responsibilities	AHP Responsibilities
<ul style="list-style-type: none">• must have the appropriate level of experience and competence (i.e. skills and knowledge) to carry out the activity and the activity should be within the scope of the allied health assistant role.• has responsibility for raising any issues related to undertaking the delegated task, and should request additional information and/or support as required• should be aware of the extent of their expertise and scope of practice at all times and seek support from allied health professionals as required• shares responsibility for raising any issues and requesting additional support throughout the delegation and monitoring process.	<ul style="list-style-type: none">• establishes diagnosis, clinical management and treatment plans• should only delegate activities that are within the scope of their own professional practice and• that they are competent to assess, plan, implement and evaluate• must only delegate activities that are within the scope of practice and level of competency,• previously demonstrated experience and/or training and qualifications of an AHA• should determine whether it is appropriate to delegate a task to an AHA and only delegate• If/when it is appropriate is able to provide the type and frequency of monitoring (i.e. task supervision) the activity requires.

(AHA Framework, AHPOQ, 2016)



At no time should you be requested or required to undertake a task that is outside your level of competence or that is not identified by the Allied Health Assistant position description.

Supervision

Supervision refers to the monitoring, advice or instruction from another person to ensure optimal healthcare is provided to clients. The Allied Health Professions Office of Queensland (APHOQ) Allied Health Assistants Framework state that:

- AHA positions are to be clinically supervised by an allied health professional.
- AHA positions will have a designated clinical supervisor.

- Formal supervision sessions will be documented in accordance with local requirements.
- Clinical supervision may be direct, indirect and/or remote.



The two forms of supervision most commonly experienced by Allied Health Assistants are 'formal' and 'informal' supervision.

Also known as professional supervision (Queensland Government, 2011b), clinical supervision can be defined as a formal process of support and learning that involves:

- developing a mutual commitment between the AHA and allied health professional to reflect on the clinical practice of the AHA
- developing knowledge and skills competence
- clarifying boundaries and scope of practice
- planning and using personal and professional resources
- identifying training and education needs
- developing accountability for work quality (Queensland Government, 2010a).

Though an assistant should only have one primary clinical supervisor, there may be several allied health professionals of the same or different disciplines who delegate tasks to the assistant (Queensland Government, 2010b). Clinical supervision should be undertaken by an allied health professional although a senior AHA may co-supervise in collaboration with an allied health professional in some work units. Where an AHA is new to the service and/or the particular clinical area, they will initially require more frequent clinical supervision. It is the responsibility of the supervising and/or delegating allied health professional (potentially the same person) to:

- assess and verify the AHA's competency within the clinical context
- define and clarify the tasks to be undertaken by the AHA within their scope of practice
- ensure the AHA has a clear understanding of the tasks to be undertaken within that context.

Delivery of clinical supervision

Clinical supervision can be delivered either directly, indirectly or remotely:

- • Direct clinical supervision occurs when the supervising allied health professional:
 - – works alongside the AHA
 - – observes and directs the AHA's activities
 - – provides immediate guidance, feedback and intervention as required.
- • Indirect clinical supervision occurs when the supervising allied health professional:

- – works on-site and is easily accessible, but not in direct view of the AHA while the activity is being performed—the AHA must rely on clear communication from the supervising allied health professional
- – is readily available within the same physical area or easily contactable (i.e. by phone or pager) should the need for consultation arise
- – designates an alternative contact person (should the need arise) if they will be unavailable.
- • Remote clinical supervision occurs when the supervising allied health professional:
 - – is located some distance from the AHA
 - – is contactable and accessible to provide direction, support and guidance as required (e.g. telephone or video-conferencing).

(AHA Framework, AHPOQ, 2016)

Working with your supervisor

Communication – Regular communication is the key. Work out with your supervisor the best method of communicating with them. Have an agreement around how often, what method, and where you will meet to communicate.

For example, try:

- telephone, e-mail or weekly meetings if you are at different sites
- use set forms or leaving notes or reports for each other. Make sure there is a special place e.g. desk, pigeon hole, or in-tray to leave any written information
- regular meetings with your supervisor/s to review what you are doing. This provides an opportunity to raise any questions or issues before they become a big problem. It can also be a chance for you to show how much you have achieved. In addition to a regular whole team meeting, try a quick scheduled catch up each morning just with your supervisor
- be aware that your supervisor is not a mind reader - state any concerns clearly as they come up
- if in doubt, ask
- if instructions are not clear to you, ask for clarification or repeat back to check if you have heard or understood correctly

Examples of inconvenient times to try and speak with your supervisor are:

- when they are clearly busy with a client, staff member or task
- right at the end of the day as they are walking out the door
- when they do not have the time or resources available to answer your questions

It may be okay to ask a simple question of someone working with a client, but this is not the time for long complicated questions or reporting a non-urgent problem. In

particular, you must not discuss one client in front of another as this is a breach of confidentiality.

For urgent matters, know who else you can contact and how, should your supervisor be unavailable. In terms of what to tell your supervisor, the level of detail they need to know will vary depending on what you are doing. It may take some negotiation with your supervisor over time to establish exactly what they like to know. Each supervisor, Allied Health Assistant and situation will be different.

Key points to report will generally include:

- any risk to, or concerns about safety
- sudden changes, whether in a client's condition, abilities or your roster or demands on your time
- specific commitments e.g. a day off training with another profession
- need for training or if you are not confident with a technique or treatment you have been asked to use
- treatment programs requiring adjustment, whether because they are too easy or too difficult for clients
- queries about prioritisation of tasks and which are most important



Additional information regarding the Queensland Health Allied Health Assistant Framework can be found on the website:
<https://www.health.qld.gov.au/ahwac/html/ahassist>

Feeding Back About Clients

When providing feedback about clients; clear and concise is best. Plan or think about what you will say prior to feeding back to your supervisor. Try to avoid vague and irrelevant details. For example, if reporting a chat with a client you may report that Mrs G is desperate to go home rather than adding in exactly what she said about her cat and how cute he is.

Consider what your supervisor needs to know – usually this is about the general progress of a client and any changes to their condition. At times specific details may be very significant e.g. if a person could find the items to make a cup of tea without help or not. Your Allied Health Professional should tell you ahead of time which specific details matter and what to watch for, or they may ask for more detail if required.



Activity 15 – Question and Answer

Answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. Who would you discuss taking recreation leave with, and who would you have sign off the paperwork to approve it?

2. Do you have set times to catch up with your supervisor? Is that often enough, is it at a convenient time?

Activity continues on the next page

Working in Care Teams

In your role as Allied Health Assistant, you may find yourself involved in a number of teams at any one time. This may include a ward team, occupational therapy departmental team and a professional team of Allied Health Assistants.

You will find your role varies within each team, but certain behaviours and skills will be necessary for you to be successful in each role. The teams will not be exclusive to client care. You may also find yourself involved in teams relating to projects and your department.

The most common models of teams in healthcare are:

- **The multi-disciplinary team** – In this team health professionals each perform individual assessment and management strategies. Their recommendations are then pooled together to make an overall plan for the client.
- **The inter-disciplinary team** – In this team all health professionals consult with one another at all stages including assessment, planning and evaluation.
- **The trans-disciplinary team** – In this team, one team member acts as the primary therapist, and other team members provide advice and information through the primary person.

(Queensland Health Statewide Occupational Therapy Clinical Education Program, 2007)

Most commonly you will find yourself working within the multi-disciplinary team model within the healthcare setting.

Multi-disciplinary Team

A multi-disciplinary team (MDT) is a group of health professionals who meet to discuss all relevant treatment options and develop an individual treatment plan for each client. This joint approach allows the team to make decisions about the most appropriate treatment and supportive care for the client while taking into account the individual client's preferences and circumstances.

Teams can consist of medical staff, nursing staff, social workers, dieticians, speech pathologists, physiotherapists, Occupational Therapists and Allied Health Assistants (The Cancer Institute NSW, 2010).

Generally, each discipline conducts an independent assessment of the client. Then each discipline develops their treatment plans independently. One person, usually the physician, orders the services and co-ordinates the care. There may be meetings to discuss progress, however often there is little direct communication amongst team members. Team members work in parallel with one another and often the medical

chart serves as a vehicle to share information (Geriatric Interdisciplinary Team Training, 2001).

It is important for you to understand your tasks and responsibilities within each team you are involved in. Where appropriate you will need to lead departmental and team meetings, case conferences as well as other team projects and activities.

When an OT is unable to attend a case conference you may be required to attend in their place. To assist with this, the OT will provide you with the relevant information for each client. You will need to be able to interpret the information and present it in a manner that is meaningful to the team.

Team Member Roles

Medical practitioners or doctors (MD):

- diagnose, treat and assist in the prevention of human physical and mental illness, disease and injury and promote good human health
- are involved in a wide range of activities including consultations, attending emergencies, performing operations and arranging medical investigations
- work with many other health professionals

Nursing staff (NUM, RN and EN):

- provide care for clients in a variety of healthcare settings
- provide physical and technical care and support for clients
- take part in the daily ward round with other nurses, doctors and allied health
- ensure clients receive treatment prescribed by health professionals
- provide emotional and psychological support and information to clients and their families

Occupational therapists (OT):

- work with people of all ages with a variety of conditions caused by injury or illness, psychological or emotional difficulties, developmental delay or the effects of aging
- their goal is to assist individuals to improve their everyday functional abilities and enable independence, well being and quality of life
- help clients maximise function and enable participation in their own lives

Physiotherapists (PT):

- provide treatment for people with physical problems caused by injury, illness, diseases and ageing

- use a range of treatments including mobilisation and manipulation of joints, massage, therapeutic exercise, electrotherapy and hydrotherapy to reduce pain, restore function and improve an individual's quality of life

Speech pathologists (SP):

- assess, diagnose, treat and provide management services to people of all ages with communication and/or swallowing impairments
- work with people of all ages who have difficulties swallowing food and drink
- people seek the assistance of a speech pathologist if they have speech, language, voice or fluency difficulties which impact on their ability to communicate effectively

Social workers (SW):

- provide information, counselling, emotional and practical support
- their primary concern is to address the social and psychological factors that surround clients' physical and/or medical presentations
- also provide assistance with resourcing care packages, information and referral to community services, advocacy and practical assistance

Dieticians (Diet):

- health professionals who improve the health of individuals, groups and communities by applying the science of human nutrition
- use their skills and knowledge to modify diets to treat medical conditions, and to advise other health professionals about the role of diet in health care, as well as educate the general public about eating for health

Psychologists:

- are experts in human behaviour, personality, interpersonal relationships, learning and motivation
- play an important role in helping individuals to enjoy and improve their quality of life by assisting in the management of many common mental health disorders, and by equipping people with the skills needed to function better and to prevent problems.

(Queensland Health, 2008)

Allied Health Assistant Role within Care Team

Allied Health Assistants are an integral part of a multi-disciplinary team (MDT) and often off act as a 'lynch pin' within the team. This tends to occur when the Allied Health Assistant works collaboratively with multiple Allied Health Professionals.

Communication between you and the rest of the team is a vital component for effective team work.

Key responsibilities as a member of a care team:

- have a good understanding of the roles of your colleagues, both Allied Health Assistant and Allied Health Professional
- maintain regular feedback to Allied Health Professionals regarding client progress
- provide regular feedback to Allied Health Professional regarding your workload levels (are you run off your feet or could you potentially take on additional responsibilities?)
- maintain positive relations including open and honest communication and a constructive climate for discussion
- demonstrate a commitment for the team
- have organised procedures

Effective communication is the ability to convey your message to other people and have that message understood without any misinterpretation. The information transferred should:

- include all relevant data
- be accurate
- be unambiguous
- occur in a timely manner

This information enables actions to be taken to provide the care that a client needs. When providing feedback to the OT and the team about a client, it is important that you are able to provide a summary of the key points relating to your contact with the client. You will need to be able to identify what information is important to the continuing care of the client.

When appropriate, this may include attending ward team meetings and ward rounds with the team to assist with discharge planning and equipment, client education and home visits. You may also need to report back to the multi-disciplinary team and departmental team meetings as a representative of Allied Health Assistants.

Occasionally you may be required to provide feedback regarding a client's progress during team case conferences. The Allied Health Assistant Model of Care outlines that when an Allied Health Professional is unable to be present at case conference, the Allied Health Professional must supply or pre-approve the feedback that the Allied Health Assistant is to provide at the case conference. The Allied Health Assistant needs to be able to interpret the information and present it in a meaningful manner to the team.

Limitations of Role

The Allied Health Assistant should discuss with the Allied Health Professional if the delegated tasks are outside scope of role and responsibilities as defined by the organisation (role description). This may occur for a number of reasons:

- lack of understanding of the role (by the AHA or the AHP)
- the Allied Health Assistant may be new to the job and not have had all the required training.
- the Allied Health Professional may have worked in another setting where the Allied Health Assistant role was different.

This communication is to ideally take place as soon as scope-of-practice issues come up. However, it may be appropriate to discuss these issues in a formal meeting.

Non-clinical Responsibilities

Managing a complex environment of teams requires good non-clinical skills such as time management, personal organisation and prioritisation.

Time Management – This can be anything you do to organise your time in your day. Suggestions to assist with this include:

- plan and schedule activities e.g. use a diary and schedule in routine activities such as ward meetings
- delegate effectively
- be efficient e.g. one task at a time, handle paper and e-mails once only and learn to say 'no' when it is appropriate
- control the small things such as talking, day dreaming and over debriefing

Personal Organisation – Organise yourself both now and in the future. Strategies to assist with this include:

- effective scheduling e.g. block in essential tasks to complete your job, schedule in high priority tasks and ensure contingency time to handle interruptions
- use 'to do' lists
- action planning for the day, week and year prioritising what you need to achieve

Prioritisation – Determine which tasks need to be achieved and manage competing demands. Strategies to assist with this may include:

- scheduling as outlined above
- use of prioritisation policies and procedures
- recommendations from OT

(Queensland Health Statewide Occupational Therapy Clinical Education Program, 2007)



Activity 16 - Working with a MDT Part A

Respond to the following activity. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

From a multi-disciplinary team (MDT) perspective draw a flow chart that illustrates your role within your MDT. Include yourself and clients in this model as well as Allied Health Professional, line managers, dieticians, nurses and etc. In this flow chart indicate who you have direct and indirect supervisory responsibilities to.

Activity continues on the next page



Activity 16 - Working with a MDT Part B (continued)

The following is an observation activity to see how effective your team is. Complete the activity after attending a team meeting. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

Team Observation Tool	
Team:	Date:
Does this team have an apparent goal? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is the goal?	
Professional Goals	
Circle the disciplines attending the meeting	MD SW NUM RN Diet SP OT PT
Do team members appear knowledgeable about their roles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do team members appear knowledgeable about the roles of other disciplines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there disciplines participating in the team with whose roles you are not familiar with?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so which ones?	
Leadership	
Who is (are) the team leader(s)?	
Does the leadership change during the meeting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What behaviours do the leaders use (summarising, initiating...)?	

Activity continues on the next page



Activity 16 - Working with a MDT Part B (continued)

Communication and Conflict	
Is there any open sharing of information?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Note any barriers to communication you observe (side conversations...)	
Is there an opportunity for differences of options to be discussed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What are the examples of conflict?	
How were they handled?	
Meeting Skills	
How is the meeting organised? (agenda...)	

Activity continues on the next page



Activity 16 - Working with a MDT Part B (continued)

Outcome	
What was accomplished or produced during the meeting?	
Are decisions and next steps clear?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was the meeting efficient? Why	

(Long & Wilson, 2001).

Key Points

- General principles of rehabilitation service provision:
 - clinical pathways
 - continuum of care
 - administering specific assessments and treatments
- Continuum of Care – When a client first accesses health services right up until the time they no longer require any services can be thought of as 'a journey' on the Health Continuum Model
- Client Care Principles:
 - Client-Centred
 - Occupational Therapy Models of Practice
 - Goal-Directed
- All care delivered by an Allied Health Assistant needs to be within that individual's scope of practice
- The purpose of the Allied Health Assistant is to '...contribute to client care by providing clinical support tasks delegated under the direct or indirect supervision of an AHP'.
- Allied Health Assistant scope of practice:
 - Supervision
 - Delegation
 - Role within the health care team
 - Personal organisational skills
- Multidisciplinary Team may include Medical staff, Nursing staff, Social Workers, Dieticians, Speech Pathologists, Physiotherapists, Occupational Therapists and Allied Health Assistants

SELF-COMPLETION CHECKLIST

Congratulations! You have completed the topics for Learner Guide: Conduct group sessions for individual client outcomes.

Please review the following list of knowledge and skills for the unit of competency you have just completed. Indicate by ticking the box if you believe that you have covered this information and that you are ready to undertake assessment.

Conduct group sessions for individual client outcomes

Essential Knowledge	Covered in topic
Legal and organisation requirements on equity, diversity, discrimination, rights, confidentiality and sharing information when supporting a client to develop and maintain skills	<input type="checkbox"/> Yes
Principles of group dynamics	<input type="checkbox"/> Yes
Nature of group learning	<input type="checkbox"/> Yes
Factors that affect behaviour in groups	<input type="checkbox"/> Yes
Understanding of group roles, leadership and facilitatory techniques	<input type="checkbox"/> Yes
Understanding of role within a care team and when and how to provide feedback about the client	<input type="checkbox"/> Yes
A working knowledge of record keeping practices and procedures in relation to conducting groups for individual client outcomes	<input type="checkbox"/> Yes
OHS policies and procedures that relate to the AHA's role in conducting group sessions	<input type="checkbox"/> Yes
Supervisory and reporting protocols of the organisation	<input type="checkbox"/> Yes



Activity 17 - Questions

For this task you are required to answer questions that relate to your work as an Allied Health Assistant conducting group sessions for individual client outcomes. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. What should you consider when planning a group session?

2. What are some indicators to identify potential conflict within a group?

Activity continues on the next page



Activity 17 - Questions (continued)

3. What are some strategies to assist with conflict resolution within a group?

4. Discuss the importance of effective communication within a group.

5. What would you do if you discovered that a piece of equipment a client is using is broken?

Activity continues on the next page



Activity 18 - Scenarios

For this task you are required to read and respond to the three scenarios provided. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

Scenario 1

You are co-facilitating a fatigue management group of ten clients. During the group, one of the clients displays inappropriate and difficult behaviours, which is disruptive to the group. As a result of this incident, you become aware that the session time is $\frac{3}{4}$ finished; however, you are not even half way through the content of the planned session.

1. How would you manage the client with inappropriate and difficult behaviour?

2. What do you do about the time issues?

Activity continues on the next page



Activity 18 – Scenarios (continued)

Scenario 2

Mr Smith is attending an upper limb group to assist with strengthening the muscles in his left upper limb. Mr Smith has difficulty understanding instructions as a result of his communication difficulties.

3. How can you ensure Mr Smith understands and is able to follow your instructions?

Scenario 3

You have been asked to co-facilitate a cooking group for four clients who have a range of impairments. During this group, you discover that one of the clients is unable to safely use a knife to cut ingredients, however he does not have this awareness.

4. How would you manage this situation?



Activity 19 - Workplace Observation Checklist

You will be observed providing support to assist with the rehabilitation of clients. The learner may choose from the following group sessions:

An upper limb group session. These clients have weakness in one or both of their upper limbs

An educational group (for example, a fatigue management group)

A functional group (for example, a cooking group)

You will need to assist with planning, conducting and evaluating the group. You must perform these tasks on at least two occasions to demonstrate competence.

WORKPLACE OBESERVATION CHECKLIST

Essential Skills and Knowledge The learner demonstrates the following skills and knowledge	1 st observation date & initials	2 nd observation date & initials	Comments	FER
Planning the group				
<ul style="list-style-type: none"> Understands the purpose/goals of the group (including researching, reading materials and liaising with appropriate staff) 				
<ul style="list-style-type: none"> Obtains information about the clients (including reading medical records/case notes, liaising with family members/other staff) 				
<ul style="list-style-type: none"> Determines which clients are suitable for the group, including considering the client's rehabilitation goals, the client's current function (including cognitive, physical and psychological functioning) and religious and cultural beliefs 				
<ul style="list-style-type: none"> Selects appropriate activities/tasks and locations to accommodate for any identified impairments. 				
<ul style="list-style-type: none"> Selects activities/tasks of potential interest to the client group 				
<ul style="list-style-type: none"> Considers the group size. 				
<ul style="list-style-type: none"> Plans to have more staff members present if it's a larger group or select those clients in which this group session is more of a priority 				
<ul style="list-style-type: none"> Liaises with the OT prior to obtaining client's consent to discuss group plan 				
<ul style="list-style-type: none"> Obtains client consent to participate in the group 				
Running the group				
<ul style="list-style-type: none"> Sets up the room to allow all clients to participate in the group 				

Essential Skills and Knowledge The learner demonstrates the following skills and knowledge	1 st observation date & initials	2 nd observation date & initials	Comments	FER
<ul style="list-style-type: none"> Provides an outline of the group session, including group goals, group rules and other necessary information 				
<ul style="list-style-type: none"> Considers client's impairments, for example if a client has communication difficulties, ensure to provide information in a way they will understand (e.g. use of pictures etc.) 				
<ul style="list-style-type: none"> Encourages all clients to be involved and participate in the group 				
<ul style="list-style-type: none"> Monitors the client's progress within the group, including social interactions, mood, behaviour, improvements/understanding and/or difficulties 				
<ul style="list-style-type: none"> Maintains appropriate client-therapist relationships at all times and demonstrates appropriate communication 				
<ul style="list-style-type: none"> Demonstrates ongoing consideration and respect of clients religious and cultural beliefs 				
<ul style="list-style-type: none"> Demonstrates an understanding of staff roles within the group (including liaison with other staff prior to commencing the group to determine roles and facilitation techniques) 				
<ul style="list-style-type: none"> Demonstrates knowledge of how to deal with challenging or difficulty behaviours within the group and knowledge of conflict resolution 				
<ul style="list-style-type: none"> Is able to effectively manage time, including ensuring all objectives/goals for the group are covered. Can prioritise and be flexible within the group if required 				
<ul style="list-style-type: none"> Assists OT to provide feedback to individual clients as required and identified 				
<ul style="list-style-type: none"> Conducts continuous evaluation of the group 				

Essential Skills and Knowledge The learner demonstrates the following skills and knowledge	1 st observation date & initials	2 nd observation date & initials	Comments	FER
(including identifying reduced participation and interest in the group. Ability to redirect the group to remain engaged in activities, obtaining feedback from group clients)				
Clean and store equipment and materials				
• Cleans any equipment as required by hospital/ centres policies and procedures				
• Returns all equipment				
• Reports any broken equipment to OT				
Documentation				
• Liaises with OT and other team members regarding client's performance within the group, including individually and at team meetings				
• Completes required documentation, including identifying client's progress, performance, strength and difficulties				

*FER – Further Evidence Required

RESOURCES

- Allied Health Assistance Documentation Manual. Models of Care: Meeting individuals and community needs through workforce design.
Web: <http://qheps.health.qld.gov.au/ahwac/docs/MOC/mocahagovguide.pdf>
- Centre for Healthcare Related Infection Surveillance and Prevention (CHRISP)
Web: <http://www.health.qld.gov.au/chrisp/>
- Mind Tools
Web: <http://www.mindtools.com>
- Queensland Health Allied Health Assistant Framework can be found on the website:
<https://www.health.qld.gov.au/ahwac/html/ahassist>
- The Australian Charter of Healthcare Rights can be found on:
<https://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/>



Appendices

Appendix 1 Communication Techniques

Techniques for Communicating With Group Members Who Have Hearing Impairments

5. Position yourself so that you are in full view of the person and your face is illuminated.
6. Speak in a normal voice.
7. Speak slowly and clearly. Stress key words. Pause between sentences.
8. Make sure no one else is talking when a group member is speaking to a hearing-impaired person or when a hearing-impaired person is speaking to a group member.
9. Make sure the room is free of background noises and has good acoustics.
10. Look for cues, such as facial expressions or inappropriate responses that indicate the individual has misunderstood.
11. If you suspect that the individual has misunderstood, restate what has been said.
12. Speak to the individual, not about the person.

Techniques for Communicating with Group Members Who Have Visual Impairments

1. Ask the individual whether assistance is needed to get to the meeting room. If the reply is yes, offer your elbow. Walk half a step ahead so your body indicates a change in direction, when to stop and so forth.
2. Introduce yourself and all group members when the meeting begins. Go around the group clockwise or counter-clockwise. This will help the group member learn where each member is located.
3. When you accompany a visually impaired person into a new meeting room, describe the layout of the room, the furniture placement and any obstacles. This will help orient the individual.
4. Try not to disturb the placement of objects in the meeting room. If this is unavoidable, be sure to inform the person about the changes. Similarly, let the individual know if someone leaves or enters the room.
5. When guiding visually impaired individuals to their seat, place their hand on the back of the chair and allow them to seat themselves.
6. Speak directly to the visually impaired person, not through an intermediary.
7. Look at the individual when you speak.
8. Don't be afraid to use words such as look and see.
9. Speak in a normal voice. Do not shout.
10. Visually impaired people value independence just as sighted people do. Do not be overprotective.
11. Give explicit instructions about the location of coffee or snacks and during program activities. For example, state, 'The coffee pot is 10 feet to the left of your chair,' rather than 'The coffee pot is right over there on your left.'

(Toseland & Rivas, 2009)

Appendix 2

Summary of Group Methods in Health Promotion

Didactic Group Methods	Description
Lecture – Discussion	Best for knowledge transmission or motivation in large groups. Requires a dynamic, effective speaker with more knowledge than the audience.
Seminar	Smaller numbers (2-20). Leader group feedback. Leader most knowledgeable in the group. Best for trainer learning
Conference	Can combine lecture or seminar techniques. Best for professional development.
Video conferencing	Opportunity for group learning with professionals, such as rural and remote doctors, nurses and so on.
Skills training	Requires motivated individuals. Includes explanation demonstration and practice, for example, relaxation, childbirth, exercise
Behaviour modification	Learning and unlearning of specific habits. Stimulus-response learning. Generally behaviour-specific, for example, smoking cessation, phobia desensitisation.
Inquiry learning	Used mainly in school settings. Requires a formulating and problem-solving through group cooperation.
Peer group discussion	Useful where shared experiences, support and awareness are important. Participants homogeneous in at least one factor, for example, old people, prisoners, teenagers.
Stimulation	Useful for influencing attitudes in individuals with varying abilities. Generally in school setting, but relevant to other groups.
Role-play	Acting of roles by group participants. Can be useful where communication difficulties exist between individuals in a setting, for example families, professional practice. Requires skilled facilitator.

Didactic Group Methods	Description
Self-help	Requires motivation and independent attitude. Valuable for ongoing peer support and values clarification. Can be therapy or a forum for social action.

(Egger, Spark & Donovan, 2005)

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