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8/10/11

Ms Mary Russell,
Chair OT board Australia
GPO Box 9958
Melbourne VIC 3001

13 OCT 2011

Dear Mary

Re: enclosed copy FYI.

Please find hard copy of my correspondence, which I had intended for submission for close of business 7/10/11 as per online AHPRA request for feedback on the proposed mandatory regulations for the proposed National Occ. Therapy Registration in July 2012.

I also enclose the copy of my open letter to the editor submitted to AJOT + the 'Connections' newsletter also FYI.

I apologise this / these are the best I can manage at this point in time with the one handed typing + my limited Word 2007 experience + fluency. If I could reedit it would be preferable more concise. Since my stroke (I was an fluent with Word 2003 but this is not available to me now.)

Handwriting this cover note is to get this away to you asap. (I will call the AHPRA office to reconfirm the correct email address which I could not reattain late FRI 7/10 + the office was

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The Executive Officer
Occupational Therapy Board AHPRA
GPO Box 9958
Melbourne Vic 3001

30th September 2011

SUBJECT: Mandatory Registration Standards

To whom it may concern,

I have recently submitted an open letter to the editors of 'AJOT/ Connections' newsletter to share my personal ordeal of experiences as a former Occupational Therapist, (1979-2001) CCHS BAPPSci (inOT)(Cumb) my original working qualification. I would like to provide some feedback of my experiences as an OT who in May 2009 (in a capital city away from my regional hometown) suffered a major stroke lesion.
It is with constructive intentions that I write to you with proactive comments, in the context of the in coming National Mandatory OT Registration Standards 2012 due to the expected influx of residually disabled/ younger post stroke and expected boom of high functioning ageing health consumers.
As it is over two years since my stroke this is not a formal notification but a summary of areas of high concern to me as both as an OT and a patient, reflecting an urgent addressing of the proposed registration standards and monitoring, for best practice and acceptable skill acquisition within OT ethics code of practice/ treatment delivery, quality assurance, peer review and mentoring and which will actually transmit to effective clinical care, empathy and rehabilitation.

My own progress was by self advocacy due to a lack of formal case management. This included finding treatment choices and resources to meet my needs requiring great effort on my behalf along with support and energy from my GP, husband and friends (mostly non health trained) I often discovered options by accident rather than design. This situation of self-advocacy is very disturbing as what then happens to non-OT's in the same situation. Fortunately my two children are young adults and reasonably self sufficient, and being a one handed grandmother one day is on the horizon hopefully. Fortunately it appears I have retained my speech communication and cognitive faculties, it could be worse.

To address effective rehabilitation outcomes, the proposed CPD audit mechanisms require implementation strategies to target inexperienced practitioners for compliance. Financial and time commitment would benefit from incentives I e tax deductions, registration credits and CPD grants and other support from employers . The area of student intake/attitude at starter levels may also require addressing from experience of low empathetic experiences, lack of interaction/ verbal review, no rehabilitation cognitive and/perceptual active screening.

This raises the issue of staff accreditation, quality of care and services in the various hospital systems. Sadly it is my observation in general that most health services have become depersonalized, less hands on clinically in the display of knowledge and skills as part of the bed-clearance mechanism. Not one OT ever inquired as to my actual life activities, routines or pleasures. To me that is quite neglectful of basic practice.

I understand that it is not compulsory to join the professional OT association. Perhaps there are mandatory issues for employers, especially private hospital sectors, to ensure accredited staff members meet the compulsory standards of registration.

Sadly perhaps in our 'time poor' society and 'busyness' of existence, the Therapists do not have hobbies to inquire what I might miss or how will I manage X, Y, Z etc. I was fortunate to know of the spike-vegetable board and organised to obtain one and many other bits I need for my own cooking resumption. With reference to the 'pp14,15. The National Board's competency/accreditation Ref: p14, 1, 25 a)b)C) for CPD requirements for Ministerial Council approval liaison with training institution's base graduate level of knowledge/skills/actual flying time should be considered as effective skill specialization/mentoring/incentives. Perhaps incentives for grants/scholarships to develop neurology or other specialty skills <u>(hands on)</u> will encourage pro action to engage and invest in? P.D for job satisfaction, accountability and efficacy. Perhaps the incentives for the private sector employers to provide relief/funds towards skill development will be seen to reinforce service quality/marketing edge.

Re: p12 The National Agency ref 1.17 (a)(b)(f).

The mentors (educators, clinicians will also require a regulation for standards selection and expertise level and different types of audits for standards) for e.g. specialized advanced level. And specialty areas. Audits will require strict procedures/systems for corrective actions/re-training and remediation processes. The input for professional state OT Association to be clarified to avoid duplication (wasted resources). Funding to administer the scheme and need per quality funding injections for services delivery (system consequences for defaults etc). non compliance or if not reaching satisfactory standards of CPD and explicit clinical skills, capably and further conscientious developments are able to be addressed and remediated or if required such as when in adequate substandard/performance on expert standards audits,, other action[s] as appropriate t aretaken to follow-up where needed to maintain appropriate skilful treatment/ assessments and evaluations.

Less talk, more action is required to have a credible, respectable system of registration that works. From the student undergrad intake screening, ongoing course monitoring and post-grad accreditation for

conscientious practitioners and auditing for the 'less conscientious' with CPD, in particular, and those not so willing to commit personal funds to their own excellence/up-to-datedness/acquiring skill time hands on in practice can be seeded out as with the excellence in school teachers, innovations with the Department of Education and Training, it would be similar to clarify therapist and remediation for possible career change (i.e. consequent alternate duties to clinical patient load for health treatment) to more suitable tasks will improve quality of health service conduction and better job satisfaction, improved confidence and capability to act/ treat if effective e-ea to hopefully better for therefore job performance and less passivity; less disinterest in OT as a profession; with better outcomes for the burnt out or not conscientious/enthused. Review of pre-screening for time motivation/aptitude to commence /continue the OT course will avoid wasting valuable training positions to enable a suitably motivated other to undertake the and remain in practice with excellence in performance with greater longevity and contribution to the OT workforce., rather than suffering in isolation, + being non productive, uninvolved, being poor PR for the profession's wonder, potential contribution to inspire recovery creatively assist as a core mutual goal?[I had hoped anyway?} but awaited in dismay +disbelief, but instead of waiting/ wasting losing time I followed up for myself o to ensure choices support creating accepting offers of help, abdicating independence to fulfill trials, stake sensible risks, new opportunities or I would not be where I am today. I am not suggesting a top-heavy onerous new bureaucratic mechanism but to address some of the mentioned suggestions amongst the above mêlée of my experiences to enable quality of care that can be expected and Is available to a decent standard. Thank you for your attention. I will pass on my concerns as related to anyone I pe4rceive of interest to advocate better OT availability in the context of the younger stroke patient [officially that means anyone under65!] with the national stroke foundation stats with one stroke per10 minutes.

This shortfall target area is an immediate example of consumer disquiiet and requires promnpt addressing in context where testable standard for OT quality audits can be reviewed and test of the new registration regulations in implementation/ remediation and putting into practice?

Yours Faithfully

In pursuit of quality care especially in OT which prior to these experiences, I have always found inspired my life but this occasion I was ashamed embarrassed disappointed to be associated with my original profession
Postscript: I trust the aforementioned can b e received constructively for the betterment. Of future stroke rehab care if required please, do not hesitate to contact if clarification needed. I would be happy pod attend meet with a working g if needed if not too onerous in time. I am 2 hours from Sydney.
Kind regards.

Karen Ma[nee yee]

Misc Points: Also, footnote left off earlier: ***RE COMSUMER FEEDBASCK/BASCK USER FRIENDLINERSS***

The simplification for consumer feedback of recipients of OT services without the draining and awkward notifications and formal system of complaint would be helpful to obtain more candid for difficulties and accolades to help define the needs; working facilities to enhance the delivery of OT in the context of the legislation and as required by the ministerial council Ref. p18.1.36,1.37.

If quality peer assurance/mentoring and consequence systems are well in place the waste in funds/time can be avoid accreditation duplications with SOPS clarified consistence standards to have the process seen as supportive, nurturing and valuing rather than punitive or with greater transparency with best practice criteria/performance rather than encouraging overstated CPD recording when not verifiable i.e. greater compliance i.e. career supportive for over working lifespan/role changes and difficult clinical situations for different stages of one's own life (? An inbuilt mentoring system valuing the experience and processes too hand on this experience for ongoing quality in delivering comprehensively for less and greater input for inclusion with the consumer).

Re CPD

To address the putt into practice of Maintenance/improvement? Knowledge, expertise, competency in practice,

Self-monitoring "checking system" needed/evaluations on baseline baselines needed. On job – where to go/contract CPD – workplace? managers? For mutual /services? Benefit/development.

Problems when an OT may not know what doesn't know or what Orr how where to find success required expertise ongoing training/ practical acquisition/ verification of achievement to amply the new therapeutic skilks to build needed skills? But?hands-on into practice/ at workplace anyway? Degree of monitoring to adequate practitioner independent [? License to proceed? Analogy]

The issues of practical competency-regency, evidence, assessment of direct clinical care? Grading (clearance for meds/intervention) degree of responsibility for the now experienced correction team context allied health managers. Less responsibility. What if the manager is not an OT? Cross-reference with other professionals; co-ordination boards PT/ST/SW?

Less established treatment units – wide ranging cross consultation similar resources. P36 CPD

of the registration standard WHAT to maintain/ develop/ bridge/ base slkills to acquire build upon?/ extend/ grading of competence?

Compliance HOW – fees/hardship for CPD

Time poverty excuses

OT Australian association- runs accredited CPD scrutinizers within professions for consistent standards. / comparative skill level grading for accountable delivery responsibilities, further CPD etc., remuneration objectivity/ productivity etc=c possubole HR / accreditation implications for corporate employers training hospitals/ ad institutions...

Best practice clinical procedures

SOP's in other professions e.g. TAFE Welding onsite – hands-on industry standard

Undergraduate practical level evaluations

Specialty clinical teaching shortfalls

Worker healthiness in a department or team. Physical rehabilitation also requires physical fitness demands of the therapist.

Ethics, professionalism and goals

- Quantifying
- Code evaluation
- Written/verbal/clinical levels require measurement and monitoring

P.31 'regency' of practice or 'special area' of practice a better focus for longevity in working profession and recognition plus 'general competency' and tease out skills/OT applications in practice? Quantification/recognition of CV skills roles/development and gaps –goals CPD to achieve who mentors this? Recognition/support mechanisms to established /quiet achievers? Innovation/community contribution/ general allowed competency breadth of experience/team input professional accessibility to workplaces loyalty service- changeability in employment venues. Fracturing skills, loss of skills to generalist breadth [jack-of-all-trades master of none] and loss of centers of excellence egg spastic centre for bobath training experience, loss of the spinal lunit RNSH ET... FUNDUING POLITICSL FICKLENESS with disease publicity/ focus"? research developments and varying limelights

p. 30 Professional Indemnity insurance p.11 arrangements

2.. abcd)? – run off cover

The issue again of investment of skills CPD overhead e.g. private practice mentality and/or highly ethical practitioner awareness; a necessary sensible overhead but perhaps the less conscientious ??? CPD - ??? responsible practitioner ! 'Just a job' just work for the money or 'not rapt in the world', may not be proactively motivated commit time and funds to skill building or professional cover. Similarly, those hesitant to feign the State Professional Association's non-compliance consequences? How to deal/police/investigate/consequences? Transparency for peer review intra-professional interaction.

At risk targets – non Association members, possible incentives needed for forming associations re CPD in-services (fee cuts already non-member rates etc) ... funded, enjoyable, pleasant venues for 'reward' for hard work. Fun while learning across cultural activity leisure, no charges for venues. Skill packs/food packs (reps supply company promo's) d/a accessibility/tourism/sports/creative occupations-return to roots? Coalface excursions, retirement preparation, innovations......Cross discipline course managers – creative/industrial design/advanced study levels/post grad study opportunities/engineering needs/ Whet the appetite/experiential needs/one handed driving.

When I was perplexed and dismayed about what was the optimal treatment for OT intervention, once I returned to my home town, I rang the local call number for the National Stroke Foundation (Melbourne based) and saw the clinical guidelines for stroke management-A quick guide for Occupational therapy from the National Foundation Stroke Site www.strokefoundation.com.au ; as I could never speak to anyone who could offer guidance regarding best practice (having been more a mental health psycho-social medicine as my main areas of interest in OT over the past 20years working in OT). It still remains a mystery as to who the 'expert OT' consultants were and what 'body of guidance' is used as the guide to practice. I have had very minimal formal OT input to my bodily recuperation and memorably an OT Aid applied some sensory (hot and cold) input to my affected limbs and stretches. All bathing was overseen and assisted by nurses and mobility attempted input attempted by physios. Eventually, I discovered by chance, the opportunity for ??bath oriented facilitation and interventions(requires significant interest, cost and professional self-development to acquire skills) which has progressed me to where I am now –(driving one handed and one footed and walking independently with an AFO and walking stick). I chanced upon Second Skin options via a chance meeting in the street, as my home metropolis is a small planet, via another patient, via another physio, and by chance via a stroke orientated masseuse. Fortunately, I am naturally independent and persevering and follow things up and, in addition, have high expectations and I work around limitations. I have been criticized with such comments as "maybe your expectations are too high". OT dispute hospital) or "No – don't sit on that office chair" (due to its wheels) and "No, don't go down those (external) stairs at all" there is one external flight to clothesline under porch! I was advised to"Just use the dryer!"/ (How un-environmental!)

With such challenges I have worked around these 'restrictions' in order to better my functionality, ably doing my visual tasks. I also do full stair flights with a rail or a stick if no rail (and so have attended life drawing sessions as the class has stair access). I have my clothes on aimers and use a garden trolley to shift loads around. I finish off near dry but damp clothes in the dryer when essential. I enjoy a hot, normal water pressure shower standing with suitable rails attached to the shower wall, which was organized by us. Where there is a will there is a way. I trust the above incidents are enlightening to emphasize the worth of 'life experience' and in particular hands-on REAL clinical experience as in facilitation, knowledge/understanding and flying time clinically. So I support monitoring and audits but I am somewhat cynical that the less conscientious will truly follow the proposed registration guidelines without quite formalised structures (measures of such inputs/achievements) and consequences of non-compliance being realized.

Perhaps when OT consumers with the extra appreciation of can enhance the importance to promote the values foot rather than experience the traumatizing reductionist on occupationally bed clearance focus due to institution priorities?> of the bean counter bottom lines? Other criteria measurements to present needs?> business/ admin mgt expertise for health allied health mgt roles also identified sis valid corporate health worker mgt roles requiring CPD or life of dept saving regimens could perhaps help the 'less conscientious understand the productivity bottomed lines and point of investment in their clinical development a and CPD and greater involvement and especially if less client oriented may be better match of interests/ skills some clinical still required for administrators for credibility/ admin delivery to understand the ground?

Postscript: I am happy for any identifying information to be blurred/removed but I am also I am happy to discuss further fully in general versus specific terms any aspects requiring clarification and keenly offer my contribution if possible.

Yours Faithfully

Karen Ma (nee Yee)