

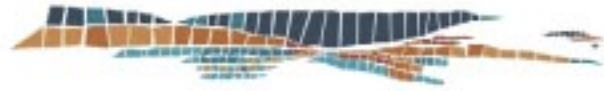
RURAL  
WESTERN  
AUSTRALIAN  
THERAPY  
ASSISTANT  
PROJECT

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A joint initiative of Disabilities Services Commission  
and Combined Universities Centre for Rural Health



Combined Universities Centre for Rural Health



# RURAL WESTERN AUSTRALIAN THERAPY ASSISTANT PROJECT

**A joint initiative of  
Disabilities Services Commission and  
Combined Universities Centre for Rural Health**

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## **LIST OF ABBREVIATIONS**

CUCRH	Combined University Centre for Rural Health
DOE	Department of Education, Government of Western Australia
DOH	Department of Health, Government of Western Australia
DSC	Disabilities Services Commission, Government of Western Australia
EEO	Equal Employment Opportunity
JDF	Job Description Form
MOU	Memorandum of Understanding
OSH	Occupational Safety and Health
SATS	School Aged Therapy Services
TAFE	Colleges of Technical and Further Education
WA	Western Australia

## EXECUTIVE SUMMARY

It is a goal of the state government to ensure that every person in Western Australia (WA) has equitable access to health care. Given the vastness of the state, this goal presents an ongoing challenge to the Department of Health (DoH) and other health care providers. One aspect of this challenge is the provision of allied health services to people in rural and remote communities. Therapy assistants, who are health workers who assist one or more therapists in their clinical duties, have been one strategy used to address this challenge.

Currently there is no single comprehensive model of therapy assistant delivery service operating in WA. There are a variety of regulatory standards from the different professional bodies and legislation, along with local standards promoted by the service provider, which therapists may choose to draw upon. These standards have not, however, been adopted or applied by all therapists. Furthermore, therapists are not specifically trained to work with therapy assistants, thus amongst therapists there exists a wide range of abilities and experience in the training, supervision and delegation of tasks to therapy assistants. Among therapy assistants themselves, there is a wide range of training, experience and abilities and an equally wide variety of duties they are expected to perform depending upon their employer. The lack of standardized requirements for: specified minimum training; a generic Job Description Form (JDF); performance indicators; and standards for ongoing monitoring may have contributed to this situation.

As a result of this project and, as a first step to creating a comprehensive therapy assistant service delivery model, a set of values were created to guide therapy assistants in their work. A generic JDF was also created to assist therapists in assessing minimal requirements, training and appropriate tasks for therapy assistants. In addition, thirteen recommendations were developed. These recommendations fall under the following categories: standards of practice; training; implementation and management issues; and monitoring and evaluation.

### Standards of Practice:

Therapy assistants consulted during the project stated that a lack of role clarity coupled with a lack of clear policies and procedures led to confusion concerning their role, both on their part and on the part of the supervising therapist. Therefore, the following recommendations are made:

***Recommendation 1: Employing organizations should adopt a common framework and understanding of therapy assistants in order to enhance role clarification and improve service delivery.*** Agreed upon standards should be implemented by all organizations employing therapy assistants. Where there are a number of different agencies employing the same therapy assistant (for instance, Department of Health and Department of Education) there should be a Memorandum of Understanding (MOU).

**Recommendation 2: The practice standards should be reflected in a set of core JDFs that encompass the range of practices that are required of therapy assistants and therapists.**

**Recommendation 3: A generic orientation package should be developed by those organizations utilizing therapy assistants.** The orientation package would be designed to be adapted for individual needs and would include guidelines and tools for the following: standards (minimum qualifications); training; orientation and work plans; supervision; delegation; performance and monitoring; and evaluation.

## **Training:**

**Presently there is no standardized training to prepare therapy assistants to undertake the tasks expected of them. In addition, therapists are not trained to use therapy assistants effectively.**

**Recommendation 4: The core competencies addressed in the training of therapy assistants should be standardized. Existing and planned training should be aligned with these core competencies.**

**Recommendation 5: Undergraduate and postgraduate curriculum for therapists should incorporate content on the role of therapy assistants and the principles of supervision and delegation.**

## **Implementation and Management issues:**

Although therapy assistants are employed in both urban and rural areas, rural service delivery poses particular challenges.

**Recommendation 6: Strategies to allow dedicated time for supervision of therapy assistants should be implemented. Furthermore, resources should be allocated to reinforce the importance of supervision and delegation as significant components of a supervising therapist's workload.**

**Recommendation 7: Generic standards of practice, JDFs, training packages and orientation manuals should outline the principles of practice while allowing for local innovation and flexibility.**

**Recommendation 8. Organizations employing therapy assistants should explore opportunities for them to network.**

**Recommendation 9: Professional associations should be encouraged to review their guidelines on therapy assistants in order to address the needs and realities of rural and remote practice and the needs of those consumers who live in these areas.**



## **Monitoring and Evaluation:**

Currently there are no mechanisms in place for tracking therapist assistants, making it difficult to facilitate the statewide adoption of standards. In addition, there are currently no agreed upon indicators that measure an individual therapy assistant's performance.

***Recommendation 10: A system should be implemented in order to monitor the locations and numbers of therapy assistants and their supervising therapists.***

***Recommendation 11: Common indicators shared by therapists and therapy assistants should be developed to monitor and evaluate the progress of clients, the performance of individual therapy assistants and the effectiveness of the entire program.***

***Recommendation 12: Further research should be undertaken to determine the effectiveness of therapy assistants in enhancing client outcomes in rural areas.***

## INTRODUCTION

Rural Western Australia (WA) is a massive area with a sparse population. Historically it has been difficult to attract allied health professionals to country areas. This has made the delivery of high quality health services to these areas an ongoing challenge. The use of therapy assistants has been one method employed to redress the imbalance between rural and urban service delivery and in recent years there has been an increase in the use of therapy assistants. While the use of therapy assistant services has been seen as beneficial to rural and remote communities, there have been concerns expressed by health professionals and others about the delivery of these services.

The need to develop a comprehensive approach to the delivery of therapy assistant services resulted from two significant events. The first of these was a discussion paper in 2000 entitled “Therapy Assistants in Rural and Remote Western Australia”. In March 2001 a videoconference entitled “Therapy Assistants in Rural Areas” was held between major stakeholders<sup>1</sup>. The videoconference identified five areas in need of further development if a comprehensive model of working with therapy assistants was to be effective. These areas were management, training, standards, models and evaluation. A complete outline of the goals and objectives of the project is in Appendix 1.

The Rural Western Australia Therapy Assistant Project has aimed to develop a comprehensive framework for the delivery of services by therapy assistants in rural WA. The need for a comprehensive approach to the delivery of services emerged primarily because of a need for role clarity, particularly as it related to job description and to supervision across health services throughout the state.

Through consultation with therapists and therapy assistants during the project, certain values and principles for the delivery of services by therapy assistants were developed. The values that were agreed upon were stated in terms of consumer rights. These rights included the rights of client: to *privacy, dignity and confidentiality*; to be treated with respect; to have access to services based on need and available resources, that is, equity; and to have opportunity to participate in the delivery of the services they receive, that is, empowerment. The first principle that was agreed upon was that the activities of the therapy assistant will be intended as best practice and selected by the therapist as the most suitable according to the clients’ need, the experience of the therapy assistant and therapist, the setting and the availability of supervision. The second principle was that all therapy assistant activities be carried out under the supervision and direction of a qualified therapist<sup>2</sup>.

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<sup>1</sup>The videoconference included over 70 participants composed of allied health professionals, therapy assistants, parents, and representatives from the Disabilities Services Commission, the Combined Universities Centre for Rural Health, the Department of Health, the Department of Education and metropolitan representatives from Therapy Focus, Rocky Bay Incorporated and the Cerebral Palsy Association of Western Australia. The regions of Albany, Bunbury, Geraldton, Kalgoorlie, Narrogin and Perth were represented.

<sup>2</sup> Therapists include physiotherapist, occupational therapists and speech therapist.

The Disabilities Services Commission (DSC) and Combined Universities Centre for Rural Health (CUCRH) jointly funded the Rural Western Australia Therapy Assistant Project. A project officer was employed from the Lower Great Southern Health Service in late August 2001. The Lower Great Southern Health Service provided infrastructure support in the form of access to technological and administrative support.

## METHODOLOGY

Three groups were set up to oversee this project: the Advisory Group, the Working Party and the Site Based Working Groups. The Advisory Group was drawn from the DSC, CUCRH, Department of Health (DoH), Department of Education (DoE), Metropolitan Allied Health Council and professionals from the fields of occupational therapy, speech pathology, physiotherapy, podiatry and dietetics. The purpose of the Advisory Group was to endorse the project, develop a framework for best practice, review the key milestones of the project, advise the working party and seek input from the groups that they represented.

The Working Party was composed of DoH allied health representatives from the South West, Northern Goldfields, Lower Great Southern, Upper Great Southern, Central Great Southern, Geraldton, Midwest, Murchison and North Midlands, as well as a Perth representative from the DSC. The purpose of the Working Party was to determine the scope of the project including the creation of goals and objectives for each of the five areas needing further development (management, training, standards, models, and evaluation). The Working Party was responsible for incorporating the views of those in their respective catchment areas and for forming their own Site Based Working Group. They were to keep the Site Based Working groups informed of the project's progress while also incorporating the ideas of the Site Based Groups into the Working Party.

The Site Based Working Groups were composed of all the participants from the videoconference (therapists, therapy assistants and other interested people) who expressed an interest in the project. There were also members who had not attended the videoconference. These groups were to ensure that the project was relevant to local requirements by giving their input to the Working Party and disseminating information about the project to other staff in their area. For a full project structure see Appendix 2.

This report was compiled from a literature review, questionnaire and focus groups. The information gained from these sources was used to recommend principles and guidelines for the employment, supervision, induction and orientation of therapy assistants.

A major Internet literature search was carried out in September 2001 using the following key words: therapies; therapists; therapist; therapy assistants; occupational therapy assistants; physical therapist assistants; physiotherapy assistants; continuing education; supervisors; supervision; state licensing boards; role.

The following search engines were used: Clinical Information Access Online (CIAO); OVID; Clinical Information Network for Allied Health (CINAHL); AUSTHEALTH; RURAL; COCHRANE Library.

In addition the following websites were accessed: the Australian Physiotherapy Association; the Australian Occupational Therapy Association; the Australian Bureau of Statistics; the Chartered Society of Physiotherapy (U.K.); and the Occupational Therapy Association of the U.K. The only website containing information on therapy assistants was the Chartered Society of Physiotherapy.

Overall, the results of the search were disappointing. In total 65 recent Australian and international papers were found. Very few contained significant research on the effectiveness of therapy assistants on client outcomes or on operational issues such as supervision or models of service.

A questionnaire was distributed to therapists across rural WA to determine the number, distribution and roles of therapy assistants across different sectors of health, education and disabilities services. Each respondent was asked to attach a current JDF with the returned questionnaire in order to determine existing standards.

The questionnaire (see Appendix 3) was sent out to members of the Working Group across the different regions. Therapists were asked to distribute the questionnaire to key people within their region. However, not all therapists chose to do this and the way in which the questionnaire was completed varied from region to region.

The questionnaires were all distributed by the 28th of September 2001 with a request to return them by the 12th of October. However, many sites did not return the questionnaire until after this date.

Questionnaires were distributed to 20 sites across rural and remote WA and were returned from thirteen sites, a response rate of 65%. Three speech pathologists, seven physiotherapists, seven occupational therapists, one pharmacist and one Local Area Coordinator completed the questionnaire. In total 137 assistant positions were identified across the thirteen sites.

Focus groups with therapy assistants were conducted using a standardised set of questions and procedures<sup>3</sup>. These groups were held in Merredin, Kalgoorlie, Midwest and Katanning. A total of 26 therapy assistants attended. All participants were female and worked in a variety of settings including schools, nursing homes and hospitals.

As with any study there were limitations. The focus groups were limited to the four sites employing the greatest number of therapy assistants. Unavoidably, therapy assistants at other sites were not able to participate. Similarly, not all therapy assistant activity was captured by the survey. Questionnaires were sent to selected sites with the understanding that recipients would be aware of the project through the Working Party; however, this was not always the case. In several cases the questionnaire was sent to sites without representation on the Working Party and therefore the recipients

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<sup>3</sup> Focus groups were conducted according to procedures described in "The Community Tool Box". (Part B, C.3, S.6) Published by the University of Kansas online. <http://ctb.lsi.ukans.edu/>

were unaware of the project. Even for those sites with representatives on the Working Party there was confusion as to the best method of filling out the survey (individually or as a group). Originally the project officer had planned on telephoning each therapist completing the questionnaire, however, in many cases there was no telephone conversation due to difficulties in contacting the therapist.

## DEFINITION OF THERAPY ASSISTANTS

The use of paid therapy assistants has occurred for a number of reasons. The most significant factor for rural WA has been the lack of therapists available to meet expanded demands and interests, and hence the need for additional personnel (Littell 1998). Moreover, the move to evidence based practice has placed a demand upon the already limited number of therapists to spend a portion of their time in 'higher' diagnostic, managerial or research activities (Aron 1997).

Data from the survey garnered ten different titles for therapy assistants; 43% of assistants were called therapy assistants and 30% of assistants were called speech pathology assistants. Therapy assistants who were not discipline specific were also known as generic workers or rehabilitation assistants. Some of these workers fulfilled the combined roles of physiotherapy assistant, occupational therapy assistant and speech pathology assistant. In the survey, 76 therapy assistants were designated as specific while 59 were designated as generic. The majority of generic therapy assistants were shared between speech pathologists and occupational therapists. Of the specific therapy assistants 51 were associated with speech pathologists. Only nine therapy assistants were dedicated solely to physiotherapy programs. No podiatrists or dieticians completed the survey.

The decision whether to employ a specific or generic assistant hinges on the debate concerning task focused versus patient focused care (Langley 1996, Ellis and Connell 2001, Figueroa-Soto, Furmansky, Hughes, Quintas, Schifter 1999, Roberts 1994). The latter emphasises a holistic approach using transdisciplinary teams to address patient needs. The former emphasises discipline specific intervention to address identified physical problems. An organization must first determine its service delivery model (eg. family centred or primary health care), and then determine whether service delivery is task focused or patient focused. The role of the therapy assistant will be considerably different under these various approaches.

## CLASSIFICATION

The Commonwealth Government has classified the position of therapy assistants as Level 2 of the Australian Qualifications Framework (this in turn relates to Certificate II at the TAFE level). For a full explanation of the learning outcomes and level of competency expected for level II, see Appendix 4.

## WORK SETTINGS OF THERAPY ASSISTANTS

Based on the response to the survey, in rural WA the majority of therapy assistants worked in schools (74%) and hospitals (12%). Relatively small proportions of assistants worked in nursing homes, client's homes, and community health.

By the nature of their position, some therapy assistants worked within the framework of more than one organization. For example, even if they were school based (with line management by DoE), they may have been supervised by a DoH therapist but received DSC funding and supervision. Due to this crossover, many rural WA therapists expressed considerable concern about the need for co-ordination and collaboration between organizations (DoE, DoH, DSC) in relation to implementation of a client's therapy program.

## TRAINING OF THERAPY ASSISTANTS

In the focus groups therapy assistants expressed the belief that they had not received adequate training for their work, although School Aged Therapy Services (SATS) assistants with previous experience in schools felt more adequately prepared than others. Many participants were unaware of any formal training for therapy assistants and expressed a desire for formal qualifications. When participants were made aware of a variety of formal training, Colleges of Technical and Further Education (TAFE) courses were then seen as an attractive option. However, concern was expressed that recognition of prior learning must be taken into account so that those therapy assistants with TAFE qualifications would not be viewed as more qualified than those with experience in the field.

Very little evaluation of the training of assistants has taken place either in Australia or internationally. Standards relating to training of assistants vary around the world ranging from no training to minimal on-the-job training to two-year college trained assistants in the United States. In the United Kingdom (UK), as in Australia, training for assistants was developed within a National Vocational Qualifications framework. Australia's equivalent is the Australian Qualifications Framework. Certificate II and III at TAFE are applicable to therapy assistants. (See Appendix 5 for a detailed list of relevant training options for therapy assistants in Australia.)

In reality training on the job was the norm. For those in the focus groups initial training varied but all agreed that missing from the current on-the-job training was information



such as the rationale of each therapy program, background information on the client's disability, and a list of available resources. The desire was expressed that prior to beginning work, therapy assistants would have liked to know more about their role and expectations, background information on the clients, roles of each professional, behaviour management, age appropriate developmental skills and developmental levels.

The Chartered Society of Physiotherapy (2000b) map a process of training that can be applied to different levels of experience. According to the society, new staff should always be given a comprehensive induction and care must be taken to ensure that both the values of care provision and the specifics of the tasks assistants are asked to perform are covered. Training needs of experienced staff who have moved into a specialized service setting (eg. physiotherapy) must be carefully assessed and an appropriate induction implemented.

## ROLE OF THERAPY ASSISTANTS

Internationally, the role of assistants varies from organization to organization and region to region (Ellis and Connell 2001) and there is a lack of clarity about what specific tasks they carry out (Duckworth 1999). What is clear is that the role of the assistant has been changing over the years with a trend towards an increase in clinical responsibilities and a decrease in level of supervision (Duckworth 1999, Ellis, Connell and Ellis-Hill 1998). A similar trend was reported in rural WA by both therapists and assistants. Based on this survey of 137 rural therapy assistants, 68 therapy assistants were involved with purely clinical work (i.e. client programs) and 48 therapy assistants carried out clinical, clerical and resource preparation. The remainder carried various different ratios of loads between clinical and clerical work. Three assistants carried out clerical work only and two assistants carried out resource preparation only. No data was available on 11 assistants. Another way of looking at their work is that 69 therapy assistants carried out individual programs, while 52 therapy assistants carried out a combination of individual and group programs. Two therapy assistants assisted the therapist only, two assistants carried out population health work, and there was no data available on one therapy assistant. Only 6% of therapy assistants in rural WA worked full time while 41% worked less than five hours a week.

Although the vast majority of therapy assistants had not made their job a full time career, there was still resentment amongst some rural WA therapy assistants about a perceived lack of career structure and progress in their field coupled with a feeling of not being valued in their work. Resentment amongst therapy assistants arises when they see other health professionals being paid a higher wage to carry out what they perceived to be similar tasks to those they carry out (Ellis and Connell 2001). In addition, rural WA therapy assistants saw their role as having expanded over the years with no increase in pay or recognition. To add to the difficulty, the role of the therapy assistant was ambiguous and without firmly established boundaries. In the focus groups the concern was expressed that when therapists were not available therapy assistants found themselves taking on the duties and responsibilities of a therapist without the support or the skills to do so.

Despite these problems therapy assistants in the focus groups raised many positive aspects of their work. They enjoyed the opportunity to have a varied caseload and to work directly with people and many felt their work was creative and allowed them flexibility. Satisfaction came from seeing clients achieve their goals and from a sense that the work they were doing was making a difference to their clients. Therapists were also positive about the role of therapy assistants, stating that the use of a therapy assistant saved the therapist time thereby freeing the therapist to carry out other duties.

## STANDARDS

Standards are a means of measuring best practice in the workplace. An understanding of organizational policy and philosophy, clear guidelines and processes, training and supervision, optimum performance of equipment, high levels of communication and committed staff form best practice. Constant monitoring and evaluation of the work is also an indicator that best practice is taking place.

In rural and remote WA, practitioners may draw upon regulatory standards from the different professional bodies and Acts (e.g. the Physiotherapy Act 1987, the Disability Act 1993) and local standards promoted by the service provider e.g. the local community care organization (Human Resource standards, the Public Sector Code of Ethics). However, there was no one consistent and agreed upon code governing therapy assistants.

To further complicate matters the role of therapy assistant was ill defined. Tasks carried out by therapy assistants across rural WA varied widely with some therapy assistants believing that they were performing tasks more suitable to a therapist while other therapy assistants were restricted to duties that do not involve direct patient care. No formal standards were in place to assess a therapy assistant's qualifications, nor were there guidelines for job descriptions.

Also lacking were formal guidelines for the training, supervision, monitoring and evaluation of therapy assistants. Furthermore, the tasks associated with supervising a therapy assistant were generally overlooked in therapists' job descriptions and work plans. While therapists valued assistants for the time they saved the therapist, therapists often had neither the time nor the established procedures to train, supervise and delegate appropriately. In this case, therapy assistants either did not receive appropriate training and the therapist did not feel comfortable delegating, leaving the therapy assistant under-utilized, or alternately the therapist may have delegated tasks without appropriate training and supervision, leaving the therapy assistant feeling overwhelmed.

As a result of the information gathered in the Rural Western Australian Therapy Project, standards were created relating to the employment, training and supervision of therapy assistants (see Appendix 6). In these standards core values, activities, standards of practice, a generic JDF, and selection criteria were proposed for both



therapy assistants and supervising therapists. Typical discipline tasks that therapy assistants may have been expected to perform were outlined as well as specific processes to be employed by supervising therapists. Improved client outcomes were the guiding principle behind these proposals.

## SUPERVISION

The main factor in effective supervision is consistent communication between the therapist and their assistant. Survey responses indicated that while therapists intuitively knew that interpersonal skills (communication skills, guidance, feedback and leadership) were important in supervision, they were unsure of what other factors contributed to effective supervision. While rural therapists wanted assistants to work independently, they also wanted the assistants to know when and how to access supervision.

Meanwhile, rural therapy assistants wanted more supervision, greater approachability and practical demonstrations from their therapists. In the focus groups, all participants expressed the opinion that there was not enough supervision and that therapists were difficult to contact when problems arose. In addition, the wish was expressed that the frequency of supervision and the depth of detail given in supervision be congruent with the needs of the therapy assistant, for example, more supervision for a new assistant or one working with an especially complex client. As part of their supervision, all therapy assistants expressed the desire for therapists to use supervision time to demonstrate practical “hands on” work with clients. As one survey respondent stated, “As therapists, I think we forget that our clinical skills have been learnt and developed over time. They are not innate. We need to teach these skills to TAs although at times, we think they are obvious and therefore don't mention them. For example, recording is one area that needs to be explained/taught.”

In the United States, the level of supervision of physiotherapy assistants is currently under debate. Assistants may have an initial co-treatment with a physiotherapist and then a co-treatment every ten business days. Guidelines produced by the American Speech-Language-Hearing Association for the supervision of speech-language pathology and audiology assistants recommend direct on-site observations for the first ten hours of direct patient contact following training and in 10% of all clinical sessions thereafter. If an assistant's performance falls below a 90% match with the speech therapist over three consecutive sessions, the assistant must be retrained in that skill and supervised until 90% consistency is reached.

In the UK, a study showed that supervision levels changed significantly over time (Ellis, Connell, and Ellis-Hill 1998). The proportion of assistants spending more than half their time with no immediate supervision had doubled in five years. The average time spent unsupervised was 67% and this decrease in supervision has led to lower job satisfaction.

In rural WA, the pattern was also towards infrequent supervision. Only 21 therapy assistants were located on site with the therapists and the majority of assistants, 81 were supervised in person once a term. Four assistants were supervised once a week; five were supervised bi-monthly while eleven assistants were supervised monthly.

## DELEGATION

Delegation has emerged as a major issue both in the literature and from rural therapists and therapy assistants. The key issue in the therapy assistant debate is that while therapists wish to delegate tasks to therapy assistants they lack the time and/or the skills to train the assistants sufficiently to carry out these tasks (Littell 1998, Saunders 1996, 1997, 1998; Chartered Society of Physiotherapy 2000; Chartered Society of Physiotherapy 1989; Parry and Vass 1997; Figueroa-Soto, Furmansky, Hughes, Quintas, Schifter, 1999). An added difficulty is that successful delegation involves a clear understanding of the role of a therapy assistant, a challenge given the ambiguous nature of the therapy assistant's role.

It is thought that empowering therapists to delegate is the key to achieving the most cost-effective staffing ratios (Aron 1997). According to Aron "It is the ability of these therapists to delegate effectively and manage comprehensively that enables [assistants] to be used to the maximum efficiency" (p.52). However, the therapist must make the final decision about delegation. As Juel and Shade write in *The Role of the PTA: A Variety of Perspectives*, "If you don't feel comfortable delegating the task to an assistant, don't. It's your call, and it's your ethical duty to ensure that your patients are receiving the quality of care that they are demanding" (p.8). In order for delegation to work successfully a relationship built on trust must be developed between the therapist and the therapy assistant, only then can recognition of the assistant's ability take place (Saunders 1997). Delegation cannot be ad hoc; it must be managed by analysing task performance, investing in training and skill building in assistants, designing the work environment and communication network (Saunders 1997). Saunders (1997) describes a Constructive Delegation Model that may be of assistance to therapists in decision-making regarding delegation to therapy assistants.

An examination of the literature revealed that the ratio of therapists to assistants is an important factor in delegation. Too many therapists working with one therapy assistant resulted in ineffective delegation and the literature suggested that the ratio of two therapists to one assistant was ideal for the completion of a full clinical load for the assistant. In rural WA the most frequent ratio was two therapists to one therapy assistant. However, some therapists supervised 10 to 20 therapy assistants. There needs to be an investigation into the level and number of therapy assistants that can be effectively supervised by one therapist.

Overall, there is a dearth of research on the effectiveness and efficiency of the therapy assistant model resulting in an absence of evidence upon which to base delegation decisions. This lack of evidence has meant that decisions of delegation have been made on the basis of professional bodies' guidelines, personal opinions and resource constraints.

## MODELS OF SERVICE DELIVERY

The setting, rather than training, has been found to have the strongest effect on patterns of primary care provided in a rural environment (Duckworth 1999, Littell 1998, Moscovice 1978). It is the setting that determines staff levels, numbers and accessibility as well as their expertise and qualifications, and approach to service delivery<sup>4</sup>. These factors in turn determine communication and decision-making processes, as well as levels of responsibility allocated to different 'ranks' of staff.

The matrix below was created using variables that therapists identified as crucial. The matrix may be of help in determining the level of complexity in certain work settings and the corresponding support needs. The matrix was created with environmental determinants in mind and should be used with local adaptations. In general the higher the complexity of the situation the more training and support will be needed.

Variables	Low Complexity	Medium Complexity	High Complexity
Location of TA relative to supervising therapist	On-site	Same town	Distant community
Patient mix	Same ages; Similar conditions	Moderate mix of ages/conditions	Wide range of ages; Diverse conditions
Service delivery model	Repetitive task-focused	Moderate mix of tasks	Wide range of tasks
Number of employers	One employer	One to two employers	Multiple employers
Number of supervisors	One supervisor	One to two supervisors	Multiple supervisors
Age group of clients	One age group	Moderate mix of age groups	Wide range of ages
Therapist characteristics	Experienced	Some experience	New graduate
Therapy assistant characteristics	Experienced	Some experience	New employee
Frequency of face to face interaction	Regular interaction	Moderate levels of interaction	Infrequent interaction
Staff turnover of therapists	High retention rates	Moderate retention rates	Low retention rates

At a lower level of support, supervision and training is required when therapy assistants have continuous access to a supervising therapist working at the same site. In these cases there is only one employer, caseload management is collaborative, and clients are seen individually. Furthermore, the therapist and therapy assistant are both experienced, no technology is involved in service delivery, and client priority is easily

<sup>4</sup> Task focused versus patient focused, transdisciplinary teamwork or discipline specific care.

determined. In terms of outcomes there is a low throughput of clients and high amounts of co-ordination and communication occurring between different groups. There is already a high degree of understanding of roles and processes with standards and quality outcomes being met, and service delivery takes place consistently within established principles.

In this setting, a therapy assistant's needs may be adequately met by informal non-accredited on-the-job training. This is appropriate when therapists and therapy assistants have the experience and expertise to orient new staff and the systems are present to support the delivery of quality outcomes.

Moderate levels of support, supervision and training are required when a small number of therapy assistants are employed within schools and the supervising therapist is located in the same town. In this case therapy assistants are discipline specific with a focus on rehabilitation and the approach is collaborative. There may be a mixture of experienced and new workers and a mixture of caseload between paediatrics, adults and seniors.

A moderate level of complexity may need informal but accredited training for the therapy assistants and therapists. This may take the form of accredited courses such as Patient Care Assistants or Allied Health Assistant training.

High levels of support, supervision and training are required when therapists and therapy assistants are working in different locations with different client groups. In this case there are a number of different organizations involved in service delivery, a number of different potential supervisors and management staff and the use of technology is high. Different ethnic and cultural groups may be involved both as clients and as service delivery providers. Communication is difficult due to such factors as distance.

A high level of complexity of therapy assistant service delivery means that a more formal approach to support and training is required. This may mean that assistants need access to formal accredited courses such as those run by TAFE - the Certificate III in Community and Health Services<sup>5</sup>. In rural WA, the provision of therapy services is affected by many factors including: isolation and the long distances between clients; lack of resources; the increased rate of injury, death, disability and chronic disease in rural versus urban areas; an ageing population with dwindling numbers of people living in rural and remote WA; pockets of ethnic diversity that are little understood and not integrated into mainstream health care of WA; shortage of health care providers and the socioeconomic disparities between rural and urban communities (Australian Institute of Health and Welfare 1998). Due to the complexity of the environment in rural WA, the majority of a therapy assistant's work will fall into the "high level of complexity" category. Paradoxically, the complex environment also restricts the ability to provide the higher levels of support and training required.

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<sup>5</sup> Therapy Assistant or Personal Carer Course.

## CONCLUSIONS AND RECOMMENDATIONS

Large distances, sparse populations and a limited supply of allied health professionals make the goal of providing equitable health care in rural areas an ongoing challenge. Therapy assistants play an important role in rural and remote communities where clients might otherwise be denied the optimal services from therapists who are only able to visit infrequently. In order to further enhance the effectiveness of therapy assistants' contributions to rural and remote communities a number of recommendations have been identified as part of this report.

In general the following broad issues must be addressed.

### Standards of Practice

Out of this project a set of standards relating to the employment and supervision of therapy assistants has been developed. In order for these standards to be useful they must be widely recognized and adopted. ***Recommendation 1: Employing organizations should adopt a common framework and understanding of therapy assistants in order to enhance role clarification and improve service delivery.***

Agreed upon standards should be implemented by all organizations employing therapy assistants. Where there are a number of different agencies employing the same therapy assistant (eg. Department of Health and Department of Education) there should be a Memorandum of Understanding (MOU).

Therapy assistants expressed concern about the lack of understanding of their roles and the policies and procedures governing their employment. Role clarification is crucial in understanding the scope and the limitations of the position of therapy assistant. An adoption of a suitable JDF will be a first step in eliminating the wide variability in titles and duties for therapy assistants and lead to a consistency in minimum qualifications and award. A component of a JDF has been compiled from an amalgamation of JDFs currently in use. However, additional work needs to be undertaken to encompass both competencies and statement of duties relevant to discipline specific and integrated assistants working within either medical or community models.

***Recommendation 2: The practice standards should be reflected in a set of core JDFs that encompass the range of practices that are required of therapy assistants and therapists.***

Currently, orientation and training varies widely between different organizations, a practice that contributes to the confusion surrounding the role of the therapy assistant. On the job training must be structured and consistent across rural WA.

***Recommendation 3: A generic orientation package should be developed by those organizations utilizing therapy assistants.***

The orientation package needs to be adapted for individual needs and include guidelines and tools for the following: standards (minimum qualifications); training; orientation and work plan; supervision; delegation; performance and monitoring; and evaluation.

## Training

To improve the standards of on-the-job training a manual should be produced describing recommended content and learning materials drawn from the practice standards and case studies of successful training programs. There are several TAFE courses for therapy assistant training currently in existence; once training requirements are standardized these courses should be examined to ensure that their course content meets the standards developed.

***Recommendation 4: The core competencies addressed in the training of therapy assistants should be standardized. Existing and planned training should be aligned with these core competencies.***

The abilities to supervise effectively and delegate appropriately are learned skills and as such should be part of the university curriculum in the training of therapists.

***Recommendation 5: Undergraduate and postgraduate curriculum for therapists should incorporate content on the role of therapy assistants and the principles of supervision and delegation.***

## Implementation and Management Issues

Although therapists and therapy assistants agree about the importance of regular supportive supervision, therapists' workloads often do not allow sufficient time for supervision to occur. Although evidence is lacking, it is probable that therapy assistants will not necessarily reduce the number of therapist hours with a client but, because regular sessions are not possible, the clients should make better progress with the therapy assistant in addition to regular assessment by the therapist.

***Recommendation 6: Strategies to allow dedicated time for supervision of therapy assistants should be implemented. Furthermore, resources should be allocated to reinforce the importance of supervision and delegation as significant components of a supervising therapists' workload.***

The diversity within the rural and remote sector requires considerable scope to make appropriate adaptations in practice standards to suit the local environment, staff levels and community need. For example, while regular meetings to discuss client progress and up-date skills are essential, video-conferencing may be more appropriate in some settings and face-to-face meetings in others.

***Recommendation 7: Generic standards of practice, JDFs, training packages and orientation manuals should outline the principles of practice while allowing for local innovation and flexibility.***



Therapy assistants cited that they felt isolated from each other and welcomed opportunities to share ideas and information with other therapy assistants. This lack of support should be addressed by developing formal and informal networks. These networks may include, but are not limited to, a buddy system, newsletters, websites and videoconferences.

***Recommendation 8. Organizations employing therapy assistants should explore opportunities for them to network.***

Professional associations have an important role to play in the development of the standards of practice for therapists and therapy assistants. At present the guidelines on the use of therapy assistants that have been prepared by professional associations have focused on settings of relatively low complexity in which the therapist and therapy assistants are on the same site and therapy assistant performs a relatively small range of tasks.

***Recommendation 9: Professional associations should be encouraged to review their guidelines on therapy assistants to address the needs and realities of the rural and remote practice and the needs of those consumers who live in these areas.***

## **Monitoring and Evaluation**

At present there is no common registry of either therapy assistants or supervising therapists. This means no direct lines of communication to promote certain practices and no ability to track trends in the use of therapy assistants.

***Recommendation 10: A system should be implemented in order to monitor the locations and numbers of therapy assistants and their supervising therapists.***

Although it is crucial to have standards of minimum qualifications and training these alone are not enough to ensure best practice. Best practice can only be assured through the development of standardized indicators that measure the effectiveness and efficiency of an individual therapy assistant's performance.

***Recommendation 11: Common indicators shared by therapists and therapy assistants should be developed to monitor and evaluate: the progress of clients, the performance of individual therapy assistants and the effectiveness of the entire program.***

The literature review identified significant gaps in defining best practice for therapy assistants. This frustrates the quest to define the most effective model under which therapy assistants should practice.

***Recommendation 12: Further research should be undertaken to determine the effectiveness of therapy assistants in enhancing client outcomes in rural areas.***

## APPENDIX ONE:

# Goals and Objectives of Rural WA Therapy Assistant Project

### Component – Management

**Goal:** To gain inter-sectoral commitment and support for the therapy assistant project.

**Objective 1:** Obtain DSC, DOH, DOE and Professional Associations (Speech Pathology, Occupational Therapy, Physiotherapy, Dietetics, Podiatry) endorsement of an inter-sectoral project designed to develop a framework for best practice in the therapy assistant model in rural/remote WA

**Objective 2:** To develop a framework of principles for inter-sectoral partnerships.

**Objective 3:** To seek funding to meet the project objectives.

**Objective 4:** To establish a system for the completion of the project.

### Component – Standards

**Goal:** To provide therapists with guidelines to assist in decision-making in relation to therapy assistant models of service delivery.

**Objective 1:** To develop a set of standards (including but not limited to):

- Therapists' responsibilities
- Induction/orientation (broad and local issues)
- Supervision and monitoring
- Training
- Culturally appropriate therapy implementation
- Documentation/reporting
- Occupational Safety and Health
- Performance Management
- Professional Development

**Objective 2:** To develop guidelines for recruitment and orientation of therapy assistants.



## Component – Training

**Goal:** To make relevant training accessible to therapists and therapy assistants in rural WA

**Objective 1:** To develop a register of current, formal therapy assistant (accredited and non-accredited) training available nationally.

**Objective 2:** To develop a register of informal therapy assistant training packages.

**Objective 3:** To establish a central resource of informal therapy assistant training packages.

**Objective 4:** To ensure that therapy assistant training programs (formal and informal) meet the needs of rural practitioners.

**Objective 5:** To ensure that therapists have access to professional development related to supervision.

**Objective 6:** To ensure training providers and advisory bodies e.g. GHTAB, ITAB are responsive and aware of rural/remote therapy assistant training needs.

**Objective 7:** To review the need for the development of a “generic” training package.

## Component – Models

**Goal:** To provide a framework which supports a comprehensive approach to therapy assistant service delivery in rural WA

**Objective:** To develop a framework for therapy assistant models inclusive of principles, service delivery options including services to Aboriginal populations, use of technologies, and guidelines (caseload priorities, working with private providers).

## Component – Evaluation

**Goal:** To develop evaluative tools to demonstrate effectiveness and efficiency of therapy assistant models.

**Objective 1:** Undertake a literature search of therapy assistant model effectiveness and efficiency.

**Objective 2:** To identify research topics related to use of therapy assistants.

**Objective 3:** To develop a paper outlining options for evaluating therapy assistant models.

## APPENDIX TWO:

### Project Structure

Three groups collaborated on the project: An Advisory Group comprising members from DSC management, CUCRH management, Curtin University, DOH, DOE, Metropolitan Allied Health Council representative, and from the Professional Bodies – Occupational Therapy, Speech Pathology, Physiotherapy, Podiatry and Dietetics performed the following functions:

- Advise the Working Party
- Support the project
- Disseminate information within own organization
- Gain input from groups they represent
- Meet a set number of times over a finite time frame to complete functions

The Working Party had a representative from various regions across Western Australia – Great Southern – Central and Lower, Midwest, Eastern Wheatbelt, along with a representative from DSC and CUCRH. The functions of the Working Party were as follows:

- Determine project scope and outline a discrete time frame
- Outline required outcomes
- Determine time frame and work breakdown structure
- Outline roles of each member
- Approach Advisory Group members
- Develop terms of reference for Advisory Group
- Be responsible for incorporating the views of those in their catchment
- Be responsible for forming their own site based work group and keep them up to date with the project
- Be responsible for bringing ideas and information to the Working Party from site based groups
- Meet regularly initially, then depending on need.
- Limit of ten participants

Site Based Working Groups based at regional centers within hospitals or community health care were comprised of all participants from the videoconference who stated their interest in the follow up of the project. Other people who were not in the videoconference but who were interested could be involved in these groups. The function of the Site Based Working Groups was:

- To give input to the Working Party through their local representative
- Disseminate information to other staff in their area
- Ensure that the project directions are relevant for local requirements
- Comment on draft copies of documents and make suggestions for improvements
- Submit ideas to the Working Party
- Action Working Party recommendations as required
- Meeting frequency depends on need and the group involved

## APPENDIX THREE:

### Distributed Material

- WA Rural Therapy Assistants Project training documents
- Letter to General Manager
- Questionnaire

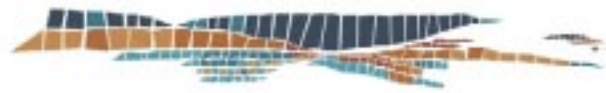
### **WA RURAL THERAPY ASSISTANT PROJECT TRAINING DOCUMENTS**

- Health Training Plan 2001 – Allied Health Assistance Summary (Australia)  
Allied Health Assistant – HLTAH1A and HLTAH2A
- List of Education programs leading to qualifications as a PTA ~ 400 institutions across USA
- WA Certificate III in Community Health and Services (Personal Carer, Therapy Assistant and Support Worker). TAFE's – Central TAFE in Perth, West Coast TAFE in Joondalup, Karratha TAFE – distance learning.
- Speech Pathology Self-Paced Learning Package for Therapy Assistants 1997  
Homes of Peace.
- Occupational Therapy Assistants – Competency Standards Draft. ASF level 3.
- Curtin Study Guide Training Course for OTA's.
- Allied Health Assistants Project Evaluation Report by RHSET.
- Personal Care Aide Training Handbook from Dongara 1996
- Health Training Package Scoping Report – Final Report 1998. From  
Community Services and Health Training Australia Limited.
- Industry Training Plan by Government Health Training Advisory Board (HDWA)  
2000
- Industry Training Plan – Addendum 2001 (important for Rural Allied Health)
- Director General's Allied Health Recruitment and Retention Taskforce 2000,  
Queensland Health Advisory Unit.

(as of 22nd October 2001)



Combined Universities Centre for Rural Health



## LETTER TO GENERAL MANAGER

20th September 2001

Dear X,

### ***RE: RURAL WA THERAPY ASSISTANT PROJECT***

This project was initiated after a discussion paper put out in 2000 generated considerable interest from those involved with Therapy Assistant models of service delivery in rural areas. Following this, a videoconference was held in March 2001 with over 70 participants who included therapy assistants, parents, Disability services Commission, Combined Universities Centre for Rural Health, Department of Health, Department of Education and metropolitan representatives from Therapy Focus, Rocky Bay Incorporated and Cerebral Palsy Association of Western Australia.

The project has progressed to the point where a part-time project officer has been employed to carry out a literature review and follow up on the status of rural therapy assistants. To this end, allied health personnel and other interested people in your health service will be contacted over the coming months in order to ascertain current models of service delivery and training of therapy assistants.

I look forward to speaking with staff in your health service in the near future. If you have any queries in relation to this process or would like further information on the progress of the project to date, please do not hesitate to contact me. You may also have information you would like to share in relation to this project.

Yours Sincerely,

Wendy Lowe  
Therapy Assistant Project Officer  
Combined Universities Centre for Rural Health  
P.O. Box 1411  
Albany, WA 6331  
Telephone: (08) 9892 2664  
Facsimile: (08) 9842 1095  
Email: [wendy.lowe@health.WA.gov.au](mailto:wendy.lowe@health.WA.gov.au)

## RURAL WA THERAPY ASSISTANT PROJECT QUESTIONNAIRE

The purpose of this questionnaire is to gain a state-wide picture of the number, distribution and roles of therapy assistants across different sectors of health, education and services for people with disabilities in rural Western Australia.

At this stage, information is being collected about anyone who assists with therapy program preparation and/or delivery, including therapy assistants, teachers' aides and assistants, patient care assistants, community health workers and nursing aides and assistants.

As you can imagine, there are a large number of variables involved in the employment of therapy assistants. I have tried to keep the questionnaire as simple as possible whilst also hoping not to lose valuable information. Your assistance in answering the questionnaire is much appreciated. I will be contacting you shortly by telephone to assist with any questions you may have about the questionnaire. It has taken about 15 – 20 minutes to complete the questionnaire in trial runs.

This questionnaire represents the first stage of information gathering about therapy assistants' from a therapist's point of view. At a later date, a second stage of information gathering will be focused on the therapy assistants themselves.

All information will be treated as confidential. The information you supply will be returned to you at a later date in the form of a report on the "**Rural WA Therapy Assistant Project**".

**PART 1:** Therapists' Name: \_\_\_\_\_

Position Title: \_\_\_\_\_

Region/Area: \_\_\_\_\_

Date: \_\_\_\_\_

Department: \_\_\_\_\_

Health    Education    DSC    Other (please specify) \_\_\_\_\_

**PART 2: HISTORY** – Please give a brief history of therapy assistant use in your region – When did TA's commence? Why? What, if any, changes have occurred in the nature of their work?

### **PART 3: TABLE OF THERAPY ASSISTANT VARIABLES**

The variables associated with employment of therapy assistants are listed below. Please read the explanation next to each variable and complete the table over the page by filling in the appropriate space with the explanatory variable **for each therapy assistant**.

One therapy assistant may work across a number of variables (locations, programs, disciplines, etc). **If this is the case, please allocate an approximate percentage for the time spent in each variable.**

- **Identification** – please allocate initials in order to distinguish between different people in your organisation – this information is confidential and is used solely for the purpose of preventing an overlap in information gathering.
- **Government organisation** – Department of Education, Department of Health, Disabilities Service Commission, other (please specify)?
- **Setting** – school, community centre, hospital, nursing home, client home, other?
- **Discipline** – occupational therapy, physiotherapy, speech pathology, teacher, other (please specify)? Or is the therapy assistant integrated – works across disciplines in a multi/transdisciplinary manner?
- **Supervision level** – face to face with therapist, on-site, limited, other? (e.g. monthly meetings face-to-face with phone calls in-between)
- **Specific or generic** – specific assignments for a particular discipline or generic tasks across a number of disciplines
- **Role** – clinical (hands-on treatment of patients/clients), clerical (administrative, support role, paperwork), resource preparation (for clinics, groups, etc), other? You can include a list of actual duties here if this helps to clarify the assistant's position. Please include an approximate percentage of time spent on each.
- **Program delivery** – individual (one-on-one hands-on, education, exercise, stretching programs), groups (exercise, diversional therapy, relaxation to a specified group of people), populations (educational, preventive health e.g. to Aboriginal population) (please state percentage of time in each if therapy assistants work across different program delivery variables)
- **Age group of clients** – early intervention, school-age, adults, seniors (community), extended care (nursing home), other? Percentage time spent on each?
- **Name/title of therapy assistant position** – therapy assistant, teacher's aide, patient care assistant, community health worker, rehabilitation assistant, nursing assistant, community rehabilitation worker, other (please specify)?
- **Hours of service** – part-time (number of hours per week) or full-time

**You may need to photocopy the table a number of times if you have a large number of therapy assistants within your organisation.**

**PART 4: STRUCTURAL SUPPORT**

Please draw a diagram showing the structure of the staff within your organisation, including therapy assistants and direct line management, seniority of staff, etc.

**PART 5: Advantages and disadvantages of service provision utilising positions of assistants**

Advantages of working with Therapy Assistants	Disadvantages associated with utilisation of Therapy Assistants

**PART 6: Issues associated with utilisation of Therapy Assistants** – could be local, regional, across different organisations, across different disciplines, linkages and networks, managerial – contractual, supervision, delegation.....

**PART 7: TRAINING**

1. What do you believe therapists need to know to be able to work with Therapy Assistants?

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2. What do you believe therapists need to be able to do to work with Therapy Assistants?

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3. What content do you believe is important to include in any Therapy Assistant training?

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4. What content do you believe is important to include in Therapy Assistant Professional Development/Continuing Education?

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5. What should a Therapy Assistant be able to do when they have completed their training?

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6. What should a Therapy Assistant know when they have completed their training?

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7. Please include a Therapy Assistant Job Description Form (JDF) with your reply if you have one.

**THANK YOU VERY MUCH FOR YOUR TIME AND PATIENCE**

**Please return to Wendy Lowe, Therapy Assistant Project Officer at:**

P.O.Box 1411  
Albany WA 6331  
Email: [wendy.lowe@health.WA.gov.au](mailto:wendy.lowe@health.WA.gov.au)  
Telephone: (08) 9892 2664

**TABLE OF THERAPY ASSISTANT VARIABLES – THERAPIST RESPONSE**

(REGION _____ )										
Identification	Government organisation	Setting	Discipline	Supervision	Specific or generic	Role	Program delivery	Age group	Name/title	Hours of service

## APPENDIX FOUR:

### Australian Qualifications Framework

The Australian Qualifications Framework provides a single, coherent framework for qualifications at the Certificate II and III (and other) levels. These levels are appropriate for a therapy assistant position of level 2 HSOA. For example, the characteristics of the learning outcomes (see Appendix 5B) for certificate II competency standards means that the:

Breadth, depth and complexity of knowledge and skills would prepare a person to perform in a range of varied activities or knowledge application where there is a clearly defined range of contexts in which the choice of actions required is usually clear and there is limited complexity in the range of options to be applied.

Performance of a prescribed range of functions involving known routines and procedures and some accountability for the quality of the outcomes.

Applications may include some complex or non-routine activities involving individual responsibility or autonomy and/or collaboration with others as part of a group or team.

(Australians Qualifications Framework Implementation Handbook 2002)

The last point is particularly important when considering the role of therapy assistants in schools, hospitals, nursing homes and when working with families and the client.

The characteristics of learning outcomes for certificate III competency standards means that the:

Breadth, depth and complexity of knowledge and competencies would cover selecting, adapting and transferring skills and knowledge to new environments and providing technical advice and some leadership in resolution of specific problems. This would be applied across a range of roles in a variety of contexts with some complexity in the extent and choice of options available.

Performance of a defined range of skilled operations, usually within a range of broader related activities involving known routines, methods and procedures where some discretion and judgement is required in the selection of equipment, services or contingency measures and within known time constraints.

Applications may involve some responsibility for others. Participation in teams including group or team co-ordination may be involved.

(Australians Qualifications Framework Implementation Handbook 2002).

## LEARNING OUTCOMES FOR CERTIFICATE II AND III

*(Australian Qualifications Framework Implementation Handbook 2002)*

Distinguishing Features of Learning Outcomes

### Certificate II

**Do the competencies enable an individual with this qualification to:**

Demonstrate basic *operational knowledge* in a moderate range of areas

Apply a *defined range of skills*

Apply known solutions to a limited range of predictable problems

Perform a range of tasks where choice *between a limited range of options* is required

Assess and record information from varied sources

Take *limited responsibility* for own outputs in work and learning

### Certificate III

**Do the competencies enable an individual with this qualification to:**

Demonstrate some *relevant theoretical knowledge*

Apply a range of *well-developed skills*

Apply known solutions to a variety of *predictable problems*

Perform processes that require a *range of well developed skills where some discretion and judgment is required*

Interpret available information, using *discretion and judgment*

Take *responsibility for own outputs* in work and learning

Take limited responsibility for the output of others

## APPENDIX FIVE:

### Training Options for Therapy Assistants

A search was carried out over the Internet on various TAFE (Technical And Further Education) sites and links in order to find out the availability of Therapy Assistant training.

In Western Australia, the results are as follows:

TAFE College	Web address	Courses available
Central Metropolitan College	<a href="http://www.central.WAedu.au">www.central.WAedu.au</a>	3452 Certificate III in Community and Health Services (Therapy Assistant) 3442 Cert III in Community & Health Services (Personal Carer)
Central West College of TAFE	<a href="http://www.centralwest.WAedu.au">www.centralwest.WAedu.au</a>	No Therapy Assistant course
Challenger College of TAFE	<a href="http://www.challengertafe.WAedu.au">www.challengertafe.WAedu.au</a>	Provides links and information on courses available at all TAFE's in WA
CY O'Connor College (Northam, rr, Merredin, Moora, Narrogin)	<a href="http://www.cyoc.WAedu.au">www.cyoc.WAedu.au</a>	No Therapy Assistant course Advertises 7004 Certificate III in Occupational Therapy Assistants but there are no course plans available
Eastern Pilbara College of TAFE	<a href="http://www.hedland.edu.au">www.hedland.edu.au</a>	No Therapy Assistant courses
Great Southern Regional College of TAFE (Albany Campus)	<a href="http://www.gsrc.WAedu.au/courses/albany">www.gsrc.WAedu.au/courses/albany</a>	Certificate IV in Community Services (Disability Work)
West Coast College (Joondalup and Carine Campus)	<a href="http://www.westcoast.WAedu.au/">www.westcoast.WAedu.au/</a>	3452 Certificate III in Community and Health Services (Therapy Assistant) – Carine Campus
West Pilbara College (Karratha)	<a href="http://www.college.karratha.WAedu.au">www.college.karratha.WAedu.au</a>	Certificate IV in Education (Assistant – Special Needs) (7022) Certificate III and IV in Community Services (Disability Work)

## COURSE DETAILS

### 3452 Certificate III in Community and Health Services (Therapy Assistant)

Total Hours 445

Modules	Title	Hours
50567	CHS1 The Work Environment	15
50568	CHS2 Workplace Safety	30
50569	CHS3 Workplace Values	15
50570	CHS4 Workplace Relations	35
50571	CHS5 First Aid and Workplace Accidents	20
50572	CHS6 Technology	30
50578	CHS11 Loss and Grief	10
50579	CHS12 Normal Growth and Development	30
50580	CHS13 Working with an Individual who has a Disability	20
50581	CHS14 Working with an Individual who is Aging	20
50585	CHS17 Meaningful Activity	10
50586	CHS18 Grieving and Dying	15
50587	CHS19 Expressing Sensuality and Sexuality	5
50597	CHS21 Core Therapeutic Interventions	20
50598	CHS22 Assisting with Physical Therapies	20
50599	CHS23 Assisting with Occupational Therapies	20
50519	CHS24 Assisting with Speech Therapies	20
50520	CHS25 Assisting with Diversional Therapies	20
3452 – Electives		
CHSWP3	Work placement in Aged Care Settings	25
CHSWP4	Work placement in Disability Services Settings	25
CHSWP5	Work placement in Physiotherapy	20
CHSWP6	Work placement in Occupational Therapy	20
CHSWP7	Work placement in Speech Pathology	20
CHSWP8	Work placement in Diversional Therapy	20

Traineeship is the off-the-job component, learners are encouraged to undertake the workplace module which is not covered in the workplace.

Comparisons with other course content may be useful. For example:

**3442 Certificate III in Community and Health Services (Personal Carer)**

Modules	Title	Hours
50567	CHS1 The Work Environment	15
50568	CHS2 Workplace Safety	30
50569	CHS3 Workplace Values	15
50570	CHS4 Workplace Relations	35
50571	CHS5 First Aid and Workplace Accidents	20
50572	CHS6 Technology	30
50578	CHS11 Loss and Grief	10
50579	CHS12 Normal Growth and Development	30
50580	CHS13 Working with an Individual who has a Disability	20
50581	CHS14 Working with and Individual who is Aging	20
50585	CHS17 Meaningful Activity	10
50586	CHS18 Grieving and Dying	15
50587	CHS19 Expressing Sensuality and Sexuality	5
50583	Hygiene and Comfort	10
50584	Mobility	10
50588	Medication	40
3442 – Elective Group		
50591	CHSWP3 Work placement in Aged Care Settings	25
50592	CHSWP4 Work placement in Disability Services Settings	25
50597	CHS21 Core Therapeutic Interventions	20
50599	CHS23 Assisting with Occupational Therapies	20
50575	Housekeeping	20
50576	Food Service	20
50577	Handling Money	5

## 6680 – Certificate III in Medical Technicians and Assistants

Total hours 384

Module	Title	Hours
31282	Using a graphical user interface	20
48038	Senior First Aid	20
55001	Work Placement	50
67702	Anatomy and Physiology (Medical Technicians and Assts)	30
67703	Work Team Communications for Medical Technicians and Assistants	30
67704	Introductory Measurement and Calculations for Medical Technicians and Assistants	30
67705	Communications for Medical Technicians and Assistants	30
67706	Occupational Safety and Health	30
67707	Manual Handling	30
67708	Infection Control	30
67709	Workplace Ethics	30
67710	Health System Overview	20
67711	Train the Trainer	24
Electives		
67712	Basic Science for Medical Technicians and Assistants	50
67700	Disinfection Techniques	51
67701	Sterilization Techniques	51
48851	Fundamentals of Anatomy and Physiology	51

### Professional Development for Teacher Assistants

A One Year Program involving weekend classes and the completion of written and practical assignment work. Students attend approximately one two-day weekend session every month for 12 months to complete the program.

The program is made up of fourteen core units and a minor specialization consisting of two units in the area of either Early Childhood Education or Children With Special Needs. Students who complete the program will be awarded the University Diploma for Teacher Assistants, and will be awarded credit towards a Bachelor of Education and Edith Cowan University.

Further information from:

The Administrative Officer, Teacher Assistant Program, Edith Cowan University,  
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## 14 Core Units

- Study Skills and the Teacher Assistant
- Understanding Self and Communicating with Others
- Making teaching Aids
- Understanding Children's Development
- Introduction to the WA Curriculum Framework
- Supporting Student Learning Mathematics I
- Supporting Student Learning Mathematics II
- Supporting Student Learning in English I
- Supporting Student Learning in English II
- Supporting Student Learning in The Arts I
- Supporting Student Learning in The Arts II
- Managing Individual and Small Group Learning
- Professional and Career Development Issues for Teacher Assistants
- Senior First Aid Certificate (External to the University)

## Electives

Students also study one pair of electives from the two minor specializations outlined below:

- Working in Early Childhood Settings I
- Working in Early Childhood Settings II

Or

- Working with the Special Needs Child I
- Working with the Special Needs Child II

Other courses and information available or advertised included:

### **Certificate III in Health (Allied Health Assistant) (7772)**

State Code V12307AFB

Accreditation Authority (0030) Victoria Office of Employment, Training and Tertiary Education

Accreditation Period 01/01/1997 to 31/12/2002

Accreditation State: Victoria

Course Contact: (3938) Mayfield Education Centre Inc

ABN 26 540 881 341

Copyright Category Undefined

ANZSIC: 086 Health Services

There are no units of competency related to this course

Nominal hours: 0

Day to Day contact: Judith Merrick, Education and Business Development Manager

Telephone: (03) 9882 7644

mec@mayfield.edu.au

web <http://www.mayfield.edu.au>

### **National Training Information Service (NTIS) Website**

[www.ntis.gov.au/](http://www.ntis.gov.au/)

Australian National Training Authority

NTIS – a database on vocational education and training in Australia. It contains detailed information on courses, qualifications, training packages, competency standards and training organizations. However, no matching record was found for the Therapy Assistant course (3452 Certificate III in Community and Health Services (Therapy Assistant)) across Australia, not even in Western Australia where it clearly exists.

## **APPENDIX SIX:**

### **Standards Relating to the Employment and Supervision of Therapy Assistants**

- Principles of Service Delivery
- Therapist activities in relation to therapy assistants
- Therapy assistant activities
- Therapist standards in relation to therapy assistants
- Therapy Assistant standards
- Therapy Assistant Job Description Form
- Therapy assistant orientation and induction checklist/summary

## PRINCIPLES OF SERVICE DELIVERY

### PRINCIPLES

Equity – Services are provided so that each consumer seeking a service has access on the basis of need and available resources.

Access – All people must have equal and open access to information, learning and health regardless of their age, gender, distance from services, race, family status, ability, pregnancy, political or religious conviction.

Empowerment – Each person must have the opportunity to participate in the services they receive.

Respect and value - Each person must have the opportunity to develop and maintain skills and to participate in activities that enable them to achieve valued roles in the community.

Rights of the individual – Each consumer's right to privacy, dignity and confidentiality must be recognized and respected.

### ORGANIZATIONAL EXPECTATIONS

Actively participate in risk management and continuous improvement activities and apply these principles to all duties performed.

Contribute to the delivery of a customer-focused service.

Maintain an awareness of, and take ownership for Occupational Safety and Health (OSH) and Equal Employment Opportunity (EEO) issues relating to the department and yourself.

Maintain knowledge of the needs of people with disabilities when accessing health services in your designated area.

Comply with public sector standards, codes of ethics and applicable codes of conduct.

Act with integrity in the performance of official duties and be scrupulous in the use of official information, equipment and facilities.

Exercise proper courtesy, consideration and sensitivity in your dealings with members of the public and fellow employees.

## **THERAPIST ACTIVITIES IN RELATION TO THERAPY ASSISTANTS**

These activities and standards have been developed in consultation with therapists and therapy assistants across rural Western Australia with the understanding that:

- All activities are to be carried out under the direction of a suitably qualified and experienced therapist.
- Under no circumstances is the therapy assistant to carry out the activities without the direction of a therapist.
- The activities are intended as a list of best practice options, from which the therapists can choose the most suitable according to the client, level of experience of therapy assistant and therapist, setting and supervision availability.

### **GOAL:**

To improve clients' outcomes through the utilization of therapy assistants in individual or group settings.

To promote health in client based and population based settings.

### **OBJECTIVES:**

To enable therapy assistants to carry out treatment programs to a high standard:

- Effective improvement in client outcomes
- Smooth running of programs – positive inter-agency collaboration
- Safe, ethical, responsible, confidential

### **MEASUREMENT:**

Relevant Outcome Measures

### **TASKS AND TECHNIQUES:**

- Occupational Therapy, Speech Pathology, Physiotherapy, Podiatry techniques
- Manual Handling
- Train the Trainer
- First Aid

### **THEORY:**

- Occupational Therapy, Speech pathology, Physiotherapy, Podiatry Theory
- As for Therapy Assistants
- Learning Theory
- Relevant outcome measures

- Supervisory/Management – Australian Standards Framework (ASF), induction/orientation, performance management, lines of responsibility, policies and procedures, pay, accountability, quality assurance
- Models of service delivery – primary health, disability, education, medical model
- Legal issues – duty of care, ethics, professional responsibility

### **ACTIVITIES:**

- Provide
- Supervise
- Develop
- Communicate
- Record
- Report
- Train/Teach/Learn
- Support
- Delegate
- Understand
- Recruit
- Resource – persons, therapy, vehicles, administration

### **SKILLS:**

- Training
- Supporting
- Developing
- Demonstrating
- Computer

## **THERAPY ASSISTANT ACTIVITIES**

These activities and standards have been developed in consultation with therapists and therapy assistants across rural Western Australia with the understanding that:

- All activities are to be carried out under the direction of a suitably qualified and experienced therapist
- Under no circumstances is the therapy assistant to carry out the activities without the direction of a therapist
- The activities are intended as a list of best practice options, from which the therapists can choose the most suitable according to the client, level of experience of therapy assistant and therapist, setting and supervision availability.

### **GOAL:**

To improve client's outcomes

To assist therapist with therapy activities

## KEY RESPONSIBILITY:

- To assist in client's treatment programs under the supervision of the relevant allied health professional
- To be involved with preventive health programs as directed by the therapist
- To carry out work in accordance with well defined practices and procedures and to participate in professional development as directed by therapist
- Other departmental duties as directed by therapist e.g. booking appointments, administrative

## MEASUREMENT:

Relevant Outcome Measures

Performance Management

## TASKS AND TECHNIQUES:

- *Occupational Therapy* – activities of daily living training and re-training, hand and upper limb rehabilitation including range of movement, strengthening and splinting, mobility and transfers, Therapy programs including fine motor, sensori-motor and handwriting, and assist with home visiting as directed by therapist
- *Speech Pathology* – resource development, practical simple articulation activities, phonological activities, assist in minimal dysfunction groups (activities), language – narrative, comprehension, semantics, use signing (Makaton), metalinguistic practice – rhyming and final sounds etc, assist in basic screening, as directed in whole class groups, feeding (non-acute) as directed by therapist
- *Physiotherapy* – chest treatments, Range Of Movement exercises, stretching, strengthening, balance work, rehabilitation techniques, walking, splinting, transfers, mobility as directed by therapist
- *Podiatry*
- Manual Handling
- Equipment maintenance
- Cardio-Pulmonary Resuscitation/emergency procedures
- First Aid

## THEORY:

- Child Development sequences
- Ageing process
- Reflexes
- Learning Theories
- Medical Terminology
- Disability Theory – Social Role Valorisation
- Behaviour Management
- Task analysis and activity matching
- Goal Attainment Scale/relevant outcome measures

- Understanding Allied Health Role
- Working in a team
- Conflict resolution
- Role identity and role boundaries
- Self-care
- Models of Service Delivery - Primary Health, Medical model, Disability model (community based, family centred, Local Area Coordinator strategies), education model (curriculum framework, developmental model, visiting teachers), Transdisciplinary, Inter- and Intra-disciplinary, and Multi-disciplinary models
- Ethics and legal issues
- Plaster casting/serial casting – lower and upper limb
- Equipment – maintenance and repair procedure
- Technology – communication, computers, wheelchair operation, etc
- Positioning clients within specialized equipment

### ACTIVITIES:

- Plan
- Prepare
- Organise
- Implement/conduct
- Communicate
- Record
- Report
- Attend
- Follow instructions
- Maintain
- Observe and report
- Tidy/clean

### SKILLS:

- Patient/client handling
- Carry out manual tasks
- Computer
- Read client notes and implement program (follow instructions)
- Organize time/prioritize
- Communicate effectively
- Match activities to goals
- Carry out training of client/patient
- Networking
- Liaison

**Please note:** The above goals, key responsibilities, theories, skills and activities may change according to therapist and setting.



## THERAPIST STANDARDS IN RELATION TO THERAPY ASSISTANTS

These activities and standards have been developed in consultation with therapists and therapy assistants across rural Western Australia with the understanding that:

- All activities are to be carried out under the direction of a suitably qualified and experienced therapist
  - Under no circumstances is the therapy assistant to carry out the activities without the direction of a therapist
  - The activities are intended as a list of best practice options, from which the therapists can choose the most suitable according to the client, level of experience of therapy assistant and therapist, setting and supervision availability.
  - The supervision is a process of identifying needs and ensuring these are met either directly or as part of the process facilitated by the therapist.
1. Facilitate and/or provide up-to-date competency based practical training in all techniques required of therapy assistant.
  2. Allocate available resources – time, space, computer, clients to complete theory based training. Ensuring within available resources, TA's have access to Competency Based Training to carry out the work.
  3. Supervise therapy – EMERGING ISSUE – TO BE DECIDED.
  4. Provide a co-visit with the therapy assistant to client location as part of the initial orientation and induction phase of employment.
  5. Telephone, videoconferencing and/or email supervision may occur in between face-to-face supervision as often as necessary.
  6. Provide a clear process for conflict resolution that is without prejudice.
  7. Recruitment of therapy assistants following Human Resource guidelines
  8. Ensure provision of Orientation and Induction occurs.
  9. Provision of performance management process with therapy assistant as appropriate.

Supervision sessions to include:

- Review of client progress
- Discussion of any difficulties arising
- Collaborative problem solving taking into account client, family, setting, other stakeholders (DSC, DOE, DOH.....) therapy assistant ability, availability of resources, equipment, funding and any other pertinent factors
- Development of therapy assistant skills as necessary
- Evaluation of therapy assistant skills
- Demonstration/teaching of necessary therapy techniques on relevant client
- Communication of administrative, managerial, and client related issues
- Record of points of discussion, outcomes, and actions to be completed by whom and by when
- Provision of resources – materials, funds, vehicles, administrative forms, uniforms as appropriate
- Report any other business arising

- Support therapy assistant to carry out treatment techniques within setting to colleagues, key stakeholders (family, school, DSC, etc)
- Maintain Duty of Care, Confidentiality
- Performance Management as appropriate

## THErapy ASSISTANT STANDARDS

These activities and standards have been developed in consultation with therapists and therapy assistants across rural Western Australia with the understanding that:

- All activities are to be carried out under the direction of a suitably qualified and experienced therapist
  - Under no circumstances is the therapy assistant to carry out the activities without the direction of a therapist
  - The activities are intended as a list of best practice options, from which the therapists can choose the most suitable according to the client, level of experience of therapy assistant and therapist, setting and supervision availability.
1. To participate in and reach satisfactory level of performance within training provided (OT, SP, PT Techniques and theory).
  2. Participate in appropriate orientation and induction of workplaces (DOH, DOE, DSC).
  3. Carry out treatment techniques with allocated clients according to specified treatment plan and as directed by therapist.
  4. Record outcomes of treatment techniques and discuss results of appropriate outcome measures with referring therapist.
  5. Utilise and maintain specialized equipment and technology as per instructions.
  6. Work with other members and key stakeholders within team – family, school, DSC, health environment.
  7. Maintain ethical and legal boundaries with clients, families and co-workers.
  8. Carry out work according to latest best practice guidelines and as directed by therapist.
  9. Communicate effectively with key stakeholders.
  10. Seek assistance when any uncertainty exists in relation to client programs.
  11. Follow description of work.

## THErapy ASSISTANT JOB DESCRIPTION FORM

These activities and standards have been developed in consultation with therapists and therapy assistants across rural Western Australia and are not intended to be a comprehensive list. They have been developed with the understanding that:

- All activities are to be carried out under the direction of a suitably qualified and experienced therapist
- Under no circumstances is the therapy assistant to carry out the activities without the direction of a therapist

- The activities are intended as a list of best practice options, from which the therapists can choose the most suitable according to the client, level of experience of therapy assistant and therapist, setting/organisation and supervision availability.
- With the development and focus on early intervention, age determinants of health and the utilization of prevention and promotion practices, there is an opportunity for the role and activities of a therapy assistant to be broadened beyond what is listed in this JDF.

## **GENERIC/CORE COMPETENCIES**

### **COMPETENCIES RELATING TO EMPOWERING CLIENTS**

Support the rights of clients and their families  
Empower clients and their families

### **COMPETENCIES RELATING TO COMMUNICATION AND RELATIONSHIP**

- Communicate and relate effectively.
- Relate and communicate with people having special communication requirements and their families.
- Relate and communicate effectively and co-operatively with members of team to enhance outcomes for clients.
- Liaise/network effectively within the organization and with the wider community.
- Represent the organization within the community as far as the therapy assistant is an employee of that organization.

### **COMPETENCIES RELATING TO ORGANISATIONAL AND MANAGEMENT**

- Manage self
- Demonstrate effective time management skills
- Participate in performance management and professional development as directed by therapist
- Participate in quality assurance, maintain statistics and accountability for all activities as directed

## COMPETENCIES RELATING TO LEGAL ISSUES

- Demonstrate knowledge of responsibilities under Duty of Care
- Demonstrate knowledge of responsibilities and rights under Occupational Safety and Health
- Demonstrate knowledge of rights and responsibilities under Equal Employment Opportunities, and the Disability Services Act
- Adhere to Public Sector Code of Ethics and Code of Conduct

## THERAPY COMPETENCIES

### COMPETENCIES RELATING TO TECHNICAL WORK

- Assist in client's treatment programs under the supervision of the relevant allied health professional (following written and verbal instructions).
- Make use of and maintain relevant equipment to carry out client treatment program.
- Prepare resources to carry out client treatment program and group sessions.
- Utilize computer and other technological support to carry out and evaluate work.
- Participate in training to assist in carrying out client treatment programs.

## SELECTION CRITERIA

The selection criteria are intended as a list of choices, from which the therapists can choose the most suitable. Organisation specific criteria may need to be added.

### ESSENTIAL

#### Demonstrated:

1. Well-developed interpersonal skills.
2. Ability to follow written and verbal instructions with and without direct supervision.
3. Effective time management skills.
4. Ability to work with people with a wide range of personal values/culture.
5. Ability and willingness to work as part of a team.
6. Willingness to learn new skills/commitment to ongoing training and professional development.
7. Demonstrate a positive attitude to people with disabilities and their participation in the community, and to people with a diverse cultural background

**Qualifications:**

Current Drivers Licence, A or E class  
Year 10 certificate or equivalent

**DESIRABLE**

**Demonstrated:**

1. Previous experience working with people with disabilities, the elderly and/or children with special needs.
2. Demonstrate commitment to working with people from different cultural backgrounds.
3. Demonstrate an awareness of a family centred approach to service provision
4. Demonstrate an understanding of the confidentiality and privacy of clients and ethical behaviour of clients
5. Computer skills and/or willingness to use computer.
6. Current knowledge of EEO principles and practices and Occupational Safety and Health.

**Qualifications:**

Current First Aid Certificate

**STATEMENT OF KEY PRODUCTS AND DUTIES**

Whilst acting on procedural instructions and guidelines in accordance with DOH, DOE and DSC requirements.

1. Carries out health and therapy treatments and adheres to safety procedures to meet individual client needs as directed by therapist.
2. Participates in preventive health programs as directed by therapist
3. Participates in skill development activities to meet individual client needs.
4. Communicates with clients in a manner consistent to meet individual client needs.
5. Refers enquiries from clients and families to Line Manager/Therapist to meet individual client needs.
6. Maintains a safe and clean environment to meet client/staff needs.
7. Carries out client/group routines that promote a safe, secure and predictable environment to meet individual client needs.
8. Provides written and verbal information to meet individual client needs.
9. Carries out therapy programs and reports changes in client behaviour to meet individual client needs as directed by therapist.
10. Communicates, participates and co-operates with team members to promote team outcomes which enhance service delivery.
11. Actively participates in the acquisition and on-going improvement of work skills to enable a high standard of service delivery.
12. Attends and contributes to client case conferences as directed by therapist.

## **Details of duties required for each allied health profession (performed only under specific instruction of each therapist)**

### ***Physiotherapist:***

- Applies and removes plaster casts under the direction of Physiotherapist or Doctor
- Assists with patients with Physiotherapy programs as directed by the Physiotherapist
- Assist Physiotherapist and other team members with transferring and mobilizing patients
- Assists Physiotherapist with treatment regimes of patients (established exercises, range of motion exercises, functional programs, stretches)
- Participates in day care activities for elderly
- Participates in community based activity groups with Physiotherapist
- Carries out lung function tests as directed by Doctor or Physiotherapist
- Assists with basic cardio-thoracic physiotherapy procedures such as postural drainage, breathing exercises and ambulation
- Assist Physiotherapist with provision of mobility aids

### ***Occupational Therapist:***

- Participate in groups for children, run during or after school including-sensori-motor, pre-writing and handwriting, play and social skills development, fine motor.
- Participate in groups for frail elderly or psycho-geriatric clients including social skills, reality based.
- Manufacture of soft hand splints-such as neoprene thumb splints or wrist gauntlets.
- Carry out activity of daily living training and retraining programs in the community.
- Power wheel chair training, mobility and general transfers.
- Assist in running client and parent training groups.
- Running play development programs with parents in the home.

### ***Speech Pathologist:***

- Resource development
- Therapy programs include: phonological; language and narrative; comprehension; semantics, as directed by Speech Pathologist.
- Implements AAC(Alternative and Augmentative Communication) programs directed by Speech Pathologist.
- Assist in basic screening.
- Feeding(non-acute) as directed by therapist.
- Assist in running client and parent training groups.
- Participate in community based activity groups as directed by Speech Pathologist.

**General Clerical Duties:**

- Re-orders and maintains store and stationery
- Maintains equipment on loan
- Sends out letters for overdue equipment
- Photocopies and collates handouts as necessary
- Assists with statistics at the end of the month
- Answers telephone, makes appointments as necessary
- Participates in changes to information technology

**General Duties:**

- Ensures appropriate compliance with OS & H pertaining to the responsibilities of this position
- To participate and contribute to quality activities and a customer focus service
- Prepares and tidies treatment areas
- Cleans electrical equipment and accessories
- Cleans linen stock
- Carries out other duties as requested by therapist
- Other duties as directed by the therapist

## **THERAPY ASSISTANT ORIENTATION AND INDUCTION CHECKLIST/SUMMARY**

### **ROLE**

- Goals, Mission Statement and Values of Organisation and how TA fits into that
- Safety within the organisation
- TA Role and expectations
- Roles of each professional (including JDF). Timetable of their visits to school and supervision sessions
- Client information – background
- Setting background – school, nursing home, hospital, community centre, client home
- School Routine/Hospital Routine/Nursing Home Routine – lunchtime, etc
- Policy on discipline/Behaviour Management (Schools especially)
- Policy on Hazard management including Emergency Procedures
- Policy on Occupational Safety and Health including Manual Handling
- List of Resources – books, videos, TV, consumables, people
- Line management – school, nursing home, hospital
- Human Resource information – pay details, sick leave, annual leave, compassionate leave, reimbursement for petrol, forms to fill in, etc
- Timetable for TA – client appointment times, preparation times, suggestions of activities for unexpected free time if client absent
- Standards – Core Competencies, Training, Supervision, Evaluation.
- Equipment – maintenance and usage, repair forms and procedure
- Technology in use
- Co-visit with therapist to client's home or school or other place of treatment

## **THEORY**

- Age appropriate developmental skills and developmental levels.
- How to deal with parents and staff members
- Behaviour management
- Conflict resolution
- Information on different types of disability/medical condition/paediatric theory
- Core competencies
- Right to privacy of clients, rights of TA's privacy
- Self-care in stressful situations

## **REQUIREMENTS**

- Senior First Aid/CPR
- Current Drivers' Licence – A or E class

## **EXTERNAL AGENCIES**

- List of TA network – naming of a 'Buddy'
- List of organisations/contact people that Therapy Assistant will be dealing with



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