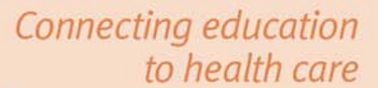
Connecting education
to health care



Allied Health Clinical Education
and Training Unit

Occupational Therapy Clinical Capability Framework

FREQUENTLY ASKED QUESTIONS

1. *Why was this done?*

The completion of an integrated and coordinated framework for clinical education and training for Occupational Therapy in Queensland Health was identified as a key desired outcome by the:

- Occupational Therapy Clinical Education Workload Management Initiative, as part of the Occupational Therapy Clinical Education Program, and the
- Allied Health Clinical Education and Training Unit, which stemmed from the Ministerial Taskforce on Clinical Education and Training.

2. *Why a capability framework?*

There were many contextual factors which impacted on the development of a clinical capabilities framework for clinical education and training for Queensland Health OTs which are depicted in the following diagram:

Contextual Factors affecting the Development of the Occupational Therapy Program Clinical Capability Framework

OT Agreement KPIs
- Integrated and coordinated framework for clinical education and training new grads / students across practice domains
- Improve access to and quality of clinical education
- Improve supervisor workload management

AHCETU requirements:
- Develop a Clinical Education and training framework for QH AH clinicians at all stages and areas of practice
- provide for safe, sustainable, high quality practice

Development of a Clinical Capability Framework

Literature Review
- challenged the efficacy of using a competency based framework for professional development
- concept of clinical capability emerged

State-wide Service Mapping Findings
- Highlighted the diverse nature of OT practice within Queensland Health in terms of caseload, practice setting, therapist experience and geographical location

Shift (back) towards Occupational Paradigm
Traditionally Occupational Therapy services in health have been delivered in biopsychosocial models of practice. This is changing!

The Occupational Therapy Agreement Key Performance Indicators:
Prior to the establishment of the OTCEP a steering committee consisting of state-wide Directors of Occupational Therapy and other relevant stakeholders developed the Key Performance Indicators used as objectives for the program. A total of 9 KPIs were established and 4 of these related specifically to quality of education, the development of an integrated training framework and associated resource development.
These include:

- Improve workload management for supervisors of pre-entry students and new graduates
- Improve access to and quality of pre-entry and graduate clinical education across QH districts
- Provide an integrated and coordinated framework for the delivery of clinical education for pre-entry students and new graduates across the three practice domains

These KPIs influenced the program towards adopting a professional development approach to providing clinical education and training, however funding (as part of the HP agreement) was limited to provide support *only* to pre-entry students and new graduates.

Allied Health Clinical Education and Training Unit (AHCETU) requirements:
Concurrently, the newly formed AHCETU developed an Allied Health Clinical Education and Training (ACCET) Framework which provide additional funding to expand the development of a Clinical Capability Framework to include all occupational therapy clinicians, regardless of stage and area of practice. The overarching goal of this framework is to enable safe, sustainable practice through a culture of lifelong learning. The establishment of the ACCET framework has been a key factor in enabling the development of a comprehensive Clinical Capability Framework for *all* occupational therapy clinicians.

It is worth mentioning that the Clinical Education Reference Group for Occupational Therapy has, to date, prioritised novice practitioners within the workforce as being a key target group for clinical education and training.

State-wide Service Mapping
Queensland Health Occupational Therapy practice was mapped through a process of state-wide consultation in 2008; this was the first time an analysis of current practice had been conducted on such a large scale. Findings highlighted the diverse and inconsistent nature of OT practice within Queensland Health in terms of caseload, practice setting, therapist experience and geographical location. The geographical isolation of many OTs working in Queensland Health (many of whom are newly graduated) reinforced the importance of developing clinical education and training that was relevant and accessible to all clinicians, not just those in metropolitan and larger regional centres.

Paradigmatic shifts with the Occupational Therapy Profession
In recent years there has been increasing emphasis (back) on the concept of occupation as a core tenet of the profession; this has been particularly evident with the development of several, widely used occupational performance models of practice which emphasize the centrality of holistic and client centred practice. This is further reflected in that WFOT standards for accreditation of educational programs require that the program philosophy has a focus on occupation.

In many areas of practice there has been a subsequent movement away from using the more traditional biopsychosocial approach (particularly in non-acute working environments). Emerging areas of practice (e.g. working with homeless persons, refugees etc.) and the increasingly multi-cultural nature of Australian society highlighted the importance of developing a professional development strategy which was responsive to change and was able to encompass the diverse and dynamic contexts in which Queensland Health OTs work.

Literature Review
Although competency based frameworks are used within the occupational therapy profession at both the undergraduate and professional practice level, a literature review regarding the use of a competency based framework as a platform for providing clinical education and training was conducted and the efficacy of its use in this context was challenged (Gardner et al, 2006; Phelps et al, 2001; Cairns, 1996; Stephenson, 1996). Within the literature, the notion of using a capability framework for professional development emerged as a construct that was highly congruent with the core philosophies of the occupational therapy profession. This is discussed in the next section.
In summary, all of these factors provided the contextual backdrop which led to the development of a Clinical Capability Framework. It is proposed that such a strategy will be able to better meet and embrace the clinical education and training needs of our increasingly diverse, dynamic and evolving workforce.

3. *What did the literature reveal to support capability as the approach for Occupational Therapy?*

When looking at the notion of capability it is helpful to also understand the concept of competency.

- Competency may be defined as the ability to *acquire* knowledge and skills related to SPECIFIC tasks within a GIVEN CONTEXT.

- Capability is the ability to *apply* knowledge and skills as required to carry out one's professional role within DYNAMIC and EVOLVING CONTEXTS.

Competency Based Approach to Learning and Development	Capability Approach to Learning to Learning and Development
Looks at *acquisition* of skills and knowledge	Looks at the *application* of skills and knowledge
Reductionist - breaks performance down into specific, repeatable, technical tasks performed in a given context. Right or wrong way of doing things.	Holistic – looks at whole professional role; acknowledges the complex interplay of variables. Emphasizes clinical reasoning and professional autonomy in decision making.
Assumes health care environments are predictable	Health care environments are never predictable as there are too many variables which impact on each other (complexity theory)
Content and learning goals set by others	Learner-centered and motivated; self directed learning goals (adult learning)
Superficial learning – often focus on minimum standards	Promotes deeper learning – facilitates use of adult learning principles so that meaning is constructed through experience and reflection
Retrospective; looks at measuring past performance and knowledge. Emphasis on assessment (pass/fail or checklist driven)	Forward looking; focuses on developing potential and continually improving performance. Acknowledges learning is a lifelong process
Static and fixed. Competencies become redundant over time as circumstances change.	Dynamic and evolving – adapt to change. "Living documents"

Capability and competency are not considered opposing or mutually exclusive constructs; they are more different points along a continuum of knowledge and skill development (Ebrall, 2007; Stephenson, 1992, 1996). Capabilities build on competencies and, according to Hase and Davis (1999, p. 3), “competence is an essential ingredient of being capable. However, capable people and organizations are those that can operate effectively in unknown contexts and with new problems. The clear implication is that learning must occur… [and] becoming capable requires different learning experiences from learning competencies”.

A capability approach for occupational therapy clinical education and training is considered to be advantageous over competency based assessment (as outlined below) as it is more congruent with the core philosophies and values of the profession.

Health care is a rapidly evolving field:

Within contemporary health care environments rapid clinical, technological and organisational changes are common place, requiring clinicians to constantly examine, refine and develop their practice. Due to uniqueness of every client, OTs need to be able to deal effectively with unfamiliar challenges in unfamiliar situations. It is within these unfamiliar clinical situations in which “risk” is most likely to occur. This risk is magnified within professions which are reliant on static competency based evaluations which have the potential to become redundant over time.

Occupational Therapists are holistic practitioners:

Capability is considered a holistic attribute which is in keeping with the holistic values underpinning client centred occupational therapy practice. OT as a profession, recognises the need to view humans as unique beings whose needs will differ based on their personal attributes and the environmental context within which they live (Law, 1998, Sumison, 2006). Hence, OTs need to be able to adapt their clinical decision making processes in accordance with individual client needs and wishes.

Occupational Therapists are clinicians not technicians

OTs are autonomous clinicians who use a process of clinical reasoning as distinct from undertaking fixed technical tasks when working with clients. This maintenance of clinical autonomy is recognised as being central to occupational therapy’s standing as a profession within the health care sector (World Federation of Occupational Therapists, 2007).

Occupational Therapists practice in a diverse range of fields:

As highlighted in service mapping data, Queensland Health occupational therapy practice is extremely diverse in terms of practice setting, geographical location, client target groups, clinical processes etc. Given the broad scope of the profession it is both unhelpful and unrealistic to establish pre-set competencies for practice which may be considered universally applicable to clinicians within a particular field or practice domain. A capabilities framework however, places value on the application of knowledge and skills which underpin high quality practice across different practice contexts and in doing so is of far greater utility to Queensland Health OTs.

Capabilities emphasise professional’s capacity for growth and development:

Bolton et al (1998, p.588) state that the notion of capability “looks forward to human potential, where competence looks back to demonstrate actuality.” Occupational therapy as a profession places great value on the development of clinicians who are engaged in a continuous process of professional and personal growth (WFOT, 2007). If follows, therefore, that the profession requires a forward looking capabilities framework which recognises the incremental nature of knowledge and skill development and taps into the strengths within clinicians which will enable them to fulfill their potential.

4. Who is the Clinical Capability Framework aimed at?

Initially the only funding source for developing an integrated and coordinated clinical education framework was the OT Clinical Education Workload Management Initiative, as one of the key performance indicators. This initiative targeted new graduates and students and therefore we defined our target group as "novice" level to include new graduates and students, but also those with similar education needs such as clinicians changing practice domain and those re-entering clinical practice after a significant break.

Additional funding from the Allied Health Clinical Education and Training Unit allowed us to extend our scope somewhat to include all Occupational Therapy practitioners.

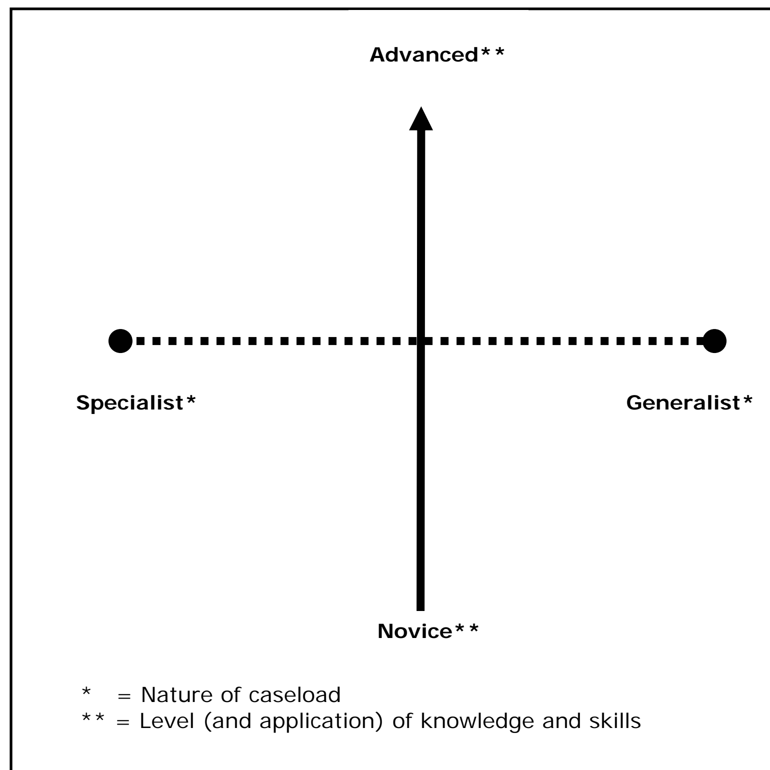
5. How do you create a framework for all OTs when we are so diverse?

Prior to the establishment of the OTCEP, a project team completed a state-wide service mapping exercise in order to obtain detailed information on current OT practice in Queensland Health. This was completed at the end of 2008 and a broad range of information was gained across the 3 practice domain areas (adult physical, mental health and paediatrics).

A comprehensive report was completed which highlighted the diverse nature of occupational therapy practice within Queensland Health. Several key themes emerged including:

- a high level of diversity and inconsistency of service delivery throughout the state
- the strong influence of geographical location on scope of practice
- a higher concentration of novice therapists in rural and remote locations

This information was used to inform the Clinical Education Program at its inception in early 2009. It became apparent that these key themes would have significant implications on the development of a state-wide clinical education and training framework. OT practice within Qld Health needed to be classified in a way that represented the diverse nature of practice/caseload and the broad range of individual clinical experience. A review of some of the UK Healthcare and Nursing literature led to the development of the following framework which may be used to describe the nature of OT practice in Qld Health:



This diagram challenges the historical view of specialists being superior to generalists in a hierarchy of occupational therapy practice. The “specialist / generalist” X axis on this diagram is merely a descriptor of the caseload or area of practice any OT in Queensland Health may work in. This axis has not been designed as a continuum and attempts to capture the reality that many practitioners work in multiple caseload areas which will fall within either a specialist or generalist category.

The Y axis depicts the novice to advanced continuum and is used to describe a therapist’s level (and application) of knowledge and skill in clinical practice. The term novice is used to encompass not only new graduates but also clinicians who may have recently changed caseloads or practice domain areas as well as therapists re-entering into the workforce. The advanced end of the continuum is used to describe therapists with high level skills and in-depth knowledge in a particular practice area or across several practice areas as a generalist.

Initially the word “expert” (rather than “advanced”) was proposed; however it was later rejected on the grounds of being potentially misleading. It was felt that this term implied the process of acquiring skills and knowledge was something finite; that there is a point at which a clinician could “arrive” and stop, rather than engaging in an ongoing process of lifelong learning and development. In fact, learning and professional development is considered to be such a complex and multi-faceted process that it was not possible (and potentially detrimental) to include interim points or definable levels along this continuum. This proposal represented a significant shift in thinking was highlighted with the Clinical Education Reference Group (CERG) as a key point for discussion and subsequent verification.

6. How was it developed?

The Occupational Therapy Clinical Capability Framework was completed following a lengthy process of consultation with experienced Occupational Therapy clinicians across Queensland Health.

The first stage of consultation involved mapping clinical services in each of the clinical practice areas (mental health, paediatrics and adult physical) across the state. Using this information, a large number of focus groups were conducted across the state to refine this information and consult practitioners on their day to day clinical practices. This gave a comprehensive picture of clinical practice across the state and the report can be accessed at http://qheps.health.qld.gov.au/cetu/docs/ot/09AH013.pdf

The second stage of consultation involved the formation of Expert Working Groups (EWGs) in the clinical practice areas (Mental Health, Paediatrics, Adult Physical). Our Clinical Education Leaders worked in consultation with these groups over a number of months to identify essential knowledge and skills required at the novice level.

What became evident once these groups had completed this stage was a significant amount of overlap. *Effectively they had all identified the OT Process as being essential, using slightly different language.* It was so encouraging to realise that across these clinical areas we had so much in common as OTs.

Streamlining the language was the next step and overseen by the Clinical Education Reference Group (CERG). Consultation with the EWGs and direction from CERG identified 8 Clinical Capability Domains that were deemed essential at the novice level across practice domains.

The final stage involved our Clinical Education Leaders developing the detail, with consultation back to our EWGs and CERG on a monthly basis.

7. How is the Clinical Capability Framework structured?

See the full Clinical Capability Framework at http://qheps.health.qld.gov.au/cetu/docs/ot/09AH063.pdf

The CCF has been constructed with eight overarching clinical capability domains:

- Understanding and promoting the occupational therapy role and identity
- Assessment and screening
- Goal setting and action planning
- Intervention
- Evaluation
- Communication
- Professional practice
- Clinical service development

Within the framework each Capability Domain is comprised of three inter-related components. These are the Capability Statement, Key Knowledge and Skills Statements and Key Concepts:

- The ***Capability Statement*** is a broad, unifying statement that has been written for both novice and advanced practitioners providing a general overview of the knowledge and skills that therapists should develop and apply in each of the capability areas.

- The ***Key Knowledge and Skills Statements*** (again for both novice and advanced occupational therapists) provide a breakdown of the nature and depth of knowledge and skills that should be developed (and applied) by therapists in promoting the delivery of high quality, safe and sustainable Occupational Therapy practice.

- The ***Key Concepts*** are listed alongside each knowledge and skills statement. These concepts are the core principles, theoretical concepts and practice issues of particular relevance to each knowledge and skills statement, and are fundamental to the clinical practice of Queensland Health Occupational Therapists. These key concepts will all have their own corresponding learning resources, and in addition will provide the foundation for *Clinical Practice Topic* learning resources to be developed in the future.

It should be noted that whilst the *Capability Statements* and *Knowledge and Skills Statements* within the CCF are intended to be fixed entities, the *Key Concepts* that are listed are contextual in nature, and therefore, may change over time as Queensland Health Occupational Therapy practice develops. As such, the framework will act as a dynamic document which will evolve over time in keeping with the growth of clinical practice and knowledge within the profession.

What is the relationship between novice and advanced Capability Statements and Knowledge and Skills Statements?

The CCF has been designed as a resource to support the clinical development of all Occupational Therapists in Queensland Health regardless of the extent of their experience, knowledge and / or skill. Because of this, *Capability Statements* and *Key Knowledge and Skills Statements* have been developed for novice and advanced therapists. These are intended to be used not as discrete levels but rather as guide points on an ongoing continuum of learning and development.

Key differences exist between the **novice** and **advanced** *Capability Statements* and *Knowledge and Skills Statements* in that advanced practitioners are expected to demonstrate greater depth and breadth of knowledge and skills and a higher degree of critical analysis and synthesis of relevant theoretical, practical and ethical concepts. Further to this, the *Capability Statements* and *Key Knowledge and Skills Statements* for advanced practitioners reflect the greater need for the application

of higher level leadership behaviours with regard to clinical service development and professional practice than for those for novice therapists. As such, the CCF, and associated learning resources, will aim to equip advanced therapists to take a strong, active role in the continued advancement of the Occupational Therapy profession.

8. Where will this document sit and how will it be used? How is the Clinical Capability Framework linked with learning resources?

Where will it sit?

To ensure accessibility to all Queensland Health Occupational Therapists, across the state, the CCF will be web based. It will be housed within the ClinEdQ website, which will be an external web-portal, and thus will allow for much greater interaction and technological capability that is currently available through QHEPS. It is envisaged that the Framework will have 'Wiki' style capabilities, in other words it will be highly interactive, with extensive hyperlinks to related topics and will allow the user to move easily throughout the web portal.

How will it be used?

The CCF was never intended to be a paper document, existing in isolation, read linearly from start to finish. Instead it is a dynamic, 'living' document, accessible at multiple points, that provides an overall unifying framework for the clinical practice development of Queensland Health Occupational Therapists. The CCF not only provides the 'scaffolding' upon which learning resources are housed, it will guide and direct the development of further learning resources in the future.

It is intended for the CCF to be used by Queensland Health Occupational Therapists as a professional development platform. It may be used by therapists individually in a self-directed way based on the therapist's own identified learning needs, or in conjunction with learning needs collaboratively identified within supervision processes. It can also be used by groups of occupational therapists, for example within peer learning groups or as a tool for inservice development and delivery.

It is a framework that is responsive to 'point of need' learning, so it is able to be utilised by a therapist who wishes to further their knowledge and skills in key concept areas, such as *'The therapeutic relationship'* or *'The OT process'* and can also be used to support their professional development in a particular clinical practice skill such as *'Handwriting'* or *'Working with Older Adults with Depression'.* The CCF also provides assistance to supervisors by providing accessible learning resources for supervisees that encourage self-directed learning and reflection on current clinical practice.

How is the CCF linked with learning resources?

The CCF is closely aligned with learning resources in a number of ways. Firstly, all learning activities will have specific learning objectives that are based on the *Key Knowledge and Skills Statements* within the framework. This will ensure that all learning resources are constructed with due consideration to key knowledge and skills that have been identified as being critical to the delivery of high quality Occupational Therapy practice within Queensland Health. The framework will also offer a structure to allow for mapping the development of *Clinical Practice Topic* resources to ensure that all areas of clinical practice are addressed in a coherent and coordinated manner.

The framework itself will act as a conduit to specific learning opportunities through the inclusion of hyperlinks between topics listed within the *Key Concepts* section of the framework and learning resources related to these concepts.

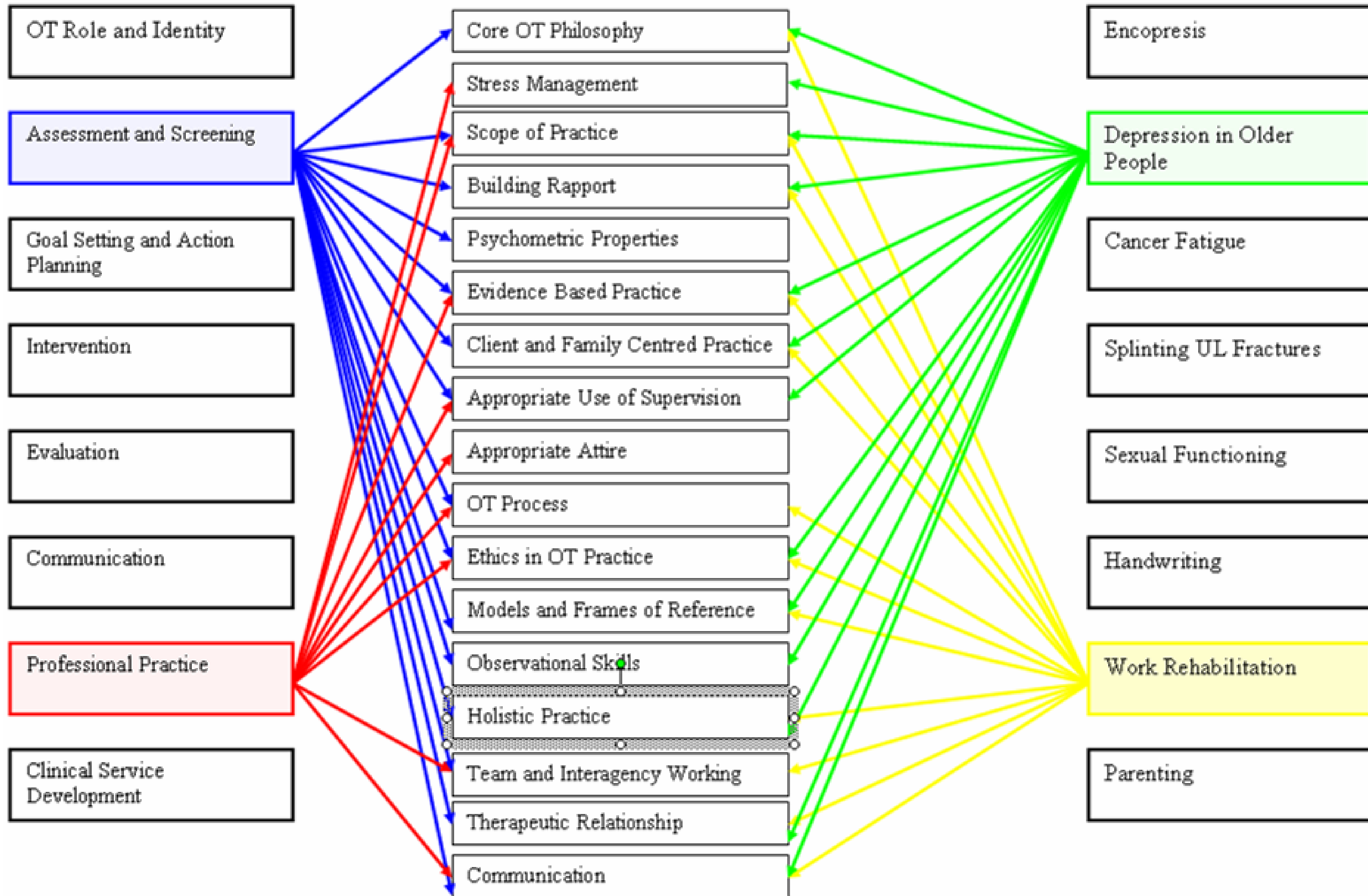
9. *The learning resources include key concepts and clinical practice topics. What is the difference?*

The attached diagram highlights the relationship between the CCF, Key Concept learning resources and Clinical Practice Topic learning resources.

Key Concepts are **core** principles, theoretical concepts and practice issues that are fundamental to the clinical practice of Queensland Health Occupational Therapists. The learning resources that have been developed for these Key Concepts will provide a bridge between the Key Concepts in theory and their application in clinical practice.

Key Concept learning resources can be accessed directly, within the CCF, so for example a therapist may access learning resources on '*Holistic Practice'* or '*Core Occupational Therapy Philosophy'* in order to enhance their knowledge and skills within this area. Additionally, understanding of key concepts will be essential within the *Clinical Practice Topic* learning resources, so the Key Concepts learning resources can also be accessed via hyperlinks from the Clinical Practice Topic learning resources. Because of this, it is important for us to develop the Key Concept learning resources first. These resources are likely to be more 'content heavy' and more reflective rather than practical in nature. The CCF provides the framework for hyperlinks between these relevant learning resources to occur.

Clinical Practice Topic learning resources are practical resources designed to assist occupational therapists in areas of specific clinical practice, for example *'Work Rehabilitation'* or *'Cancer Fatigue'*. To develop these resources, it is planned to harness the expertise that exists within our workforce, so Queensland Health occupational therapists across the state will be invited to work with us to develop them. The Clinical Practice Topic learning resources will be practical and informative. It is envisaged that these resources will utilise a variety of media including videos, diagrams, flow charts, 'how to' tips and so on. The number and variety of Clinical Practice Topics that are of relevance to occupational therapists within Queensland Health is envisaged to be ever expanding, and therefore these resources will continue to be developed over time.



Capability Domains
Key Concepts
Clinical Practice Topics
OT Role and Identity
Assessment and Screening
Goal Setting and Action Planning
Intervention
Evaluation
Communication
Professional Practice
Clinical Service Development
Core OT Philosophy
Stress Management
Scope of Practice
Building Rapport
Psychometric Properties
Evidence Based Practice
Client and Family Centred Practice
Appropriate Use of Supervision
Appropriate Attire
OT Process
Ethics in OT Practice
Models and Frames of Reference
Observational Skills
Holistic Practice
Team and Interagency Working
Therapeutic Relationship
Communication
Encopresis
Depression in Older People
Cancer Fatigue
Splinting UL Fractures
Sexual Functioning
Handwriting
Work Rehabilitation
Parenting

10. What is the basis for your learning approach?

The clinical capabilities framework and associated learning resources are being developed to address the specific needs of Queensland Health Occupational Therapists. In order for this to occur:

- The learning materials must be adaptable and relevant to occupational therapists working in diverse professional roles.
- The learning resources must be effectively integrated to promote holistic occupational therapy practice.
- The learning materials must allow for occupational therapists to develop a sense of ownership and control over their own professional development.
- The learning materials must be designed so that occupational therapists can continuously refine and build upon their knowledge by re-visiting the resources.

In order for this to occur, the resources will be underpinned by a solid foundation of both evidence and theory. The initial development of learning resources and activities has been influenced by three main theoretical frameworks - adult learning theory, constructivism and spiral curriculum. A brief overview of each of these is provided below:

Adult Learning Theory

In learning environments, teachers have traditionally determined the knowledge that students are required to learn and the way in which learning occurs. On the contrary, adult learning theory emphasises the value of the learner taking responsibility for their development (Knowles, 1984).

Adult learning theory is based on four key assumptions:

1. Adults are self directed and prefer to take responsibility for their own learning. Guidance, structure and facilitation should be provided to allow learners to discover things for themselves rather than relying on a teacher's instruction. Adults tend to be more motivated to learn if they consider the learning to be responsive to their needs and if they have been involved in the planning and evaluation of their instruction.

2. Adults learn through experience (including making mistakes). Thus, they learn best when they actively engage in tasks and apply knowledge rather than through the more passive process of memorising facts and content.

3. Adults have a problem-solving orientation to learning. As a result, problem-centred learning is preferable to content-oriented learning.

4. Adults learn best when the topic is of immediate value or relevance to their vocation or personal life. They are ready to learn when they take on new roles.

Adult learning theory enables learners to take greater control over the direction and pace of their own learning. This self-directed learning process is a key part of the Occupational Therapy Clinical Education Program as it enables the clinician to engage in learning which is responsive to their immediate needs or problems. Furthermore, it focuses on a clinician's future potential and acknowledges that learning is a life long, continuous process.

The learning materials developed within the Occupational Therapy Clinical Education Program will not focus upon prescriptive, "recipe book" style information. Instead they will facilitate learning by:

- Assisting therapists in accessing existing information and resources relating to clinical practice topics (e.g. handwriting, work rehabilitation, functional implications of depression) or key

concepts from the capabilities framework (e.g. occupational therapy philosophy, therapeutic relationship, client centred practice).

- Providing key questions to assist therapists in critically examining the information and resources that they access and evaluating the relevance of these resources into their practice.
- Supporting therapists in developing clinical reasoning skills through the exploration of the impact of treatment decisions on therapeutic outcomes.
- Encouraging therapists to engage in structured reflection on their practice.

Constructivism

Constructivism is a term that broadly refers to the idea that everyone creates (or constructs) his or her own, unique perception of reality. This is heavily influenced by culture, personal expectations and language. In other words, everyone attributes their own personal meaning to events. This includes the personal meaning attributed to various learning activities. Constructivism has several implications for the development of learning resources within the clinical education program.

1. According to Novak (1998), deeper learning occurs when activities and programs are meaningful (or relevant) to the learner's experience. Within the clinical education program, key questions are embedded within the learning resources to encourage participants to reflect on their own clinical practice, and apply new ideas to their work.

2. When learning resources are developed, a clear systematic relationship should be established between learning objectives, activities and evaluation. In addition, programs of learning should be developed so that all elements of the program are directly relevant to the learner (Biggs, 2003). Within the clinical education program, the intended learning outcomes of all learning activities have been designed to correspond with the key knowledge, skills and values outlined within the CCF. These clinical capabilities have been developed through a lengthy process of collaboration between expert occupational therapists working in adult physical, mental health and paediatric practice domains. This has helped to ensure that all learning resources that are created will be of direct relevance to the professional and clinical development needs of occupational therapists in Queensland Health. Furthermore, as the clinical capabilities (and, in turn, the intended learning outcomes of the resources) have been developed for both novice and advanced practitioners, the content of the learning resources will be broadly applicable to all occupational therapists regardless of whether they are in novice or advanced practice roles.

Spiral Curriculum

Within a spiral curriculum, ongoing learning and development is promoted, by revisiting key learning concepts over time at increasingly complex levels (Bruner, 1960). The idea of a spiral curriculum is particularly advantageous within the Occupational Therapy Clinical Education Program in that it allows for important clinical concepts to be introduced to novice practitioners and then reviewed over time so that their understanding (and learning) can deepen further. The learning resources created within the clinical education program will be designed to encourage therapists to revisit and reflect upon their prior learning and re-examine this is the context of new experiences that they are exposed to over time. The inclusion of specific learning activities targeted at more advanced practitioners (and requiring more complex analysis of key concepts) will offer a further layer of learning for clinicians accessing the resources.

Promoting an Integrated Program of Learning

Within the Occupational Therapy Clinical Education Program a range of different mechanisms for the delivery of educational opportunities is being developed. At this stage, these opportunities include online learning resources, educational teleconferences for new graduates and statewide educational workshops. Each of these mechanisms have been chosen to optimise access to learning opportunities for all therapists, especially those working in rural and remote settings for whom distance can often be

problematic. Together, these learning opportunities are intended to form part of a broad, integrated program of learning. As a result, all of these different learning mechanisms will have shared learning objectives (stemming from the clinical capabilities framework) and aim to enable therapists to refine their knowledge and capabilities. By embracing adult learning principles it is anticipated that the learning resources will support therapists in taking responsibility for their own learning and in applying this learning to the unique practice scenarios that they encounter. This will help to ensure the development of dynamic, self-motivated occupational therapists within Queensland Health, who are equipped to engage in an ongoing process of learning and development throughout their professional careers.

11. What is the Clinical Capability Framework not intended to do?

The clinical capability framework has been designed as an adaptable resource that will be linked to a range of learning activities and resources. Due to the wide consultation that took place during the development of the capability framework, it is anticipated that it will be relevant to all occupational therapists in Queensland Health. The capability framework is intended to provide guidance about the potential of holistic clinical occupational therapy practice. Thus, it is designed as a tool to support occupational therapists to build skills, refine ideas and to continuously grow and evolve as clinicians. As such, it cannot be used to measure performance or as a performance management tool. This is because it is not designed to measure performance, or to retrospectively assess technical skills. As an alternative to assessment, self-evaluation questions that support learners to generalise increasingly advanced ideas into practice will be embedded within the associated resources.

In addition, it is not intended that the clinical capability framework and associated resources replace other learning opportunities such as separate professional development activities, work shadowing, supervision or peer support. In fact, the capability framework and learning resources may be utilised as a tool within these other activities. For example, an occupational therapist may identify that it would be helpful to complete a specific resource and discuss reflections during supervision or as a peer learning activity. Other occupational therapists may elect to complete specific resources and keep a private ‘journal’ of reflections. Due to the adaptability of the resources, there are many ways in which they could be used as an adjunct to existing professional development activities.

12. Why haven’t we launched / implemented the Clinical Capability Framework yet?

Whilst the Clinical Capability Framework has been completed, it was never intended to be used as a document in isolation. It is vital that it co-exists with the associated learning resources. It had to be developed first in order to provide the ‘scaffolding’ upon which learning resources are housed and to guide and direct the development of the resources.

It has been designed with a view to being housed on a website with comprehensive capability. In addition, a critical level of content will be required for the learning resources to be meaningful and engaging to the diverse range of occupational therapists in Queensland Health from the outset.

For these reasons, it is essential that implementation or “launch” held over until a suitable internet site is available through ClinEdQ, and a critical level of content is reached and uploaded.

13. Why are senior staff and Directors of OT critical to the success of implementation?

Traditionally it is part of the culture of Occupational Therapy and health employment that off site professional development activities such as workshops and conferences have been most popular and sought after. Perhaps this has been due to the challenge of getting approved time away from clinical duties whilst in the work environment. As a non mandatory framework of on site professional development activities, this program is obviously at risk of not being used by staff.

However Queensland Health has clearly stated that professional development is core business and it is of the utmost importance that we embrace this. As such it is vital that senior staff strongly lead the importance of on site professional development activities. This will involve:

- culture change
- leadership
- role modeling
- incorporating the program within PAD
- incorporating the program within supervision as appropriate

In addition where possible we must look towards sanctioned or quarantined time for on site professional development where possible.

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