



Auckland District Health Board – Occupational Therapy

# 2011 NZAOT Clinical Workshops Nga Kete o te Matauranga Baskets of Knowledge Waitangi November 2-4

Feedback to the Profession

*Prepared by ADHB Workshop Delegates*

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## CONTENTS

### Introduction..... 5

### Feedback 1..... 5

Heather Clarke, NZROT, Occupational Therapy Intern Supervisor, Mental Health Services, ADHB....5	
Standing Together as One: Reflecting on our Disaster Response: Tracey Partridge .....5	
Digging up the Daisies: Interactive Problem Solving: Nichola Billing & Madeline Marchant .....6	
My Reflections: .....6	
Identifying Quality Learning Opportunities for Students: A skills acquisition workshop: Marlies Dorrestein & Kim Frenchman .....6	
My Reflections: .....6	
Real Life and Cyber Space: Neil Pendleton & Clive James .....6	
My Reflections: .....7	
Pacific People and Western Systems: Nurturing the Space between us: Marina Elisara, Rachel Kapa Vivian & Manase Lua .....7	
My Reflections: .....7	
Occupational Therapy Contributing to Primary Health: Dana Campbell & Dr Linda Wilson.....7	
My Reflections: .....8	

### Feedback 2..... 8

Karen Jack, NZROT, Auckland City Hospital, ADHB .....8	
Making Baskets without Waste: Applying lean thinking principles to everyday practice: Melanie Scott & Kimberley Cameron .....8	
My Reflections: .....8	
External Memory Aids (EMA): Making it real: Jonathan Armstrong .....8	
My Reflections: .....9	
Enabling Change to improve service or create new practice opportunities: Dr Kirk Reed, Head of Dept, School of Occupational Science & Therapy, AUT University .....9	
My Reflections: .....10	
Sharing our baskets of knowledge through meaningful reporting: Melinda Cooper .....10	
My Reflections: .....10	
Progression towards Aotearoa Model for Occupational Therapy: Rita Robinson .....10	
Therapeutic use of self in Leadership: Who are you?: Liz Gow .....10	



My Reflections: .....	11
<b>Feedback 3.....</b>	<b>11</b>
Anneke Williams, NZROT, Community Rehab Programme, A+ Links, ADHB.....	11
Management of phantom limb pain (PLP): Denise Gow, Hutt Valley DHB .....	11
External memory aids (EMA): Making it real!: Jonathan Armstrong, Cavit ABI .....	12
Key Messages:.....	12
<b>Feedback 4.....</b>	<b>12</b>
Sandy Ash, NZROT, Practice Supervisor, Home Health A+ Links, ADHB .....	12
Lean Thinking: Melanie Scott & Kimberley Cameron (Canterbury DHB) .....	12
Take Home Messages:.....	12
Occupational Therapy: Contributing to Primary Health by Dana Campbell & Linda Wilson (Otago School).....	13
Ways Forward:.....	13
<b>Feedback 5.....</b>	<b>13</b>
Taryn Kearney, NZROT, Auckland City Hospital, ADHB.....	13
Making Baskets without the Waste: Applying lean thinking principles to every day practice: Melanie Scott & Kimberley Cameron, Canterbury DHB.....	13
My Reflections: .....	14
Management of Phantom Limb Pain: An occupational perspective and mirror therapy: Denise Gow, Hutt Valley DHB .....	14
Occupational Therapy Contributing to Primary Health: Dana Campbell, Otago Polytechnic/Southern DHB. Dr Linda H Wilson, Otago Polytechnic .....	15
My Reflections: .....	15
Getting it Right: Right time, right equipment, right service!: Sandy Ash, Home Health, A+ Links, Auckland DHB (our very own!!) .....	15
My Reflections: .....	16
External Memory Aids: 'Making it real': Jonathon Armstrong, ABI Rehabilitation (ex ADHB).....	16
My Reflections: .....	17
Nurturing the space between Us: Pacific people and western systems: Marina Elisara, Faleola Services Counties Manukau DHB. Rachel Kapa-Vivian, Tikanga Afohe – Isa Lei WDHB. Manase Lua, LeVa.....	17
Key Points: .....	17



My Reflections: .....17  
Digging Up the Daisies: Interactive problem solving: Nicola Billing & Madeline Marchant,  
Counties Manukau DHB .....18

## **Feedback 6..... 18**

Megan Ward, NZROT, Home Health A+ Links, ADHB.....18  
Kaiwhakaora Ngangahau relationships with Whanau Ora: lived experiences: Jane Hopkirk. ....18  
Nurturing the space between us: Pacific people and western systems: Marina Elisara, Rachel  
Kapa-Vivian and Manase Lua. ....18

## **Feedback 7..... 19**

Carolyn Simmons Carlsson, Professional Leader: Occupational Therapy, Physical Health Services,  
ADHB .....19  
Workshop 1: .....19  
Key take home messages: .....20  
Workshop 2: .....20

## **And lastly ... ..... 21**

## **Watch out for 2012 NZAOT Conference: 21**

## **Figures ..... 22**

Figure 1.....22  
Figure2.....22  
Figure 3.....23



## Introduction

Five ADHB Occupational Therapists were awarded scholarships to attend the 2011 NZAOT Clinical Workshops Nga Kete o te Matauranga: Baskets of Knowledge, held at Waitangi, Bay of Islands this year. Funding was made possible through the *Occupational Therapy Innovation, Learning and Development Fund* via an Expressions of Interest process.

**'Harvesting our catch, and resetting our net' was the theme of the Clinical Workshops.**

This newsletter format allows the sponsored delegates to contribute back to all ADHB Occupational Therapists through sharing some of their reflections and perspectives about the workshops they had attended. As you will see, some workshops were attended by more than one person, thereby providing more than one perspective which is great.

**Contributors to this newsletter include:**

- Heather Clarke
- Sandy Ash
- Anneke Williams
- Karen Jack, and
- Taryn Kearney
- Megan Ward

*The content of this newsletter is an amalgamation of the contributors' notes and thoughts. It does not necessarily reflect the viewpoint of the ADHB, NZAOT, nor the workshop presenters.*

Enjoy reading!

Carolyn



## Feedback 1.

**Heather Clarke, NZROT, Occupational Therapy Intern Supervisor, Mental Health Services, ADHB.**

I was very honoured to receive the scholarship and have the opportunity to present at the workshops. The setting in Waitangi was gorgeous and the environment led to feeling relaxed. It was great to get up early every morning and have a walk along the beach before a day of learning.

I was really impressed with the quality of the workshops. The powhiri at Te Tiriti o Waitangi marae was incredibly moving and it was a privilege to be welcomed onto a marae with so much history.

The key theme was working together, accepting difference and working in partnership. I recommend attending any upcoming NZAOT clinical workshops (... and conferences) as they are practically based and you have an opportunity to reflect and take away new learning back to the work setting. Below is a synopsis of some of the sessions I attended.

**Standing Together as One: Reflecting on our Disaster Response: Tracey Partridge**

This was an emotional/reflective workshop where we heard stories from the Christchurch Occupational Therapists about their experiences of the Christchurch earthquake. We then worked in small groups to consider as Occupational Therapists how do we need to prepare for a disaster and support our clients.

One key theme was around developing flexibility and ensuring equipment can be moved or adapted to another setting with less disruption for the client. Another factor was the importance of developing resilience and independence with our clients in our current clinical work so they are prepared for a disaster. One therapist said she works in the



same area as her children's school, has water stored, her petrol tank filled at midway and plenty of cash stored as an emergency.

### **Digging up the Daisies: Interactive Problem Solving: Nichola Billing & Madeline Marchant**

Counties Manukau DHB Occupational Therapists have been using this tool for problem solving to develop solutions to issues in their work setting. One example they used was the issue of not receiving appropriate referrals in an acute inpatient physical setting.

The framework used is called the A3 model which was originally developed by Toyota in the 1970's as a process for ensuring lean manufacturing. The A3 model helps to guide analysis, define the nature and evidence of the issue. The model goes through a number of stages to help reach a solution to the problem. The initial stages involve asking the questions: Do we have a problem? Do we have a solution? The next stage is looking at the current condition and where things stand today. Next is the analysis stage and a useful tool to address the root causes of the problem is asking the question Why five times. This enables a deeper analysis of the root cause of the problem. Within this stage evidence is also included with relevant data pictured in graph form. The next stages are identifying the goal, proposed solution and implementation plan.

#### **My Reflections:**

It is important when using this model that the problems need to be understood before a solution is developed. The solution needs to stand up to analysis and link problems to the goal. This tool when used within a team environment can help reduce personality issues and manage conflict situations in an objective way. I can see this tool being effective for team planning and as a group of practice supervisors to help analyse problems and develop a solution that at times can be counter intuitive.

### **Identifying Quality Learning Opportunities for Students: A skills acquisition workshop: Marlies Dorrestein & Kim Frenchman**

This workshop provided a tool to identify learning opportunities for students. The first part of the tool was to identify all the tasks that you and your team /services engage in. AUT has developed grading criteria for each placement and year level which they cover in their Fieldwork Supervisors workshops. They developed a template for each year level to consider from your task analysis what you would expect a student able to do under the following headings: participate, assist, supervised and independent. The tool also helps the student to identify their learning objectives and can relate to the competencies criteria for the placement.

#### **My Reflections:**

It is a useful tool set out in a table format that lists the tasks clearly with the expectation of the student's level of engagement and support required. I think it would be beneficial to have in all work settings in a folder to help clarify expectations of students and supervisors. The tool is accessible on the AUT website under fieldwork.

### **Real Life and Cyber Space: Neil Pendleton & Clive James**

Is the use of gaming/screen time an addiction? As health professionals do we need to include questions that look at computer/gaming use as we do for drug and alcohol? What does gaming/computer use addiction look like and what are the effects? These were some of the questions that were looked at within this session.

#### **Facts:**

- The term "internet addiction" was first included in a medical dictionary in 1995
- 12% of urban youth are addicted to the internet
- China has legislation to limit youth time on the internet



- Someone who is addicted spends 35 hours per week on average (above study and work) on the internet
- There is a correlation of ADHD to internet addiction in teenagers
- Internet addiction is often combined with other psychiatric diagnosis
- There is a correlation between depression and internet addiction in teenage youth
- Location of internet access, scope of internet use and reduced scholastic achievement are significant predictors for internet addiction

### My Reflections:

We need to include as part of initial assessments screen/internet usage in a day/week. The facilitator has developed a draft screening tool to look at screen usage which I have a copy if anyone would like. I think this screening tool would be useful especially in the area of child and adolescent mental health/early intervention.

### Pacific People and Western Systems:

#### Nurturing the Space between us: Marina Elisara, Rachel Kapa Vivian & Manase Lua

This was the first Pacific Occupational Therapy presentation at an Occupational Therapy conference. It focused on defining culture, looking at the NZ socio cultural context and the norms and values important to Pacific Island people that are different to Western. There are seven main Pacific ethnic communities in NZ from the islands of: Samoa, Cook Island, Tonga, Nuie, Fiji, Tokelau, Tuvalu. There are 15 Pacific Island OT's in NZ (10 of these are in Auckland). 66% of Pacific Island peoples live in Auckland. Pacific island people tend to have large families and in 20 years time there will be significant resources needed for health care to meet the population growth.

#### Values of Western and Pacific Island worlds:

	Pacific	Western
Education	Observation/oral /kinesthetic	Literacy
Governance	Connectedness	Autonomy
Power	People	Knowledge

The common Pacific Island models are Fonofale and Fonua. Most models are Christian based. Models are evidence-based and policies in health are developed around them. Wellbeing and relational self is interconnected and seen as a total being compromising spiritual, mental and physical aspects. Wellbeing is also seen as relational self to communities and communal practices. Spirituality grounds a person's life, land, and life - all interconnected.

### My Reflections:

The key learning was the importance of being *quiet* (not talking too much) and investing time with the person and family first before developing treatment plans, and spouting evidence. Family is a part of the relational self and needs to be present within therapy sessions.

### Occupational Therapy Contributing to Primary Health: Dana Campbell & Dr Linda Wilson

This presentation was based from an Otago Polytech Honours students research looking at the Occupational Therapy role in a GP practice in Invercargill. It looked at the literature and identified three key areas for primary health:

1. Preventive Health- disability postponement and prevention of disease
2. Health Promotion- empower individuals to take control and responsibility for their health and,
3. Population Health- initiatives designed to advantage certain populations.

Possibilities identified in a GP practice: equipment for early intervention, specialist assessments i.e. driving and cognition, skill based intervention i.e. stress management, assertiveness training and balanced lifestyle, social skills interventions i.e. advocacy, life skills, domestic violence.



### My Reflections:

This was a valuable workshop as we had the opportunity to work in small groups to look at the barriers, possible strategies and supports available to providing primary health services in our geographical region.



## Feedback 2.

### Karen Jack, NZROT, Auckland City Hospital, ADHB

#### Making Baskets without Waste: Applying lean thinking principles to everyday practice: Melanie Scott & Kimberley Cameron

- Lean thinking = “continuously improving towards the ideal through the relentless reduction of waste, variation and burden” (Dolan & Hawes 2011)
- Occupational Therapists are skilled in implementing lean thinking due to task analysis
- Time is the most important thing for our patients: We get paid – they don’t!

#### 4 x tools were discussed:

##### “5 S’s”

- Sort (discard what not needed)
- Set in order (rearrange to be handy)
- Shine (clean and tidy)
- Standardise
- Sustain (keep it up!)

##### “Five Why’s”

- Ask why something happens – then ask why again, and repeat to unpack the problem and look for solutions

#### TIM WOODS

- Transport – moving products/information i.e.) moving equipment; transporting for trial
- Inventory – Excessive storage of products/information i.e.) old brochures; poor filing system

- **Motion** – Moving more than is required to perform the process i.e.) finding forms; location of printer/keys
- **Waiting** – People unable to continue their work due to waiting on people/equipment i.e.) waiting for meetings to begin
- **Over Production** – Producing more than is needed or before its needed/requested ie) peaking too soon; long reports
- **Over processing** – more work completed than is required ie) maintaining a waiting list
- **Defects** – processes required that create a defect/mistake and additional work needed to correct it ie) incomplete referrals
- **Staff Under-utilisation** – not placing people where they can use their knowledge/skills/abilities to the fullest ie) when an assistant could complete

#### Value Stream Mapping

- Task analysis via visual representation ie) flow chart, maps, graphs
- Can use cost analysis to demonstrate benefits to the service and DHB
- Discussed Kotters Eight Step Process of Successful Change as a way of ensuring implementation of projects

### My Reflections:

During the session we used TIM WOODS to identify “waste” in our services to identify possible areas for change/problem solving. We brainstormed as a group and found many similarities between services. We also watched a video and identified inefficient practices - TIM WOODS provided a framework to structure discussion and thought, and task analysis enabled us to reduce the number of steps required to complete a task (streamlining tasks) therefore improving efficiency.

#### External Memory Aids (EMA): Making it real: Jonathan Armstrong

- 40% of people experience a long term reduction in memory after concussion or mild head injury



- *Aids/strategies* improve *general* performance. Compensation = best framework with external, better than internal mechanisms
- *Practice* improves *specific* occupations
- One EMA may not be sufficient – may need 5-6
- Barriers to using EMA include:
  - Reduced insight from pt or family
  - Losing the EMA
  - Aphasia/agnosias
  - Affordability of EMA
  - Co-morbidities such as decreased hearing/vision/dexterity
- To increase success with EMA's:
  - Develop client insight into impact on daily lives
  - Chip away at this – it is not always essential for success
  - Get patient to “buy in”
  - Check what EMA's previously used by patient to normalize (can use questionnaire)
  - Make specific memory goals
  - Reduce cognitive load by utilizing automatic/procedural memory (instead of new skill)
  - Get others “on-board” to increase repetition/sustained use and to normalize (i.e.) family, friends, MDT
  - Make it real/meaningful to the individual - personalise

### My Reflections:

The information presented guides the practitioner on how to successfully implement EMA's to compensate for reduced memory following mild head injuries. Success relies on whether patient and family “buy in” to using EMA. “Buy in” can be more successful if the patient is using familiar aids (i.e. i-phone), to remember things that are important to them, and if their family are aware of the aid thereby reinforcing its use/ consistent approach.



### Enabling Change to improve service or create new practice opportunities: Dr Kirk Reed, Head of Dept, School of Occupational Science & Therapy, AUT University

- Project Management Theory to develop services or emerging areas
- Prior to proposing a change need to think about how it will impact on people
- Needs to be participatory to be successful – people will feel ownership if participating
- Needs clear achievable aims and timeframes with a determined beginning and end
- Need to gain evidence to support the project (see Lean Thinking section ie. TIM WOODS and cost analysis for ways of doing this)
- Comprised of 4 stages – each need to be signed off before next phase started

#### Concept (rationale)

- Can use *project charter*

Kirk suggested the following for generating concepts:

#### Outline 3-4 good ideas

- What led to project
- What project will achieve
- Why it is needed
- What is included/excluded
- What will be produced by project
- Who are key stakeholders that need to be involved
- Discuss with site manager
- Present idea to staff at meeting for discussion

#### Definition (recipe)

- Define goals, objectives and strategies
- Define how big the project will be and its boundaries
- Identify key stakeholders (including who will support and hinder and how important each is to the project)
- Locate the project within the organization structure and create a project committee for involving consumers of concept including those for expert advice



- Break the project down into tasks and activities
- Plot task on timeline to create phases/deadlines/pathways (can use Gantt chart)
- Identify the resources required (including human resources)
- Determine the cost and budget
- Determine the quality and how will be monitored including risk analysis with contingencies to reduce impact
- Develop a reporting process for informing stakeholders and the information system
- How to be launched for “buy in” and sustainability

**Then:**

- Implementation
- Conclusion/evaluation

**My Reflections:**

Anyone who is considering change in their service could use the structure above to guide thinking and consider potential obstacles/negative impact of projects. The structure provided guides thinking to ensure change is necessary, appropriate, implemented and sustained. The project management process can be followed by any practitioner to implement change.

A good reference is: Dwyer, J, Stanton, P & Thiessen, V (2004), Project Management in health and community services: Getting good ideas to work.. Allen and Unwin, Crow’s Nest, New South Wales.

**Sharing our baskets of knowledge through meaningful reporting: Melinda Cooper**

**My Reflections:**

When we complete standardized assessments we must report on the findings. However, reports are often lengthy and the reader may tire of reading and come away with a different “take-home” message than we are proposing. The role of the Occupational Therapist is to apply the results of the standardized assessment (i.e. *person*) to the *environment*

and the *occupations* thereby advising how the deficits and strengths impact on their *occupational performance*. Relaying the performance components is not enough. We must relate the deficits/strengths to daily occupations to identify appropriate intervention strategies/recommendations. Discussing the impact on daily occupations will engage the reader so that they come away with clarity regarding what is proposed.

**Progression towards Aotearoa Model for Occupational Therapy: Rita Robinson**

In this session, we discussed the hope to create a model of Occupational Therapy unique to New Zealanders. Currently we use international models which some have critiqued as Eurocentric – originating in the west, but practiced (even imposed) on people from diverse ethnicities. A new movement towards diverse approaches and meanings is arising. NZAOT hopes to lead progress toward an Aotearoa model (or models) of Occupational Therapy *by* the people of New Zealand, *for* the people of New Zealand. They acknowledge that this is a long term project and would like input from many rather than direction from few. Over the coming years people will be invited to participate in discussions to generate a model/models to reflect our unique experience/practice in New Zealand.

**Therapeutic use of self in Leadership:**

**Who are you?: Liz Gow**

Liz lead us through a series of activities to reveal our ability to use ourselves as a therapeutic tool to manage people. We identified 3 things that described *who* we are (rather than *what* we do/roles), and one of our strengths.

- Important to get to know yourself more – what makes you tick and what makes you react – then you can channel this for successful management. We need to be aware of what pushes our buttons so we do not transfer or counter transfer



- Acknowledge your own needs and have compassion on yourself! Value what you do.
- Recognise that we are *our own resource* to maintain our wellbeing/balance – be present to yourself to listen to what is occurring for you
- Know your own learning style and the learning style of your team members to communicate effectively and efficiently (and successfully).

Another activity was to brainstorm things we avoid doing/don't like doing then identify what worked before, identify a personal value we have, a strength we have and use them to provide motivation to feel uncomfortable but do the task anyway, to allow *growth*:

- 3 different management styles include:
  - Democratic (discuss)
  - Autocratic (tell what to do)
  - Laissez-faire (whatever). Must move between the styles at the appropriate time
- Recognise whether you are naturally *people* oriented or *task* oriented – then apply at the appropriate time
- Sometimes we need to notice growing negative elements in the workplace, and sometimes we need to predict problems then stop before they arise
- Important to have fun in and out of work – think of something you really enjoy doing and can do in 5 minutes, then think about how to incorporate into your day (at home or at work). One suggestion was breathing/visualization as a timeout technique to manage our own response to a stressor (task we don't enjoy).
- Remember no problem can be solved from the same consciousness that created it! Try something different.

### My Reflections:

The workshop was quite reassuring and most helpful to me was the concept of having compassion for oneself. I found the activities gave us permission to identify our strengths rather than hide them as we are conditioned to do from “tall poppy syndrome”. Furthermore, understanding our weaknesses

or different ways of doing things to other people will enable us to see things from a different perspective – for example, if we have tried something and it didn't work, try something else (i.e. Utilize the other persons learning style).



## Feedback 3.

### Anneke Williams, NZROT, Community Rehab Programme, A+ Links, ADHB

#### Management of phantom limb pain (PLP): Denise Gow, Hutt Valley DHB

Denise explained the physiology of pain and causes of phantom limb sensations. Importance of formal and informal assessment, get client's story e.g. tell me about your day, what does the pain stop you doing?

Importance of educating client re pain causes and physiology.

Sources of PLP:

Irritation of neuromas or scar tissue

Sensitisation of pain processing system (burning, throbbing, tingling)

Cortical reorganisation

Mismatch between motor commands and expected sensory input

Pre-amp pain may persist as a “memory” in the phantom (some research queries this)

Somatosensory strip: sensory map (in brain) may move and superimpose e.g. may ‘feel’ their fingers from amputated hand on their face – caused by interhemispheric reorganisation from connections with the intact limb

Combine use of education, meditation/relaxation/imagery with mirror therapy.

Move unaffected limb, reflected in mirror so it looks like the affected limb is moving also.

Give simple explanations to clients e.g. the visual input revives motor neurones and may



shift the brain back to a more “normal state” providing relief

It is never too late to try mirror therapy e.g. she had client who had PLP for 17 yrs and after a few months of mirror therapy had relief of pain.

**For further info:**

[www.noigroup.com](http://www.noigroup.com)

Also Google Ramachandran, Diers

**External memory aids (EMA): Making it real!: Jonathan Armstrong, Cavit ABI**

Jonathan spoke about 4 key areas he identified from his Masters research, using qualitative interviews with 8 OTs:

1. Developing client insight
2. Getting client buy in
3. Getting others on board
4. Making it real

He gave more detail for each of these areas.

**Key Messages:**

- Address insight issues, keep chipping away
- Do groundwork re previous use of EMAs – if someone used EMAs before their injury, more likely to use the same EMA effectively after injury
- Set meaningful memory goals
- Get others involved – to support and reinforce re use of EMAs
- Practise use of EMAs in meaningful activities, make it real – no matter how technologically advanced the EMA, it will only work if the person practices use of it, more likely to use if the activity has value and meaning
- One EMA will not necessarily answer all client’s issues, may need 5 or 6 depending on relevant activity e.g. may need diary for appointments but a clean/dirty sign on washing machine to remind person to hang out.



## Feedback 4.

### Sandy Ash, NZROT, Practice Supervisor, Home Health A+ Links, ADHB

I really enjoyed the clinical workshops. It was very interactive. All the presenters engaged the audience working in break out groups to problem solve and share practice. The influence of Waitangi was very evident with the cultural interaction. To sit in a treaty house to participate in a presentation on Whanau Ora has a lasting impact. The opportunities to mix and mingle at breaks and at the dinner set the scene for networking with colleagues and reps.

### Lean Thinking: Melanie Scott & Kimberley Cameron (Canterbury DHB)

They presented an overview of the lean thinking process they implemented of the community Child Development Team in ChCh

Lean Thinking “is about continuously improving towards the ideal through the relentless reduction of waste, variation and burden”. Dolan & Hawes (2009)

#### Tools of Lean Thinking

**5 S’s** - Sort, Set in Order, Shine (Clean), Standardise, Sustain

**5 Why’s** – why is it done this way, why can’t it change etc

**TIM WOODS** – T – Transport

I – Inventory

M- Motion

W – Waiting

O – over Production

O – Over processing

D – Defects

S – Staff under utilisation

Value Stream Mapping- visually completes a task analysis, write out all the steps and then streamline

#### **Take Home Messages:**

- Lean Thinking is about good people working with processes that do not work well



- Waste does not add value to your service! It costs you money and time.
- Successful change efforts require planning, organisation, resources and action.

**Occupational Therapy: Contributing to Primary Health by Dana Campbell & Linda Wilson (Otago School)**

Dana (Hons Student) presented a research study questioning: “What possible services can Occupational Therapy provided from a GP practice?”

**Outcomes:**

- equipment for early intervention
- specialist assessments e.g. driving and cognition
- skill based interventions i.e. stress management, balance lifestyle choices
- social skills interventions i.e. life skills

Linda presented a discussion on Occupational Therapy Roles in Primary Health.

**Barriers may be role blindness, role recognition, role reticence and role respect**

**Ways Forward:**

- Use GP practices for undergraduate placements
- Present about Occupational Therapy role at medical school undergraduate training
- Further research
- Market Occupational Therapy
- Promote the bio psychosocial model not the medical model
- Advocate with policy makers at MOH
- Offer to work at a GP practice 1 day a week



## Feedback 5.

### Taryn Kearney, NZROT, Auckland City Hospital, ADHB

**Making Baskets without the Waste:**

**Applying lean thinking principles to every day practice: Melanie Scott & Kimberley Cameron, Canterbury DHB**

Lean thinking “is about continuously improving towards the ideal through the relentless reduction of waste, variation and burden” Dolan and Hawes (2009)

**Tools of Lean Thinking**

5 S’s - Sort, Set in Order, Shine (clean), Standardise (housekeeping), Sustain  
 5 whys (cause)  
 Wastes – Tim Woods  
 Value Steam Mapping

**TIM WOODS**

**T** – Transport: moving products that are not required to form the process (e.g. moving equipment to reach what you need).

**I** – Inventory: excessive storage of products or information. Leads to excessive cost (e.g. stock piling pamphlets that become out dated).

**M** – Motion: people or equipment walking/moving more than is required to perform the process (e.g. searching for staff/notes, moving between multiple levels in building)

**W** – Waiting: people unable to process or continue their work because they are waiting on people or equipment.

**O** – Over Production: making more than is needed, required or requested (e.g. making splints in advance).

**O** – Over Processing: more work completed than is required (e.g. completing paper waitlist and using computer waitlist system).

**D** – Defects: Processes required that create a defect or mistake and additional work is required to



correct it (e.g. incomplete referral)

**S** – Staff Under-utilisation: a result of not placing people where they can (and will) use their knowledge, skills and abilities to the fullest (e.g. therapy staff doing task that could be completed by the therapy assistant).

#### Value Stream Mapping

“A value stream map is a visual representation of the material, work, and information flow, as well as the cue times between processes for a specific customer demand” Dolan and Hawes (2009) (Task Analysis)

Kotter’s Eight Step Process of Successful Change

*Set the Stage:* A sense of urgency. The guiding team

*Decide what to do:* Change vision & strategy

*After it happens:* Communicate. Empower others. Short term wins. Don’t let up

*Make it stick*

New Culture

#### My Reflections:

This workshop allowed me to critique my day to day routine and evaluate how I can manage my time more effectively. It highlighted that ‘waste’ within an administration context has a knock-on effect on the time available for quality interventions with clients. The value stream mapping concept links closely to task analysis which Occupational Therapists do on a daily basis. ‘Lean thinking’ principles are not complex, yet often over looked. Having an acronym to these principles enable us to remember each point and easily incorporate them into our routines.

#### Management of Phantom Limb Pain: An occupational perspective and mirror therapy: Denise Gow, Hutt Valley DHB

##### Pain:

Neuropathic

Sensations

Fluctuates

Psychosocial

Stimulating muscles, decreases pain

Different presentations

##### Phantom Complex (Andrew Blogs)

3 elements:

Stump pain (? Infection, bone spurs, neuromas – loose bundle axon fibres)

Phantom limb sensation

Phantom limb pain

50-80% patients experience limb pain

##### Stump Pain

Early post-amputation pathology

Changes in pain processing system

Hyperalgesia

Allodynamic

##### Sensation

Abnormal phantom limb posture

Weight

Temperature (blood flow)

Severe pain can extend beyond phantom due to risk of overuse e.g. painful hip/knee on “good leg”.

##### Pain Assessment

Location

Description

Intensity

Triggers

Reason

History of pain

What does pain stop you doing?

What are you able to do?

Pattern to pain and why?

What has worked in the past?

Coping strategies

##### Sources of Phantom Pain

Neuromas or scar tissue

Sensitisation of the pain processing system

Cortical reorganisation

Mismatch between motor commands and

“expected” sensory input

“pre-phantom” pain may persist as a

“memory” in the phantom

Neighbouring areas on homunculus take over the phantoms lost representation.

##### Meditation/relaxation

Breathing

Imagery



### Mirror Imagery Training

Vision dominates touch and proprioception  
Mirror training – reflection of existing hand  
Visual input revives motor neurons.

### Mirror Therapy Researchers

Lorimer Mosely  
David Butler  
Ramacharidran  
Mac Iver

### **Occupational Therapy Contributing to Primary Health: Dana Campbell, Otago Polytechnic/Southern DHB. Dr Linda H Wilson, Otago Polytechnic**

#### **Key strategies are Promotion and Prevention.**

Preventative Health: there are 2 strands – disability postponement and prevention of disease or injury. *Education before event*

Health Promotion: empowers individuals to take control and responsibility for their health

Population Health: initiatives designed to advantage a certain population or group of people.

Predicted to increase equality in health status among populations.

### Literature Review

Potential to make occupational therapy more accessible.

Not always been successful – ‘doubling’ role with community OTs

Examples of interventions: balanced lifestyles, pain management, mental illness, domestic violence, child development, socialising skills and stress management

### Possibilities within GP Practice

*Equipment* – early intervention

*Specialist Assessments* – driving and cognition

*Skilled based interventions* – stress management

*Social skills interventions* – life skills, domestic violence, advocacy

*Connections with existing services in the community*: mental health and falls prevention  
*Keeping individuals out of hospital*  
*Focus on early intervention before Population Health*

### New Roles

Role blindness  
Don't see it, not recognised  
Role recognition  
clarification of task  
how things are done/supported  
differentiation accompanied by conflict  
Role reticence  
Providing what is already happening  
Role respect  
Sense of esteem shown to others  
Valued as legitimate expertise

### **My Reflections:**

I really valued the group discussion during this workshop. Although I recognised the need and role for Occupational Therapists within primary health, I was initially apprehensive as to how this service would run. My concerns were that therapist would likely be working in isolation, and there could be a risk of role boundaries becoming blurred. With supportive systems and structures, the occupational therapist role within primary health care could prevent hospitalisations and encourage wellness within local communities.

### **Getting it Right: Right time, right equipment, right service!: Sandy Ash, Home Health, A+ Links, Auckland DHB (our very own!!)**

- Ministry of Health EMS Service Accreditation (SA) “better soon, most convenient”
- Generic accreditation number and email address.
- Managed by Occupational Therapy Practice Supervisor and Physiotherapy Practice Supervisor. Training provided.
- Monitoring and auditing is very important. Included accessible printout of month's applications.
- Can address urgent need and still refer to specific discipline.



- ☑ Service accreditation list of equipment (no complex equipment can be issued across disciplines)

#### Positives

- ☑ Broader knowledge base about equipment by health professionals.
- ☑ Reducing waiting times for patients.
- ☑ Effective use of therapy/therapy assistant time.
- ☑ Eliminating duplications of assessments and home visits.

#### My Reflections:

I really valued the ideas presented in this workshop as I have had some experience working in a rural community setting. I came across patients who were geographically quite isolated and health professionals often had to travel 45mins or more to complete home visits. Having service accreditation within a rural community setting would decrease wait times and risk to patients, while incorporating 'lean thinking' principles into the organisation.

#### External Memory Aids: 'Making it real':

##### Jonathon Armstrong, ABI Rehabilitation (ex ADHB)

40% of people with concussion/mild head injury and 70-80% people with moderate/severe head injury, experience memory problems post Traumatic Brain Injury. Literature suggests that compensatory approach is best. Strategy/aid improves 'specific' performance.

#### Barriers identified:

- Getting external memory aid lost
- Insight – problem, the need, client and others
- Remembering how to use it
- Other impairments – vision, dexterity, dyspraxia
- Finances/funding
- Others increasing patient's dependency
- Cultural/language/use of time – support of patient rather than encouraging independence.

- Grief, loss, embarrassment for having to use a memory aid.
- Stigma

#### 4 Baskets of Knowledge (see Figure 1 at end of Newsletter)

- *Insight*
- *Buy-In*
- *Getting Others on board*
- *Making it real*

**Insight:** sometimes experiencing supported failure allows the patient to recognise problems. Psychologists caution that the failure cycle emphasis is negative (Dirrette, 2010). Ask yourself – “Does this patient need insight if others are supportive?”

**Buy In:** Making it meaningful (important to the patient)

- Do the ground work
- What they use before?
- Normalise (we all use memory aids)
- Setting memory goals
- Keeping it simple
- Reduce cognitive load
- Procedural memory “how to....”
- Making it meaningful (give objective accomplishments)
- Relate to real life
- Incorporate it into goal related activities.
- Use something routine, habitual
- Repetition

#### Getting others on board

- Model the use of aids
- Let patient see you write in your diary
- Friends/Family input
- Reinforcement
- Repetition
- Feedback
- Sustained use
- Summary:
- Address insight issues
- Ground work important
- Meaningful memory goals
- Get others involved
- One memory aid with not answer all of patients issues
- Engage patients in real life activities.



### My Reflections:

The points discussed gave me insight into the rehabilitation processes for patients experiencing memory deficits following TBI. The workshop highlighted how the quality of interventions received within an acute setting impact on the transition to rehabilitation services. I believe my role within the acute setting, is to identify the severity on TBI and begin to address insight issues. By understanding the rehabilitation process, I can educate patients' and their families on the occupational therapist's role following discharge from an acute ward. If used correctly, external memory aids can enable patients to increase their participation in daily occupations.

### Nurturing the space between Us: Pacific people and western systems: Marina Elisara, Faleola Services Counties Manukau DHB. Rachel Kapa-Vivian, Tikanga Afohe – Isa Lei WDHB. Manase Lua, LeVa

#### 7 main Pacific ethnic groups (2006 Census)

- ✘ Samoan
- ✘ Cook Island
- ✘ Tongan
- ✘ Niue
- ✘ Fiji
- ✘ Tokelau
- ✘ Tuvalu

Pacific people live mainly in Auckland, Wellington and Waikato

Large families → increased health demands (see Figure 2 at end of Newsletter).

#### Our Culture, Our World

- Shapes norms
- Influenced by meeting a need “trained by the resources from our environment to meet human needs”
- Born into roles/develop specific skills. “you can’t change it – just deal with it”

- Relationships are how you get things done (connectedness/survival)
- Relationships before knowledge

#### Values of these 2 Worlds

Pacific	Western
Observation/Oral	Literacy
Kinesthetic	Autonomy
Connectedness	Knowledge
People	
Trial/error	

#### Pacific Models of Health

- ✘ Fonua Model
- ✘ Fa’afaletu Model
- ✘ Papao Model
- ✘ Fonofale Model (developed after 1970s dawn raids (see Figure 3 at end of Newsletter).

#### Wellbeing & Relational Self

##### The relational Self

Is seen as total being - comprising of spiritual, mental and physical elements which cannot be separated.

##### Wellbeing

Involvement in communities/communal practices as an important source of meaning.

#### Spirituality

Grounds a person’s life and gives sense of meaning  
Interconnected/unity – body, mind and spirit.  
Trauma present = spiritual disconnection or “crisis” occurs.

#### Key Points:

- ✘ Investing in time is important
- ✘ Get to know your patient and their family
- ✘ Engagement first “they don’t care about what you know, until they know you care”

#### My Reflections:

This workshop highlighted that Pacific peoples value relationships before knowledge, and how the nature of acute settings impact on their experiences of hospitalisation. Gaining



an understanding of the values within these cultures has given me insight into what occupations may be meaningful to these patients.

**Digging Up the Daisies: Interactive problem solving: Nicola Billing & Madeline Marchant, Counties Manukau DHB**

Working through dilemmas and create a gold standard of practice

***“A problem well stated, is a problem half solved” (John Dewey/Charles Kettering)***

**Problem solving using A3 tool:**

An A3 report guides the dialogue and analysis. It identifies the current situation, the nature of the issue, the range of possible solutions, the means to put it into practice and the evidence that the issue has actually been addressed.

A3 is structured, logical, step-by-step and objective. It reduces wastes and errors, defines the issues.

**A3 Example**

Title:	Version:	Date:
<p><b>What is the Problem?</b></p> <ul style="list-style-type: none"> <li>-Why is this a problem?</li> <li>-5 Why's</li> <li>-What are the measures we will use to determine success?</li> </ul> <p><b>Current Condition:</b></p> <ul style="list-style-type: none"> <li>-Where do things stand today? (Use charts, drawings, or maps).</li> </ul> <p><b>Analysis:</b></p> <ul style="list-style-type: none"> <li>-Readdress what is the problem.</li> <li>-Identify the root causes of the problem.</li> </ul>	<p><b>Target Condition:</b></p> <ul style="list-style-type: none"> <li>-What is the goal ?</li> <li>-Why does the goal matter?</li> </ul> <p><b>Proposed Solutions:</b></p> <ul style="list-style-type: none"> <li>-How can you achieve your target condition?</li> <li>-Consider- does your analysis show a clear link between the problem definition , root causes and the solutions proposed ?</li> </ul> <p><b>Implementation Plan:</b></p> <ul style="list-style-type: none"> <li>-What do you need to do to implement the above ideas. (Detail the plan to roll out the identified solution into the work area in a sustained way).</li> </ul> <p><b>Follow-up:</b></p> <ul style="list-style-type: none"> <li>(Present the hard data proving that the problem has been 'fixed').</li> <li>-What are we going to do now?</li> </ul> <p>Sign off: _____ Date _____</p>	

The A3 problem solving tool helps to define a specific issue and look at possible solutions. Many of the ideas presented in this workshop link closely with 'Lean thinking' principles. It became clear during case study examples, that often the problem identified at the start of process, may not be the underlying cause. This process helps to guide clear and effective problem solving.



## Feedback 6.

### Megan Ward, NZROT, Home Health A+ Links, ADHB

#### Kaiwhakaora Ngangahau relationships with Whanau Ora: lived experiences: Jane Hopkirk.

This was a very reflective session with lots of discussion and interaction. The concepts of dependent, independent and interdependent models were explored. We all brought different perspectives of what this could mean for the people we work with, and how we can facilitate positive outcomes. There was a lot of emphasis placed on empowerment for people and their whanau, rather than providing solutions helping people to make their own, so they are sustainable for the future.

Getting to know someone from a Whanau Ora perspective looks at where they come from and their collective communities. Viewing themselves often as a collective unit rather than an individual. As the health profession we should not be afraid to be more than just a distant figure, we should allow rapport to develop by opening up and showing we have a background also. This can lead to really positive interventions.

#### Nurturing the space between us: Pacific people and western systems: Marina Elisara, Rachel Kapa-Vivian and Manase Lua.

A really brilliant quote that really summed up this talk was:

***“They don't care about what you know, until they know you care”.***

This quote showed how knowledge and expertise is not always viewed favourably until the person sees that you really want to help. By developing rapport and showing you're genuinely interested in the person's situation, only then your input will be valued.



This was a lovely session which really showed us some insights into the Pacific culture. Relationships and family were seen as the foundation, and most important thing was harmony, everyone knowing their place and role. Learning and respect was developed through doing and your relationships with others.

The best way to approach Pacific people was to show respect and allow time. Also to understand that the whole family has the right to be included in your intervention.



## Feedback 7.

### **Carolyn Simmons Carlsson, Professional Leader: Occupational Therapy, Physical Health Services, ADHB**

Whilst I only attended the last day to present two workshops, I did get to soak up some of 'buzz' and atmosphere that this year's Clinical Workshops had generated. Some of the words I heard about the workshops during breaks included the following:

- *Awesome*
- *Inspiring*
- *Didn't realise how great these workshops are*
- *Really good stuff*
- *Great networking*

It is times like these when I realise how far NZAOT has come and the value of being an NZAOT member. Quality & being part of a Community of Practice!!

No-one has mentioned the dinner yet, so it remains for me to give you a taste of this.

I am not normally an enthusiast of the proverbial "conference dinner" however this in itself was a great event. Picture a lovely, warm, sunny evening in the Bay; a slow leisurely ride on the ferry from Waitangi to

Russell (Never mind the salt spray and dishevelled hairdo afterwards! And the cacophony of chatter when you get a bunch of Occupational Therapists together – OMG); being welcomed at the historical old 'Duke' (The Duke of Marlborough Hotel) with a glass of complementary wine on the patio, followed by a splendid 3 course meal ... and only one "OT activity". Can't ask for more than that! Thanks NZAOT (... and nzaotevents.com). These workshops just get better and better!

In terms of what I presented, the first workshop focussed on the OTBNZ CCFR and was co-authored with my good friend and co-dreamer Merrolee Penman, who unfortunately could not attend. Merrolee and I have submitted the coaching notes for the December OT Insight.

My second workshop tooted the ADHB trumpet and focused on our supervision framework. Both workshops were well attended.

Below, are a few key slides to give you the gist of the workshops.

### **Workshop 1:**



#### **CCFR OBJECTIVE WRITING 101**

#### ***HOW TO TAKE THE 'ANGST'***

#### ***OUT OF IT?***

Carolyn Simmons Carlsson & Merrolee Penman  
November 5 2011



## Outline of Session

### Overall Aim:

- To assist you to stop 'struggling' with writing CCFR objectives by offering tools that enable easier 'doing' of the CCFR

### You will:

- evaluate how ready you are to be a self-directed learner & consider your learning style
- reflect on the CCFR objectives you have written
- be introduced to different strategies that may assist you to rewrite your objectives – as you see fit
- gain a greater understanding of the benefits of the CCFR tool in relation to your practice and your accountabilities as a registered practitioner

## CCFR Summary ...

- Self-directed process giving NZROTs the opportunity to demonstrate competence, provide evidence of professional development & update their records through a secure on-line tool
- CCFR tool allows the OTBNZ to perform audits & review practitioners' ongoing competence
- *Only* practising NZROTs are required to participate in the CCFR ... it is mandatory to have a CCFR supervisor!
- There are different expectations for supervision if you have a Condition on Scope of Practice

### Key take home messages:

- The CCFR is mandatory and within this we have a duty as registered Occupational Therapists to be competent in its implementation
- The CCFR on-line tool is a helpful-to-professional practice, well-constructed reflective tool
- Engagement in the CCFR requires confidence and technological competence, and even more importantly a reflexive approach to being a professional
- This means we need to develop the attributes for self-directed learning and understand the process, beginning with understanding one's learning style
- It's not that hard to write objectives when you draw from your day-to-day living practice and/or experiences

## Workshop 2:



# Supervision *From* Policy to Practice

Carolyn Simmons Carisson  
Professional Leader: Occupational Therapy  
Allied Health Supervision Portfolio - ADHB

[CSC Supervision & Consultation Services](#)

November 5<sup>th</sup> 2011



## Outline of Workshop

### Overall aim:

- Enable participants to understand what is required to build a robust supervision framework (*firm foundations*)

### You will:

- Walk through the ADHB supervision framework: from policy to practice
- Identify and highlight the key elements for building a sustainable framework and culture
- Have the opportunity to work with or begin to develop your own framework
- Have an opportunity for questions and discussion with a subject matter expert



## Key take home message

- **Building a robust supervision framework and culture across multiple professions requires multi-level leadership, time, funding, and attention to sustainable implementation of the fundamental elements that underpin quality supervision from policy to practice.**





**And lastly ...**

**Watch out for 2012  
NZAOT Conference:  
*Maramatanga Hou*  
Fresh Perspectives**

**Kingsgate Hotel, Hamilton  
September 19 – 21 2012**

**Themes:**

- On people's occupational development
- On claiming professional power
- On existing practice
- On the profession's scope
- On occupation
- On community and societal involvement
- On responsiveness to Maori

**Call for Abstracts close December 31 2011**

**Online Early Bird: June 1 2012**

Your Professional Leaders, Carolyn & Ellen are more than willing to support you if you would like to submit an abstract.

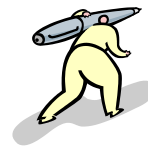
Go to <http://www.nzaotevents.com>



**PS.** If anyone is interested in the Lean Six Sigma Tools please contact Carolyn [carolynsc@adhb.govt.nz](mailto:carolynsc@adhb.govt.nz) who has attended the Green Belt Training.

Green belt Training provides knowledge and skills to solve different types of business problems utilising Lean Six Sigma, change management & project management thinking and tools.

END!



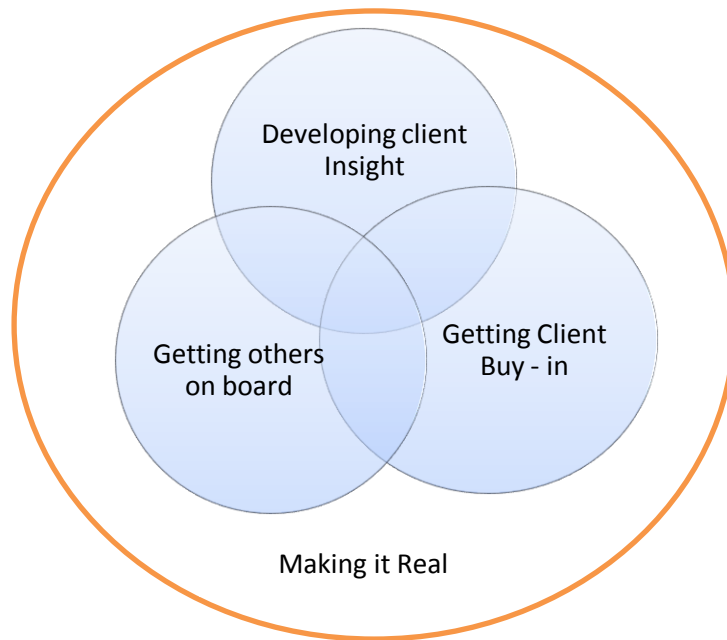
Any 'typos' are to be forgiven!



## Figures

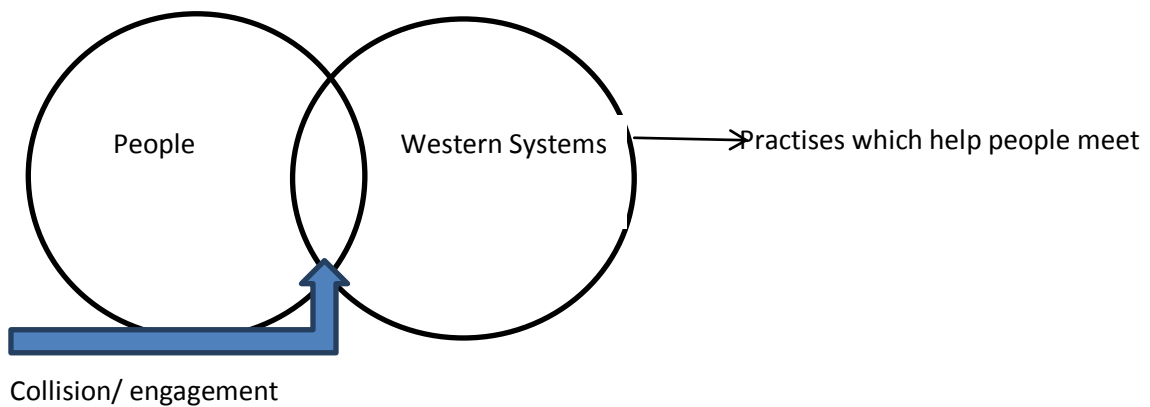
### Figure 1.

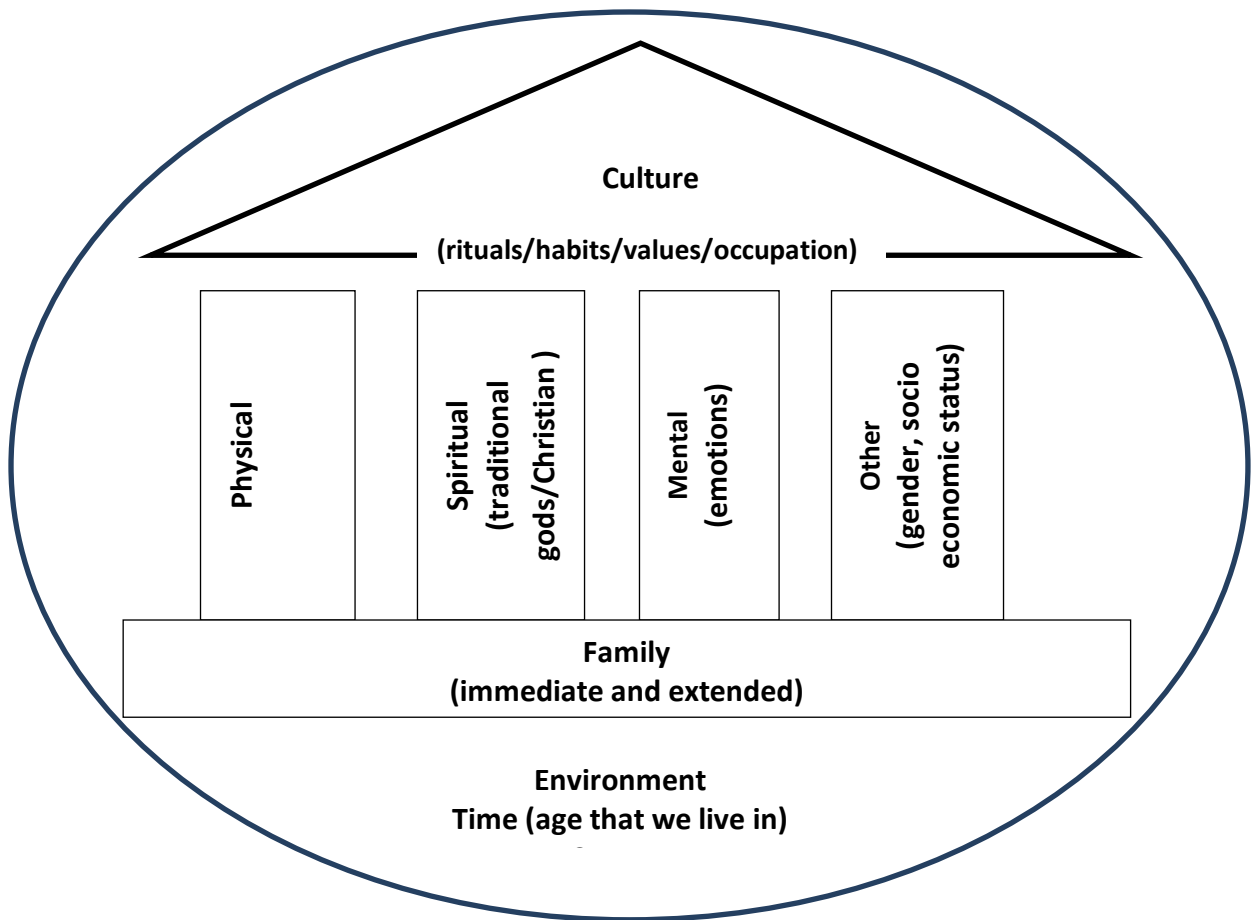
Four baskets of Knowledge (from External Memory Aids: 'making it real': Jonathon Armstrong, ABI Rehabilitation)



### Figure2.

Families (from Nurturing the Space between Us: Pacific people and western systems Marina Elisara, Faleola Services Counties Manukau DHB. Rachel Kapa-Vivian, Tikanga Afohe - Isa Lei WDHB. Manase Lua, LeVa)





**Figure 3.**

**Fonofale Model (developed after (from Nurturing the Space between Us: Pacific people and western systems: Marina Elisara, Faleola Services Counties Manukau DHB. Rachel Kapa-Vivian, Tikanga Afohe – Isa Lei WDHB. Manase Lua, LeVa)**

