COTNS COLLEGE of OCCUPATIONAL THERAPISTS of NOVA SCOTIA

CONTINUING COMPETENCE PROGRAM

Competence Assessment Blueprint Validation Report

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EXECUTIVE SUMMARY

Current evidence has called into question the validity of self-assessment as a measure of professional competence. As such, the College of Occupational Therapists of Nova Scotia is moving to a written competence assessment, using a key feature approach, to identify those who may not be meeting the standards of the College. A key feature approach has been demonstrated to effectively assess clinical reasoning skills and predict registrants who will receive a regulatory complaint. This report summarizes the results of a survey to validate the content of the competence assessment.

An assessment blueprint was developed by the Continuing Competence Committee based on practice questions and regulatory complaints received by the College and other occupational therapy regulatory bodies in Canada. The blueprint included regulatory issues, relevant legislation, and essential competencies. The validation survey was created by the Committee and was administered by Dalhousie School of Occupational Therapy to reduce reporting bias. Participants were asked to rate the frequency, importance, their confidence on regulatory issues, and were provided an opportunity to comment on the use of a competence assessment. Quantitative data was analyzed using descriptive statistics; qualitative comments were subjected to content analysis by a qualified qualitative researcher.

The results of the survey validate the regulatory issues as they all were rated as important. The use of support personnel was the least supported as a large portion of participants rated this issue as "not applicable". This may reflect the rural practice of occupational therapy, where traditional support personnel are not available. However, these practice settings may use non-traditional support personnel, such as nursing assistants or patient family members. Documentation, professional boundaries, informed consent, and confidentiality and privacy were consistently rated as frequent, important, and confident activities. While ethical issues and duty to report were rated as the least frequent and confident activities, they were rated higher in importance, suggesting these will be essential topics to include in a continuing competence program. The use of legislation in the assessment blueprint was not supported by the ratings or comments of participants.

Comments provided by the participants demonstrate a divide between those that support the concept of a competence assessment and those that do not. Many participants were questioning the rationale and evidence for the use of a competence assessment. This was related to participants' perspective of a lack of transparency from the College in communicating this new direction, despite efforts made by the College. Finally, participants' comments support the use of a general approach to assessment as many concerns were raised about practice-specific knowledge.

In conclusion, the results validate the use of regulatory topics in assessing competence but suggest the removal of legislation from the assessment blueprint. The College will need to explore alternative and creative methods to engage registrants and communicate the rationale and evidence supporting the competence assessment.

INTRODUCTION

The College of Occupational Therapists of Nova Scotia is mandated by legislation to ensure the public receives safe, ethical, and effective occupational therapy services. The College administers a continuing competence program to ensure registrants are competent to provide quality service to the public. Professional competence has been defined as the habitual and judicious use of knowledge, skills, clinical reasoning, values, and judgments in daily practice for the benefit of the individual and community being served (Epstein & Hundert, 2002).

Consistent with best practice guidelines, the College's competence program historically used self-assessment and documentation of learning activities as evidence of competence. However, recent evidence suggests a change in best practice. A review of the self-assessment literature demonstrated poor correlation between self-assessment and external measures of competence (Davis et al., 2006). These findings were independent of level of training, specialty, domain, or methodological procedures. Of particular concern, those therapists who perform poorly on external measures of competence are most likely to over-estimate their performance (Kruger & Dunning, 1999; Parker, Alford, & Passmore, 2004; Hodges, Regehr, & Martin, 2001). Furthermore, their self-assessment did not improve when provided with performance of their colleagues (Kruger & Dunning, 1999) or expert feedback (Hodges, Regehr, & Martin, 2001).

The uses of professional portfolios and continuing education credits as a measure of continuing competence are also questionable as they often rely on self-assessment. Even if therapists are able to identify their areas of weakness, they are more likely to participate in educational activities that reinforce what they know than address what they do not know (Regehr & Mylopoulos, 2008; Regehr & Eva, 2006). In addition, participation in educational activities does not ensure a change in practice (Regehr & Mylopoulos, 2008; Mazmanian, Daffron, Johnson, Davis, & Kantrowitz, 1998) and imposing education requirements does not improve therapists reported levels of competence (Lysaght, Altschuld, Grant, & Henderson, 2001).

Based on this evidence, the College decided to restructure its continuing competence program. It is apparent from the literature that if the College is to improve the competencies of registrants that are not meeting the standards of practice, the College will need a mechanism to identify these registrants for targeted intervention (Regehr & Eva, 2006). To this effect, the College chose to use a written assessment using a key feature approach. A key feature is a critical or essential step in resolving a problem, a step where candidates are most likely to make an error (Page, Bordage, & Allen, 1995). A recent literature review has demonstrated that a key feature format can effectively assess clinical reasoning skills (Hrynchak, Takahashi, & Nayer, 2014). Specifically, they found that assessments using key feature could distinguish between novice and expert practitioners and level of training. In addition, key feature tests have been demonstrated to predict regulatory complaints of physicians (Tamblyn et al., 2007). Using such an assessment, the College will be able to identify those members who may not be competent to provide safe, effective, and ethical care for further assessment and education. This report summarizes a survey to validate the content of the written assessment.

METHODOLOGY

Blueprint

The blueprint for the assessment was developed by the Continuing Competence Committee of the College based on a review of practice questions and complaints received by occupational therapy regulatory bodies in Canada. Due to the broad nature of occupational therapy practice, it was determined the assessment would measure the essential competencies, relevant legislation, and regulatory issues that are common in most, if not all, occupational therapy practice areas and settings (see Appendix 1). These were considered the core competencies of the profession and are expected of all registrants in the College. This distinguishes core competencies from clinical competencies, which are situational and context specific and will be assessed for those who do not meet the standard in the written assessment. The blueprint was developed according to the *Standards for Educational and Psychological Testing* (American Education Research Association, 2014).

Survey

The Continuing Competence Committee developed a short validation survey that was circulated to all current College registrants by e-mail. The survey was conducted by Dalhousie School of Occupational Therapy to reduce reporting bias and used Opinio Survey Software. The survey consisted of four sections:

Regulatory Issues

This section explored participants' perspective of regulatory issues considered to be important to providing safe and competent occupational therapy services. Participants were asked to reflect on the past twelve months of their practice and rate frequency, importance, and their confidence with each regulatory issue. Frequency was rated categorically as never, monthly, weekly, and daily. Importance and confidence were rated on a five-point Likert scale, with one being not at all important/confident and five being very important/confident. Ratings per provided for eleven regulatory issues (see Appendix 2).

Relevant legislation

In this section, participants were asked to rate their familiarity with each legislation on a five-point Likert scale, with one being not at all familiar and five being very familiar. The survey asked participants to rate eight pieces of legislation thought to be relevant to the practice of occupational therapy in Nova Scotia. Participants were given an opportunity to list additional legislation they felt were relevant.

Exam structure

This section looked at how the assessment may be delivered. Participants were asked where they would like to write a proctored assessment with the following options provided: a local testing facility, work place, at home and they will provide an individual to proctor, or any of the above. In addition, participants were asked what season would be most convenient to write an assessment. Finally,

participants were provided the opportunity to provide written comments on the move to a written competence assessment. This was included to evaluate the current opinion of registrants and determine the level of registrant engagement the College needed to provide.

Demographics

Demographic information was collected to compare the sample size to the registrant population according to data submitted annually by the College to the Canadian Institute for Health Information (CIHI). Responses were optional and included participants' age range, how long they have practiced as an occupational therapist, and their primary role, practice area, setting, and client age group.

The essential competencies were not included as they have previously been validated (Takahashi, Beggs, & Herold, 2011; Takahashi & Herold, 2010).

Analysis

All responses were initially recorded as the percentage of respondents that selected that response. Frequency data was grouped into two categories: not applicable, never, or monthly; and weekly or daily. Importance, confidence, and familiarity scores were subjected to descriptive statistics using Microsoft Excel to calculate the mean, standard deviation and the minimum and maximum scores. For importance data, a "not applicable" response was assigned a value of zero as these were seen as the least important. "Not applicable" data was excluded from confidence data as a confidence level could not be attributed to this response. This response option was not provided for relevant legislation.

Written statements under the assessment structure section were subjected to content analysis by a qualified qualitative researcher. Identified themes and their mapped statements were reviewed by the primary author and any discrepancies were resolved by discussion and consensus.

The percentage of participants in each demographic category was compared to the percentage of registrants in each category based on the 2016 CIHI data submitted by the College.

RESULTS

Of those who were sent the survey, 173 (33% of registrants) responses were recorded and 127 (24% of registrants) completed the full survey.

Demographics

The demographic characteristics of the participants compared to College registrants are presented in Table A (see Appendix 3). The sample was generally representative of the registrant population. There was an over-representation of the 30-39 age group (47.2% vs. 34.4%) and an under-representation of the 40-49 age group (25.6% vs. 35.0%). In addition, there was a significant over-representation of the community practice setting (25.4% vs. 3.5%) and under-representation of the general hospital practice setting (27.0% vs. 52.0%).

Frequency

The most frequently encountered regulatory issues were confidentiality and privacy, documentation, use of title, and professional boundaries. The regulatory issues least frequently encountered were ethical issues, conflict of interest, and duty to report (see Table 1).

Table 1. Frequency of Regulatory Issues

	NEVER/MONTHLY		WEEKLY/DAILY		
REGULATORY ISSUES	n	%	n	%	N
Professional Boundaries	30	20.1%	119	79.9%	149
Informed Consent	58	40.8%	84	59.2%	142
Documentation	17	12.2%	122	87.8%	139
Confidentiality & Privacy	6	4.4%	131	95.6%	139
Scope of Practice	67	49.3%	69	50.7%	136
Use of Title	21	15.7%	113	84.3%	134
Support Personnel	85	63.4%	49	36.6%	134
Conflict of Interest	111	84.1%	21	15.9%	132
Conflict Resolution	95	72.0%	37	28.0%	132
Ethical Issues	100	75.8%	32	24.2%	132
Duty to Report	111	84.7%	20	15.3%	131

Importance

Regulatory issues were well supported as the most frequent response was “very important” (see Table C in Appendix 4). All regulatory issues, with the exception of support personnel, received an average rating of at least four in importance (see Table 2). Support personnel received an average rating of 2.98, but demonstrated significant variability. This was a result of “not applicable” having the second highest response rate. The most important regulatory issues were confidentiality and privacy, documentation, professional boundaries, and informed consent. The least important regulatory issues were duty to report, conflict of interest, and support personnel.

Confidence

Participants reported they were confident in their ability to demonstrate competence in most of the regulatory issues. All categories received a “very confident” as the most frequent response with the exception of conflict resolution, ethical issues, and duty to report (see Table D in Appendix 4). Similarly, these also received the lowest average rating with ethical issues and duty to report receiving less than four (see Table 3). Most regulatory issues were rated as less confident than important with the exception of use of title, support personnel, and conflict of interest. The regulatory issues that participants reported they were most confident in were confidentiality and privacy, use of title, professional boundaries, and informed consent.

Table 2. Importance of Regulatory Issues

REGULATORY ISSUES	n	Min	Max	Mean	SD
Professional Boundaries	149	0	5	4.66	0.94
Informed Consent	142	0	5	4.56	1.14
Documentation	139	0	5	4.67	0.93
Confidentiality & Privacy	137	0	5	4.88	0.63
Scope of Practice	136	0	5	4.30	0.99
Use of Title	134	0	5	4.22	1.19
Support Personnel	134	0	5	2.98	2.10
Conflict of Interest	132	0	5	4.07	1.45
Conflict Resolution	132	0	5	4.40	0.97
Ethical Issues	132	0	5	4.52	1.00
Duty to Report	131	0	5	4.22	1.54

Table 3. Confidence of Regulatory Issues

REGULATORY ISSUES	n	Min	Max	Mean	SD
Professional Boundaries	146	2	5	4.57	0.57
Informed Consent	135	2	5	4.47	0.65
Documentation	132	2	5	4.45	0.65
Confidentiality & Privacy	135	3	5	4.65	0.56
Scope of Practice	131	2	5	4.21	0.80
Use of Title	129	3	5	4.58	0.59
Support Personnel	89	1	5	4.08	0.90
Conflict of Interest	118	2	5	4.16	0.89
Conflict Resolution	130	2	5	4.08	0.77
Ethical Issues	127	2	5	3.99	0.81
Duty to Report	112	1	5	3.89	0.96

Familiarity

Participants did not report familiarity with most of the identified legislation as they all received an average rating of less than four (see Table 4). The most frequently reported response varied from one to four (see Table E in Appendix 4). The most familiar legislation was identified as the *Personal Health Information Act* and the *Occupational Therapists Act*. The least familiar legislation was the *Involuntary Psychiatric Treatment Act* and the *Hospitals Act*. Additional reported legislation included the *Workers Compensation Act* and the *Occupational Health and Safety Act*.

Table 4. Relevant Legislation

LEGISLATION	n	Min	Max	Mean	SD
Occupational Therapists Act	129	1	5	3.43	0.93
Personal Health Information Act	129	2	5	3.98	0.84
Personal Directives Act	122	1	5	3.26	1.11
Adult Protection Act	121	1	5	3.12	1.11
Child & Family Services Act	110	1	5	2.50	1.16
Protection of Persons in Care Act	121	1	5	2.87	1.21
Involuntary Psychiatric Treatment Act	109	1	5	2.34	1.31
Hospital Act	118	1	5	2.27	1.14

Exam Sitting

Participants indicated that they would prefer to write the assessment at work (39.8%) or any location (26.6%); the least reported location was at home (8.6%). Half of participants indicated they would prefer to write the examination in the winter and a quarter reported in the spring. The summer was the least supported time (4.7%).

Qualitative Analysis

There were 66 recorded written responses that reflected participants' opinion on the move to a written competence assessment. Analysis identified nine themes that were represented, with overlap between themes for each comment.

Assessment Concept Supported (n=16)

Sixteen participants expressed support for the concept of the assessment. Some responded that they enthusiastically and unconditionally supported the concept. One response stated "I think it's a good idea to help us all remain on the same level regarding competencies and legislative information." Others saw it as an improvement on the current Continuing Competence Program: "I think a competency exam is a great addition and better way of determining professional competency that the Continuing Competency Portfolio." Many comments were supportive but expressed concern over the content, questioning the rational for the move, or making alternative suggestions.

Assessment Concept Not Supported (n-21)

Many participants expressed that they did not support the concept of the assessment. Some comments were a single expression of non-support as evident by these comments such as "unwarranted," or "I don't see the need for a competency exam." Others were paired with comments that questioned the principle of an assessment, such as "I do not feel that a competency exam is a true reflection of an OT's ability to provide a high standard of practice in their particular area." Alternative suggestions were common for those who did not support the concept.

Questioning the Proof of Principle (n=20)

The respondents both in support and not in support of the assessment questioned the validity of a written assessment as a viable tool for maintaining competence. Some participants were asking for evidence or a rationale for why the College is using a written assessment. One participant stated "Does the evidence indicate that it meets the desired outcome" while another made this comment:

> *"I am very interested to know what prompted the creation of the exam. For example: is this being created because of increasing numbers of complaints against members? Is this best practice in the field? Is there evidence to support the writing of the exam as it decreases the number of complaints and/or increased OTs confidence?"*

Others were making comparisons to other jurisdictions or other health care professionals. Yet, others questioned the concept on grounds on the ability of a written assessment to reflect practice or due to the content of the assessment. These were reflected by comments like "I think it may be hard to test clinical competency. Just because an individual knows the legislation and "rules of conduct" does not necessarily translate into being a competent therapists."

Finally, other comments were based on assumptions about continuing competence. These comments related to the evidence of competence upon graduation, completion of credentialing, and years of experience: "We have been through a professional program, written a national exam, completing our continuing competency portfolio and now an exam when a lot of us have been practicing for years."

Alternative Suggestions (n=18)

There were many suggestions to alternative measures in replacement of a written assessment. These suggestions included yearly submission of professional portfolios, practice audits, and use of continuing education credits. These were reflected in comments like "In Ontario, they provide their OTs with mandatory education modules to complete. I think this would be a better use of our time" or "Why not have a requirement for so many educational credits specific to your clinical area of practice instead… like some other professions." Other suggestions were to simplify the professional portfolio currently required under the Continuing Competence Program. A few registrants proposed changes to the blueprint of the assessment based on the broad nature of occupational therapy.

Concern about Content and Practice Knowledge (n=21)

One of the most frequent concerns of participants was the content of the assessment. Specifically, there was concern that it would require practice knowledge of areas the participant did not work in. One participated commented "given the wide variety of areas of practice, it is my hope and expectation that any competency exam will focus more on the skills we possess as OTs and not necessarily knowledge of specific areas of practice; for example, I would have very little current knowledge of pediatrics, as it is not an area in which I practice." Most participants expressed concern over the wide scope of practice of occupational therapy and what it meant for the assessment. Others were concerned that the legislation included in the survey applied to specific practice areas: "Depending on

our area of practice, some of these Acts don't apply. i.e. Hospital Act if you're in community; child protection if in long-term care or adult private practice." In addition, there was concern about what content from the legislation would be tested. Many of these comments were coupled with other themes, including support for the assessment, non-support for the assessment, and questioning the principle of proof.

Concern about Non-Traditional OT (n=10)

Similar to concerns about content, ten participants expressed concern about how the assessment would affect those working in non-traditional roles without direct client care, including leadership, research, academic, and education. Participants felt these roles are providing value in social or health change, represent the profession, and have a strong profile in promoting the value of occupational therapy, opening doors for our future workforce. They were concerned that these roles will be disadvantaged and may require them to give up their designation, which is often not required for these positions. These concerns are represented in the following comment provided by a participant:

> *"there should be significant consideration of the impact this program will have to the formal leaders in organizations that are in the OT profession. It runs the risk of formal leaders having to give up their ability to maintain their licence and not be able to call themselves OT. Losing that voice in leadership of organizations is a serious loss to the profession. Some consideration should be made for formal leaders."*

These comments were often coupled with a recommendation for the assessment to be broad in nature and not require specific clinical knowledge.

Exam Logistics (n=17)

There were seventeen participants that commented on how the assessment would be administered. Some of these included suggestions or questions about preparing for the assessment: "I recommend some guidance and prep from the college about how to best prepare, study, and write an exam for those of us who are out of practice." Other comments related to where they write the assessment. These comments often related to an online platform for convenience. There were a few questions as to who should write the assessment. Finally, participants were concerned about the outcome of the assessment and its potential effect on registration, as a participant expressed "what does it mean if you score below a certain level? Can you still practice? If you are given a mentor what does that look like in terms to time and scheduling?"

Communication (n=8)

Participants felt there was a lack of transparency from the College on the implementation of the assessment. A few participants mentioned that this was the first time they have heard of the assessment and requested copies of previous annual general meeting minutes. One participant stated "I think the College has done an extremely poor job of justifying the creation of this exam. Nor has

there been much explanation as to the success or failure of the competency program." Requests for further communication were made, including with professional practice coordinators.

Anxiety (n=7)

A few participants expressed feelings of anxiety or trepidation on behalf of themselves or colleagues. These were related to feeling stressed about not performing well, having not written a test in a long time, or feeling anxiety despite being highly respected in the field. One participant stated "I admit I am nervous about writing an exam. I have not written an exam in 18 years."

DISCUSSION

The results of this survey validate the use of the regulatory issues for the assessment of competence. While use of support personnel was not as well supported, this may reflect the participants' definition. Many therapists practicing in rural Nova Scotia may not have access to traditional support personnel, such as therapy or rehabilitation assistants, but may use other human resources, such as nursing assistants or patient's family members. Similar assignment principles apply to non-traditional support personnel and will be evaluated in the assessment.

Regulatory issues that were reported as frequent activities were likely to receive high confidence ratings. This suggests participants' level of confidence, and potentially their competence, is dependent on how often the issues are encountered. Therefore, activities that are not encountered often but are rated as important will be higher risk activities. This was the case for ethical issues and duty to report, which were rated as least frequent and lowest confidence but were rated higher for importance. These topics will be essential to include in the College's Continuing Competence Program. Conversely, use of professional title was reported as frequent and confident activities, but received a lower importance rating; this topic may not be relevant for the Continuing Competence Program. Finally, Participants consistently rated documentation, professional boundaries, informed consent, and confidentiality and privacy as frequent, important, and confident skills. Interestingly, documentation received a relatively lower confidence rating despite being a frequent and important activity. These will be core issues to include in the assessment to establish registrants' level of competence.

The use of relevant legislation in the assessment was not supported. With the exception of the *Personal Health Information Act*, participants reported not being familiar with the included legislation. In addition, participants' comments identified that many of the included legislation was practice specific and participants were concerned about including these components in the assessment. This survey would support the removal of relevant legislation from the assessment blueprint; however, the listed legislation may be grouped into categories, such as capacity or duty to report legislation, and be included as references for the regulatory issues.

While the survey data supports the regulatory topics identified, comments provided by participants called into question the use of a written assessment for demonstration of competence. Many participants either did not support this move and/or questioned the evidence and rationale of the assessment.; however, as demonstrated in the introduction, current evidence supports the use of a

written test in assessing and identifying potential risks to competence (Hrynchak, Takahashi, & Nayer, 2014; Tamblyn et al., 2007). The discrepancy between evidence and reports from participants may relate to communication from the College. Some participants stated this was the first time that they had heard of the change, despite the College's efforts to communicate to registrants in annual reports and newsletters. Alternative strategies for communication for both the content, purpose, and the rationale will need to be considered to further engage College registrants.

Finally, while participant comments were divided on the support of a written test, they do support the assessment of core competencies over clinical competencies. Many participants were concerned about the evaluation of clinical competencies and made recommendations to keep the assessment broad in nature and only evaluate competencies that are common to practice areas and settings. This further validates the concept of core competencies included in the assessment blueprint.

Given the nature of the survey and unequal demographic distribution, it is possible that these results reflected a biased opinion; yet, the strong comments expressed and the polarized opinions in the survey suggest that reporting biases were limited. Furthermore, the College received a good response rate from registrants, thereby limiting the chances of a biased opinion. It is possible that those who agree with the assessment may not have participated and the opinions over-represent those who oppose this move. Alternatively, registrants who practice in a more traditional hospital setting may feel confident in their ability to demonstrate competence or feel indifferent and therefore did not feel the need to participate.

In conclusion, this survey data validates the use of regulatory issues in an assessment of registrants' core competencies. The College will need to reconsider the role of relevant legislation in the competence assessment. Additionally, the College will need to consider alternative strategies to provide information and engage its registrants in the delivery of the Continuing Competence Program.

APPENDIX 1

DRAFT ASSESSMENT BLUEPRINT

Regulatory Topics

- Professional boundaries
- Consent
- Documentation and record keeping
- Confidentiality and privacy
- Scope of practice
- Use of title
- Assigning service components to support personnel
- Conflict of interest
- Conflict resolution
- Ethical practice/issues
- Duty to report

Nova Scotia Legislation

- Occupational Therapists Act
- Personal Health Information Act
- Personal Directives Act
- Adult Protection Act
- Child and Family Services Act
- Protection of Persons in Care Act
- Involuntary Psychiatric Treatment Act
- Hospitals Act

Essential Competencies

- Assumes professional responsibility
- Thinks critically
- Utilizes an occupational therapy process to enable occupation
- Communicates and collaborates effectively
- Manages own work and advocates within systems

APPENDIX 2

JURISPRUDENCE EXAM MEMBERSHIP VALIDATION SURVEY

REGULATORY ISSUES

For each item below, think about your practice over the past 12 months, and rate:

a. the frequency with which you had to deal with the particular regulatory issue;
b. the importance of the regulatory issue in ensuring occupational therapists provide safe, ethical, and effective care; and
c. the degree to which you feel you can demonstrate competence for each regulatory issue:

1. Develops and maintains professional boundaries when interacting with clients:

Frequency				
Never	Monthly		Weekly	Daily
Importance				
Not at all important				Very important
1	2	3	4	5
Confidence				
Not at all confident				Very confident
1	2	3	4	5

2. Obtains informed consent from clients/families or substitute decision-makers where the client lacks capacity:
3. Documents occupational therapy services and keeps records in compliance with relevant legislation:
4. Maintains client confidentiality and privacy in accordance with relevant legislation:
5. Actively identifies areas outside your scope of practice:
6. Demonstrates proper use of title:
7. Assigns and supervises support personnel :
8. Identifies and manages conflicts of interest:
9. Seeks to resolve conflict with colleagues and clients:
10. Resolves ethical issues:
11. Complies with duty to report :

LEGISLATION

For each item below, please rate your familiarity with the legislation and its applicability to your practice. Please add any additional legislation that you think is relevant to your practice:

12. Occupational Therapists Act

Not at all familiar				Very familiar
1	2	3	4	5

13. Personal Health Information Act (PHIA)/Confidentiality Act
14. Personal Directives Act
15. Adult Protection Act
16. Child and Family Services Act
17. Protection of Persons In Care Act
18. Involuntary Psychiatric Treatment Act
19. Hospitals Act
20. Additional Legislation:

EXAM STRUCTURE

21. Where would you prefer to write the exam if it is proctored:
    - ☐ At a local testing facility
    - ☐ At my work place
    - ☐ At home and I will provide an individual to proctor
    - ☐ Any of the above
22. When would be the most convenient time to write the exam:
    - ☐ Spring
    - ☐ Summer
    - ☐ Fall
    - ☐ Winter
23. Please provide comments on the College's move to a competency exam as part of the continuing competency program:

DEMOGRAPHICS

24. Please specify your age group:
    - ☐ Under 30
    - ☐ 30-39
    - ☐ 40-49

- ☐ 50-59
- ☐ Over 60

25. How long have you practised as an occupational therapist:
    - ☐ Less than 5 years
    - ☐ 5-10 years
    - ☐ 11-20 years
    - ☐ 21-30 years
    - ☐ Over 30 years

26. In what primary capacity do you currently practice occupational therapy:
    - ☐ Direct service provider
    - ☐ Manager
    - ☐ Professional practice leader/coordinator
    - ☐ Educator/researcher

27. What age group do you predominantly work with:
    - ☐ Preschool (0-4)
    - ☐ School age (5-17)
    - ☐ Mixed pediatric (0-17)
    - ☐ Adults (18-64)
    - ☐ Seniors (65+)
    - ☐ Mixed adults (18+)
    - ☐ All ages

28. In what primary area do you currently provide occupational therapy services:
    - ☐ General physical health
    - ☐ Mental health
    - ☐ Neurological
    - ☐ Musculoskeletal
    - ☐ Vocation rehabilitation
    - ☐ Palliative care
    - ☐ Teaching/research
    - ☐ Medical legal
    - ☐ Non-clinical
    - ☐ Other:

29. Where do you primarily provide occupational therapy services:
    - ☐ General hospital
    - ☐ Rehabilitation facility
    - ☐ Community
    - ☐ Residential care/assisted living
    - ☐ School board
    - ☐ Private practice
    - ☐ Post-secondary education
    - ☐ Association/Government
    - ☐ Other:

APPENDIX 3

DEMOGRAPHICS

Table A. Participant versus College Registrants Demographics

CATEGORY	n	PERCENTAGE	
		SURVEY	COLLEGE REGISTRANTS
Age Group			
Under 30	16	12.8%	14.3%
30-39	59	47.2%	34.4%
40-49	32	25.6%	35.0%
50-59	14	11.2%	13.0%
Over 60	4	3.2%	3.3%
TOTAL	125		
Experience			
Less than 5 years	16	12.7%	18.0%
5-10 years	41	32.5%	22.8%
11-20 years	42	33.3%	34.0%
21-30 years	18	14.3%	19.3%
Over 30 years	9	7.1%	5.9%
TOTAL	126		
Position			
Direct service provider	102	84.3%	80.6%
Manager	9	7.4%	7.9%
Professional Practice Leader/coordinator	4	3.3%	7.2%
Educator/researcher	6	5.0%	4.4%
TOTAL	121		
Client Age			
Preschool (0-4)	6	4.9%	2.7%
School Age (5-17)	6	4.9%	2.7%
Mixed Pediatric (0-17)	8	6.6%	6.2%
Adults (18-64)	32	26.2%	25.5%
Seniors (65+)	22	18.0%	10.6%
Mixed Adults (18+)	40	32.8%	37.5%
All ages	8	6.6%	14.9%
TOTAL	122		

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Table A Continued

CATEGORY	n	PERCENTAGE	
		SURVEY	COLLEGE REGISTRANTS
Area of Practice			
General physical health	39	31.7%	33.7%
Mental health	26	21.1%	18.9%
Neurological	10	8.1%	7.5%
Musculoskeletal	5	4.1%	5.3%
Vocational rehabilitation	9	7.3%	6.6%
Palliative care	0	0.0%	0.9%
Teaching/research	4	3.3%	4.0%
Medical/Legal	0	0.0%	4.2%
Non-clinical	9	7.3%	5.7%
Other	21	17.1%	13.2%
TOTAL	123		
Practice Setting			
General hospital	34	27.0%	52.0%
Rehabilitation facility	12	9.5%	6.8%
Community	32	25.4%	3.5%
Residential care/assisted living	10	7.9%	5.9%
School board	2	1.6%	0.2%
Private practice	17	13.5%	13.9%
Post-secondary education	6	4.8%	4.4%
Association/Government	5	4.0%	4.6%
Other	8	6.3%	8.6%
TOTAL	126		

APPENDIX 4

RELATIVE FREQUENCY OF RESPONSES

Table B. Frequency of Regulatory Issues Raw Data

REGULATORY ISSUE	N/A	Never	Monthly	Weekly	Daily	n
Professional Boundaries	3.4%	6.0%	10.7%	13.4%	66.4%	149
Informed Consent	8.5%	12.0%	20.4%	23.2%	35.9%	142
Documentation	5.8%	2.9%	3.6%	15.1%	72.7%	139
Confidentiality & Privacy	2.9%	0.7%	0.7%	3.6%	92.0%	137
Scope of Practice	3.7%	2.2%	43.4%	38.2%	12.5%	136
Use of Title	3.7%	4.5%	7.5%	11.2%	73.1%	134
Support Personnel	27.6%	20.1%	15.7%	14.2%	22.4%	134
Conflict of Interest	6.8%	16.7%	60.6%	8.3%	7.6%	132
Conflict Resolution	0.8%	6.1%	65.2%	22.0%	6.1%	132
Ethical Issues	2.3%	11.4%	62.1%	18.9%	5.3%	132
Duty to Report	13.7%	37.4%	33.6%	3.8%	11.5%	131

Table C. Importance of Regulatory Issues Raw Data

REGULATORY ISSUE	N/A	1	2	3	4	5	n
Professional Boundaries	2.7%	0.7%	0.0%	2.0%	14.1%	80.5%	149
Informed Consent	4.9%	0.0%	0.7%	0.7%	16.2%	77.5%	142
Documentation	2.9%	0.0%	0.7%	1.4%	13.7%	81.3%	139
Confidentiality & Privacy	1.5%	0.0%	0.0%	0.0%	4.4%	94.2%	137
Scope of Practice	2.9%	0.0%	0.0%	8.8%	37.5%	50.7%	136
Use of Title	3.7%	0.7%	2.2%	14.2%	21.6%	57.5%	134
Support Personnel	30.6%	0.7%	0.0%	12.7%	20.9%	35.1%	134
Conflict of Interest	8.3%	0.8%	1.5%	9.8%	24.2%	55.3%	132
Conflict Resolution	2.3%	0.0%	0.8%	9.8%	26.5%	60.6%	132
Ethical Issues	3.0%	0.0%	0.8%	4.5%	22.0%	69.7%	132
Duty to Report	10.7%	0.0%	0.0%	3.1%	18.3%	67.9%	131

Table D. Confidence of Regulatory Issues Raw Data

REGULATORY ISSUE	1	2	3	4	5	n
Professional Boundaries	0.0%	0.7%	2.1%	37.0%	60.3%	146
Informed Consent	0.0%	0.7%	6.7%	37.0%	55.6%	135
Documentation	0.0%	0.8%	6.8%	39.4%	53.0%	132
Confidentiality & Privacy	0.0%	0.0%	4.4%	25.9%	69.6%	135
Scope of Practice	0.0%	1.5%	19.1%	36.6%	42.7%	131
Use of Title	0.0%	0.0%	5.4%	31.0%	63.6%	129
Support Personnel	1.1%	3.4%	20.2%	37.1%	38.2%	89
Conflict of Interest	0.0%	4.2%	20.3%	30.5%	44.9%	118
Conflict Resolution	0.0%	1.5%	21.5%	43.8%	33.1%	130
Ethical Issues	0.0%	1.6%	28.3%	39.4%	30.7%	127
Duty to Report	1.8%	4.5%	27.7%	34.8%	31.3%	112

Table E. Familiarity of Legislation Raw Data

LEGISLATION	1	2	3	4	5	n
Occupational Therapists Act	1.6%	14.0%	37.2%	34.9%	12.4%	129
Personal Health Information Act	0.0%	4.7%	21.7%	44.2%	29.5%	129
Personal Directives Act	5.7%	20.5%	29.5%	30.3%	13.9%	122
Adult Protection Act	5.8%	27.3%	28.1%	27.3%	11.6%	121
Child & Family Services Act	23.6%	27.3%	30.9%	11.8%	6.4%	110
Protection of Persons in Care Act	15.7%	23.1%	30.6%	19.8%	10.7%	121
Involuntary Psychiatric Treatment Act	37.6%	20.2%	21.1%	12.8%	8.3%	109
Hospital Act	31.4%	28.8%	26.3%	8.5%	5.1%	118

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