2025

THERAPEUTIC PROTOCOLS-
OCCUPATIONAL THERAPY

Ministry of Health
Male' Republic of Maldives

RELEASE RECORD

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1. INTRODUCTION

DEFINITION

AOTA's Definition of Occupational Therapy for the Model Practice Act defines occupational therapy as the therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for the purpose of promoting health and wellness and to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life" (AOTA, 2004).

2. SCOPE OF PRACTICE

The scope of practice includes the domain and process of occupational therapy services. These concepts are intertwined with the domain defining the focus of occupational therapy and the process defining the delivery of occupational therapy. The domain of occupational therapy is the everyday life activities (occupations) that people find meaningful and purposeful. Within this domain, occupational therapy services enable clients to engage (participate) in their everyday life activities in their desired roles, context, and life situations. Clients may be individuals, groups, communities, or populations. The occupations in which clients engage occur throughout the lifespan and include

- Activities of daily living (self-care activities);
- Education (activities to participate as a learner in a learning environment);
- Instrumental activities of daily living (multistep activities to care for self and others, such as household management, financial management, and childcare);
- Leisure (nonobligatory, discretionary, and intrinsically rewarding activities);
- Play (spontaneous and organized activities that promote pleasure, amusement, and diversion); • Social participation (activities expected of individuals or

individuals interacting with others); and • Work (employment-related and volunteer activities)

3. INFRASTRUCTURE

3.1 LAYOUT

- Reception
- Waiting area
- Access to washroom and drinking water in the waiting area
- Adequate classroom space (Individual Sessions), including storing and securing of equipment and supplies
  - Air-conditioned
  - Bag cubbies
  - Shoe rack area
  - Adequate lighting
- Common Area
  - It should include equipment for Activities of Daily Living such as a functioning kitchen, laundry area and bedroom. (ADL Training Room)
  - An Area for group sessions
- Accessibility to the clinic/center or service environment
  - Ramps
  - Lift and stairs
  - Curbs
  - Wide enough doorway for Wheelchair accessibility

3.2 EQUIPMENT

- Standardized assessments
- Goniometer
- Dynameter
- Measuring tape
- Adjustable table and chair
- Padded floor mats and walls
- Sensory Equipment's
- Wheelchair

4. COMPETENCY OF THERAPIST/PRACTITIONER

4.1 QUALIFICATIONS

- Should have minimum of Bachelor's Degree of Occupational Therapy
- Should have a minimum of 5 hours of Continuing Professional Development (CPD) per year. This may include journal article reading, clinical supervision, participation in OT specific workshops/webinars (Online and/or in person) and/or case consultations.

4.2 CLINICAL SUPERVISION

- All clinicians should have access to clinical supervision to ensure patient safety and high-quality care. It is recommended that clinicians take part in monthly supervision sessions, which can be in the form of group supervision or individual or online.
- New graduate Occupational Therapists are required to access weekly supervision from an Occupational Therapist with 2 or more years of clinical experience. They are also recommended to attend case consultations and group supervision sessions as needed.

4.3 LICENSE

Should be registered under Maldives Allied Health Council.

5. REFERRAL

5.1 WHO CAN REFER TO OT

- Self-referral/ Parental referral
- School Referral (Teachers)
- Medical Practitioner
- Allied Health Professionals

5.2 WHO OT CAN REFER TO

- Medical Practitioner
- Allied Health Professionals

6. INITIAL ASSESSMENT AND PROCEDURES

6.1 CONSENT

- Consent to assess and intervene should be given voluntarily by the caregiver
- Consent to contact other health and medical professionals and other relevant caregivers such as teachers and extended family.
- Follow Health Service Act 29/2015 and Healthcare Professional Act 13/2015

6.2 HISTORY

- Personal Information
- Medical History
- Developmental History

- Family History
- Educational History
- Employment History
- Social History
- Behavioural History

6.3 ASSESSMENT COMPONENTS

- Fine motor
- Gross motor
- Sensory Processing
- Play and Leisure
- Self-care- ADLs/IADLs
- Social participation
- Productivity

7. GOAL SETTING

- Goals must be occupation focused
- Goals must be family cantered and collaborative
- The goals must be specific, measurable, achievable, realistic, and timely.
- Regularly reviewed
- Used as a key outcome measure

8. INTERVENTION PLANNING

8.1 FREQUENCY:

- Frequency of sessions will depend on the child's goals and needs. The following table provides a guide on the frequency of therapy in Paediatrics. To request for

intensive therapy funding, documentation should be presented on the child's progress and goal attainment in the 3-month period. The documentation must include, child goals, outcome measures and progress reports.

- Each session can vary from 30 - 60 minutes.
- Sessions can take place in a clinic setting or in the community (home or school). See annex for home/community visit guideline.

TABLE 1

Cincinnati Children's Hospital Medical Center, Division of Occupational Therapy, and Physical Therapy Guidelines for Frequency of Therapy Services in a Pediatric Medical Setting

Factors	Intensive 3–11×/wk	Weekly/Bimonthly 1–2×/wk or Every Other Week	Periodic Monthly or Less Often at Regularly Scheduled Intervals	Consultative Episodic or as Needed
Potential to participate and benefit from the therapy process (takes into consideration age, diagnosis, prognosis, and motivation)	Patient has potential for rapid progress; or potential for rapid decline or loss of functional skills due to current medical condition	Patient demonstrates continuous progress toward established goals	Patient demonstrates slow rate of attainment of goals in identified areas and/or does not regress for reasons unrelated to their disease process	Patient/caregiver is able to meet new challenges associated with a change in life stage or medical condition. PT/OT uses clinical decision making and problem solving skills to identify problems, recommend solutions in response to new challenges or specific issues identified by the family
Critical period for skill acquisition or for potential regression related to development or medical condition	Extremely critical period	Critical Period	Not in a critical period and/or episodically critical period related to development, change in life stage or medical condition	Specific challenges identified by patient and/or caregiver, or have a need for specific adaptive equipment
Amount of clinical decision making and problem solving needed from a licensed therapist	Requires the clinical skills and problem solving of a licensed therapist; a limited part of therapy program can be safely performed by patient and/or caregiver	Requires the clinical skills and problem solving of a licensed therapist for a significant part of the therapeutic program; some exercises/activities can be safely performed by patient and/or caregiver	Requires the clinical skills and problem solving of a therapist to periodically reassess condition and update home program; home program can be safely performed by patient and/or caregiver	Home Program can be carried out safely by patient and/or caregiver. Clinical skills and problem solving of a licensed therapist needed for specific challenges identified by the family or patient.
Level of support present to assist the patient in attaining goals (ie, ability to attend appointments, compliance with therapy recommendations, etc)	High level of support present to assist the patient in attaining goals	High level of support present to assist the patient attaining goals	Level of support is adequate to maintain skills and/or various factors present that impede patient's ability to made steady progress toward goals	Level of support is adequate to allow patient to meet new challenges associated with a change in life stage or medical condition, with consultative services of therapist

Modified from Iowa Department of Education, Des Moines, IA, February 2001.

8.2 FAMILY/CARER SUPPORT:

Paediatrics:

- Parents should be encouraged to be present in all therapy sessions. Parents should be informed that therapy sessions will educate and inform the parent on how to support the child at home to practice the goals.

- Parents are required to be present during therapy sessions for a minimum 6 therapy session of a 3-month therapy block.
- Families and professionals will share responsibility and work collaboratively towards goal attainment.

8.3 INTERVENTION FRAMEWORKS:

- Strength based approach:
    - Professionals shall utilize a strength-based approach with the client to focus on what they can do and their emerging abilities to work on their goals.
    - When working with families, a strength-based approach will be utilized to educate and capacity-build to support the families to make informed decisions about their clients' care and support the client.
- Family cantered practice:
    - Therapists and clients/families work in partnership to prioritize their needs when goal setting and intervention planning. It is based on building on the family strengths and supports they have in the community.
- Multi-Disciplinary Team (MDT) approach
    - Occupational Therapist will utilize a Multi-Disciplinary Team (MDT) approach and will work with other health professionals and educators.
    - Client goals should be clearly defined and communicated to all team members
    - Joint goal setting is recommended when required and available.
    - Sessions can be with an occupational therapist or joint session with another health professional.

8.4 OCCUPATIONAL THERAPY PROCESSES

- Occupational Therapists will use occupational therapy models and frameworks to guide their practice. Some of the recommended models are:
    - Canadian Occupational Performance Measure: COPM
    - Occupational performance Model - Australia (OPMA)
    - Other relevant Occupational Therapy Models can be used as well
- Therapeutic relationships
    - Occupational Therapists will work on developing a therapeutic relationship with the client as well as family members.
- Occupational Therapists will identify and analyze the occupational roles of the client.
- Evaluating factors impacting participation in occupation.
- Planning and developing occupation-based interventions. Clinicians will modify intervention plans accordingly. Interventions should be individualized and flexible to the client.
- An occupational therapy practitioner uses professional and clinical reasoning, best available evidence, and therapeutic use of self to select and implement the most appropriate types of interventions.
- An occupational therapist is responsible for determining outcomes of the occupational therapy intervention and selecting appropriate outcome measures to identify the client's ability to engage in their desired occupations.

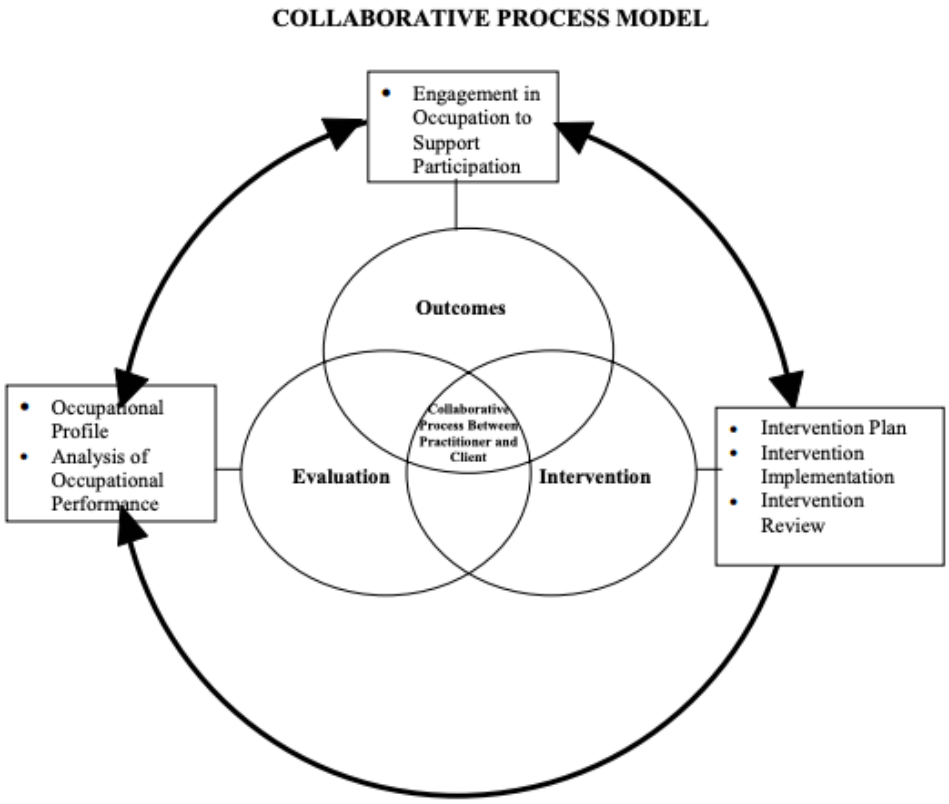

Figure: Illustration of the framework emphasizing client–practitioner interactive relationship and interactive nature of the service delivery process (AOTA 2002, 614).

9. OUTCOME MEASURE/ PROGRESS

- Goals must be reviewed every 3-6 months and new goals should be set accordingly.
- The occupational therapy practitioner ethically reports outcomes to payers and referring entities as well as to relevant local, regional, and national databases and registries, when appropriate.
- must accurately assess the desired outcome, implying that it has been examined for validity and reliability for the specific population it is applied to.
- Use of standardized assessment such as COPM or parent friendly/modified version of COPM or the Performance Quality Rating Scale (PQRS - see Annex).

10. PROGRESS REPORTS

- Intervention Summary
- Results of Outcome measure

- Client's strengths and areas that require further development
- New reviewed goals
- Recommendation
- Therapist Information (Name and Registration Number)

11. DOCUMENTATION

Documentation must be completed within 48 hours from client related contact. The notes should include the date, time and pace of intervention, and who was present at the session.

Documentation should include the SOAP notes.

Subjective: Information provided by the client or the caregiver. (Client's current status, behaviour and other information relevant for the therapy process).

Objective: Specific tasks performed during the treatment session to address the client's goals. (Measurable, Quantitative and observable actions during the session).

Assessment: How the client did or how they responded during the treatment. (Adds validity and interpreting the information written in the Subjective and Objective sections.)

Plan: What you intend to do next time to address how the client responded this time such as next steps, revisiting of steps, etc. (Treatment plan for next time).

12. DISCHARGE PLAN

Discharge may occur if it meets the following criteria:

- At the request of the client/family.
- If the child has met the age-appropriate milestones and no longer requires support from occupational therapy to develop their skills.
- If the client has improved their condition so that they can participate in required activities of daily living safely.

- If the client is transitioning from one service to another (eg: from acute to outpatient)
- If the client has progressed to a point where continuation of therapy will unlikely cause a significant improvement.

Discharge process:

- Use clinical reasoning to justify the client's discharge.
- Provide a discharge summary to the family (or referrer) highlighting intervention, and progress.
- Provide recommendations if further support is needed.
- Provide parent, family or caregiver support and education as needed.
- Coordinate transition of the client to another service if applicable

Assessment process	**Severity**	**Frequency of sessions**	**Recommendation**
AUTISM SPECTRUM DISORDER			
1. Sensory Profile 2 2. The Bruininks- Oseretsky Test of Motor Proficiency Second Edition (BOT-2) 3.Modified Ashworth Scale 4. Paebody Development Motor Scale (PDMS-2) 5. Beery- Buktenica Developmental Test of Visual- Motor Intergration (BEERY VMI) 6. Functional Independance measure (FIM) 7. Parent interview	Level 1 (mild)	1-2 weekly or bi-monthly or monthly.	MDT approach is recommended
	Level 2 (moderate)	1-2 weekly or bi monthly or monthly.	
	Level 3 (severe)	2 X week	

8. Clinical Observations				
CEREBRAL PALSY				
1. Sensory Profile 2 2. BOT 2 3. PDMS-2 3. BEERY VMI 4. Range Of Motion (ROM) 5. Gait analysis 6. Modified Tardieu Scale 7. FIM 8. Parent interview 9. Clinical Observations	**FINE MOTOR**			MDT approach is recommended
	MANUAL ABILITY CLASSIFICATION SYSTEM	Level 1	1-2 weekly or bi monthly or monthly.	
		Level 2	1-2 weekly or bi monthly or monthly.	
		Level 3	1-2 weekly or bi monthly or monthly.	
		Level 4	2 X week	
		Level 5	2 X week	
	GROSS MOTOR			
	GROSS MOTOR FUNCTION CLASSIFICATION SYSTEM	Level 1	1-2 weekly or bi monthly or monthly.	
		Level 2	1-2 weekly or bi monthly or monthly.	
		Level 3	2 X week	
		Level 4	2 X week	
		Level 5	2 X week	

DOWN SYNDROME			
1.Oral motor checklist 2.Modified Ashworth Scale 3. BEERY VMI 5.BOT 2 6. PDMS-2 7. Sensory Profile 2 8. FIM 9. Parent interview 10. Clinical Observations	Mild	1-2 weekly or bi monthly or monthly.	Adjustment of assessment according to the client capabilities
	Moderate	1-2 weekly or bi monthly or monthly.	
	Severe	2 X week	
GLOBAL DEVELOPMENT DELAY			
1. Sensory Profile 2 2. The Bruininks-Oseretsky Test of Motor Proficiency Second Edition (BOT-2) 3.Modified Ashworth Scale 4. Beery- Buktenica Developmental Test of Visual- Motor Integration (BEERY VMI) 5. FIM 6. Parent interview 7. Clinical Observations	Mild	1-2 weekly or bi monthly or monthly.	
	Moderate	1-2 weekly or bi monthly or monthly.	
	Severe	2 X week	
ATTENTION DEFICIT HYPERACTIVE DISORDER			
1. Sensory Profile 2 2. The Bruininks-Oseretsky Test of Motor	Mild	1-2 weekly or bi monthly or monthly.	

Proficiency Second Edition (BOT-2) 3. Beery- Buktenica Developmental Test of Visual- Motor Intergration (BEERY VMI) 4. PDMS-2 5. FIM 6. Parent interview 7. Clinical Observations	Moderate	1-2 weekly or bi monthly or monthly.	
	Severe	2 X week	

ANNEX

STANDARDIZED ASSESSMENT TOOLS

Following is recognized OT assessment tools to evaluate occupational performance skills.

ASSESSMENT	**AGE RANGE**	**LINK**
SENSORY PROFILE 2	0-14	https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Motor-Sensory/Sensory-Profile-2/p/100000822.html
The Bruininks- Oseretsky Test of Motor Proficiency Second Edition (BOT-2)	4-21	https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Motor-Sensory/Bruininks-Oseretsky-Test-of-Motor-Proficiency-%7C-Second-Edition/p/100000648.html
Modified Ashworth Scale	-	https://www.physio-pedia.com/Modified_Ashworth_Scale
Paebody Developmental Motor Scale (PDMS-2)	0-5	https://www.pearsonclinical.co.uk/store/ukassessments/en/peabody-individual-achievement-test/Peabody-Developmental-Motor-Scales-%7C-Second-Edition/p/P100009032.html
Beery- Buktenica Developmental Test of Visual- Motor Integration (BEERY VMI)	2-99	https://www.pearsonclinical.co.uk/store/ukassessments/en/Store/Professional-Assessments/Motor-Sensory/Brief/Beery-Buktenica-Developmental-Test-of-Visual-Motor-Integration-%7C-Sixth-Edition/p/P100009092.html
Functional Independence measure (FIM)	3-18	https://www.physio-pedia.com/Functional_Independe

		nce_Measure_(FIM)?lang=en
Range Of Motion (ROM)	-	https://www.physio-pedia.com/Range_of_Motion_Normative_Values?utm_source=physiopedia&utm_medium=related_articles&utm_campaign=ongoing_internal

CLINICAL OBSERVATIONS

Following is recommended toys and equipment for conducting clinical observations to evaluate occupational participation and performance skills.

- Peg board
- Balls
- Balance beam
- Puzzles (insert puzzles and jigsaw)
- Pretend play toys (baby, kitchen set cars etc)
- Blocks
- ADL board
- Beads
- Pencil
- Scissors

HOME/COMMUNITY VISIT GUIDELINES

Home and community visits are encouraged at the discretion of the clinic and practitioner. However, depending on the scope of practice of the Occupational Therapist, home visits may be a required part of assessment and intervention.

Purpose of home/community visits:

- Provide treatment at home or in the community where it is the client's natural environment
- To improve family involvement
- To assess the risks that may hinder participation in occupation and activities of daily living
- Assess and provide adaptive equipment and modifications

Home/community visit requirements:

- If the client has a condition that reduces their ability to participate in activities of daily living, then a home visit can be conducted. Some of the conditions may include (but not limited to)
    - Stroke
    - Cerebral Palsy
    - Autism
    - Acquired Brain/head Injury
    - Multiple Sclerosis
    - Muscular dystrophy
- If the client has a condition that makes it medically unsafe to leave the home environment.
- If the client is unable to leave the home without needing support (wheelchair, special transportation, walking frame, etc).
- Be under the care of a doctor or medical practitioner/specialist who can collaborate on a home health plan.

Occupational Therapists are required to follow their respective clinic and organisational policies on home/community visits.

INTERVENTION RESOURCES

Occupation Domains	Intervention	Session time	Assistive products	Equipment	Consumables	Occupations
Self-care	Dressing	10 minutes	Visuals, Buttoning helper	Clothes Toys	-	- Occupational Therapist
	Eating	20 minutes	Modified cutlery, plates and cups	Spoons Plates Sensory play Toys	Food/ drink with different tastes and textures	- Occupational Therapist -Speech Therapist -Dietitian - Occupational Therapist
	Toileting	15 minutes	Visuals Modified Toilet seat	Child toilet seat	-	- Occupational Therapist Psychologist
	Shower		Modified equipment for showering			- Occupational Therapist
	Brushing teeth		Modified equipment for brushing			- Occupational Therapist
	Hair cut		Modified equipment for haircuts			- Occupational Therapist

	Sleep		Visuals			- Occupational Therapist Psychologist
Productivity	Routines/Transitions	10 minutes	Visuals Timers Social Story			- Occupational Therapist -Psychologist
	Writing	10 minutes	Pencil grasps Weighted Pencils Markers Paper	Blackboard Sand Whiteboard Clay		- Occupational Therapist
	Cutting	10 minutes	Adaptive scissors	Paper Scissors Clay		- Occupational Therapist
	Attention/concentration		Visuals			- Occupational Therapist -Psychologist
Leisure	Play	20 minutes	-	Toys		- Occupational Therapist
Social Participation	Indoors	45 minutes	Visuals, Social Story,	Timer, Noise cancelling headphones		- Occupational Therapist -Psychologist

						-Speech Therapist
	Outdoors	45 minutes	Visuals, Social story	Noise cancelling headphone, Weighted vests		-Occupational Therapist -Psychologist -Speech Therapist

PERFORMANCE QUALITY RATING SCALE

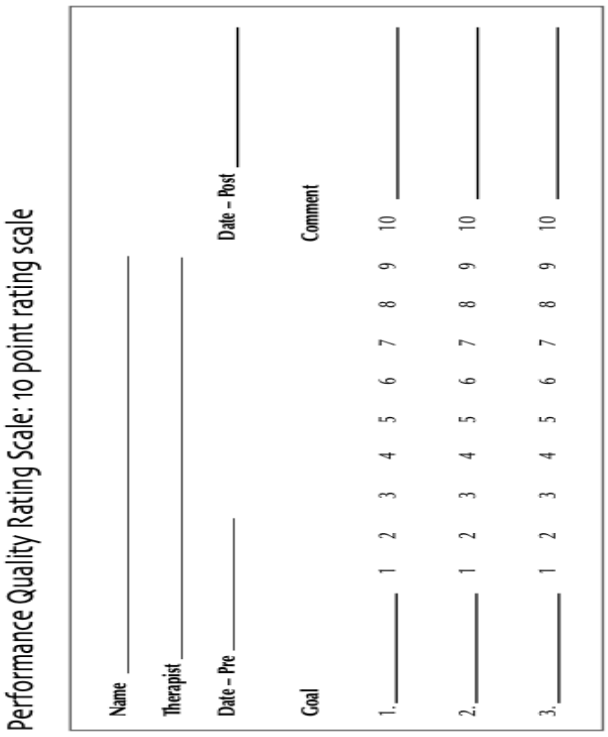

Figure 25
Enabling Occupation in Children: The Cognitive Orientation to daily Occupational Performance (CO-OP) Approach © CAOT 2004

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