



JOB DESCRIPTION OCCUPATIONAL THERAPIST ASSISTANT

Employee Name: _____

POSITION SUMMARY:

Services of the Occupational Therapist Assistant (OTA) will be furnished under the supervision of a physical therapist. The OTA performs services planned, assigned, delegated and supervised by the physical therapist and functions as an active member of the home health team, providing services in accordance with the physician's orders.

EDUCATION AND EXPERIENCE REQUIREMENTS:

1. Is licensed by the Florida Therapist Licensing Board to practice as a Occupational Therapy Assistant.
2. Recommend a minimum of one year experience in an acute care facility.

GENERAL REQUIREMENTS:

1. Must have genuine interest and concern for all clients with a special desire to work with the elderly client.
2. Must be sufficiently mature and emotionally stable to work well with others.
3. Must possess good physical and mental health.
4. Must have a clean and neat appearance.
5. Must be courteous and kind in manner.
6. Can work harmoniously and skillfully with other staff members, patients and their families.
7. Must be flexible and able to tolerate change or changing demands.
8. Ability to promote the practice of therapy to the physicians, community, patients and their families. This includes the ability to verbally articulate and define therapy terminology.

ENVIRONMENT: The Occupational Therapist Assistant travels to and fro, and performs duties in each patient's home. The climate is not routinely controlled. Occasionally there may be exposure to blood, body tissues and other potentially infectious fluids. There can be exposure to loud and unpleasant noises, unpleasant odors, unclean homes and dust. May be subject to hostile and emotionally upset patients, family members or visitors. Work environment not controlled by employee. Road and weather conditions are variable.

PHYSICAL REQUIREMENTS:

1. Able to speak, read and write in English.
2. Able read assignments, follow directions,
3. Able to communicate and respond clearly on telephone and respond to patient's spoken needs.
4. The ability to physically transfer, lift or assist patients whose average weight is 160 pounds with or without the aid of mechanical devices.
5. Able to spend 80% of the work shift standing and/or moving about.
6. Able to walk, climb stairs, stoop, twist, bend and squat to perform essential job functions.

MENTAL REQUIREMENTS: Able to concentrate on detail with frequent interruptions, Able to follow, complete and remember daily routines and requirements, Able to comprehend and utilize professional education materials, Able to cope with the mental and emotional stress of the position.

EQUIPMENT: Must be able to use all modalities associated with occupational therapy.

DUTIES AND RESPONSIBILITIES:

1. Provides direct patient care that has been delegated by the Occupational Therapist.
2. Performs active and passive exercises, muscle reeducation, gait and functional training, activities ensuring pain relief and function restoration.
3. Observes, records and reports to the occupational therapist and/or the patient's physician, physician assistant, or advanced registered nurse practitioner the patient's reaction to treatment and any changes in the patient's condition.
4. Instruct patients in the care and use of wheelchairs, braces, crutches, canes, prosthetic and orthotic devices.
5. Prepares clinical notes and medical updates/summary notes in a timely manner.
6. Instructs other health care personnel and family members when appropriate.
7. Participates in inservice education and case conferences.
8. Ensure HIPAA guidelines and procedures are maintained.

I have read the above job description and fully understand the conditions set forth therein, I shall perform these duties to the best of my ability.

Administrator

Employee

Date

ORIENTATION CHECKLIST: PROFESSIONAL STAFF

Employee Name: _____

I. GENERAL ORIENTATION

- _____ AGENCY ORGANIZATIONAL STRUCTURE
- _____ PHILOSOPHY, GOAL & OBJECTIVES, MISSION
- _____ TOUR OF FACILITY
 - a) LOCATION OF ADMINISTRATIVE OFFICES
 - b) LOCATION OF EMERGENCY LIGHTS/EXITS
 - c) LOCATION OF FIRE EXTINGUISHERS
 - d) LOCATION OF FIRST AIDE BOX
 - e) EMERGENCY EVACUATION ROUTES
- _____ INTRODUCTION TO STAFF/CLIENTS
- _____ SCOPE OF SERVICES
- _____ EMPLOYMENT POLICIES/JOB DESCRIPTION
- _____ COMPLAINTS POLICY/GRIEVANCE FORM
- _____ PAYROLL
- _____ CORPORATE COMPLIANCE PLAN



II. CLINICAL ORIENTATION

- _____ CLIENT RIGHTS AND RESPONSIBILITIES
- _____ ADMISSION/DISCHARGE CRITERIA/THERAPY SERVICES
- _____ MEDICAL EMERGENCIES
- _____ PSYCHIATRIC EMERGENCIES
- _____ DOCUMENTATION REQUIREMENTS/TIME FRAMES
- _____ CLINICAL RECORDS

III. CONFIDENTIALITY/HIPAA GUIDELINES

- _____ CLIENT/FAMILY/SIGNIFICANT OTHER
- _____ PROGRAM/STAFF
- _____ INFORMATION

IV. SAFETY/RISK MANAGEMENT/INFECTION CONTROL

- _____ ACCIDENTAL/INCIDENT REPORTING
- _____ OSHA
- _____ UNIVERSAL PRECAUTION
- _____ BIOHAZARDOUS/INFECTION WASTE
- _____ HIV UPDATE
- _____ TB UPDATE
- _____ EMERGENCY PREPAREDNESS
- _____ FIRE DRILL
- _____ CARE OF ENVIRONMENT

I HAVE READ AND UNDERSTAND THE POLICIES AND PROCEDURES OF THE AGENCY AND HAVE HAD THE OPPORTUNITY TO HAVE ALL OF MY QUESTIONS/CONCERNS ADDRESSED TO MY COMPLETE SATISFACTION.

I AGREE TO ABIDE AND UPHOLD ALL POLICIES AND PROCEDURE, AND HAVE BEEN ADVISE THAT FAILURE TO DO SO MAY RESULT IN TERMINATION OF EMPLOYMENT.

I ALSO AGREE THAT AS A CONDITION OF EMPLOYMENT THAT I WILL PROVIDE THE AGENCY WITH A FOURTEEN (14) DAY WRITTEN NOTICE OF INTENT TO TERMINATE EMPLOYMENT.

EMPLOYEE SIGNATURE/TITLE

DATE

OCCUPATIONAL THERAPY COMPETENCY (page 1)



Name: _____

TASKS/BEHAVIORS COMPLETED	DATE PERFORMED OR COMPETENT	INITIALS OF EMPLOYEE OR CONTRACTOR	COMMENTS
Referral process			
ASSESSMENT OF:			
Level of Function			
Physical Assessment/ Rehab. Program			
Independent Living/ ADL's training			
Therapeutic exercise to right/left hand			
Patient/Family Education			
Perceptual motor training			
Fine motor coordination			
Neuro-developmental training			
Sensory treatment			
Orthotics/Spiriting			
Adaptive equipments/Body image training			
Pain Management			
Discharge plan discussed with patient on admission/Review of all Literature			
Communication with PCC/Case Manager			
Timely paperwork submission/review of Regulations			



TASKS/BEHAVIORS COMPLETED	DATE PERFORMED OR COMPETENT	INITIALS OF EMPLOYEE OR CONTRACTOR	COMMENTS
Timely notification for patient visits/use of calendar			
All paperwork due by the last day of the 3 rd week by 5pm or by 9:00 am the Monday after the last day of the 3 rd week to process billing.			
Review of documentation/revisit			
Review of documentation admission			
Notification of patient of discharge 2 wks prior & document			
Evaluation for additional services			
COMMENTS			

SIGNATURE OF ORIENTEE _____

SIGNATURE OF PRECEPTOR _____