Canadian Council of Physiotherapy University Programs

Conseil Canadien des Programmes Universitaires de Physiothérapie

National Physiotherapy Entry-to-Practice Curriculum Guidelines

2019

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Introduction

A curriculum is a comprehensive map or plan for learning. In the context of a physiotherapy[1] education program, it identifies the academic and clinical components upon which the practice of physiotherapy is based.

1 The terms physiotherapy and physiotherapist will be used consistently throughout this document and are considered synonymous with physical therapy and physical therapist respectively.

Context

Entry-to-practice physiotherapy education programs in Canada are located exclusively in universities. The Canadian Council of Physiotherapy University Programs (CCPUP) includes representation from each Canadian physiotherapy program and oversees the guidelines for physiotherapy curriculum. All physiotherapy programs are delivered at the graduate level and each awards a professional master's degree (e.g. Master of Physical Therapy or Master of Science in Physical Therapy or similar). Programs complete an accreditation review conducted by Physiotherapy Education Accreditation Canada (PEAC) at least every six years. Graduates of an accredited education program are eligible to challenge the national Physiotherapy Competency Exam (PCE) administered by the Canadian Alliance of Physiotherapy Regulators (CAPR), and if successful, to apply for licensure in their Canadian jurisdiction of choice. Graduates of education programs in the province of Quebec who seek licensure in Quebec are not required to challenge the PCE.

Process

BACKGROUND

The National Curriculum Guidelines (the Guidelines) revision project was led by the CCPUP Curriculum Committee with its first meeting in December 2015. Dr. David Cane was hired as the consultant to lead the project. Initial assessment by Curriculum Committee members suggested that revision of the existing Essential Competency Profile for Physiotherapists in Canada (2009) was in order. Dr. David Cane facilitated a meeting in Halifax in June 2015 which included representation from all National Physiotherapy Advisory Group (NPAG) member organizations (CAPR, CCPUP, PEAC, and Canadian Physiotherapy Association [CPA]). Discussions in Halifax supported the renewal of the Essential Competency Profile 2009 and resulted in the initiation of the Joint Physiotherapy Practice Profile (Triple P) Project. CCPUP and the other NPAG member organizations formally approved and subsequently contributed to the funding for the Triple P Project.

As the essential competencies were determined to be foundational for the Guidelines, the work of the CCPUP Curriculum Committee was put on hold until the completion of the Triple P Project. For continued liaison, three committee members – Alison Greig, Bernadette Martin, and Hélène Moffet – served as Triple P Project Subject Matter Experts and Bernadette Martin was also a member of the Triple P Project Steering Committee.

The Triple P Project was completed in May 2017; the Competency Profile for Physiotherapists in Canada 2017 (Competency Profile) (Appendix A) was subsequently approved by all NPAG member organizations and published in December 2017. The Competency Profile was used to inform the revision of the Guidelines and includes:

- Statement of Entry-to-Practice
- 7 Domains of practice
- 34 Essential Competencies and
- 140 Entry-to-Practice milestones

CURRICULUM COMMITTEE

Building on the work of the Triple P Project, the Curriculum Committee resumed its activities in late 2017 to revise the Entry-to-Practice Physiotherapy Curriculum: Content Guidelines for Canadian University Programs (2009). The Curriculum Committee was chaired by Bernadette Martin and included representation from several Canadian entry-to-practice physiotherapy programs (both English and French) and the National Association for Clinical Education in Physiotherapy (NACEP). Members from PEAC, CAPR, and CPA were also invited to participate during key activities.

During 2018, the Curriculum Committee focused on the Academic Content component of the Guidelines. A two-day workshop with the expanded stakeholder membership was held in May 2018 and resulted in a draft that underwent three rounds of review between July and October. The Guidelines for Academic Content were approved by CCPUP in November 2018.

As the Guidelines for Academic Content were nearing completion, the Curriculum Committee began work with NACEP to revise and update the clinical education curriculum described in the Entry-to-Practice Physiotherapy Curriculum: A Companion Document – Clinical Education Guidelines for Canadian University Programs (2011). Concurrently there was associated work underway to conduct a scoping literature review, a web search and a search of the grey literature for health professional education programs nationally and internationally, seeking information about clinical practicum hours requirements. In addition, a review of published literature on incorporation of simulation in clinical practicums was completed. These related projects were discussed in depth at the CCPUP meetings in October 2018 and informed the ongoing work of the Curriculum Committee. In May 2019, the Curriculum Committee circulated a clinical education survey to all physiotherapy programs. The survey results provided the format for a World Café discussion at the CCPUP annual meeting in June 2019 that also included clinicians from key clinical practice areas. Themes from the World Café were used by the Curriculum Committee to draft the Clinical Education Experiences component of the Guidelines which underwent two further rounds of review by programs, in September and October 2019.The Clinical Education Experiences component of the Guidelines was approved by CCPUP in November 2019.

National Curriculum Guidelines

GUIDING PRINCIPLES

Revision of the Guidelines followed these principles:

GENERAL

- Canadian physiotherapy university programs prepare graduates for safe and effective entry-level practice as generalists.
- Curriculum guidelines must be relevant within a national context, while recognizing jurisdictional differences, and must be sufficiently flexible to accommodate the anticipated evolution of professional practice.
- The focus should be on academic content and clinical education experiences that support the essential competencies and entry-to-practice milestones of the Competency Profile, while respecting the diversity of conceptual frameworks and delivery models that contribute to the depth and breadth of physiotherapy education in Canada.

CLINICAL EDUCATION

- Clinical competence develops along a continuum from novice to entry-level practitioner and is facilitated by the progression of clinical education experiences.
- Clinical education experiences should be of adequate intensity, breadth, and duration to enable achievement of professional competencies required for effective entry-level practice.
- A minimum number of hours of clinical education should be identified.
- Overall, clinical education experiences should include exposure to patients/populations whose needs reflect different points along the healthcare continuum (simple to complex, acute to chronic, health promotion). Diversity of clinical experience is necessary.
- Experience should be gained in a variety of clinical contexts and with diverse patients/populations (gender, culture, and a variety of age groups).
- Exposure to emerging areas within physiotherapy practice is encouraged.
- All experience gained in clinical patient care settings will be with human patients / populations.

It is understood that each education program will develop and implement its own curriculum design and delivery model for the learning content within the Guidelines. Each program's curriculum will also be informed by that program's strategic planning and consultation processes. This will result in a diversity of programs across Canada, each with unique strengths, areas of emphasis, completion timelines, and degree titles. It is likely that many programs will go beyond the Guidelines in selected areas, depending on the philosophy and resources of their university or faculty. It is also understood that assessment of clinical competencies and determination of adequate clinical education experiences for each individual student will be managed by the student's own program, and that each program is responsible for further defining and administering any program-specific clinical education requirements.

OVERVIEW

While curriculum design includes several important considerations – curriculum models, objective outcomes, scaffolding of curriculum, curriculum mapping, linkage of assessment to objectives and objectives to program outcomes, program evaluation and strategies for curriculum design including technology – the purpose of the Guidelines is to describe the recommended elements of the academic and clinical content of a program's curriculum. The Guidelines reflect current physiotherapy practice and evolving sciences that influence practice while accommodating emerging areas of practice. The Guidelines outline two components of the entry-to-practice curriculum:

1. **ACADEMIC CONTENT**, including:
   Part A: Foundational entry-to-practice knowledge
   Part B: Minimum entry-to-practice skills
   Part C: Common conditions in physiotherapy practice
2. **CLINICAL EDUCATION EXPERIENCES**

ACADEMIC CONTENT
PART A: FOUNDATIONAL ENTRY-TO-PRACTICE KNOWLEDGE

Part A includes key/required/standard (Core) content and content areas considered to be additional (Non-Core). Core content areas and topics have been grouped into four sections of foundational knowledge with a total of 28 subsections. Core content establishes a broad knowledge base for the development of skill and competency. Included is a section of Non-Core knowledge including emerging topics which may be introduced by some programs and which inform ongoing curriculum discussions.

CORE FOUNDATIONAL KNOWLEDGE	
Basic content	1. Anatomy & Neuroanatomy 2. Human Physiology 3. Pathology & Pathophysiology 4. Lifespan 5. Movement Science 6. Exercise Science 7. Pain 8. Pharmacology 9. Psychological Sciences 10. Social Sciences
Physiotherapy therapeutics	11. General Topics 12. Airway Management 13. Electrophysical Agents 14. Group Programming 15. Mobility – General 16. Mobility – Soft Tissue 17. Therapeutic & Assistive Devices 18. Therapeutic Exercise 19. Wound Care
Professional practice	20. Therapeutic Alliance 21. Autonomous Practice 22. Ethical Practice 23. Collaborative Practice 24. Communication & Education 25. Critical Appraisal & Research
Context of practice	26. Canada's Health System 27. Global Health Environment 28. Practice Management
NON-CORE KNOWLEDGE	
	29. Emerging Topics in Practice

See Part A: Foundational Entry-to-Practice Knowledge for details.

ACADEMIC CONTENT
PART B: MINIMUM ENTRY-TO-PRACTICE SKILLS

Part B includes the basic skills to be demonstrated by graduates at entry-to-practice. The skills are described in direct alignment with the seven Domains within the Competency Profile. These skills provide further detail to the essential competencies and entry-to-practice milestones within each Domain. The majority of skills are mapped to Domain 1: Physiotherapy Expertise, with fewer minimum skills within the other six Domains.

MINIMUM ENTRY-TO-PRACTICE SKILLS	
Domain 1: Physiotherapy Expertise	Client-Centered Approach Client Safety Client Information Tests and Measures Outcome Measures & Rating Scales Airway Management Education – Client Communication Electrophysical Agents Application Exercise Interventions Group Programming Soft Tissue Interventions Therapeutic & Assistive Device Use Wound Care
Domain 2: Communication	
Domain 3: Collaboration	
Domain 4: Management	
Domain 5: Leadership	
Domain 6: Scholarship	
Domain 7: Professionalism	

See Part B: Minimum Entry-to-Practice Skills for details.

ACADEMIC CONTENT
PART C: COMMON CONDITIONS IN PHYSIOTHERAPY PRACTICE

The conditions commonly encountered in physiotherapy practice are grouped into four areas and twelve sections according to physiological systems. Conditions are labelled as either Level 1 or Level 2:

- Level 1: entry-to-practice physiotherapists are expected to know and understand the etiology, pathophysiological mechanisms, natural history, typical clinical presentation (signs/symptoms, impairments), differential diagnoses, prognosis, current physiotherapy management and basic non-physiotherapy management (medical, surgical). Note: Level 1 conditions are Key Indicator conditions most commonly encountered by the entry-to-practice physiotherapist.
- Level 2: entry-to-practice physiotherapists are expected to be aware of these conditions and understand the condition type/category and general clinical presentation. Note: Level 2 conditions are introduced within curricula as Learning Transfer conditions which are less prevalent but provide an opportunity for more in-depth or independent learning.

<table>
<tr><th colspan="2">COMMON CONDITIONS</th></tr>
<tr><td colspan="2">Cardiovascular-Pulmonary</td></tr>
<tr><td colspan="2">Musculoskeletal</td></tr>
<tr><td colspan="2">Neurological</td></tr>
<tr><td>Other Conditions</td><td>Cognitive
Gastrointestinal
Genetic
Integumentary
Immune
Metabolic
Oncology
Urinary/Reproductive</td></tr>
</table>

See Part C: Common Conditions in Physiotherapy Practice for details.

CLINICAL EDUCATION EXPERIENCES

Physiotherapy clinical education is the component of the entry-to-practice curriculum in which students gain practical experience in a number of diverse professional settings, for the purpose of learning and applying physiotherapy knowledge, skills, behaviours and clinical reasoning. Clinical education serves to develop professionalism, practice expertise and skill in communication, collaboration, management, leadership and scholarship, needed by physiotherapy students for safe, competent, autonomous, entry-level practice as graduates.

Clinical education experiences are described in relation to the clinical practice hours and contexts needed to apply and strengthen the skills, confidence, judgment, efficiency, and responsibility of students prior to graduation and independent practice.

CLINICAL EDUCATION GUIDELINES
Clinical hours
Area of clinical practice
Context of practice
Supervision of students

See Clinical Education Experiences: Minimum Expectations for details.

NATIONAL CURRICULUM GUIDELINES: CURRICULAR FRAMEWORK

The Guidelines, in conjunction with the Competency Profile, are intended to assist programs to design and implement a curriculum that will serve to develop professionalism, physiotherapy practice expertise and skill in communication, collaboration, management, leadership, and scholarship.

The Competency Profile presents the expectations for competence at the point of entry-to-practice. The Statement of Entry-to-Practice describes how graduates will be prepared for independent practice as safe, competent, and autonomous entry-to-practice physiotherapists. In the Academic Content component of the Guidelines, there is further detailing of the foundational knowledge, minimum skills, and commonly encountered conditions in practice which support the entry-to-practice milestones. The Guidelines recommend settings for the application of this knowledge, skill and competency in the Clinical Education Experience component. Together the Competency Profile and the Guidelines present a comprehensive curricular framework. The inter-relationship of these as a curricular framework is illustrated in Figure 1.

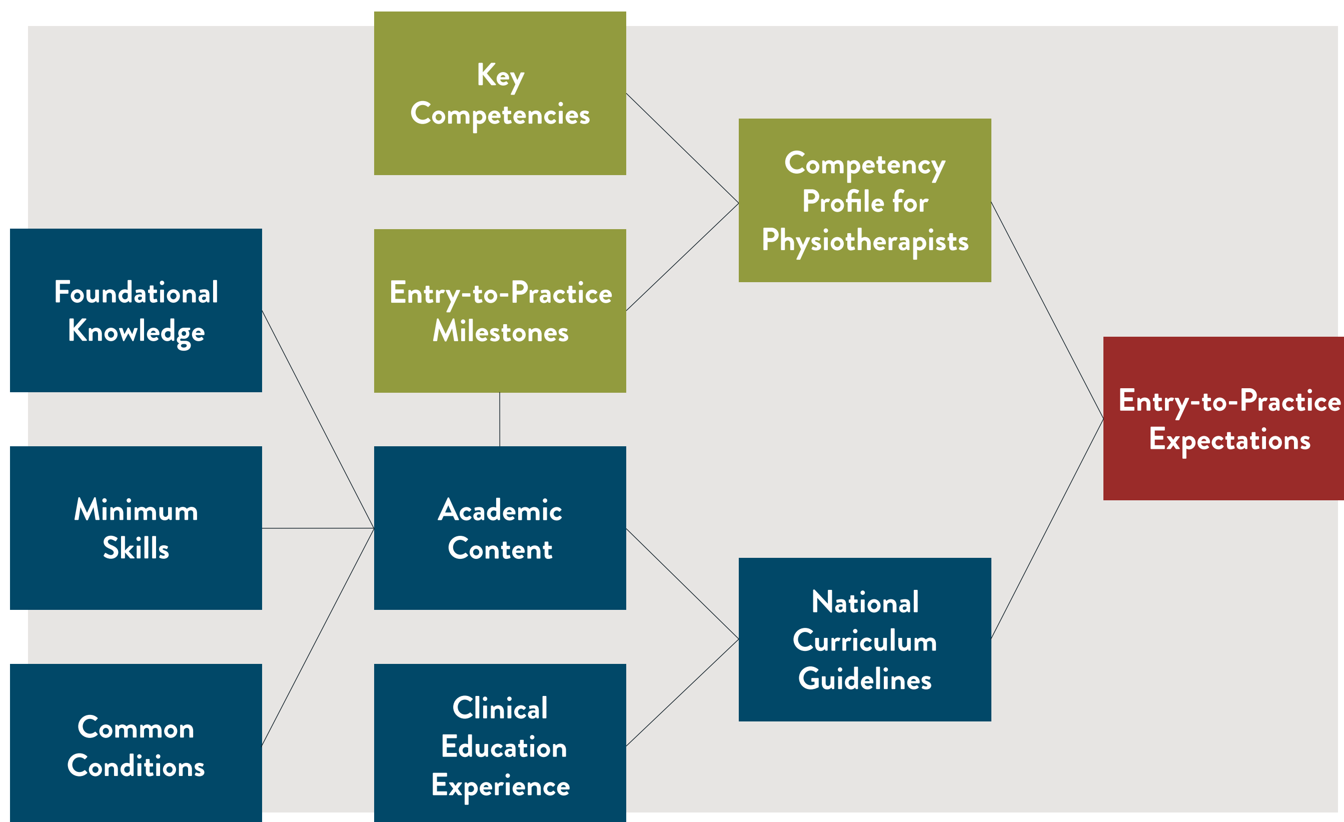

Figure 1: Entry-to-Practice Curricular Framework

This document with the inclusion of both the Guidelines and the Competency Profile within a curricular framework, is designed for physiotherapy programs as a comprehensive tool for developing, mapping, reviewing and/or evaluating curriculum content, clinical activities, milestones and competencies. Each program's self-described student outcomes inform how the Competency Profile and the Guidelines are integrated into their respective curriculum.

Programs may also consider utilizing other national physiotherapy documents including the PCE blueprint, the CAPR Core Standards of Practice, the CPA Position Statements, provincial/territorial physiotherapy regulatory standards, regulations and codes of conduct and the PEAC Accreditation Standards, when developing or implementing curriculum.

National Curriculum Guidelines: Components in Detail

ACADEMIC CONTENT
PART A: FOUNDATIONAL ENTRY-TO-PRACTICE KNOWLEDGE

Required or standard (Core) content areas, as well as content areas considered to be elective or additional (Non-Core), are included in Part A. Core content areas and topics are grouped into four sections of foundational knowledge with a total of 28 subsections. This Core content provides the backdrop of knowledge for all Domains within the Competency Profile. Included is an additional section of emerging topics considered Non-Core, but which are introduced to students by some programs. It is understood that some students may have gained knowledge in some of these content areas during their undergraduate studies and/or within required pre-requisite coursework. Therefore not all of these topics are consistently included within a professional entry-to-practice physiotherapy program curriculum.

CORE KNOWLEDGE: BASIC CONTENT - AREAS AND TOPICS

1. ANATOMY & NEUROANATOMY

a. Histology of muscle, bone and skin

b. Anatomical development and terminology

c. Gross Anatomy of musculoskeletal, neurological, cardiovascular, respiratory and integumentary

d. Regional Anatomy - Head and Neck, Back, Upper & Lower Limbs, Thorax, Abdomen, Pelvis & Perineum

e. Neuroanatomical development

f. Anatomy of the brain, central, peripheral and autonomic nervous systems

g. Motor and sensory distribution of the cranial and peripheral nerves

h. Anatomy of the vestibular system

2. HUMAN PHYSIOLOGY

a. Physiology from cellular to macro systems

b. Physiological Systems:

i. Cardiovascular

- cardiovascular structures/function, mechanical function of the heart, electrical activity of heart, hemodynamics, coronary, cerebral and peripheral circulation, fluid dynamics
- normal/abnormal heart rate, blood pressure, heart sounds
- clot / thrombosis, fluid balance / venous stasis, edema, lymphedema
- blood pressure regulation - hypo/hypertension, syncope

ii. Cognition

- arousal, attention, orientation, emotion, processing and registration of information
- retention, memory, recall
- communication, language
- perception, decision-making

iii. Integumentary
- skin characteristics
- skin breakdown/wounds
- scar formation

iv. Immune
- inflammation - process & signs, stages of healing
- infection - bacterial, viral, local/systemic, sepsis
- immune responses

v. Metabolic
- blood glucose regulation, fluid/electrolyte balance and hormonal control, red blood cell formation, acid-base balance
- endocrine and renal physiology/structures
- energy systems/production
- normal/abnormal temperature - hypo/hyperthermia

vi. Musculoskeletal
- posture - normal/abnormal, lordosis/kyphosis, scoliosis
- bone structure/physiology
- muscle structure/physiology
- anthropometrics - limb length, limb girth, body composition

vii. Neurological
- CNS/PNS, cranial nerves function
- neuro-physiological development
- nervous system responses to injury/aging including repair, neuroplasticity
- neurotransmission, muscle tone, motor function, sensory/normal processing, sensorimotor integration, nerve conduction testing

viii. Respiratory
- respiratory structures/function, defence mechanisms, mechanics of respiration
- pulmonary circulation, gas transport/exchange, control of ventilation
- normal and abnormal breath sounds, breathing patterns, lung volumes, oxygen saturation, hypoxia// hypercapnia

ix. Urinary / Reproduction
- urinary structures/function
- reproductive structures/function
- pregnancy and post-partum

3. PATHOLOGY/PATHOPHYSIOLOGY

a. Nature of disease, injury and their causes, processes and consequences

b. Common pathological processes and mechanisms

c. Impact of pathology on physiology, structure and function

d. Processes of inflammation, degeneration and regeneration

e. Stages of healing - soft tissues, bone

f. Environmental factors that impact health

4. LIFESPAN

a. Typical (anatomical, biological, neurological, psychological) development Neonate/Infant to Adult
b. Anatomical, biological, neurological, psychological and social dimensions of Aging
c. End-of-Life considerations

5. MOVEMENT SCIENCE

a. Biomechanics, kinematics, kinetics
    i. Tissue mechanics, arthrokinematics, muscle contraction
    ii. Biomechanical measurement
    iii. Functional mobility/stability, manipulation tasks
    iv. Effects of injury, illness, disease, genetics, environmental factors, pharmacological agents
b. Sensorimotor Control
    i. Motor control/learning theories, models and principles
    ii. Motor development
    iii. Neuroplasticity - injury and practice induced, positive/negative effects on recovery
    iv. Effects of injury, illness, disease, genetics, environmental factors, pharmacological agents
    v. Effects of practice, feedback, cognition
c. Ergonomics
    i. Ergonomic principles
    ii. Ergonomics and Mobility - posture, gait, balance control, prosthetics/orthotics, ADLs, ambulatory assistive devices

6. EXERCISE SCIENCE

a. Cellular to system level physiological response to exercise
    i. Principles of aerobic and anaerobic metabolism
    ii. Aerobic and Anaerobic conditioning, tolerance and capacity
    iii. Physiological effects of deconditioning and bedrest/immobility
    iv. Principles of strength, power and endurance training
b. Types of exercise - concentric, dynamic/isotonic, eccentric, isokinetic, isometric
c. Exercise applications - active assistive, active, resistive, aerobic/endurance training
d. Measurement of energy/work/power, body composition, aerobic/anaerobic fitness, muscle strength and endurance, flexibility, balance, coordination
e. Exercise assessment, prescription and progression principles and methodology
f. Exercise and physical activity parameters, measurement and monitoring
g. Exercise prescription factors/guidelines for healthy populations, fitness, high performance, age, gender, pregnancy
h. Exercise prescription factors/guidelines for populations with chronic conditions, illness/disease, frailty, injury
i. Risk factor screening

7. PAIN

a. Biopsychosocial model of Pain
b. Types of Pain - nocioceptive, neuropathic, nociplastic
c. Mechanisms of Pain - inflammatory, mechanical, primary nociceptive, peripheral neuropathic, central neuropathic, CNS adaptation, psychosocial
d. Processes of pain - abnormal nociceptive processing, pro- and anti-nociceptive modulation

8. PHARMACOLOGY

a. Basic pharmokinetics
b. Names, drug classifications, indications, basic adverse reactions and side effects for medications (non- prescription/prescription) used in conditions commonly encountered in physiotherapy practice (see Appendix 3: Common Conditions in Physiotherapy)

9. PSYCHOLOGICAL SCIENCES

a. Cognitive functions of learning, perception, attention, memory, motivation, coping and self-efficacy
b. Behavioral functions related to change, social participation and communication

10. SOCIAL SCIENCES

a. Quality of life concepts, disability and function
b. Sociocultural diversity - gender, age, ethnicity, religion, gender identity, physical capabilities
c. Social theories of change
d. Critical disability studies

CORE KNOWLEDGE: PHYSIOTHERAPY THERAPEUTICS - AREAS AND TOPICS

11. GENERAL PHYSIOTHERAPY THERAPEUTICS TOPICS

a. Assessment/Clinical Reasoning/Intervention approaches used in physiotherapy - clinical flags system
b. Conditions seen in physiotherapy (see Appendix 3: Common Conditions in Physiotherapy)
c. Infection control - routine practices, universal precautions
d. Safe client handling
e. Outcome Measures and Rating Scales (See list in Appendix 2 Entry-to-Practice Minimal Skills / Assessment) - reference guidelines for selection, psychometric properties, context of use
f. Rehabilitation approaches and programming for individuals and groups - specific populations, injury prevention, health promotion/wellness

12. AIRWAY MANAGEMENT

a. Indications/contraindications, implications, principles, strategies and approaches for airway management
b. Breathing strategies - active cycle of breathing, forced expiratory techniques, assisted cough/huff, paced breathing, pursed lip, breath stacking, maximum inspiratory hold
c. Positioning - breathing facilitation, postural drainage, maximizing ventilation and perfusion
d. Manual/mechanical techniques - percussion and vibrations, suctioning
e. Respiratory assistive devices - oscillation PEP, inhalers, nebulizers, mechanical in/exsufflation

f. Oxygen therapy - oxygen titration, delivery systems

g. Suctioning - oral, tracheal, airway

h. Ventilatory support - invasive/non-invasive ventilation

13. ELECTROPHYSICAL AGENTS (EPA)

a. Indications/precautions/contraindications, implications, principles, strategies and approaches for all EPA

b. Potential negative / harmful effects of EPA modalities used in physiotherapy

c. Principles of calibration and routine maintenance for EPA equipment

d. EPA Modalities:

   i. Biofeedback

   ii. Contrast baths

   iii. Functional electrical stimulation (FES)

   iv. Heat modalities

   v. Cold modalities

   vi. Interferential (IFC)

   vii. Laser

   viii. Neuromuscular electrical stimulation (NMES)

   ix. Paraffin Wax

   x. Transcutaneous electrical nerve stimulation (TENS)

   xi. Ultrasound

14. GROUP PROGRAMMING

a. Needs assessment of populations

b. Frameworks and approaches for development, implementation and evaluation of a program

15. MOBILITY – GENERAL

a. Indications/contraindications, implications, principles, strategies and approaches for movement interventions

b. Gait/locomotion - patterns, analytical approaches, weightbearing status

c. Posture, balance, coordination, agility, dexterity

d. Physical handling - principles, safety, equipment

16. MOBILITY- SOFT TISSUE

a. Indications/contraindications, implications, principles, strategies/approaches for soft tissue techniques

b. Massage - therapeutic, connective tissue

c. Manual traction

d. Manipulation - peripheral joints

e. Mobilization - spinal and peripheral joints

f. Neurodynamic techniques - mobilization, nerve gliding/flossing exercises

g. Passive range of motion, stretching

17. THERAPEUTIC & ASSISTIVE DEVICES

a. Indications/precautions/contraindications, implications, principles, safety, strategies and approaches for all devices

b. Potential negative / harmful effects of devices used in physiotherapy

c. Ambulatory devices - canes, crutches, walkers, walking poles, wheelchairs

d. Assistive, adaptive, protective devices - splints, taping/wrapping, bandaging, braces, orthotics, garments, collars

e. Compression therapies - compression garments, taping and bandaging, vasopneumatic devices

f. Mechanical devices - standing frames, tilt table, body weight support devices

g. Prosthetic devices - upper and lower limb types

18. THERAPEUTIC EXERCISE

a. Indications/contraindications, implications, principles, strategies/approaches for therapeutic exercise

b. Therapeutic exercise / training interventions:

   i. Activity training for work and/or recreation/play/leisure

   ii. Aerobic capacity/interval/endurance training

   iii. Aquatic exercise

   iv. Balance, proprioception, coordination, agility training

   v. Energy conservation

   vi. Flexibility exercises - range of motion, stretching

   vii. Functional activities training - bed mobility, transfers, age appropriate skills, ADL

   viii. Gait / Locomotion training

   ix. Motor planning/control exercises

   x. Neuromotor developmental activities

   xi. Pelvic floor exercises

   xii. Postural exercises

   xiii. Relaxation training

   xiv. Strength / power training

19. WOUND CARE

a. Wound (epidermal and dermal) management

   i. Prevention, pressure assessment/offloading, positioning, foot care, exercise

   ii. Basic skin hygiene, wound healing / barriers to healing

   iii. Debridement, dressings, blister/scar management, compression

CORE KNOWLEDGE: PROFESSIONAL PRACTICE - AREAS AND TOPICS

20. CLIENT-PHYSIOTHERAPIST THERAPEUTIC ALLIANCE

a. Definition and management of the therapeutic relationship
b. Models and integration of client/family centered care
c. Integration of an evidence-informed practice approach in all aspects of PT care
d. Strategies to integrate empathy, active listening, kindness and sensitivity
e. Cultural competence, safety and humility
f. Principles of shared decision-making and goal setting
g. Client safety - physical, emotional and social factors
h. Harassment and abuse (sexual, child, elder) - recognition of signs, trauma informed practice principles
i. Consideration of prognostic factors relevant to individual client
j. Theories and models for employing professional judgement, clinical reasoning, differential diagnosis
k. Theories and communication approaches for supporting behavioural change, motivation of client, having difficult conversations
l. Determinants of health and behaviour
m. Outcome measures - application/integration, appropriateness for client/population

21. AUTONOMOUS PROFESSIONAL PRACTICE

a. Autonomous practice and regulated professions
b. Essential competencies for physiotherapists in Canada
c. Physiotherapy roles and areas of practice
d. Role and function of physiotherapy professional organizations
e. Federal and provincial/territorial legislation for physiotherapy and health care service delivery
f. Professional regulatory requirements - standards of practice, competencies and practice guidelines
g. Professional regulatory processes for registration, mandatory reporting, concerns and discipline
h. Privacy and confidentiality requirements for health information, documentation and record-keeping
i. Healthcare provider and/or employer requirements - clinical practice guidelines, care pathways/stratified care, discharge planning tools and protocols
j. Models, approaches and principles of client-centered care
k. Informed consent - comprehensive, initial/ongoing
l. Health law and disability
m. Legal liability, malpractice, fraud and negligence
n. Principles and competencies for safe client care and adverse events
o. Continuing competence - requirements, evaluation, maintenance and growth
p. Lifelong learning and continuing professional development
q. Self-reflection and evaluation strategies
r. Provider/Self wellness and compassion fatigue

22. ETHICAL PRACTICE

a. Ethical theories and reasoning models, bioethics
b. Professional codes of ethics and values
c. Altruism, duty to treat and social accountability
d. Disability and ability models
e. Human rights, diversity, equity and inclusion
f. Advocacy and social justice for clients, communities, self and profession
g. Conflicts of interest – potential, real and perceived
h. Self-assessment of own values and ethics
i. Professional boundaries - recognition, management, real/potential breaches
j. Principles of ethical business practices
k. Ethical use of social media and technology

23. COLLABORATIVE PRACTICE

a. Principles and processes for client/family/community centered team-based care
b. Principles and competencies of interprofessional collaborative practice
c. Credentials, education, relevant competencies and scope of practice for typical interprofessional team members
d. Principles and processes of effective team functioning
e. Principles and theories of leadership
f. Frameworks and approaches for team-based assessment, care and evaluation
g. Principles and strategies for team development
h. Strategies for conflict resolution and management
i. Consultation and referral practices
j. Principles, strategies and requirements for supervision, assignment and delegation

24. COMMUNICATION AND EDUCATION

a. Models and strategies for verbal and written communication
b. General health/medical and physiotherapy terminology
c. Models and requirements for documentation and electronic medical/health records
d. Augmented communication - use of devices, models, technology, interpreters
e. Team communication strategies - briefing/debriefing, urgent situations
f. Theories of teaching and learning - adult education principles
g. Strategies to address the teaching and learning needs of individuals and populations
h. Development and assessment of learning outcomes
i. Learning resource selection and development
j. Use of media and social media

25. CRITICAL APPRAISAL AND RESEARCH

a. Fundamentals of critical appraisal
b. Sources and levels of evidence
c. Literature search strategies
d. Theoretical foundations of research
e. Principles of ethical conduct in clinical research
f. Federal and provincial/territorial legislation and standards related to clinical research
g. Research design – quantitative, qualitative and mixed methods
h. Development and testing of clinical research questions
i. Issues of bias and validity
j. Common methods of sampling and data collection/analysis
k. Descriptive and inferential statistical methods
l. Principles of preparing a clinical research proposal, scientific paper, abstract or poster
m. Theories and models of knowledge exchange/translation and integration into practice
n. Measurement of impact of interventions
o. Psychometric properties of outcome measures

CORE KNOWLEDGE: CONTEXT OF PRACTICE - AREAS AND TOPICS

26. CANADA'S HEALTH SYSTEM

a. History of Canada's health care system
b. History of health for Canada's Indigenous populations
c. The Canada Health Act and associated provincial acts
d. Canadian health care and social service structures and organizations
e. Health care sectors, service delivery and funding models
f. Continuum of health care service delivery
g. Health policy and implications for disability issues and physiotherapy practice
h. Roles of Health Canada, provincial/territorial health organizations and Canadian Institute for Health Information
i. Physiotherapy practice in Canada

27. GLOBAL HEALTH ENVIRONMENT

a. Determinants of Health - World Health Organization and Public Health Agency of Canada
b. Constructs, models and frameworks that inform health and physiotherapy practice
c. Indicators and measurements used globally for population and community health status and risk factors
d. World Health Organization International Classification of Function (ICF)
e. Chronic and non-communicable disease management
f. Health prognosis of populations
g. Health trends - Aging population

28. PRACTICE MANAGEMENT

a. Organization structures
b. Organization governance and communication
c. Organizational vision, mission, policies and regulations
d. Public and private funding structures and models
e. Factors that influence availability and access to programs
f. Principles and strategies for caseload and waitlist management
g. Health human resource policies and regulations
h. Human, space and equipment management
i. Health records and practice information management
j. Client and provider safety and risk management
k. Quality assurance/improvement activities
l. Service delivery evaluation
m. Client satisfaction evaluation
n. Regulation and accreditation requirements for programs and clinical sites
o. Basic business plan and program proposals
p. Basic business financial concepts
q. Marketing principles and advertising regulations

NON-CORE KNOWLEDGE

Note: This area includes topics that are NOT core entry-to-practice content areas. Some physiotherapy programs introduce emerging topics but these are included here for information only and to inform ongoing curriculum discussions.

29. EMERGING TOPICS IN ENTRY-TO-PRACTICE

a. Emerging roles & team models - primary care, consultant, family care team member
b. Vestibular Rehab - BPPV Interventions
c. Pelvic Floor assessment/management/interventions
d. Telerehabilitation
e. Integration of assessment and intervention technologies and artificial /machine intelligence - wearable technology, prosthetics, end-effectors, virtual /augmented reality, smart monitors / health trackers
f. Ordering of diagnostic imaging, nerve conduction and lab tests
g. Ultrasound imaging in physiotherapy
h. Digital Health technologies
i. Personalized and precision medicine / rehab
j. Cerebral stimulation (tDCS)
k. Dry Needling
l. Therapy / Assistance Dogs

ACADEMIC CONTENT
PART B: MINIMUM ENTRY-TO-PRACTICE SKILLS

The Minimum Skills outlined in Part B further define the essential competencies and entry-to-practice milestones of the seven Domains of the Competency Profile. These skills are basic and represent the minimum level of ability expected at entry-to-practice.

The majority of the skills align with Domain 1 Physiotherapy Expertise and are grouped into 15 subsections. Each of the remaining six Domains have three – seven associated minimal skills. The skills are not listed in a chronological/practical order and should be chosen as appropriate for the client.

DOMAIN 1 – PHYSIOTHERAPY EXPERTISE

Appendix A - Competency Profile Domain 1

1. CLIENT CENTERED APPROACH

a. Elicit the "client's story" by using empathetic and culturally safe approaches
b. Use plain language to encourage client to ask questions and promote understanding
c. Use coaching/behavioural change approaches when indicated
d. Obtain comprehensive informed consent covering relevant components:
    i. Explanation of encounter
    ii. Diagnosis, prognosis
    iii. Assessment and intervention procedures
    iv. Risks and benefits
    v. Financial implications
    vi. Expected outcomes & timelines
    vii. Planned assignment of care to others
    viii. Options for care, including no care
e. Respects client's right to refuse care, decline options and/or withdraw from services
f. Follow client's advance directives

2. CLIENT SAFETY

a. Apply proper body mechanics
b. Properly position, drape and stabilize the client
c. Determine need for assistance/employment of equipment in all client handling situations
d. Recognize and respond to the adverse effect of an intervention - pain, deterioration, fatigue
e. Initiate/Perform emergency protocols/procedures as needed
f. Perform first aid or CPR when indicated
g. Use routine practices and universal precautions for infection control:
    i. Use aseptic and sterile techniques as indicated
    ii. Demonstrate proper sequencing for all precautions

3. CLIENT INFORMATION

a. Take a history and review data from other sources:
   i. Past client history and past treatment
   ii. Current history/history of present condition
   iii. Demographics
   iv. General health status
   v. Primary concern(s)
   vi. Current symptom(s)
   vii. Medications
   viii. Medical/surgical history
   ix. Social history
   x. Present and premorbid functional status/activity
   xi. Social/health habits
   xii. Living environment
   xiii. Occupation
   xiv. Growth and development
   xv. Lab tests and results - pulmonary function, blood gases/hemoglobin, nerve conduction, EKG/ECG
   xvi. Imaging - x-ray, CT scan, MRI, Ultrasound
   xvii. Consultations with other health professionals/team members
   xviii. Patient goals/expectations

b. Ask focused questions regarding:
   i. Clinical Flags
   ii. Fatigue
   iii. Pain
   iv. Malaise - fever, chills, sweats
   v. Nausea/vomiting
   vi. Dizziness/lightheadedness
   vii. Unexplained weight change
   viii. Numbness/Paresthesia
   ix. Weakness
   x. Mental health status/cognition changes
   xi. Physical, sexual or psychological abuse
   xii. Headache
   xiii. Sexual dysfunction
   xiv. Orthopnea, syncope
   xv. Palpitations

xvi. Cough, sputum, hemoptysis

xvii. Wheezing, stridor, clubbing

xviii. Peripheral edema

xix. Difficulty with swallowing

xx. Heartburn, indigestion, change in appetite

xxi. Change in bowel function, incontinence

xxii. Urinary frequency, urgency, incontinence

c. Determine client goals and expectations of physiotherapy

d. Assess client self-management and understanding of current health condition

e. Assess risk factors - comorbidities, smoking, nutritional, alcohol/drug use, activity level

f. Assess stage of behaviour change

g. Assess need and goals for group programming

h. Identify available resources in the community for group programming

4. TESTS AND MEASURES

a. Complete general inspection and observation of client

i. Appearance, posture, physical signs of pain, malalignment/deformity, physiological and psychological state

b. Measure height, weight, body composition (Body Mass Index calculation), waist girth, limb length, limb girth

c. Measure and characterize pain - severity, quality, location, behaviour, mechanisms

d. Complete objective examination of:

i. Vitals - heart rate, respiratory rate, blood pressure, oxygen saturation

ii. IPPA - Inspection, Palpation, Percussion, Auscultation

iii. Peripheral circulation - pulses

iv. Skin - color, temperature, integrity, mobility, hair/nail growth, wounds, signs of pressure and risk, lesions/moles

v. Spinal and peripheral joint range of motion - passive/active

vi. Abnormal movement patterns, tone

vii. Muscle length, flexibility

viii. Muscle strength - manual muscle testing, dynamometry

ix. Muscle endurance

x. Joint accessory movement

xi. Ligament integrity/laxity

xii. Neurological - myotomes, dermatomes, deep tendon reflexes, cranial nerve integrity

xiii. Neurodynamic tests - peripheral nerve integrity testing, neural tension

xiv. Special tests for selective tissue tension, nerve/vascular structures

xv. Sensory testing - light touch, sharp/dull, temperature, deep pressure, localization, proprioception, vibration, stereognosis, graphesthesia

xvi. Postural alignment and positioning, boney landmarks

xvii. Balance - static, dynamic, functional, postural reflexes

xviii. Gait - step length, speed, characteristics of gait, abnormal gait patterns

xix. Cognition - arousal, attention, orientation, perception, processing, retention, recall, language

xx. Motor function - motor planning and control, sensorimotor integration, coordination, dexterity, agility

xxi. Age-appropriate development - neuromotor, sensory, primitive reflexes

xxii. Mobility - bed mobility, transfers, wheelchair management, functional

xxiii. Functional abilities - ADL, home management, leisure/fitness

xxiv. Basic ergonomics - work, school, play, recreation

xxv. Therapeutic and assistive devices - ambulatory aids, splints, supports

xxvi. Prosthetic devices - general alignment and fit, safety, impact on function

5. OUTCOME MEASURES AND RATING SCALES

a. Select rating scales, screening tools and outcome measures (PT administered or self-report) for levels of impairments, activity limitations and participation restrictions

b. Aggregate data across clients and analyze results

c. Administer / Perform tests, measures and scales including:

i. 2 or 6 Minute Walk Tests (2MWT, 6MWT)

ii. 5 or 10 Meter Walk Test (5MWT, 10MWT)

iii. Berg Balance Scale (BBS)

iv. Borg Rating of Perceived Exertion Scale (RPE)

v. Chedoke-McMaster Stroke Assessment Scale (Chedoke)

vi. Disabilities of Arm, Shoulder & Hand (DASH)

vii. Glasgow Coma Scale (GCS)

viii. Gross Motor Function Classification System (GMFCS)

ix. Lower Extremity Functional Scale (LEFS)

x. Mini Mental State Examination (MMSE)

xi. Modified Borg Dyspnea Scale (MBS)

xii. Neck Disability Index (NDI)

xiii. Oswestry (Low Back Pain) Disability Index (ODI)

xiv. Patient Specific Functional Scale (PSFS)

xv. Roland-Morris Disability Questionnaire (Roland-Morris)

xvi. Sit to Stand Test (30CST, 5XSST)

xvii. Timed Up and Go (TUG)

xviii. Upper Extremity Functional Index (UEFI)

xix. Visual Analog Scale (VAS)/Numerical pain rating scale

xx. Western Ontario & McMaster Universities Osteoarthritis Index (WOMAC)

6. CARE PLANNING

a. Establish short and long term goals
b. Ensure goals are specific, measurable, attainable, relevant and time-based
c. Identify precautions and contraindications
d. Select and justify interventions
e. Establish criteria for discharge based on client goals and current functioning
f. Articulate a specific rationale for a referral
g. Consider billing/ reimbursement options for client

7. AIRWAY MANAGEMENT

a. Apply breathing strategies - active cycle of breathing, forced expiratory techniques, assisted cough/ huff, paced breathing, pursed lip, breath stacking, maximum inspiratory hold
b. Employ positioning for breathing facilitation, postural drainage, maximizing ventilation and perfusion
c. Use manual techniques - percussion, vibration
d. Use and/or teach use of respiratory assistive devices - oscillation PEP, inhalers, nebulizers, mechanical in/exsufflation
e. Perform oxygen titration
f. Apply oxygen delivery devices - nasal cannula, Venturi mask
g. Perform suctioning - oral, tracheal, airway
h. Use ventilatory support - invasive/non-invasive ventilation

8. EDUCATION/CLIENT COMMUNICATION

a. Assess prior levels of learning for client/family/caregiver to ensure clarity of education
b. Determine client characteristics that affect learning
c. Provide education and instruction:
    i. Client condition and physiotherapy care
    ii. Purpose of and results of assessments and interventions, progress, outcomes, discharge plans
    iii. Physiotherapy interventions
    iv. Safe and effective techniques
    v. Proper use of equipment/devices
    vi. Parameters, dosage and guidelines for interventions
    vii. Recognition of normal and abnormal response to interventions
    viii. Management of risk factors, injury prevention
    ix. Role of client/family/care provider and other team members
d. Provide client with home program information
e. Use communication approaches to encourage behaviour change

9. ELECTROPHYSICAL AGENTS (EPA)

a. Apply EPA modalities:

  i. Biofeedback
  ii. Contrast baths
  iii. Functional electrical stimulation (FES)
  iv. Heat modalities
  v. Cold modalities
  vi. Interferential (IFC)
  vii. Laser
  viii. Neuromuscular electrical stimulation (NMES)
  ix. Paraffin Wax
  x. Transcutaneous electrical nerve stimulation (TENS)
  xi. Ultrasound

10. EXERCISE INTERVENTIONS

a. Select, prescribe and/or perform:

  i. Aerobic capacity/interval/endurance training
  ii. Aquatic exercise
  iii. Ambulatory devices training
  iv. Balance, coordination, agility training
  v. Body mechanics training
  vi. Cardiac rehabilitation training
  vii. Device/equipment training for assistive/adaptive/protective devices
  viii. Energy conservation training
  ix. Flexibility exercises - range of motion, stretching
  x. Functional activities training - age appropriate skills, ADL
  xi. Gait and locomotion training
  xii. Mobilization / graded activity
  xiii. Injury prevention training
  xiv. Neuromotor developmental training
  xv. Neuromuscular education or re-education
  xvi. Postural training
  xvii. Proprioceptive training
  xviii. Pulmonary rehabilitation training
  xix. Relaxation training
  xx. Return-to-activity/work/play/sport
  xxi. Sensory training/retraining - sensory integration, desensitization
  xxii. Strength and power training
  xxiii. Wheelchair skills training

11. GROUP PROGRAMMING

a. Plan and select appropriate topics for groups with class format delivery - Falls prevention, Post-surgical exercise regimes

b. Provide and/or oversee delivery of programming to groups of clients

12. SOFT TISSUE INTERVENTIONS

a. Perform manual techniques for:

    i. Massage - therapeutic, connective tissue

    ii. Manual traction

    iii. Mobilization - spinal and peripheral joints

    iv. Neurodynamic techniques - mobilization, nerve gliding/flossing exercises

    v. Passive range of motion, stretching

13. THERAPEUTIC & ASSISTIVE DEVICES

a. Use or apply devices:

    i. Ambulatory devices - canes, crutches, walkers, walking poles, wheelchairs

    ii. Assistive, adaptive, protective devices - splints, taping/wrapping, bandaging, braces, orthotics, garments, collars

    iii. Compression therapies - compression garments, taping and bandaging

    iv. Mechanical devices - standing frames, tilt table, body weight support devices

    v. Prosthetic devices - upper and lower limb types

14. WOUND CARE

a. Perform wound (epidermal and dermal) management:

    i. Prevention and interventions strategies - compression, pressure relief, positioning, foot care, compression, exercise

    ii. Basic wound hygiene

    iii. Monitoring of skin, wounds, blisters and scars

15. TRANSITION / DISCHARGE

a. Adjust, revise or discontinue interventions when goals are achieved, client's status changes or intervention is no longer effective

b. Differentiate between discharge of the client, discontinuation of service, and transfer of care

c. Prepare needed resources and equipment for client

DOMAIN 2 – COMMUNICATION

Appendix A - Competency Profile Domain 2

Perform mandatory communication and/or reporting

a. Use and integrate Electronic Medical/Health records into practice
b. Consider setting for communication - case conference, health record, educational event
c. Include all relevant aspects of care in health record:
    i. Client consent for care
    ii. Client assessment
    iii. Care plan
    iv. Interventions
    v. Reassessment, progress notes
    vi. Equipment
    vii. Discharge/transition
    viii. Relevant client/family/care provider communication
    ix. Referrals and consultations
d. Accurately interpret documentation from other health care professionals

DOMAIN 3 – COLLABORATION

Appendix A - Competency Profile Domain 3

Identify who needs to collaborate in the plan of care

a. Participate in interprofessional continuum of care planning and follow up care with client/family/caregiver
b. Collaborate and coordinate with external agencies, community care, equipment suppliers, schools, funders
c. Participate in collaborative health rounds, specialty care clinics, meetings
d. Seek resources to resolve conflict when necessary

DOMAIN 4 – MANAGEMENT

Appendix A - Competency Profile Domain 4

a. Contribute to business planning and clinical operations
b. Ensure accurate use of billing and diagnostic codes
c. Maintain responsibility for assigned care

DOMAIN 5 – LEADERSHIP

Appendix A - Competency Profile Domain 5

a. Promote health/wellness in the community
b. Identify available resources in the community
c. Act as a role model for physiotherapy students

DOMAIN 6 – SCHOLARSHIP

Appendix A - Competency Profile Domain 6

a. Discriminate among the levels of evidence

b. Evaluates and understands commonly reported psychometric properties of clinical tests and outcome measures

c. Facilitate uptake of best practice in clinical settings and community

d. Share expertise with colleagues

e. Participate in ongoing professional education

f. Understand basic clinical research designs and systematic reviews

g. Understand Clinical Practice Guidelines

DOMAIN 7 – PROFESSIONALISM

Appendix A - Competency Profile Domain 7

a. Acknowledge personal biases

b. Respect the knowledge and rights of the client/family

c. Apply knowledge of health law to prevent issues of negligence or liability and to supports clients' rights

d. Disclose and document any conflict of interest that cannot be avoided

ACADEMIC CONTENT
PART C: COMMON CONDITIONS IN PHYSIOTHERAPY PRACTICE

The conditions commonly encountered in physiotherapy practice are grouped into four areas and twelve sections according to physiological systems. These conditions include diseases, disorders, surgeries and injuries. The area of physiotherapy practice in which each condition is typically seen is also indicated. Conditions are labelled as either Level 1 or Level 2:

Level 1 condition: entry-to-practice physiotherapists are expected to know and understand the etiology, pathophysiological mechanisms, natural history, typical clinical presentation (signs/symptoms, impairments), differential diagnoses, prognosis, current physiotherapy management and basic non-physiotherapy management (medical, surgical). Note: Level 1 conditions are Key Indicator conditions most commonly encountered by the entry-to-practice physiotherapist.

Level 2 condition: entry-to-practice physiotherapists are expected to be aware of these conditions and understand the condition type/category and general clinical presentation. Note: Level 2 conditions are introduced within curricula as Learning Transfer conditions which are less prevalent but provide an opportunity for more in-depth or independent learning.

COMMON CONDITIONS	
Cardiovascular-Pulmonary	
Musculoskeletal	
Neurological	
Other Conditions	Cognitive Gastrointestinal Genetic Integumentary Immune Metabolic Oncology Urinary/Reproductive

CARDIOVASCULAR-PULMONARY

1. CARDIOVASCULAR (CV) CONDITIONS	AREAS OF PHYSIOTHERAPY PRACTICE			
LEVEL 1 CV CONDITIONS	CV-PULM	MSK	NEURO	OTHER
a. Arrhythmias	●			
b. Arterial Disorders - Aneurysm, Atherosclerosis: coronary, peripheral	●	●		●
c. Cardiac Surgery/Interventions - Coronary Artery Bypass, Coronary Valve Replacement, Heart Transplantation, Angioplasty	●	●		
d. Heart Failure, Cor Pulmonale	●			
e. Heart Valve Disorders	●			
f. Hypertension/Hypotension	●			
g. Myocardial Ischemia / Infarction	●			
h. Venous Disorders - Deep Venous Thrombosis, Chronic Insufficiency	●			●
LEVEL 2 CV CONDITIONS				
i. Atrial / Ventricular Septal Defects	●			
j. Cardiomyopathy	●			
k. Endocarditis	●			
l. Haemophilia	●	●		
m. Sickle Cell Disease	●	●		

2. PULMONARY (PULM)	AREAS OF PHYSIOTHERAPY PRACTICE			
LEVEL 1 PULM CONDITIONS	CV-PULM	MSK	NEURO	OTHER
a. Asthma	●			
b. Atelectasis	●			
c. Bronchiectasis	●			
d. Bronchitis - Acute	●			
e. Chronic Obstructive Pulmonary Disease, Chronic Bronchitis, Emphysema	●	●	●	
f. Critical Illness (Multisystem)	●	●	●	
g. Cystic Fibrosis	●			
h. Idiopathic Pulmonary Fibrosis	●			

LEVEL 2 PULM CONDITIONS	CV-PULM	MSK	NEURO	OTHER
i. Acute Hypoxemic Respiratory Failure	●	●	●	
j. Bronchopulmonary Dysplasia	●			
k. Environmental - Pneumonitis, Silicosis	●			
l. Pulmonary Contusion	●			
m. Infectious Conditions - Influenza, Tuberculosis, Acute Bronchiolitis	●			
n. Sarcoidosis	●			

MUSCULOSKELETAL

3. MUSCULOSKELETAL (MSK) CONDITIONS	AREAS OF PHYSIOTHERAPY PRACTICE			
LEVEL 1 MSK CONDITIONS	CV-PULM	MSK	NEURO	OTHER
a. Amputations - congenital, traumatic/surgical		●		
b. Ankylosing Spondylitis	●	●		
c. Bursitis		●		
d. Fibromyalgia		●	●	
e. Fractures - traumatic, pathological		●		
f. Frailty	●	●	●	
g. Headache		●	●	
h. Developmental Dysplasia of the Hip		●		
i. Joint Disorders - dislocations/subluxations, internal derangement, hyper/hypo mobility		●		
j. Juvenile Idiopathic Arthritis		●		
k. Ligaments: sprains, laxity		●		
l. Low Back Pain - non-specific		●		
m. Muscles: contusions, strains		●		
n. Myofascial/Fascial Conditions		●		
o. Neck Pain: non-specific, cervicogenic, radicular		●	●	
p. Osteoarthritis		●		
q. Osteonecrosis - Avascular Necrosis		●		
r. Osteoporosis, Osteopenia		●		
s. Rheumatoid Arthritis		●		

LEVEL 1 MSK CONDITIONS (CONT.)	CV-PULM	MSK	NEURO	OTHER
t. Spinal Postural Disorders - Scoliosis, Abnormal Kyphosis / Lordosis		●		
u. Spinal Stenosis		●		
v. Spinal Disc Herniation		●		
w. Spondylolysis/Spondylolisthesis		●		
x. Surgery (Bone/Joint) - spinal, joint replacements, fracture fixation		●		
y. Surgery (Soft Tissue) - repairs/reconstructions, transfers		●		
z. Tendons: Tendinopathy, Tendinitis/ Tenosynovitis, Tendon Ruptures/Tears		●		
aa. Torticollis		●		
ab. Whiplash Associated Disorders		●		
LEVEL 2 MSK CONDITIONS				
ac. Legg-Calve-Perthes Disease		●		
ad. Osgood-Schlatter's Disease		●		
ae. Osteogenesis Imperfecta		●		
af. Plagiocephaly		●		
ag. Sarcopenia		●		
ah. Talipes Equinovarus		●		

NEUROLOGICAL

4. NEUROLOGICAL (NEURO) CONDITIONS	AREAS OF PHYSIOTHERAPY PRACTICE			
LEVEL 1 NEURO CONDITIONS	CV-PULM	MSK	NEURO	OTHER
a. Amyotrophic Lateral Sclerosis			●	
b. Facial Nerve Palsy		●	●	
c. Brachial Plexus Disorders		●	●	
d. Carpal Tunnel Syndrome		●	●	
e. Cerebellar Disorders			●	
f. Cerebral Palsy Syndromes		●	●	
g. Stroke: Cerebrovascular Accident, Transient Ischemic Attack	●		●	
h. Complex Regional Pain Syndrome		●	●	
i. Developmental Coordination Disorder			●	

LEVEL 1 NEURO CONDITIONS (CONT.)	CV-PULM	MSK	NEURO	OTHER
j. Guillain-Barre Syndrome	●		●	
k. Multiple Sclerosis			●	
l. Parkinson Disease			●	
m. Peripheral Nerves: injury, entrapment, neuropathy		●	●	
n. Post Concussion Syndrome		●	●	
o. Radicular Pain/Radiculopathy		●	●	
p. Spinal Cord Injuries / Disorders	●		●	
q. Traumatic/Acquired Brain Injuries	●		●	
LEVEL 2 NEURO CONDITIONS				
r. Alcoholic Neuropathy		●	●	
s. Benign paroxysmal positional vertigo (BPPV)		●	●	
t. Cervicogenic Dizziness		●	●	
u. Chronic Fatigue Syndrome	●		●	
v. Coma	●		●	
w. Encephalitis	●		●	
x. Hydrocephalus		●	●	
y. Meningitis	●		●	
z. Seizure Disorders - Epilepsy			●	
aa. Unilateral Vestibular Hypofunction		●	●	

OTHER

5. OTHER: COGNITIVE CONDITIONS	AREAS OF PHYSIOTHERAPY PRACTICE			
LEVEL 1 COGNITIVE CONDITIONS	CV-PULM	MSK	NEURO	OTHER
a. Alzheimer Disease	●	●	●	●
b. Anxiety Disorder	●	●	●	●
c. Aphasia			●	●
d. Autism Spectrum Disorder			●	●
e. Delirium	●	●	●	●
f. Dementia	●	●	●	●
g. Depression	●	●	●	●

LEVEL 2 COGNITIVE CONDITIONS	CV-PULM	MSK	NEURO	OTHER
h. Substance Use Disorders				●
i. Attention-Deficit / Hyperactivity Disorder				●
j. Bipolar Disorder				●
k. Obsessive Compulsive Disorder				●
l. Post Traumatic Stress Disorder				●
m. Schizophrenia				●
n. Sleep Disorders	●	●	●	●
6. OTHER: GASTROINTESTINAL CONDITIONS				
a. Abdominal Surgery: Resection, Ostomy (Level 1)	●			●
b. Dysphagia (Level 2)			●	●
7. OTHER: GENETIC CONDITIONS				
LEVEL 1 GENETIC CONDITIONS				
a. Down Syndrome			●	●
b. Duchenne Muscular Dystrophy		●	●	●
LEVEL 2 GENETIC CONDITIONS				
c. Charcot Marie Tooth Disease		●	●	●
d. Friedreich/Hereditary Ataxia			●	●
e. Huntington Disease			●	●
8. INTEGUMENTARY CONDITIONS				
a. Burns / Frostbite (Level 1)	●	●		●
b. Wounds - Pressure Ulcers (Level 1)	●	●	●	●
c. Dermatitis / Cellulitis (Level 1)				●
9. IMMUNE CONDITIONS	**CV-PULM**	**MSK**	**NEURO**	**OTHER**
LEVEL 1 IMMUNE CONDITIONS				
a. Human Immunodeficiency Virus (HIV) Infection	●		●	●
b. Infections: local / sepsis, bone / joint	●	●	●	●
c. Tumours: benign	●	●	●	●

LEVEL 2 IMMUNE CONDITIONS	CV-PULM	MSK	NEURO	OTHER
d. Autoimmune Polymyositis		●	●	●
e. Systemic Lupus Erythematosus		●		●
f. Scleroderma		●		●
g. Shingles/Herpes Zoster		●	●	●
10. METABOLIC CONDITIONS				
a. Diabetes Mellitus (Level 1)	●	●	●	●
b. Chronic Kidney Disease (Level 1)				●
c. Obesity (Level 1)		●		●
d. Gout (Level 2)		●		●
11. ONCOLOGY CONDITIONS				
LEVEL 1 ONCOLOGY CONDITIONS				
a. Breast Cancer		●		●
b. Lymphedema	●	●		●
c. Lung Cancer	●	●		●
d. Tumours: Malignant / Metastasis	●	●	●	●
LEVEL 2 ONCOLOGY CONDITIONS				
e. Cancer Cachexia		●		●
f. Colorectal Cancer		●		●
g. Head and Neck Cancer	●	●		●
h. Leukemia	●			●
i. Lymphoma		●		●
j. Melanoma		●		●
k. Prostate Cancer	●	●		●
12. URINARY / REPRODUCTIVE				
a. Incontinence: Urinary, Fecal (Level 1)		●	●	●
b. Pelvic Floor Dysfunction Female (Level 1)		●		●
c. Pregnancy – Prenatal, Post-Partum (Level 1)		●		●

CLINICAL EDUCATION EXPERIENCES

1. CLINICAL HOURS

Each student must complete a minimum of 1025 hours in clinical placements which are normally scheduled within clinical education credit courses.

APPLICATION

- A minimum of 820 hours must be in settings that provide direct, clinical patient care.
- Students may complete one placement (or components of more than one placement) in a setting that does not involve direct clinical care for patients (examples: Physiotherapy Association, Lung Association, Sports Science Council, Research Lab) if the student has (or will have, by graduation) successfully completed the required mix of clinical experience (i.e. hours, areas of practice and practice settings).

2. AREAS OF CLINICAL PRACTICE – PATIENT POPULATIONS

Each student must acquire a broad clinical experience including a minimum of 100 hours each in areas of clinical practice with patients/populations who have the following types of conditions:

- Cardiovascular / Pulmonary
- Neurological
- Musculoskeletal

APPLICATION

- Experience with each designated population listed above, may be realized during one clinical placement or through components of multiple clinical education credit courses.

3. PRACTICE SETTINGS

Each student must acquire clinical experience in each of the following settings:

- Acute / Hospital Care
- Rehabilitation or Community Care
- Ambulatory Care or Private Practice

APPLICATION

- Setting Definitions:

  #### Acute / Hospital Care

  Physiotherapy care, as part of an Interprofessional team, provided for patients during an acute illness, an acute exacerbation or a surgical intervention which necessitates admission to an acute care facility.

Rehabilitation or Community Care

Physiotherapy care, as part of an interprofessional team, provided for a patient to maximize functional independence. Typically following the diagnosis of a new condition, an injury leading to a disability, an acute illness or surgical intervention and/or the progression of a chronic condition. Rehabilitation or community care could be provided within a rehabilitation hospital/unit, clinic, homecare, schools, etc.

Ambulatory Care or Private Practice

Physiotherapy care, as a sole physiotherapy service or as part of an interprofessional team, for a patient who lives in the community and attends physiotherapy as an out-patient. This care could be provided at private or public physiotherapy clinics, work sites, etc.

4. SUPERVISION OF STUDENTS

The majority of clinical education hours are supervised and evaluated by a qualified physiotherapist.

APPLICATION

- While the majority of clinical education hours are supervised by qualified physiotherapists, students may at times be supervised by other qualified professionals (subject to provincial / territorial regulatory requirements). These clinical education opportunities may allow students to gain experience in more non-traditional and/or role-emerging settings.

Conclusions and Recommendations

The journey to update the National Entry-to-Practice Curriculum Guidelines was long but very rewarding. It is the first time several seminal national professional physiotherapy documents (Competency Profile, PCE Blueprint, Curriculum Guidelines) have been reviewed, integrated and aligned through purposeful, related processes. There was cross representation from NPAG organizations in review activities and consistent broad consultation from many key stakeholders. The overall experience was very positive and it increased the energy level within the CCPUP community.

The structure of the Guidelines dovetails with the Competency Profile in key sections; this structure was purposeful. The new structure with main sections and subsections should allow for frequent and efficient review. Being able to consider changes in physiotherapy practice in a more responsive way should keep the Guidelines current and practical for programs and external stakeholders. The Curriculum Committee envisions an active cycle of renewal based on emerging trends and informed by CCPUP and NPAG partner organization activities and projects.

While the primary users of the Guidelines will be academic programs and their faculty, the Guidelines will be of interest to many others, both internal and external to the profession in Canada. Examples include program applicants, physiotherapy students, physiotherapist assistant students, accreditors of academic programs, regulators of physiotherapy practice, internationally educated physiotherapists, national and international credentialing agencies, employers of physiotherapists and health human resource professionals as well as funders, legislators, planners, and policy developers, other professional groups and international agencies.

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- Canadian physiotherapists via the Competency Profile survey
- NPAG partners within CCPUP meeting discussions
- PT Program Faculty Members, survey responses

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Appendix A: Competency Profile for Physiotherapists in Canada (2017)

This Appendix includes excerpts from the Competency Profile that inform the Guidelines. Access the full Competency Profile at:

NPAG Website: Essential Competency Profile 2017 or PEAC Website: Essential Competency Profile 2017

From Page 7 of the Competency Profile:

DEFINITIONS OF KEY TERMS

Term	Definition
Essential competency	An essential competency is a required ability of a physiotherapist.
Milestone	A milestone is an ability that is expected of a physiotherapist at a specific stage in the career. It is related to an essential competency.
Entry-to-practice	Entry-to-practice is the point in time following completion of education and assessment (at the point of licensure as a physiotherapist).
Entry-to-practice milestone	An entry-to-practice milestone is an ability that is expected of a physiotherapist at entry-to-practice. It is related to an essential competency.
Proficiency	Proficiency is the expected level of performance associated with the milestones at a defined point in the career.
Entry-to-practice proficiency	Entry-to-practice proficiency is the expected level of performance associated with the milestones at entry-to-practice. It is described below.

STATEMENT OF ENTRY-TO-PRACTICE

Entry-to-practice physiotherapists have the ability and responsibility to use their broad knowledge base to inform their practice. They work in an autonomous, safe organized manner, and employ sound clinical decision-making.

Autonomy: They are aware of and work within the physiotherapy scope of practice. They appropriately seek guidance when they encounter situations outside of their ability.

Safety: They are aware of and consistently comply with standards and regulations relevant to their practice environment. They have an understanding of the risks, cautions, contraindications, and best practices relevant to conditions commonly encountered in physiotherapy practice.

Organization: They practices in an organized manner but may require more time to complete tasks than an experienced physiotherapist.

Clinical Decision-Making: Clinical decision-making is largely driven by the knowledge and skills acquired through academic and clinical education, rather than by practice experience. They use a clinical reasoning approach that may be more time consuming and effortful than an experienced physiotherapist.

DOMAIN 1 PHYSIOTHERAPY EXPERTISE

As experts in mobility and function, physiotherapists use clinical reasoning that integrates unique knowledge, skills and attitudes to provide quality care and enhance the health and wellbeing of their clients.

	ESSENTIAL COMPETENCIES		ENTRY-TO-PRACTICE MILESTONES
1.1	Employ a client-centered approach.	1.1.1	Act in a manner that respects client uniqueness, diversity and autonomy, and is in the client's best interest.
		1.1.2	Provide the client with relevant information throughout care.
		1.1.3	Actively involve the client in decision-making.
		1.1.4	Empower client to engage in their own care.
		1.1.5	Build and maintain rapport and trust with the client.
		1.1.6	Ensure ongoing, informed client consent.
1.2	Ensure physical the emotional safety of client.	1.2.1	Identify client-specific precautions, contraindications and risks.
		1.2.2	Employ safe client handling techniques.
		1.2.3	Apply assessment and intervention procedures in a manner that enhances the client's safety and comfort.
		1.2.4	Monitor and respond to client's physical and emotional state throughout care.
		1.2.5	Identify and respond to near misses and adverse events.
1.3	Conduct client assessment.	1.3.1	Interview client to obtain relevant information about health conditions, and personal and environmental factors.
		1.3.2	Determine client's expectations, and their relevance to physiotherapy.
		1.3.3	Obtain relevant information about client's status from other sources.
		1.3.4	Identify comorbidities that impact approach to assessment.
		1.3.5	Identify urgent health conditions that require immediate attention and take appropriate action.
		1.3.6	Identify non-urgent health-related conditions that may benefit from referral to other services and advise client accordingly.
		1.3.7	Select and perform appropriate tests and measures.

1.4	Establish a diagnosis and prognosis.	1.4.1	Interpret assessment findings and other relevant information.
		1.4.2	Identify client's body structure and function impairments, activity limitations and participation restrictions.
		1.4.3	Develop a physiotherapy diagnosis.
		1.4.4	Develop a working prognosis.
		1.4.5	Determine if physiotherapy is indicated.
		1.4.6	Determine if referral to another physiotherapist or another provider is indicated.
1.5	Develop, implement, monitor and evaluate an intervention plan.	1.5.1	Establish physiotherapy goals.
		1.5.2	Determine an intervention plan.
		1.5.3	Implement planned interventions.
		1.5.4	Assist client to develop self-management skills.
		1.5.5	Monitor and respond to client status during interventions.
		1.5.6	Reassess client status and needs as appropriate.
		1.5.7	Modify intervention plan as indicated.
1.6	Complete or transition care.	1.6.1	Evaluate client outcomes and goal attainment.
		1.6.2	Develop a discharge or transition of care plan.
		1.6.3	Prepare client for discharge or transition of care.
		1.6.4	Ensure effective transfer of information at transition.
1.7	Plan, deliver and evaluate programs.	1.7.1	Identify opportunities for group physiotherapy programming.
		1.7.2	Establish program goals and develop a plan.
		1.7.3	Implement program plan.
		1.7.4	Evaluate program.

DOMAIN 2 COMMUNICATION

As communicators, physiotherapists use effective strategies to exchange information and to enhance therapeutic and professional relationships.

	ESSENTIAL COMPETENCIES		ENTRY-TO-PRACTICE MILESTONES
2.1	Use oral and non-verbal communication effectively.	2.1.1	Speak clearly and concisely.
		2.1.2	Listen actively, to build trust and foster exchange of information.
		2.1.3	Use and respond to body language appropriately.
		2.1.4	Give and receive feedback in a constructive manner.
2.2	Use written communication effectively.	2.2.1	Write in a clear, concise and organized fashion.
		2.2.2	Ensure written communication is legible.
		2.2.3	Prepare comprehensive and accurate health records and other documents, appropriate to purpose.
2.3	Adapt communication approach to context.	2.3.1.	Adjust communication strategy consistent with purpose and setting.
		2.3.2	Use appropriate terminology.
		2.3.3	Adjust communication based on level of understanding of recipient.
		2.3.4	Ensure communication is timely.
		2.3.5	Share information empathetically and respectfully.
2.4	Use communication tools and technologies effectively.	2.4.1	Employ assistive and augmentative devices to enhance communication.
		2.4.2	Use electronic technologies appropriately and responsibly.
		2.4.3	Use images, videos and other media to enhance communication.

DOMAIN 3 COLLABORATION

As collaborators, physiotherapists work effectively with others to provide inter- and intra- professional care.

	ESSENTIAL COMPETENCIES		ENTRY-TO-PRACTICE MILESTONES
3.1	Promote an integrated approach to client services.	3.1.1	Identify practice situations that may benefit from collaborative care.
		3.1.2	Engage client as a team member.
3.2	Facilitate collaborative relationships.	3.2.1	Recognize and respect the roles of others.
		3.2.2	Share information about the physiotherapist's role and knowledge.
		3.2.3	Negotiate shared and overlapping roles and responsibilities.
		3.2.4	Maintain mutually supportive working relationships.
		3.2.5	Interact with others in a manner that promotes inclusion.
3.3	Contribute to effective teamwork.	3.3.1.	Respect accepted principles for teamwork.
		3.3.2	Participate in shared leadership.
		3.3.3	Share relevant information with the team.
		3.3.4	Participate and be respectful of all members' participation in collaborative decision-making.
		3.3.5	Participate in team evaluation and improvement initiatives.
3.4	Contribute to conflict resolution.	3.4.1	Recognize conflict or potential conflict, and respond constructively.
		3.4.2	Apply conflict resolution principles in a structured fashion.

DOMAIN 4 MANAGEMENT

As managers, physiotherapists manage self, time, resources and priorities to ensure safe, effective and sustainable services.

	ESSENTIAL COMPETENCIES		ENTRY-TO-PRACTICE MILESTONES
4.1	Support organizational excellence.	4.1.1	Support organizational mission and vision.
		4.1.2	Comply with organizational policies, procedures and directives.
		4.1.3	Address discrepancies between employer expectations and professional standards.
		4.1.4	Follow proper business practices.
4.2	Utilize resources efficiently and effectively.	4.2.1	Provide services that balance client needs and available resources.
		4.2.2	Address issues related to waitlists, caseloads and access to services.
		4.2.3	Manage own time effectively.
		4.2.4	Address issues related to availability of equipment and supplies.
4.3	Ensure a safe practice environment.	4.3.1	Identify risks and mitigate hazards in the workplace.
		4.3.2	Maintain a clean, organized and accessible work environment.
		4.3.3	Adhere to individual, team and system-level safety practices.
		4.3.4	Apply best practices for infection control.
		4.3.5	Adapt work environment to enhance emotional safety.
		4.3.6	Ensure regular equipment cleaning and maintenance.

4.4	Engage in quality improvement activities.	4.4.1	Apply quality improvement strategies in direct service provision.
		4.4.2	Participate in organizational quality improvement initiatives.
		4.4.3	Use outcome data to evaluate service delivery.
4.5	Supervise others.	4.5.1	Assess the competence of personnel involved in physiotherapy service delivery prior to assigning care.
		4.5.2	Assign care to personnel involved in physiotherapy service delivery, and monitor delivery.
		4.5.3	Contribute to orientation and training of personnel involved in physiotherapy service delivery.
		4.5.4	Provide guidance and feedback to personnel involved in physiotherapy service delivery.
4.6	Manage practice information safely and effectively.	4.6.1	Maintain comprehensive, accurate and timely records of client and practice management.
		4.6.2	Manage health records and other information in paper and electronic format.
		4.6.3	Ensure secure retention, storage, transfer and destruction of documents.
		4.6.4	Maintain confidentiality of records and data, with appropriate access.

DOMAIN 5 LEADERSHIP

As leaders, physiotherapists envision and advocate for a health system that enhances the well-being of society.

	ESSENTIAL COMPETENCIES		ENTRY-TO-PRACTICE MILESTONES
5.1	Champion the health needs of clients.	5.1.1	Advocate for accessibility and sustainability of physiotherapy and other services across the continuum of care.
		5.1.2	Foster client engagement in finding solutions to address health needs.
		5.1.3	Promote a culture of client-centeredness.
5.2	Promote innovation in healthcare.	5.2.1	Maintain awareness of emerging technologies and advocate for their application to enhance physiotherapy services.
		5.2.2	Advocate for new approaches to improve client care.
		5.2.3	Promote solutions to challenges encountered in physiotherapy practice.
5.3	Contribute to leadership in the profession.	5.3.1.	Promote the value of physiotherapy to client health.
		5.3.2	Engage in activities to support advancement of the physiotherapy profession.
		5.3.3	Contribute to leadership activities in the workplace.

DOMAIN 6 SCHOLARSHIP

As scholars, physiotherapists demonstrate a commitment to excellence in practice through continuous learning, the education of others, the evaluation of evidence, and contributions to scholarship.

	ESSENTIAL COMPETENCIES		ENTRY-TO-PRACTICE MILESTONES
6.1	Use an evidence-informed approach to practice.	6.1.1	Incorporate best available evidence into clinical decision-making.
		6.1.2	Incorporate client context into clinical decision-making.
		6.1.3	Incorporate personal knowledge and experience into clinical decision-making.
		6.1.4	Make decisions using an established clinical reasoning framework.
		6.1.5	Use a structured approach to evaluate effectiveness of decisions.
6.2	Engage in scholarly inquiry.	6.2.1	Identify ethical considerations related to scholarly inquiry.
		6.2.2	Formulate researchable questions relevant to practice.
		6.2.3	Access reliable sources of information.
		6.2.4	Critically appraise information.
		6.2.5	Contribute to research activities.
		6.2.6	Contribute to knowledge management.
6.3	Integrate self-reflection and external feedback to improve personal practice.	6.3.1	Seek feedback from others on personal performance and behavior.
		6.3.2	Compare personal performance and behavior with professional and organizational expectations.
		6.3.3	Identify learning needs based on self-reflection and external feedback.
		6.3.4	Develop and implement a plan to address learning needs.
6.4	Maintain currency with developments relevant to area of practice.	6.4.1	Access emerging information relevant to area of practice.
		6.4.2	Determine potential for applicability of emerging information to personal practice.
6.5	Contribute to the learning of others.	6.5.1	Identify the physiotherapy-related learning needs of others.
		6.5.2	Contribute to the education of peers and other healthcare providers.
		6.5.3	Contribute to the clinical education of students.
		6.5.4	Assess effectiveness of learning activities.

DOMAIN 7 PROFESSIONALISM

As autonomous, self-regulated professionals, physiotherapists are committed to working in the best interest of clients and society and to maintaining high standards of behavior.

	ESSENTIAL COMPETENCIES		ENTRY-TO-PRACTICE MILESTONES
7.1	Comply with legal and regulatory requirements.	7.1.1	Comply with applicable federal and provincial / territorial legislation .
		7.1.2	Comply with regulatory requirements.
		7.1.3	Maintain confidentiality and privacy as appropriate.
7.2	Behave ethically.	7.2.1	Use an ethical framework to guide decision-making.
		7.2.2	Address real, potential or perceived conflicts of interest.
		7.2.3	Promote services in an ethical manner.
7.3	Embrace social responsibility as a health professional.	7.3.1	Maintain awareness of issues and advances affecting the health system locally, nationally and globally.
		7.3.2	Demonstrate awareness of the social determinants of health and emerging trends that may impact physiotherapy practice.
7.4	Act with professional integrity.	7.4.1	Behave with honesty and respect for others.
		7.4.2	Behave in a manner that values diversity.
		7.4.3	Work within physiotherapy scope of practice and personal level of competence.
		7.4.4	Accept accountability for decisions and actions.
		7.4.5	Maintain professional deportment.
		7.4.6	Maintain professional boundaries.
		7.4.7	Respond constructively to changes affecting the workplace.
7.5	Maintain personal wellness consistent with the needs of practice.	7.5.1	Balance personal and professional demands.
		7.5.2	Address physical, emotional and psychological factors negatively impacting workplace performance.

Resources

Academy of Acute Care Physical Therapy – APTA Minimum Skills Task Force. (2015). *Core competencies for entry-level practice in acute care physical therapy 2015*. https://cdn.ymaws.com/www.acutept.org/resource/resmgr/docs/2015PT-core-competencies.pdf

Academy of Geriatric Physical Therapy. (2011). *Essential competencies in the care of older adults at the completion of the entry-level physical therapist professional program of study*. https://geriatricspt.org/pdfs/AGPT-PT-Essential-Competencies.pdf

American Physical Therapy Association. (2005). *Minimum required skills of physical therapy graduates at entry-level*. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/BOD/Education/MinReqSkillsPTGrad.pdf

American Physical Therapy Association. (2011). Neurologic entry-level curricular content integrated with a normative model of physical therapist professional education. http://www.neuropt.org/docs/default-source/residency/2011_neurologic_entry-level_curriculum_guidelines7e676feaff3d.pdf?sfvrsn=6bd05743_2

Association of Faculties of Pharmacy of Canada. (2017). *Educational outcomes for first professional degree programs in pharmacy in Canada*. http://www.afpc.info/system/files/public/AFPC-Educational%20Outcomes%20 2017_final%20Jun2017.pdf

Blackstock, F. C., Watson, K. M., Morris, N. R., Jones, A., Wright, A., McMeeken, J. M., Rivett, D. A., O'Connor, V., Peterson, R. F., Haines, T. P., Watson, G., & Jull, G. A. (2013). *Simulation can contribute a part of cardiorespiratory physiotherapy clinical education: Two randomized trials*. Simulation in Healthcare, 8(1), 32–42. https://doi.org/10.1097/SIH.0b013e318273101a

Canadian Alliance of Physiotherapy Regulators. (2017). *Core Standards of Practice for Physiotherapists in Canada*. https://www.alliancept.org/publications/

Canadian Alliance of Physiotherapy Regulators. (2018). *Physiotherapy Competency Examination Blueprint*. https://www.alliancept.org/taking-the-exam/preparing-for-the-exam/exam-blueprint/

Canadian Alliance of Physiotherapy Regulators. (2020). *List of Regulator Websites*. https://www.alliancept.org/regulator-websites/

Canadian Physiotherapy Association. (2020). *Position Statements*. https://physiotherapy.ca/position-statements

Chipchase, L. S., Blackstock, F. C., Patman, S., & Barnett-Harris, A. (2018). *Keep the momentum going: pushing the boundaries of clinical learning and assessment*. Journal of Physiotherapy, 205–207.

Council of Canadian Physiotherapy University Programs. (2009). *Entry-to-Practice Physiotherapy Curriculum: Content Guidelines for Canadian University Programs*. http://www.physiotherapyeducation.ca/Resources/National%20PT%20Curriculum%20Guidelines%202009.pdf

Council of Canadian Physiotherapy University Programs. (2011). *Entry-to-Practice Physiotherapy Curriculum: A Companion Document – Clinical Education Guidelines for Canadian University Programs*. http://www.physiotherapyeducation.ca/Resources/Clin_Ed_Guidelines_FINAL_%202011.pdf

Frank, J. R., Snell, L., & J., S. (Eds.). (2015). *CanMEDS 2015: Physician competency framework. Royal College of Physicians and Surgeons of Canada*. http://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e.

Halupa, C. (Ed.). (2015). *Transformative Curriculum Design in Health Sciences Education*. IGI Global. https://doi.org/10.4018/978-1-4666-8571-0

Holdsworth, C., Skinner, E. H., & Delany, C. M. (2016). *Using simulation pedagogy to teach clinical education skills: A randomized trial*. Physiotherapy Theory and Practice, 32(4), 284–295.

Melling, M., Duranai, M., Pellow, B., Lam, B., Kim, Y., Beavers, L., Miller, E., & Switzer-McIntyre, S. (2018). *Simulation experiences in Canadian physiotherapy programmes: a description of current practices*. Physiotherapy Canada, 70(3), 262–271.

National Association for Clinical Education in Physiotherapy. (2015). *A checklist of key cardiorespiratory interventions for entry-level physical therapy students*.

National Physiotherapy Advisory Group. (2009). *Essential Competency Profile for Physiotherapists in Canada*. http://npag.ca/English/joint.html

National Physiotherapy Advisory Group. (2017). *Competency Profile for Physiotherapists in Canada*. http://npag.ca/English/joint.html

Norman, K., Craig, M., Caballes, J. C., Davidson, J., Dawson, A., Mong, A., Schilling, C., Wallace, V., & Wood, E. (2018). *The "1,025" Hours Project: A report to CCPUP/NACEP*. Submitted 2018 October to CCPUP/NACEP.

Partnership for Dietetic Education and Practice. (2013). *The integrated competencies for dietetic education and practice*. https://www.pdep.ca/library/Accreditation-Policies-and-Standards/PDEP-ICDEP-2013-.aspx

Physiotherapy Board of Australia, & Physiotherapy Board of New Zealand. (2015). *Physiotherapy practice thresholds in Australia and Aotearoa*. https://physiocouncil.com.au/wp-content/uploads/2017/10/Physiotherapy-Board-Physiotherapy-practice-thresholds-in-Australia-and-Aotearoa-New-Zealand.pdf

Physiotherapy Education Accreditation Canada. (2012). *Accreditation Standards (in revision)*. https://peac-aepc.ca/english/accreditation/accreditation-standards.php

Pritchard, S. A., Blackstock, F. C., Nestel, D., & Keating, J. L. (2016). *Simulated patients in physical therapy education: systematic review and meta-analysis*. Physical Therapy, 96(9), 1342–1353.

Watson, K., Wright, A., Morris, N., McMeeken, J., Rivett, D., Blackstock, F., Jones, A., Haines, T., O'Connor, V., & Watson, G. (2012). *Can simulation replace part of clinical time? Two parallel randomised controlled trials. Medical Education*, 46(7), 657–667.

World Confederation for Physical Therapy. (2011). *WCPT guideline for physical therapist professional entry level education*. https://www.wcpt.org/sites/wcpt.org/files/files/Guideline_PTEducation_complete.pdf

World Confederation for Physical Therapy. (2011). *WCPT guideline for the clinical education component of physical therapist professional entry level education*. https://www.wcpt.org/sites/wcpt.org/files/files/Guideline_clinical_education_complete1.pdf

NOTE: Resources list above with url links were retrieved, at those links, in January 2018.