January 2019

Integrating Best Practice Into Fieldwork: A Narrative Inquiry Into The Level II Experiences Of Occupational Therapy Students

Cherie Graves

Follow this and additional works at: https://commons.und.edu/theses

INTEGRATING BEST PRACTICE INTO FIELDWORK: A NARRATIVE INQUIRY
INTO THE LEVEL II EXPERIENCES OF OCCUPATIONAL THERAPY STUDENTS

by

Cherie Amber Graves
Masters of Occupational Therapy, University of North Dakota, 2006

A Dissertation

Submitted to the Graduate Faculty

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy
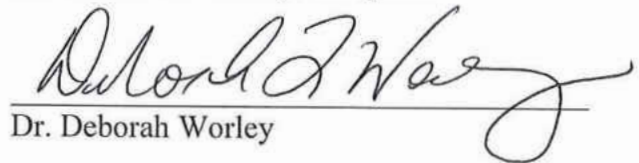
Grand Forks, North Dakota
August
2019
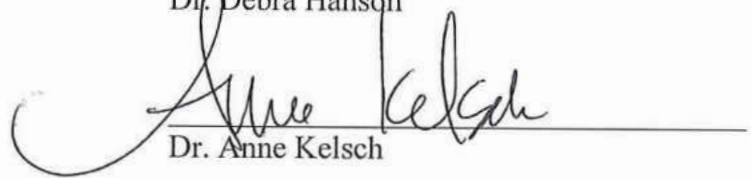
This dissertation, submitted by Cherie Amber Graves in partial fulfillment of the requirements of the Degree of Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

_____
Dr. Joshua E. Hunter, Chairperson

_____
Dr. Deborah Worley

_____
Dr. Debra Hanson

_____
Dr. Anne Kelsch

This dissertation is being submitted by the appointed advisory committee as having met all of the requirements of the School of Graduate Studies at the University of North Dakota and is hereby approved.

_____
Dr. Chris Nelson, Associate Dean
School of Graduate Studies

7/19/19
_____
Date

ii

PERMISSION

Title   Integrating Best Practice Into Fieldwork: A Narrative Inquiry Into the
      Level II Experiences of Occupational Therapy Students

Department Educational Leadership

Degree   Doctor of Philosophy

  In presenting this dissertation in partial fulfillment of the requirements for a
graduate degree from the University of North Dakota, I agree that the library of this
University shall make it freely available for inspection. I further agree that permission for
extensive copying for scholarly purposes may be granted by the professor who supervised
my dissertation work or, in his absence, by the Chairperson of the department or the dean
of the School of Graduate Studies. It is understood that any copying or publication or
other use of this dissertation or part thereof for financial gain shall not be allowed without
my written permission. It is also understood that due recognition shall be given to me and
to the University of North Dakota in any scholarly use which may be made of any
material in my thesis or dissertation.

                 Cherie Amber Graves
                 July 16, 2019

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

First and foremost, I would like to thank the four occupational therapy students who willingly participated in my research study throughout the 24 weeks of Level II fieldwork. Without them, this research and the contributions to the occupational therapy profession would not have been realized.

I would like to thank my advisor, Dr. Joshua Hunter, who stepped in as my advisor when the position was vacant. Thank you for your patience, your guidance, your thoughts, and your feedback throughout this process.

I also wish to thank my dissertation committee members, Dr. Deborah Worley, Dr. Debra Hanson, and Dr. Anne Kelsch. Your guidance and feedback throughout this process was always helpful and insightful.

Finally, I would like to thank my family – Andy, Oliver, and Willow. Andy, thank you for doing more than your share for the last six years. Thank you for understanding and rarely complaining when I wasn't able to be present. Thank you for your patience, love, and support. To Oliver and Willow, thank you for always giving me hugs when I needed them most. To mom, dad, Ginger, and Dawn, thank you for always being willing to help in so many ways.

Without you all, I would not have made it this far. Thank you!

ABSTRACT

The purpose of this study was to explore occupational therapy student's experiences with integrating best practice professional ideals during Level II fieldwork. Occupational therapy students in the United States complete 24 weeks of Level II fieldwork prior to graduation. Students transition from the classroom setting where they are prepared with knowledge about the professions best practice ideals, to the fieldwork setting where many factors impact the learning experience. Using qualitative research, a narrative inquiry was undertaken to explore the experiences of four occupational therapy students during their Level II fieldwork experiences. I interviewed each student on five occasions throughout the 24 weeks. In addition, the students each wrote two reflective letters toward the end of the timeframe. From the study, four themes emerged: 1) students experienced a theory-to-practice gap, 2) student factors impacting integration of best practice, 3) site-specific factors impacting integration of best practice, and 4) academic factors impacting integration of best practice. Several implications of the findings have been explored for the student, the fieldwork educator and the academic setting and recommendations made to facilitate student transition. Future research is recommended on numerous topics as result from my study First, what is the impact of various curricular designs and pedagogies on student learning, implementing of best practice, and student professional identity development? Second, what is the impact of various fieldwork supervision models and fieldwork structures on student learning,

implementing of best practice, and student professional identity development? Third,

what is the impact on the student's journey to self-authorship with the application of the

self-authorship model (Baxter Magolda, & King, 2004)? How is self-authorship related

to student's ability to integrate best practice ideals into fieldwork? Fourth, how can

greater understanding of transition theory lead to more effective transitions from

classroom to fieldwork and fieldwork to the workplace?

CHAPTER I

INTRODUCTION

The term best practice has been used throughout the occupational therapy profession and has been interpreted in different ways. The definition used to guide this inquiry comes from Strong (2003), who stated the required elements of best practice include client-centered, evidence-based practice, and occupation-based practice. Without the simultaneous presence of all three elements, it is not best practice. Occupational therapy students witness strong emphasis on best practice professional ideals throughout academic coursework, however, often report discrepancy from these ideals during fieldwork experiences (Clarke, Martin, de Visser, & Sadlo, 2015; Clarke, Martin, Sadlo, & de Visser, 2014; Crabtree, Justise, & Swinehart, 2012; Ripat, Wener, & Dobinson, 2013; Towns & Ashby, 2014). This discrepancy has been referred to as the theory-to-practice gap; indicating a discrepancy between best practice professional ideals and the realities of practice (Di Tommaso, Isbel, Scarvell, & Wicks, 2016; Finlay, 2001; Gupta & Taff, 2015; Morley, 2009; Ripat et al., 2013; Robertson & Finlay, 2007; Toal-Sullivan, 2006; Towns & Ashby, 2014). The following section will provide a brief description of the foundation of the occupational therapy profession and best practice professional ideals, with greater depth provided in the literature review.

Occupational Therapy

Occupational therapy, officially founded in 1917, has origins in using activities of everyday life to restore individuals to better health (Christiansen & Haertl, 2014). These activities of everyday life became known as occupations thus the name of the profession, occupational therapy. From the beginning, the profession was founded on the value of respect and individuality for all humans, focusing treatment on the goals and needs of each individual person (Hooper & Wood, 2014). It was believed that individuals experiencing mental and physical challenges had assumed broken habits of living, resulting in disconnect between the individuals and their lives (Christiansen & Haertl, 2014). Treatment to improve the health of individuals experiencing this disconnect was to assist them in reconnecting and participating in activities of everyday life (Christiansen & Haertl, 2014). The use of occupations with a focus on each individual client represent two of the three best practice professional ideals guiding my study (Strong, 2003). The last professional ideal is evidence-based practice, which surfaced in the latter half of the 20th century as society moved toward an emphasis on scientific research to support interventions (Law & MacDermid, 2014).

Best Practice Ideals

Strong (2003) identified best practice ideals of the profession as the simultaneous integration of client-centered, evidence-based, and occupation-based care. Client-centered practice is described as a process in which occupational therapy practitioners identify the importance of clients and their significant others in the identification of occupational challenges they face and allowing them to contribute to the development of possible solutions to the challenges (Boyt-Shell et al., 2014a). Client-centered practice is

reliant on identifying the clients valued occupations and goals for therapy. The focus of occupational therapy services should be on the meaningful occupations in a client's life and their ability to participate in those occupations (Hooper & Wood, 2014). In addition, practitioners are tasked with providing services that are supported by research evidence. Evidence-based practice is described as the process in which practitioners develop a question, search the evidence, evaluate the evidence, and implement the evidence while considering the wishes of the client and his/her family (Law & MacDermid, 2014). Utilizing evidence-based practice demonstrates to consumers of occupational therapy services, insurance companies who reimburse services, and organizations that offer services, that the treatment provided is the best treatment that has been proven to be effective in the research literature.

Background of the Problem

While students are engaged in the didactic portion of the curriculum they become prepared for the ideals of practice through content required by the accreditation standards for occupational therapy education (Accreditation Council for Occupational Therapy Education [ACOTE], 2018). Curriculum pedagogy often is driven by the content required by accreditation standards leading to an emphasis on foundational knowing and technical skills rather than a conceptual understanding and professional ways of knowing (Hooper, 2010). Despite this preparation, students are not always prepared for the realities of practice. During fieldwork experiences students often report discrepancies from what they learned during academic preparation and what they experienced in practice (Aiken et al., 2011; Di Tommaso et al., 2016; Finlay, 2001; Gupta & Taff, 2015; Morley, 2009; Ripat et al., 2013; Robertson & Finlay, 2007; Toal-Sullivan, 2006; Towns

& Ashby, 2014). For example, occupational therapy students report fieldwork educators undervaluing the use of theory and best practice ideals in practice, some even stating it as unnecessary (Ripat et al., 2013; Towns & Ashby, 2014). While on Level II fieldwork, students quickly experience the demands of the practice environment, contributing to daily pressures which occupational therapy practitioners face in their day to day work of providing services to clients.

The practice environment for occupational therapists, specifically within the medical model is complex and ever changing, contributing to the challenge of providing services that meet the best practice professional ideals. Occupational therapy literature has identified factors impacting practice within the medical model such as length of stay in a facility (Griffin, 1993) and the established ways of practice of the occupational therapists at the facility (Craig, Robertson & Milligan, 20014; Griffin, 1993). According to Aiken, Fourt, Cheng, and Polatajko (2011), clinicians often struggle with living up to the professional ideals due to job pressures, time pressures, tight budgets, medical model paradigms, and organizational issues. This is supported by Craig, Robertson, and Milligan (2004) who argue that it can be frustrating for occupational therapists when they realize that their practice is not consistent with the core values of the profession such as promoting participation and engagement in meaningful activity.

The healthcare system within the United States operates within the medical model which emphasizes the impairments of a person and "views sickness as something that must be fixed" (White, 2019, p. 263). When the occupational therapy profession sought alignment with the medical model during the emergence of physical medicine and rehabilitation in the mid-1930's, the focus of the profession shifted from participation in

occupation to a focus on fixing the body (Christensen & Haertl, 2014). Occupational therapists began practicing alongside physical therapists modeling the same focus on remediating impairment, first in an effort to gain legitimacy and later in an effort to be seen as a reimbursable service through Medicare (Christensen & Haertl, 2014). Overtime the profession distanced itself from using occupation as a means for rehabilitation and the job duties of an occupational therapist looked similar to those of a physical therapist, creating ongoing tension and role confusion. Despite often practicing alongside each other on the interdisciplinary team, physical therapy and occupational therapy each have its own unique knowledge base, scope of practice, and skill sets to contribute to the healthcare team.

Purpose of the Study

The purpose of this research study is to re-tell the individual stories shared by the students about their experiences of integrating best practice professional ideals during fieldwork. The study involves the use of narrative inquiry qualitative methodology including two methods of collection, a series of five in-depth one-on-one semi-structured interviews and two reflective letters written by each student.

Conceptual Frameworks

To conceptualize my topic, I drew upon relevant literature and theoretical perspectives including Vygotsky's Sociocultural Learning Theory (Vygotsky, 1978), Community of Practice (Wenger, 1998, 2000), Lifeworld Perspective described by Dall' Alba (2004; 2009), and Model of Self-Authorship (Baxter Magolda, 1999). Each theory will be briefly described including its relevance to my topic. Models are more fully explored in the literature review.

Sociocultural Learning Theory

Vygotsky brought a new perspective to learning theories when he introduced his theory emphasizing sociocultural impacts on learning (Palinscar, 1998). During the 1970's when Vygotsky's work became recognized, learning theories primarily focused on an individual's own cognitive development and skill acquisition, emphasizing the learner and the skill or content to be learned (Palinscar, 1998). Vygotsky's theory of learning placed emphasis on the role of the social environment on an individual's learning. A primary assumption of Vygotsky's theory, zone of proximal development, presumes that individuals can learn more effectively when paired with others whom have greater expertise and when an individual's participation in the learning experience increases over time (Vygotsky, 1978). The assumption of zone of proximal development can readily be seen in fieldwork education in occupational therapy. In traditional on-campus professional programs of occupational therapy, students are engaged in a highly social environment with peers and faculty. While the social environment changes when students transition to fieldwork, students continue to learn from others within their social environment, such as fieldwork educators, team members, other students, clients, and families. The social nature of professional programs and workplace learning is described in the literature citing the importance of Vygotsky's work.

Community of Practice

Wenger (1998) drew from Vygotsky's work on sociocultural learning and began describing a community of practice, a formal or informal group who identify themselves within a common practice. Individuals who participate in these communities determine collectively how competence is defined in a given context (Wenger, 2000) and requires

three elements: joint enterprise, mutuality, and shared repertoire. Joint enterprise is

described as having an understanding of the community and enough competence to

contribute to it. Mutuality is described as mutual engagement by members of the

community such as establishing norms and relationships. Lastly, a shared repertoire

describes collective resources and experiences such as language, routines, tools, stories,

etc. and to demonstrate competence is to have access to and ability to use the collective

resources (Wenger, 2000).

Occupational therapy students enter fieldwork as the learner where he or she

participates in the community of practice by interacting with members, learning their

shared practice, and developing an identity of being a competent member within the

community of practice. Across the literature, many professional disciplines recognize the

value that communities of practice can provide for professional development.

Lifeworld Perspective

The lifeworld perspective described by Dall' Alba (2004; 2009) adds concepts

that are valuable to my conceptual framework. Where the previously mentioned theories

largely describe learning through practice, they do not emphasize learning about practice;

both of which are important. According to Dall' Alba (2004; 2009), placing too much

emphasis on learning through practice increases the risk of individuals learning particular

routines and activities and not developing a full and appropriate understanding of

rationale behind specific practices. In comparison, the lifeworld perspective emphasizes

a stronger ontological dimension in addition to the epistemological dimension. Through

our lived experiences we come to know that there are many ways of practicing

occupational therapy but knowledge of what it means to be an occupational therapist

(ontological) is intertwined with an understanding of what occupational therapy involves (epistemology) (Sandberg & Dall' Alba, 2009). My research has crossed the boundary of academic knowledge gained through the didactic portion of curriculum and into the experiential and practice knowledge gained during fieldwork. When does learning about practice and learning through practice occur? Do students on Level II fieldwork learn what it means to be an occupational therapist or do students learn how to practice the way it is done at the fieldwork site? Fieldwork education is primarily conducted using the apprenticeship model in which the fieldwork educator is viewed as the expert and the student tries to embody and practice as their fieldwork educator does. Students often report feeling pressure to adapt to the norms of their fieldwork environment and do not have the skills, confidence, or resilience to withstand the pressure to conform to the practice environment. Dall' Alba's (2009) states there are many ways to practice a particular discipline; but is there enough emphasis on what it means to be an occupational therapist?

Model of Self-Authorship

The model of self-authorship became a relevant theoretical perspective to describe the students personal and professional development, from relying on external authority to guide thinking to more internal ways of thinking (Baxter Magolda, 1999). Baxter Magolda (1992, 1999, 2001, 2008, 2014) conceptualized self-authorship throughout her longitudinal research spanning several years. Over the years she and another colleague have further defined and applied the concept throughout college student development literature (Baxter Magolda & King, 2004, 2012). Adding the lens of student development

helps to describe the students' personal journal as they progress throughout an academic program including fieldwork experiences.

My conceptual framework incorporated an empirical concept from the literature as well as key theoretical perspectives related to my research wonder. The empirical concept which contributed to the lens in which I viewed my wonder was the theory-to-practice gap in occupational therapy practice. The theoretical concepts which contributed to the lens used to view my wonder included Vygotsky's Sociocultural Learning Theory (1978), Community of Practice (Wenger, 1999, 2000), Lifeworld Perspective (Dall' Alba (2004, 2009), and the Model of Self-Authorship (Baxter Magolda, 1999). This lens assisted me in viewing the topic from various angles including sociocultural implications on student cognitive development, students' epistemological development, and the theory-to-practice gap which continues to be present in the occupational therapy profession.

Research Gap

The gap that my study fills is hearing the authentic voice of the students during their fieldwork experiences in order to inform practice for occupational therapy educators, academic fieldwork coordinators, fieldwork educators, and fieldwork students. Results provide greater understanding of students' experiences on Level II fieldwork and factors that either supported or hindered implementation of best practice. The vision I have is that this research will support the profession and influence practice in a way that is most reflective of the best practice ideals.

Research Wonders

The research wonders pertaining to this study were:

9

1. What stories were shared about the experience of integrating best practice professional ideals during students' first Level II fieldwork placement?

2. What stories were shared about the impact of a second Level II fieldwork placement on students' experience of integrating best practice professional ideals?

3. What stories were shared about factors that impact students' ability to integrate best practice professional ideals during Level II fieldwork experiences?

Definition of Terms

Terminology included here was specifically considered in this study in direct relation to occupational therapy practice. Terminology may not be familiar to others outside the occupational therapy profession. Definitions come from a variety of sources including scholarly literature, textbooks, and professional organizations.

Best practice: "Best practice occupational therapy occurs within the union of client-centered and family-centered practice, evidence-based practice, and practice based upon occupation" (Strong, 2003, p. 197).

Fieldwork educators: Registered occupational therapists who have provided supervision to Level II occupational therapy fieldwork students (ACOTE, 2018).

Level II fieldwork: Full-time, 24 weeks of field experience required before graduation with goal of reaching entry-level generalist practice (ACOTE, 2018).

Client-centered practice: Client-centered practice refers to "service that incorporates respect for and partnership with clients as active participants in the therapy process. This approach emphasizes clients' knowledge and experience, strengths, capacity for choice, and overall autonomy" (Boyt-Schell et al., 2014a, p. 1230).

Evidence-based practice: Evidence-based practice requires that decisions about health care are based on the best available, current, valid, and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources (Dawes et al., 2005, p. 4).

Occupation-based practice: Practice that enables the performance or engagement in an occupation that a client wants to, needs to, or is expected to do (Polatajko & Davis, 2012).

Occupation: "Occupations are the ordinary and familiar things that people do every day" (Christiansen, Clark, Kielhofner, Rogers, & Nelson, 1995, p. 1015).

Organization of the Study

Chapter 1 presents an explanation of the problem, details on the purpose, scope and content of the study, and definitions of important terminology used throughout the study. Chapter 2 provides an overview of relevant literature related to my study. Chapter 3 describes the research methodology, methods I utilized and my relationship to the focus of the research. The next four chapters (4-7) present the narratives for each of the students involved in my study. Chapter 8 describes my synthesis of the research findings, discussion of findings related to relevant literature, implications for occupational therapy education and practice and recommendations for future research.

CHAPTER II

REVIEW OF THE LITERATURE

Chapter II begins with a historical timeline presenting the professionalization of occupational therapy. From the historical overview the reader gains understanding of professional ideals and guiding philosophies. Three professional ideals are identified in greater detail describing best practice in occupational therapy in addition to the barriers and rewards of implementing each of the ideals. The reader is then introduced to the didactic and fieldwork components of occupational therapy education programs. Emphasis is placed on knowledge integration from the perspective of various learning theories and the transition from the classroom to the fieldwork environment.

The History of Occupational Therapy

Moral Treatment Pre-paradigm

The profession of occupational therapy has been influenced by social and political factors years before its official founding in 1917. Tracing the roots of the profession back to the 18th and 19th centuries, the Age of Enlightenment and the Moral Treatment Movement were the first key movements that stimulated a change in thinking toward a democratic and humanitarian philosophical perspective (Christiansen & Haertl, 2014). The premise behind the moral treatment movement was the belief that individuals experiencing mental and physical challenges had assumed broken habits of living that resulted in disconnect between the individuals and their lives. As such, it was believed

that reconnection and participation in activities of everyday life could restore an individual to better health (Christiansen & Haertl, 2014). The profession was founded upon the beliefs of respect and individuality for all humans and the need to engage in creative activity for well-being (Bockoven, 1971). Everyday activity was valued for individuals in asylums dating back to 1822 when the use of restraints was replaced with engagement in daily activities such as self-care, hospital industry work, and organized hobbies (Meyer 1922, 1977). Founders of the profession were influenced by the philosophy behind moral treatment and believed individuals experiencing mental illness could be treated by habit training as a process to improve habits, participation, and balance between work and play (Christiansen & Haertl, 2014).

Following the Moral Treatment Movement, the Industrial Revolution dating from 1820 – 1870, influenced the Arts and Crafts movement of the early 1900s (Christiansen & Haertl, 2014). The focus of the Arts and Crafts movement was the recognition of skilled craftsman and craftswomen whose handiwork was replaced by machines and factories as a result of industrialization in the United States and England. The value of handicrafts as a treatment media combined elements of recreation and work, mental activity and muscular exercise, and provided an opportunity for individuals to use creativity and self-expression (Christiansen & Haertl, 2014). Crafts became a popular therapeutic media used in practice although never used alone, rather in combination with everyday activities such as work, exercise and play to contribute to a balanced program (Shannon, 1977).

Paradigm of Occupation

Beginning in 1900, the United States experienced the Progressive Era, lasting approximately 20 years and characterized by significant social progress, including reform in the education system and the treatment of mental health (Christiansen & Haertl, 2014). This time frame was also marked by World War I resulting in many wounded soldiers needing reconstruction, the term previously used in reference to rehabilitation. Following WWI, reconstruction aides became a permanent role within medicine in the United States, contributing to the beginning of the occupational therapy profession (Christiansen & Haertl, 2014). In 1917 in Clifton Springs, New York, George Edward Barton founded the Society for the Promotion of Occupational Therapy which later became known as the American Occupational Therapy Association (AOTA). The initial founding members and advocates for the profession were professionals in other disciplines including nursing, social work, psychiatry, and neuropathology (Christiansen & Haertl, 2014). The founding members were influenced by the moral treatment movement and recognized for challenging traditional medical thinking and asserting correlation between occupation and health as a treatment modality (Meyer, 1922, 1977).

The term 'occupation' refers to how individuals occupy or use their time and includes participation in self-care, home maintenance and management, rest and sleep, leisure, social participation, education, work, and play (AOTA, 2014). Between 1920 and 1939, founding members, Adolph Meyer and William Dunton, advocated that occupational therapists played an important role in helping patients to create and/or re-organize daily habits and regain a sense of optimism (Christiansen & Haertl, 2014). Many believed that idleness resulting from physical or mental illness was morally wrong

and also contributed to further disability, disorientation, and depression. Adolph Meyer advocated that participation in various occupations could reduce risk of depression and increase self-confidence, ultimately leading to motivation for continued recovery (Christiansen, 2007).

While occupation was gaining momentum, the medical field was also advancing and professionals were pursuing biological explanations for mental illness (Christiansen & Haertl, 2014). Searching for validity for the field of occupational therapy, the leaders of the profession made a decision to more closely align with medicine in the 1920s and 1930s. The mid 1930s began the Rehabilitation Movement originating in the area of Physical Medicine and Rehabilitation. This movement began to gain strength led by physicians and physical therapists approaching rehabilitation from a scientific pathology-focused perspective. Aligned with the medical field, occupational therapists began to assume roles and adopt strategies focused on improving individual components, such as strength, endurance, and range of motion and emphasis surrounding engagement in occupation was reduced (Christiansen & Haertl, 2014). This marked the beginning of occupational therapists working within the medical model of healthcare in which the profession became distanced from occupation in order to obtain legitimacy as a profession. The medical model operates under the assumptions that symptomology can be explained by a biological factor that can be tested and potentially treated. The focus is on "fixing" the symptoms and remediating impairment (White, 2019).

Mechanistic Paradigm Emerges

The time frame of 1940–1959 was marked by changes such as legislative policies, major health care advances, worsening conditions in mental health institutions and United

States involvement in WWII resulting in the need for rehabilitation for many veterans (Christiansen & Haertl, 2014). The treatment focus of occupational therapy had shifted from the use of arts and crafts to the use of rehabilitation techniques which better aligned with the medical model than the professions occupational roots. Early on it was recognized that occupation was not accepted as scientific by the medical discipline, leading to increased pressure on occupational therapy professionals to provide scientific evidence for their interventions (Christiansen & Haertl, 2014). According to Cole and Tufano (2008) this pressure "led to the mid-century paradigm shift toward reductionism" (p. 8). By the late 1940s the paradigm of the profession had shifted from occupation-centered to what has become known as the mechanistic paradigm which functioned within the medical model. This change in paradigm, shifted focus from the importance of occupation on health and holism to a focus on remediation of impairment and disease.

Occupational therapy practitioners developed a biomedical perspective, adopting the more prominent medical model with emphasis on the remediation of impairment rather than engagement and participation in occupation (Yerxa, 1993). Closer alignment with the medical model distanced the profession from its occupational perspective, deeply impacting its ability to stay true to the humanistic, client-centered, and occupation-focused philosophy, which it was founded on. All decision-making power was taken from the client and placed in the hands of the therapist, creating a hierarchical relationship rather than shared power characterized in client-centered care (Burke & Cassidy, 1991; Rebeiro, 2000). While the profession of occupational therapy advanced during this time, it became distanced from its professional ideal of providing client-

centered practice (Rebeiro, 2000), as well as distanced from its original occupational roots.

The hierarchical and unequal power driven by the medical model contributed to a consumer led grassroots movement in the 1950s-1960s, shifting focus from illness back to health and well-being (Diasio, 1971; Rebeiro, 2000). The grassroots movement coincided with a time frame marked by unrest and change. Historical issues significant during this time included civil rights, healthcare access, and healthcare funding. Legislation passed in 1965 created Medicare and Medicaid which provided health care access to millions of individuals, particularly older adults, individuals with disabilities, and those living in poverty (Christiansen & Haertl, 2014). Health care workers and rehabilitation providers, including occupational therapists experienced change in their practice as a result of the legislative changes. Occupational therapy practitioners continued to strive for closer alignment with the medical model and science-driven therapy in order to gain recognition and reimbursement from systems such as Medicare and Medicaid (Christiansen & Haertl, 2014).

In the 1960s and 1970s leaders in the profession began to call for a new paradigm with renewed focus on occupation and its influence on health and well-being (Christiansen & Haertl, 2014). Despite this call to action, practice continued to be influenced by the medical model, specifically rehabilitation emphasizing individual bodily systems and their impact on function rather than the role of occupation on health and well-being. The profession continued to advance by increasing emphasis on science and theory development in efforts to increase public recognition and obtain legitimacy of the profession (Christiansen & Haertl, 2014).

17

The time frame of 1980–1999 was marked by the beginning of the technology age, in which computers became essential to health care as well as all other areas of society (Christiansen & Haertl, 2014). The health care industry continued to experience scientific advances and growing use of technology, contributing to the rising cost of health care. During this time frame the profession focused on research, efficacy, and defining the scope of occupational therapy practice (Christiansen & Haertl, 2014). Practice was influenced by legislation such as the Individuals with Disabilities Education Act (IDEA), the Americans with Disabilities Act (ADA), and the Balanced Budget Act (Christiansen & Haertl, 2014). The IDEA legislation updated in 1997 impacted early intervention and school based services. Through this legislation, occupational therapy became one of the specialized services that was provided which gave rise to an increase of therapist practicing in the schools (Christiansen & Heartl, 2014). The ADA of 1990 provided protection from discrimination for individuals with disabilities. This created opportunities for occupational therapists to advocate for clients and consult with organizations to ensure ADA compliance (Christiansen & Heartl, 2014). Despite growth from these two pieces of legislation, the growth of the profession slowed due to the Balanced Budget Act of 1997, which was a policy enacted to contain health care costs (Christiansen & Heartl, 2014). An important marker in occupational therapy history during this time frame was the development of the academic discipline of occupational science; created to provide foundation and research to the study of occupation as a science. The study of occupation was influential in the creation of occupation behavior models, many of which came to fruition beginning in the 1990s (Christiansen & Haertl, 2014).

Contemporary Paradigm Emerges

The present paradigm emerged in the late 1990's which called again for a re-focus on occupation and the need to demonstrate the unique value of the profession. This time frame has led to increased emphasis on cost containment and evidence based practice, linking reimbursement to clinical effectiveness. There is increased attention on population health, global health disparities, and occupational justice. With increased need to justify value of services, the creation of occupation behavior models and the discipline of occupational science helped to facilitate a refocus on occupation for the profession (Christiansen & Haertl, 2014). The contemporary paradigm emphasizes occupation as the unique value that the occupational therapy profession contributes to health. The profession set out to assert the influence of occupation on health and wellness and focusing on occupational challenges and using occupation to improve health. Additional focus during the contemporary paradigm was on the interaction between the person, the environment, and the occupation and the resulting impact on occupational performance (Christiansen & Haertl, 2014).

Occupational therapy has visibly been influenced and can trace its roots back to many historical, social, and political events over the past couple centuries, contributing to the profession it is today. Occupational therapy continues to progress with momentum led by leaders in the field. The Centennial Vision was created in 2006 with goals to propel the profession forward into the year 2017, the 100th anniversary of occupational therapy (AOTA, 2007). Currently, the profession is guided by Vision 2025 to help meet the challenges of today's health care environment (AOTA, 2017). According to Gary Kielhofner, an iconic leader in the field, the profession needed a broader definition of the

domain of occupational therapy, re-focusing the profession on its original roots of

occupation, leading the profession to the contemporary paradigm (Kielhofner, 2009).

<div align="center">**Best Practice in Occupational Therapy**</div>

Client-Centered Practice

Occupational therapy has been philosophically guided by professional ideals

including humanistic, holistic, and client-centered care. The profession embraces a

client-centered approach where the client is seen as a partner, equally sharing the power

with the therapist and taking an active role in the treatment process (Law, Baptiste, &

Mills, 1995). The nature of client-centered care requires "respect for clients, involving

clients in decision making, advocating with and for clients in meeting their needs, and

otherwise recognizing clients' experiences and knowledge" (Canadian Association of

Occupational Therapy [CAOT], 1997, p. 49). It recognizes the need for partnership with

the individual and the need to ensure services are accessible and fit the context of

people's lives (Law et al., 1995). While there has been a variety of definitions for client-

centered practice in the literature, most share common tenets, such as: establishing

effective partnership and collaboration with clients by using effective communication,

encouraging shared decision making, respecting diversity, recognizing power, identifying

strategies to realign and equally distribute power in the therapeutic relationship, and

providing services in a client's authentic environment (Law et al., 1995; Sumsion, 2006;

Sumsion & Law, 2006). Occupational therapists seek to involve the client as an active

participant in the treatment process while simultaneously empowering them. According

to Yerxa (1967), the client receiving occupational therapy services is seen "not as an

object or thing to be manipulated, controlled, or made to conform but as a unique

individual whose very humanness entitles him/her to choices in determining his/her own destiny" (p. 3).

The capacity for the occupational therapy profession to continue to be guided by the professional ideal of client-centered practice has been increasingly difficult due to the rapidly changing health care environment including time and financial constraints and the biomedical paradigms that tend to be reductionistic in nature (Finlay, 2001). Gupta and Taff (2015) suggest that client-centered practice occurs on a continuum from less ideal to more ideal depending on the context of the intervention. Client-centered practice must occur in the community or home context in which the client is able to lead the treatment by participating in familiar and valued occupations (Gupta & Taff, 2015).

Power of client-centered practice. In the healthcare literature terminology is present for both client-centered care and patient-centered care. Exploring the constructs resulted in identifying the core components of each, components that are different, and components that consistent across both. In occupational therapy, client-centered practice is the preferred terminology. While it was difficult to locate literature specific to occupational therapy regarding the benefits of client-centered care, literature was located within a broader healthcare literature base. For example, scholars support the impact of shared decision-making on greater patient satisfaction, better quality of life, and improved patient compliance (Korner & Modell, 2009; Zimmerman, Michaelis, Quaschning, Muller, & Korner, 2014). In addition, a study conducted by Plewnia, Bengel, and Korner (2016) demonstrated patient-centered care was connected to improved treatment outcomes in a medical rehabilitation setting. While these are not

specific to the occupational therapy literature, they are still important to consider regarding the benefits of using a client-centered approach.

Barriers to client-centered practice. Barriers to client-centered practice have been identified in the literature by several authors in the field of occupational therapy. Restall, Ripat, and Stern (2003) conceptualized barriers identified in the literature and divided them into four groups: clinician barriers, client barriers, client-clinician relationship barriers, and contextual or environmental barriers. According to Sumsion (1999), clinician barriers may be connected to clinician confidence, clinician values, and perception of client safety. Client barriers may be connected to family, level of education, culture, problem-solving skills, or issues related to social environment (Restall, Ripat, & Stern, 2003). Client-clinician barriers may relate to expectations of the relationship and past experiences of the client (Restall et al., 2003). Wilkins, Pollock, Rochon, and Law (2001) identified contextual or environmental barriers such as time pressures, philosophy of program or institution, and approaches used by other team members. These barriers identified by Restall, Ripat, and Stern (2003) were similar to factors identified by Sumsion and Lencucha (2009), who identified factors related to the team, system, and family as either facilitators or barriers to client-centered practice. For example, interdisciplinary team dynamics such as role clarity and cohesion may be identified as support factors to a client-centered approach (Sumsion & Lencucha, 2009).

Client-centered practice continues to be a vital construct in occupational therapy academic programs ensuring students are prepared to enact a client-centered approach during fieldwork opportunities. Although with the challenges reported by practicing therapists regarding client-centered practice, one may question the experience a student

22

may have when trying to integrate this best practice ideal during fieldwork, which has been communicated as an expectation in their academic program. The next best practice professional ideal to be explored is occupation-based practice.

Occupation-Based Practice

Occupation-based practice can only be understood with a well-developed understanding of occupation. Occupation is identified as the domain of concern for occupational therapy (Fortune, 2000; Gupta & Taff, 2015) and recently referred to as the threshold concept of the profession (Fortune & Kennedy-Jones, 2014). While it has not always been the primary focus of practice throughout the history of the profession, in the 1960's and 1970's, occupational therapy leaders and scholars called for occupational therapists to reclaim their occupational roots and meet society's occupational needs (AOTA, 2007; Waghorn, Lloyd, & Clune, 2009; Whiteford, Townsend, & Hocking, 2000).

Historically, the founders of the occupational therapy profession used the term *occupational work* and identified principles to further delineate the purpose (Hinojosa, Kramer, & Brasic Royeen, 2017). Although the founders were often referring to work, the principles of *occupational work* were generalizable to engagement in almost any occupation, including leisure. During the timeframe of mid 1930's through 1960's the term occupation was rarely seen in the literature of the profession. In the early 1960's leaders in the field began to move the profession back to the term which originally defined the profession. Occupation has become a commonplace term since the late 1980's (Hinojosa, Kramer, & Brasic Royeen, 2017). In the 1990's the profession began to clarify its terminology by proposing definitions, one of which was *occupation* resulting

in the following definition, "occupations are the ordinary and familiar things that people do every day" (Christiansen et al., 1995, p. 1015). In 2012 the profession formally identified occupation as the core of occupational therapy in the official documents of the professional association, recognizing the change in terminology from *purposeful activity* in the 1979 official document to the term *occupation* in the 2012 official document. Despite this move as a profession toward occupation, the full potential of occupation has not been realized in practice.

According to the *Occupational Therapy Practice Framework* (OTPF), occupation refers to the daily life activities in which an individual wants or needs to do in daily life (AOTA, 2014). Occupations occur and change over time and across contexts (Pierce, 2003). Occupations have personal and cultural meaning and influence many aspects of an individual's life, such as ones identify, health, life satisfaction, and social relationships (Price & Miner, 2007). The *Occupational Therapy Practice Framework* identifies a broad range of occupations categorized as activities of daily living, instrumental activities of daily living, rest and sleep, education, work, play, leisure, and social participation (AOTA, 2014, S43).

Occupation-based practice refers to the use of occupation during the evaluation and intervention phases of the occupational therapy process. Fisher (2014) states "…we are employing occupation-based methods when we make use of a person's engagement in occupation as the method of our evaluations and interventions" (p. 98).

Occupation-based evaluation. Evaluation is the first phase of the occupational therapy process. During evaluation the therapist is collecting and analyzing data about the client's occupational performance, identifying both strengths and challenges the client

is experiencing. The first step of evaluation is completing an occupational profile where the therapist collects information about the client regarding their occupational history, occupational contexts, and occupational goals (AOTA, 2014). This subjective data is collected generally through an interview process with the client and/or family members. A client's occupational history helps the therapist gain an understanding of the occupations the client wants, needs, or is expected to do. The contextual information allows the therapist to gain understanding of the physical and social environments where the client performs these occupations as well as other cultural considerations related to the client and/or family. Lastly, the occupational profile collects information on the client's occupational goals. Why is the client seeking services? What concerns do they have regarding their occupational performance? What daily occupations do they need, want, or are expected to do? What outcome are they hoping to achieve?

The next step of the evaluation process is when the objective data is collected regarding the client's occupational performance. During occupation-based evaluation a client is engaged in an occupation that they need, want, or are expected to do, for the purpose of the therapist being able to assess their performance while engaging in that specific occupation. During the evaluation the occupational therapist is analyzing the individuals' occupational performance as well as the task to determine the barriers the individual is experiencing, preventing them from successfully engaging in the occupation. A client's performance may be impacted by the client's body structures and functions, the context of the performance, or by the transaction among them such as skills and patterns of performance (Chisholm & Boyt Schell, 2014). Based on data gathered by the occupational therapist during the evaluation, the client and therapist collaborate in

determining if therapy is indicated. If a treatment need is identified, the client and

therapist collaborate to determine a treatment plan and goal for therapy. The next phase

of the occupational therapy process is intervention.

Occupation-based intervention. The information collected through the

evaluation process is analyzed and used to determine the best treatment approach for the

intervention phase, which includes intervention plan and intervention implementation. A

therapist establishes a treatment plan in collaboration with the client by first identifying

the range of appropriate interventions to address the client's occupational performance

concerns. To identify interventions best suited for each client, therapists must frequently

ask questions related to client preference, effectiveness of interventions, environmental

parameters, client's response to intervention, focus of intervention, and outcomes of the

interventions (Chisholm & Boyt Schell, 2014).

Occupational therapy interventions are categorized in five main groups,

(1) occupations and activities, (2) preparatory methods and tasks, (3) education and

training, (4) advocacy, and (5) group interventions (AOTA, 2014). Occupation-based

interventions are client-directed and focused on the client's occupations and targeted

outcomes. The participation in the meaningful occupation is thus the therapeutic agent of

change (Fisher, 2014). Occupation is used as the method to promote positive change to

support the individuals' occupational outcome (Gray, 1998; Pierce, 2003).

According to the Philosophical Base of Occupational Therapy,

Occupations are activities that bring meaning to the daily lives of individuals,

families, communities, and populations and enable them to participate in society.

All individuals have an innate need and right to engage in meaningful occupations

throughout their lives. Participation in these occupations influences their development, health, and well-being across the lifespan. Thus, participation in meaningful occupations is a determinant of health and leads to adaptation. (AOTA, 2017, 7112410045p1)

Throughout the occupational therapy literature, occupation as a means and occupation as an end are terms used to describe two ways in which occupation is viewed (AOTA, 2017; Trombly, 1995). According to Trombly (1995), occupation as means refers to "the occupation acting as the therapeutic change agent to remediate impaired abilities or capacities" (p. 964). Here the focus of the session is on remediating impaired abilities or capacities rather than improving occupational performance. For example, a child who has right handed weakness and incoordination identifies playing board games as one of his favorite occupations. During his therapy session, the therapist engages him in playing a board game as a means of improving right hand strength and coordination. This demonstrates the use of occupation (board game) as the means for improving impaired abilities (right hand weakness and incoordination). Trombly (1995) defines occupation as ends as being "not only purposeful but also meaningful because it is the performance of activities or tasks that a person sees as important" (p. 963). The occupations chosen are occupations that the client needs, wants, or is expected to do to return to his previous life roles (Gillen, 2014).

Occupation as ends refers to engaging a client in occupations that directly address the occupational goals the client has for therapy. For example, an adult who was recently injured in a car accident, sustaining a spinal cord injury has a goal of being able to transfer himself from his wheelchair to his bathtub. During his therapy session, the

therapist engages him in this occupation (accessing and completing bathing) by teaching

him to use a sliding board to move from one surface to another. The therapist also makes

recommendations for adaptive equipment such as a tub bench, grab bars, and hand held

shower. The therapist provides physical assistance required to perform the transfer safely

and as the client progresses throughout treatment, the therapist will decrease the amount

of assistance needed until the client is able to complete the transfer independently.

Power of occupation-based practice. Fisher (2014) identifies three advantages

to using occupation-based practice. The first of which is political. When occupation is

used in evaluation and intervention methods and an occupational lens is adopted by

occupational therapy practitioners, a strong message is sent to other professions stressing

the fundamental importance of occupation. Without using occupation, the unique

perspective or role of the profession is invisible. Second, using occupation-based

performance analysis as an evaluation method provides the practitioner with a valid way

to assess the quality of an individual's occupational performance rather than simply the

outcome of the performance. Moreover, occupation-based task analysis as an evaluation

method is a valid way to assess the extent of the barriers impacting occupational

performance. When therapists use occupation-based task analysis rather than

assessments of underlying factors, they are better able to identify if the underlying factors

actually do impact occupational performance (Fisher, 2014). For the final advantage

Fisher (2014) referenced Pierce (1998) who identified the power of occupation as being

dependent on the extent that the occupation unfolds naturally, matches the person's goals,

and produces "desirable levels of pleasure, productivity, and restoration" (Pierce, 1998, p.

490).

The power of occupation can provide a combination of experiences including a sense of enjoyment, accomplishment, and renewal. The subjective experiences individuals have when engaged with meaningful occupations are critical to reaching their occupational goals (Fisher, 2014). Estes and Pierce (2012) found that using an occupation-based approach was more enjoyable, rewarding, effective, client and family-centered, and was strongly tied to the professional identity of the therapist. Practitioners who place high importance on an occupational perspective report a stronger professional identity in practice and are more likely able to resist pressure to adopt related knowledge from other disciplines and keep focus on occupational issues (Ashby, Ryan, Gray, & James, 2013).

Barriers to occupation-based practice. Barriers to occupation-based practice have been identified in the literature including time requirements, artificial environment, lack of supplies and storage, therapist shift in thinking and creativity (Estes & Pierce, 2012). Di Tommaso, Isbel, Scarvell, and Wicks (2016) completed an exploratory study to gain an understanding of occupational therapists' perceptions of occupation in practice. They found that many participants favored impairment-based interventions despite the motivating nature of occupation-based interventions. Participants also identified power differentials between junior and senior therapists and workplace culture as inhibiting the use of occupation in practice (Di Tommaso et al., 2016). For recent graduates, workplace culture was seen as inhibiting the use of occupation-based practice. Some participants reported that they unknowingly conformed to workplace culture while other participants report intentionally conforming to workplace culture due to the perceived power

29

differential between themselves and senior therapists (Di Tommaso et al., 2016; Wilding & Whiteford, 2007).

A study completed by Aiken et al. (2011) explored the meaning gap experienced by occupational therapists working in a large teaching hospital. Findings indicated the existence of two realities; one describing the way participants felt occupational therapy should be practiced and the other describing the way occupational therapy is actually practiced. Participants described an incongruence between their ideal occupation-based practice and the demands of practice such as program demands, time constraints, medically focused care, and expectations of other staff (Aiken et al., 2011). The last best practice professional ideal to explore, as conceptualized by Strong (2003), is evidence-based practice.

Evidence-Based Practice

Evidence-based practice (EBP) originated in the medical field in the 1980's and has since infiltrated into all of health care, although it had a slow start in occupational therapy (Dubouloz, Egan, Vallerand, & von Zweck, 1999; McCluskey, 2003). In 1985, Ottenbacher and Petersen asserted that research evidence was imperative to demonstrate the value of occupational therapy services to consumers and health care providers. During a time when emphasis was beginning to focus on scientific evidence, Ottenbacher and Petersen stated that without the evidence to validate the profession, it would not be viewed as scientifically viable (Ottenbacher & Petersen, 1985). According to Tickle-Degnen (1999), evidence-based practice began gaining momentum in occupational therapy by the year 1999, although it has taken several additional years for the concept to have gained broad understanding in the field of occupational therapy.

Evidence-based practice describes the use of research evidence, clinical experience of therapist, and patients' values in order to inform clinical decision-making (Sackett et al., 2000). Up until the emergence of research evidence, therapists relied only on evidence from expert therapists and peers, trusted teachers and supervisors, discussions with clients and families, therapists own clinical experience, and findings of a single published article without first critically analyzing (Hasselkus, 2000). The following formal definition demonstrates the encompassing facets of evidence-based practice:

> Evidence-based practice requires that decisions about health care are based on the best available, current, valid, and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources. (Dawes et al., 2005, p. 4)

Although there are various opinions on the steps to the process of implementing evidence-based practice, there is a general consensus on the following five steps: (1) posing a clinical question; (2) searching for the evidence; (3) appraising the literature; (4) making a decision; and (5) assessing the effectiveness of the intervention and the proficiency of the practitioner regarding evidence-based practice (Law & MacDermid, 2014). In step one, the therapist formulates a clear question about a client's problem to guide their literature search. Step two involves searching the evidence in relevant databases by using the research question previously developed. In step three the therapist appraises the literature by evaluating the trustworthiness, value, and relevance to a particular client. This is often the most challenging step due to interpretation of statistics

31

and understanding various research designs. In step four the therapist works with the client for collaborative decision making to determine how the information gained from the literature can be applied specifically to address the client's problem. Last of these steps involves evaluating both the outcome of the intervention that was implemented and the skill of the therapist in completing the steps of the evidence-based practice process (Law & MacDermid, 2014).

    Evidence-based evaluation. To implement evidence-based evaluation methods a therapist starts with the five step process identified previously. The first step is to determine the clinical question related to assessment for a particular client. For example, what are the most valid and reliable methods for assessing occupational performance for older adults who have sustained a stroke? This question would lead into step two, searching relevant databases for evidence related to assessments of occupational performance. In step three the therapist critically reviews the literature to determine if there is an assessment that is more supported than others for the client. Next, the therapist shares with the client the information gained from the literature and together with the client determines which assessment or combinations of assessments would be most appropriate. Finally, the therapist evaluates the outcome of the assessment and their own skills with carrying out evidence-based practice.

    Each time an assessment tool is utilized there is risk of error, producing a score or conclusion measuring more than just the client's performance (Law & MacDermid, 2014). The context of the assessment, the attributes of the therapist and the assessment tool itself, can all contribute to error when administering an assessment. Standardized assessment tools increase the likelihood of collecting data that is reliable and valid,

increasing the accuracy of the conclusions as compared to unstandardized assessments tools that have low reliability and low validity, increasing the risk of producing results that are inconsistent and inaccurate. Choosing standardized assessment tools with demonstrated reliability and validity make better use of therapist and client time and resources as well as increasing the likelihood of obtaining accurate clinical information and recommendations leading to greater opportunity to improve client outcomes (Law & MacDermid, 2014).

Evidence-based intervention. To implement evidence-based intervention methods a therapist again starts with the five step process. To begin, the therapist determines the clinical question related to intervention for a particular client (Law & MacDermid, 2014). For example, what are the most effective interventions for increasing independence in activities of daily living for older adults who have sustained a stroke? This question would lead into step two, searching relevant databases for evidence related to interventions for activities of daily living and interventions for older adults who have sustained a stroke. In step three the therapist critically reviews the literature to determine what treatment approaches are supported by the literature for the client (Law & MacDermid, 2014). Next, the therapist shares with the client the information gained from the literature and together with the client determines which treatment approach would be most appropriate. Finally, the therapist evaluates the outcome of the intervention and their own skills with carrying out the evidence-based practice process (Law & MacDermid, 2014).

Power of evidence-based practice. The power of evidence-based practice can be viewed from both a micro and macro level. From a micro level perspective, utilizing

evidence-based practice provides a therapist with a toolbox to aid in clinical decision making, such as selecting the best assessment and interventions procedures from a wide range of possibilities (Tickle-Degnen, 1999). It also enables therapists to stay current with the rapidly changing health care environment while also improving client outcomes and providing high-quality care (Law & Baum, 1998). In addition, the consumers of occupational therapy services and other health care professional services expect interventions that are effective, provided by competent therapists, and that will meet their needs and preferences.

From a macro-level perspective, the professional discipline of occupational therapy has a responsibility to ensure best practice is being provided to consumers (Law & Baum, 1998). For the past several years, the increased emphasis on health care spending has heightened the need to be accountable for the services provided. Occupational therapy practitioners need to demonstrate financial accountability by using the most effective methods to ensure best outcomes and lowest cost possible (Law & Baum, 1998). Using evidence-based practice increases the likelihood of identifying interventions most likely to produce the desired results. It sets a standard of care that ensures the most effective and efficient methods are utilized (Egan, Dubouloz, von Zweck, & Vallerand, 1998; Law & Baum, 1998). It is widely known and accepted that evidence-based practice is imperative across the health care spectrum of services in order to provide high quality, efficient, and effective services while maintaining fiscal responsibility (Wilkinson, Hinchliffe, Hough, & Chang, 2012).

Barriers to evidence-based practice. Two of the primary misconceptions about evidence-based practice (EBP) is the belief that evidence-based practice is not client-

centered and it does not respect the therapists' years of clinical experience (Law &

MacDermid, 2014). Thus, some research in the field regarding EBP highlights feelings

of tension between remaining client-centered and using research evidence to approach

treatment as well as perceiving EBP as a threat to current practice believed to be effective

(Dubouloz et al., 1999; Graham, Robertson, & Anderson, 2013; Reagon, Bellin, &

Boniface, 2008). In similar studies, Cameron et al. (2005), Hitch (2016), and Sweetland

and Craik (2001) found that when years of practice increased, the use of research

evidence in making clinical decisions decreased suggesting that the more experience a

clinician has, the more they rely on clinical experience and reasoning rather than research

evidence. This is concerning when considering the learning needs of occupational

therapy students who are supervised by experienced clinicians during fieldwork

placements. Students are well versed in accessing, searching, and appraising the

literature but do need guidance with integrating evidence into treatment with a client.

Thus clinicians who are not using evidence as one source of information to make clinical

decisions, will negatively influence a fieldwork students' ability to achieve confidence in

integrating research evidence into practice. Role modeling on fieldwork provides

important learning opportunities for students and will influence a student in determining

if and how they should use research evidence in practice (Morrison & Robertson, 2016;

Stube & Jedlicka, 2007; Wenger, 2002). The same principle applies to new graduates

who are more likely to engage in using research evidence when encouraged by a senior

therapist, supervisor, or manager (Kellegrew, 2005; Morrison & Robertson, 2016),

supporting the assumptions behind communities of practice. Senior therapists who

demonstrate and encourage evidence-based practice are essential for encouraging evidence-based behaviors in new graduates (Morrison & Robertson, 2016).

It has been widely reported that practitioners perceive evidence-based practice as important to the occupational therapy profession and to client care, although studies repeatedly identify multiple barriers preventing practitioners from engaging in evidence-based practice. When considering barriers to evidence-based practice, lack of time (Bennett et al., 2003; Kristensen, Borg, & Hounsgaard, 2011; Lyons et al., 2011; McCluskey, 2003; McKenna et al., 2005; Salls, Dolhi, Silverman, & Hansen, 2009; Sweetland & Craik, 2001), lack of skills required (Dopp, Steultjens, & Radel, 2012; Fange & Ivanoff, 2009; Gilman, 2011; Lyons et al., 2011), lack of relevance, applicability, availability, quality of evidence (Bennett et al., 2003; Copley & Allen, 2009; Dopp et al., 2012; Fange & Ivanoff, 2009; Gilman, 2011; Lyons et al., 2010; McCluskey, 2003; Sweetland & Craik, 2001), and lack of support, organizational barriers (Cameron et al., 2005; Kristensen et al., 2011; Salls et al., 2009; Lyons et al., 2010; Sweetland & Craik, 2001) have frequently been reported in the literature. The evidence suggests that recent graduates, students with post-graduate qualifications, or training in evidence-based practice feel more confident in their knowledge and skills related to evidence-based practice (Graham, Robertson, & Anderson, 2013; Hitch, 2016; McCluskey, 2003; Sweetland & Craik, 2001).

The profession of occupational therapy has experienced significant change and growth since its inception. From the early focus on the use of occupation for mental wellness, to the mid-century emphasis on restoring body functions and structures, and finally a resurgence to bring back the focus on occupation. Moreover, the increasing

36

importance of incorporating evidence into practice has led to scientific evidence supporting the effectiveness of the profession. Through the changes overviewed in this chapter, the professionalization of the profession is evident, although an additional aspect in becoming a profession is the educational preparation of the professionals who enter the profession.

<div align="center">**Occupational Therapy Entry-Level Education**</div>

Historical Overview

The first minimum training standards for occupational therapy education were initiated in 1923 and later revised in 1930 (AOTA, 2017). In 1931, the first bachelor's degree was offered in occupational therapy. In 1935, the Journal of the American Medical Association published the Essentials of an Acceptable School of Occupational Therapy, later to become known as the professional standards. The professional standards were updated several times with the most recent revision in 2018 (ACOTE, 2018) (Appendix A). By 1938 there were five schools jointly accredited by AOTA and the American Medical Association (AMA).

The American Journal of Occupational Therapy (AJOT) was first published in 1947 and in 1952 the Minimum Standards for an Occupational Therapy Department were published. By 1955, most practicing occupational therapists had a certificate rather than a bachelor's degree. By 1958, AOTA published a document outlining the requirements for master's level curriculum in occupational therapy. New York University opened the doors of the first PhD program in occupational therapy in 1973. In 1979, AOTA published the first professional document for common language, *Uniform Terminology for Occupational Therapy*. The document was updated in 1989 and 1994. The first

program offering a doctoral degree in occupational science was opened by the occupational therapy department at University of Southern California in 1991. Also in 1991, the professions first independent accrediting body was founded. The United States Department of Education currently recognizes ACOTE as accrediting body for occupational therapy and occupational therapy assistant education programs. This ended the joint accreditation with the AMA which began in 1933. In 1999, ACOTE established a post-baccalaureate entry for occupational therapists and mandated all schools to become compliant by 2007. In 2002, the initial terminology document, U*niform Terminology for Occupational Therapy,* was replaced by the *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2017*)*, updated in 2008, and 3rd edition recently published in 2014. Also in 2014, occupational therapy practitioner licensure was achieved in all 50 states and three jurisdictions (AOTA, 2017).

Philosophy, Knowledge, and Identity

The philosophy of occupational therapy education aligns with the philosophical beliefs of the profession, however, the emphasis remains on beliefs about knowledge, learning, and teaching (AOTA, 2015). The goal of occupational therapy education is to convey the perspective and beliefs of the profession; viewing humans as occupational beings, occupation as a health determinant, and participation in occupation as a fundamental human right. Education promotes clinical reasoning and integration of professional values, theories, evidence, ethics, and skills. The education process includes academic coursework and fieldwork experiences promoting the development of sound reasoning "that is client-centered, occupation-based, and theory driven while encouraging the use of best evidence and outcomes data" (AOTA, 2015, p. 1).

Occupational therapy professional education programs instill the theoretical knowledge that is specific to the discipline, often referred to as occupation behavior models. Theoretical knowledge offers students a framework to view practice, explanations about the occupational therapy process, and language to describe occupational therapy practice (Ashby & Chandler, 2010; Ashby et al., 2013). Through learning and embracing the professional values, beliefs, and knowledge, students begin forming their professional identity. Many authors believe that professional identity develops over time but is initiated and fostered during professional education programs and continues as a life-long process (Adams, Hean, Sturgis, & Clark, 2006; Davis, 2006; Ikiugu & Rosso, 2003; Turpin et al., 2012).

Wenger (1998, 2000) identified education programs as a time for construction of identity through communities of practice, which contribute to a person's identify formation by active participation within a social community. Education programs vital role in the development of professional identity has led to a strong call for the primary emphasis of occupational therapy education programs to be on occupation (Boehm et al., 2015; Hooper, 2010; Trede, Macklin, & Bridges, 2011).

Curriculum Pedagogy

In a profession as diverse as occupational therapy, educators may find themselves asking questions such as "What content do we need to teach?" or "What do the accreditation standards require that we teach?". According to Hooper (2010), approaching curriculum design from this mindset may unintentionally emphasize knowledge of specific content while ignoring how the content is connected to occupation. In this way, the core subject of the profession, occupation, appears invisible or

unimportant to students. In addition, a content-driven curriculum may lead educators to feel pressure to teach a large amount of content using teaching and learning strategies that deliver content but do not effectively help students connect their knowledge to the core subject of occupation (Hooper, 2010). Reflecting back to the late 1990's when scholars in the profession called for a re-focus on occupation, scholars also called for occupation to be the central theme in occupational therapy education. Yerxa (1998) stated, "our education programs need to initiate a curricular renaissance by using occupation as the central organizing idea of the curriculum" (p. 369). Occupational therapy scholars (Nielson, 1998; Wood et al., 2000; Yerxa, 1998) used the term occupation-centered education to identify the importance of occupation as the core construct in occupational therapy education.

   Subject-centered education. The focus of subject-centered education is to assist educators and students in keeping the core subject of a profession at the center of learning (Hooper, 2006; Palmer, 1997). According to Palmer (1997), subject-centered education deflects other methods of pedagogy including teacher-centered and student-centered. In teaching-centered the focus is on objectivism where the teacher's expertise is truth and knowledge lies within the teacher (Palmer, 1997). In student-centered pedagogy the focus is on relativism where truth lies within the individual. What is true for one person may not be true for another. The emphasis within subject-centered education is on the creation of a community of learners involving teachers, students, and the subject; where knowledge is co-constructed around the subject (Palmer, 1997). According to Hobson and Morrison-Saunders (2013),

We are advocating that as teachers, one of the most effective things we can do is

simply bring our attention onto the subject at hand, and enable our students to join

us in this mutual inquiry. In this manner, teacher and student collectively share in

the learning process in a charged atmosphere during which thinking can enter the

room. (p. 781)

Subject-centered education keeps the focus of learning on the core subject of occupation

and on the community of learners who study occupation. The plethora of topics taught in

occupational therapy education could easily take the spotlight away from the core of

occupation, where students learn specific skills or knowledge but do not learn to connect

it to occupation. For example, the topic of muscle weakness is taught to students

including skills to learn how to evaluate the muscle weakness and provide skilled

intervention to improve muscle weakness. However, in occupational therapy the

question needs to be connected to occupation, such as, "What occupations are difficult

due to the muscle weakness"? "What occupations has the client needed assistance with

due to the muscle weakness"? "Are there ways we can modify the occupation to allow

the client to complete it more independently"?

In occupational therapy, Barbara Hooper (2006) began the study of subject-

centered education. She advocates for a two-tiered approach in which an educator

conveys the specific content to be taught (tier one) and then ties that content to the core

subject of occupation (tier two). Hooper (2006) argues that subject-centered education

helps to remind occupational therapy educators that very few topics are inherently

occupation-centered, but by incorporating instructional practices such as the two-tier

approach, the topic becomes occupation-centered by the opportunities for students to link

the topic to occupation. This method of pedagogy serves as one strategy to teach an occupation-centered curricula and to assist students in making connections between the plethora of topics covered within occupational therapy education in relation to the occupational core of the profession.

Concept-based teaching. Concept-based teaching is a novel pedagogy in occupational therapy education and provides opportunity for identifying core professional concepts and streamlining curriculum development in a profession with a wide-ranging scope of practice. In a concept-based curriculum, content is organized around key concepts of the profession (Giddens, Caputi, & Rodgers, 2015). Concept-based teaching requires faculty to study major concepts within the profession and use the concepts as a structural framework for all content delivery. This strategy is useful to link essential content knowledge to concepts for students to develop an in-depth understanding and improved ability to generalize concepts across varying populations and across the life span.

Generalization of concepts is done by teaching course concepts to a few identified exemplars (Giddens et al., 2015) that depict the concept applied to different populations. For example, in a curriculum utilizing concept-based teaching the concept of occupational therapy evaluation would be taught in one course. Students would first learn the broad concept of evaluation and how it applies to the occupational therapy process. They would be introduced to evaluation methods for evaluating client performance with occupation. Through their evaluation of client performance while completing an occupation, students would be observing for client factors that are impacting the performance. Based on the student's findings, they would be introduced to

42

evaluation methods for assessing particular factors within a client, such as sensory functions, mental functions, neuromuscular functions, etc. (AOTA, 2014). In this way students learn that the same evaluation methods can be used for a client who sustained a stroke who is experiencing cognitive impairment and a client who has chronic mental illness, such as schizophrenia, with resulting cognitive impairment.

In a content-drive curriculum, coursework is often divided by client populations such as pediatrics, adults with physical dysfunction, adults with psychosocial dysfunction, etc. With this type of curriculum organization, evaluation methods would be taught in each course, specific to the population; evaluation for pediatrics, evaluation for adults with physical dysfunction, evaluation for adults with psychosocial dysfunction, etc. As a result, students often develop compartmentalized thinking limiting their ability to generalize their knowledge. For example, they do not generalize that the same evaluation method can be used for a client with similar impairments regardless of the client experiencing a physical dysfunction or a psychosocial dysfunction.

The implementation of both subject-centered education and concept-based teaching theoretically will provide benefits for students and educators. Further study is needed regarding both of these pedagogies in relation to occupational therapy education, student learning, and implementation of best practice on fieldwork.

Fieldwork Education

The purpose of fieldwork education in the United States is to move forward each new generation of occupational therapy practitioners from the role of a student to the role of a practitioner (AOTA, 2016). Fieldwork experiences are an integral part of occupational therapy education where students "achieve competence in applying the

occupational therapy process and using evidence-based interventions to meet the occupational needs of a diverse client population" (AOTA, 2016, p. 1). It has been suggested that during fieldwork experiences students learn to apply theoretical and scientific principles learned in their academic programs. Students should also have opportunities to incorporate evidence-based and client-centered principles while focusing on purposeful and meaningful occupation, into the services provided to clients (ACOTE, 2018; AOTA, 2016).

In the United States, occupational therapy students complete 24 weeks of full time Level II fieldwork, as required by ACOTE standards (ACOTE, 2018). The practice setting and model of supervision can be determined at the program level with consideration of ACOTE standards. The majority of Level II fieldwork placements in the United States occur in traditional settings in which the role of occupational therapy is already established.

Several studies have identified the importance of fieldwork placements in the role of professional socialization and development of professional identity in occupational therapy students (Adams et al., 2006; Ashby, Adler, & Herbert, 2016; Richard, 2008; Trede et al., 2011). A recent study by Ashby, Adler, and Herbert (2016) involving occupational therapy students internationally found that fieldwork education was considered to be the most influential aspect of academic preparation on the professional identity formation of students. This finding was also supported by Adams et al. (2006) and Trede, Macklin, and Bridges (2011) and highlights the importance of fieldwork education on student learning and identity. However, fieldwork experiences vary from setting to setting thus the focus on best practice professional ideals during fieldwork is

not always present, creating feelings of dissonance in students (Ripat et al., 2013; Towns & Ashby, 2014). This leads to the importance of understanding the transition from classroom to fieldwork and the implications for student learning.

Knowledge Integration

Classroom to Fieldwork

The classroom context serves as the first community of practice an occupational therapy student becomes a part of during their academic preparation, launching the beginning of their professional identity formation. Students build strong relationships with each other during the didactic portion of their degree program and are surrounded by supportive peers with shared experiences. Occupational therapy students not only attend class together, they often live, eat, and study together. Both formal and information professional socialization within the curriculum contributes to a student's professional identity (Adams et al., 2006). As students transition from the classroom context to the fieldwork context they experience opportunity to continue to develop their already forming professional identity, which is progressively developed over time (Boehm et al., 2015).

Transitioning from the classroom to the fieldwork context results in a significant change in learning context and environment for students. Leaving behind their peers and the community of practice which they have become a part of, further complicates the transition, as students often are dispersed on fieldwork placements throughout a wide region. Students no longer have frequent interactions with their fellow peers and faculty, rather their interactions may include their fieldwork educator as well as other members of the interdisciplinary team.

Fieldwork supervision. The apprenticeship model of supervision in which one fieldwork educator supervises one fieldwork student, has been the most common supervision model used in the United States (Evenson, Roberts, Kaldenberg, Barnes, & Ozelie, 2015). Traditional fieldwork setting with 1:1 apprenticeship model emphasizes the fieldwork educator as the expert and the fieldwork student as an apprentice, gaining competence throughout the fieldwork by observing and modeling what is completed by the fieldwork educator. The apprenticeship model is derived from a social learning strategy known as cognitive apprenticeship which is based upon the assumption that novices learn by doing as they are placed in a mentoring relationship, in which the mentor models and coaches, supports and challenges, and reflects and provides feedback to the mentee during the learning experience (Brown, Collins, & Duguid, 1989; Collins, Brown, & Newman, 1989; Collins, 1991).

Under this model the fieldwork educator is solely responsible for assisting the student in the integration of academic knowledge into the fieldwork setting. It has been reported that students on traditional fieldwork placements perceive the need to adopt the identity of their fieldwork educator who is modeling what practice looks like in that particular setting. Students report feeling pressure to conform to the existing practices and carry out occupational therapy practice as their fieldwork educator has modeled (Clarke et al., 2014; Di Tommaso & Wilding, 2014). Power differentials between fieldwork student and fieldwork educators have been reported in the literature (Crist, 2007; Di Tommaso & Wilding, 2014; Pfeifer et al., 2008).

Activity system impact on transition. Le Maistre and Pare (2004) conducted a longitudinal study investigating the school to work transition in four professions:

education, social work, physiotherapy, and occupational therapy and completed interviews with students in their last years of their academic program, beginning professionals in their first year of practice, and experienced practitioners who have supervised both students and beginning professionals. The researchers believe the activity systems of the academic program and the workplace are so different, contributing to the challenges new graduates experience with the transition from school to work. They summarized their findings in a statement saying,

> We believe that interns and new practitioners, faced with hurly-burly of initial practice, fail to transform the objects of the university study – that is, the theories, methods, and tools of their trade – into the mediational means of workplace activity. Instead, they adopt means that will enable them to make it through the day. (Le Maistre & Pare, 2004, p. 48)

Theory-to-practice gap. Throughout academic coursework students are oriented to the importance of best practice professional ideals in occupational therapy practice. Students become familiar with how practice should be enacted according to professional ideals and they often experience discomfort when discrepancy is experienced during fieldwork and upon graduation (Towns & Ashby, 2014). In a study conducted by Ashby, Adler, and Herbert (2016) exploring the professional identity formation of occupational therapy students internationally, 97% of students surveyed considered occupation-based practice to be an important factor in being in occupational therapist and 64% of students identified discrepancies between their expectations of occupation-based practice and what was observed during practice.

In a similar study conducted by Ripat at al. (2013), students who were

transitioning to new graduates reported tension when they experienced discrepancy

between the valued client-centered practice they understood from academic coursework

and the difficulty they experienced when trying to implement their client-centered skills

in practice. Students were able to recognize the system factors that influenced their ability

to implement client-centered care including time, finances, and institutional barriers; all

of which are reflected in the literature amongst clinician barriers to client-centered

practice.

   Results of these two studies emphasize the need to use teaching methods that

bridge the theory-to-practice gap and teach students to integrate the skills during

fieldwork by providing strategies for students to overcome the barriers that are present in

the real-world.

Theoretical Perspectives

   Minimal occupational therapy literature exists describing the process in which

students gain and apply knowledge and skills during the fieldwork supervisory

relationship (Richard, 2008). The transition from classroom to fieldwork has rarely been

explored from the sociocultural theoretical perspective. Guile and Young (2003)

advocated for the belief that learning is a social process that occurs when individuals

interact in new contexts rather than a process in which knowledge is transferred into an

individual's brain and can be transferred between different contexts. Sociocultural

perspectives such as Vygotsky's sociocuultural learning theory (1978) and communities

of practice (Wenger, 1998) address the link between learning and the sociocultural

environment of the practice setting. Viewing the learning process from this lens

emphasizes the impact of the surrounding environment on students learning and may explain the pressure students and new graduates report (Di Tommaso et al., 2016; Wilding & Whiteford, 2007) to conform to the established practice within a facility. An additional lens in which to view the learning process is from the student developmental perspective. Baxter Magolda (1992, 2001, 2008, 2014) and Baxter Magolda and King (2004, 2012) provide understanding on the student's individual developmental journey which can be applied to student learning throughout fieldwork.

Sociocultural learning theories. Sociocultural learning theorists assert that knowledge belongs to the community as a whole and participants within the community of practice challenge each other and work collaboratively together to construct knowledge that can be applied to practice (Palinscar, 1998; Vygotsky, 1978). Vygotsky's Zone of Proximal Development (ZPD) can be used as a lens in which to view the learning that occurs between a student and a fieldwork educator during the supervisory relationship. The assumption behind Vygotsky's zone of proximal development is that a learner (student) is capable of learning and achieving more when assisted by a more capable teacher (fieldwork educator) (Vygotsky, 1978). The fieldwork educator utilizes their individual knowledge, skills, and expertise in occupational therapy practice to verbalize and demonstrate during supervision.

Community of Practice (Wenger, 2000) also provides understanding to the impact of the surrounding social context on a student's experience. This theory provides a lens to understand the broader social context including the shared definition of competence, established norms and relationships, and the shared repertoire such as language, routines,

and tools. (Wenger, 2000). These factors at each individual fieldwork setting impacted the overall experience for the students throughout my study.

Model of self-authorship. This theory has often been used to describe college student development as they journey to self-authorship. Built on previous work by developmental researchers including Jean Piaget and Robert Kegan, Baxter Magolda (1999) applied the concept of self-authorship, coined by Kegan (1994), to postsecondary pedagogy. Self-authorship is comprised of three dimensions of development: the epistemological or cognitive dimension, the intrapersonal dimension, and the interpersonal dimension (Baxter Magolda, 1999, 2008; Kegan, 1994). Understanding the relationship within these three dimensions leads to clearer understanding of adult development (Baxter Magolda, 2008). The epistemological or cognitive dimension refers to how individuals view the world. The intrapersonal dimension refers to how individuals view themselves and the interpersonal dimension refers to how individuals view social relations (Baxter Magolda, 2008). The interaction among these three dimensions influences the rate at which an individual developmentally progresses from relying on external authority for ways of knowing to relying on their own internal ways of knowing (Baxter Magolda, 2008).

Baxter Magolda (2014) emphasizes that informational knowing, having a fund of knowledge and skills, is not sufficient to face complex problems and solutions that are not clearly defined. College students and graduates will presumably experience complex problems upon entering the workforce, if not sooner. Potential problems may include interpersonal dynamics, power dynamics, ethical dilemmas, and discrepancy between ideal practice and what was experienced on fieldwork. Baxter Magolda argues the need

50

for college students and graduates to demonstrate self-authorship in order to navigate these types of problems (2001, 2008, 2014) and to be able to represent themselves within a professional community of practice.

Baxter Magolda and King (2012) built upon previous work to identify a ten position continuum in which a student moves throughout during their development. The beginning of the continuum identifies a student relying fully on external authority for their own meaning making. Over time the student begins to recognize shortcomings in their external authority and they enter the phase referred to as crossroads where they are questioning external authority and beginning to create their internal voice. Gradually the student begins to trust their internal voice and uses their own internal voice to know how to respond to external authority. The final position refers to a person coming to full understanding that one's philosophy of life is the core of one's being (Baxter Magolda & King, 2012, p. 19). This theoretical model also considers the students' personal characteristics, personal experiences, personal interpretation of experiences in relation to how they move along the continuum.

Baxter Magolda conducted longitudinal research over several years to develop the concept of self-authorship (Baxter Magolda, 1992, 2001, 2008, 2014). This research also led to the creation of the Learning Partnership Model (Baxter Magolda & King, 2004) providing a practical framework for educators in order to facilitate the development of students' self-authorship. The framework describes three key assumptions and three key principles to incorporate to foster self-authorship in college students. The model places value on students' current experiences, how students understand their experiences,

engaging students in new experiences, and building learning partnerships among students and between students and educators (Baxter Magolda & King, 2004).

Summary

This chapter provided a historical overview of the occupational therapy profession with special attention to the best practice professional ideals. This chapter also reviewed the literature available regarding the benefits of incorporating the professional ideals as well as the barriers that have been shown to impede implementation. In addition, this chapter explored literature regarding the transition from academic classroom to fieldwork and the implications on student learning.

CHAPTER III

METHODOLOGY

In this chapter I describe the research paradigm, methodology and research methods I used to undertake a narrative inquiry research study exploring the experience of integrating best practice ideals for occupational therapy students during Level II fieldwork. Other information covered in this chapter includes student selection, gathering data (referred to here as field texts), ethical considerations, and process used to move from field texts to interim research texts to final research texts.

In the methodology of narrative inquiry, field texts refer to the data that is gathered, composed, and created (Clandinin, 2013) between the student and the researcher. The researcher then steps back from the close contact with students to begin analyzing and interpreting the field texts to compose interim research texts; partial texts which are open to allow students and researcher opportunities to further compose storied interpretations and negotiate meanings (Clandindin, 2013). Finally, the researcher will move to final research texts, when the texts become visible to public audiences. Final research texts may be in the form of academic publications, dissertations, theses, and presentations (Clandindin, 2013).

In order to explore the pieces of the puzzle around my area of wonder, I engaged in qualitative research using a narrative inquiry methodology. Narrative inquiry lives within the constructionism paradigm which assumes knowledge is constructed between

the interactions of individuals and their environment (Clandinin, 2007). In constructionism, this experience cannot be fully understood without or in isolation from the individual experiencing it. To address this concern of integrating experiences and individuals, students were invited to engage in all four stages of narrative inquiry – living, telling, retelling, and reliving (Clandindin, 2013) throughout the study.

Exploration within my study focuses attention on how students experienced the influencing factors (physical and otherwise) in their environment and the resulting impact on their ability to integrate academic knowledge of professional best practice ideals during fieldwork. Students lived out their stories (during fieldwork) and told stories about their living (during interviews), thus *living* and *telling*. *Re-telling* stories occurred when we began to explore our lived and told stories. Lastly, *re-living* stories occurred as we personally changed from living and telling stories.

The method used to compose field texts included a series of five, in-depth, one-on-one, semi-structured interviews with each student and letter writing where each student wrote two letters with different areas of focus, which are outlined later in this chapter. The results of this study may inform the practice of occupational therapy academic educators by preparing students with strategies for the transition from academic coursework to fieldwork. Results may inform the practice of fieldwork educators by identifying strategies to help facilitate students' application of theoretical knowledge and best practice ideals during fieldwork. Lastly, the results of this study may provide insight regarding past student experiences, challenges, and successes that might be used to better prepare future occupational therapy students.

Research Paradigm

This research study is epistemologically informed by the constructionism paradigm which was born from rejection of objectivism which reached popularity during the Enlightenment, occurring in the late 17th and 18th centuries. Objectivism assumes that meaning is held within an object independent of any consciousness (Crotty, 2013). In contrast, the central concept within constructionism assumes that objects do not hold meaning alone, rather meaning is ascribed to objects by human beings through interactions and engagement with the world and each other. According to Crotty (2013), the foundation of constructionism is "all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context" (p. 42). This is relevant to my research study because of the importance of the social context as the students interacted in their environment and applied what they learned in the classroom to their fieldwork experience. The knowledge constructed by each student, both in the classroom and while on fieldwork, is dependent on their interactions with others and their world.

From the constructionism perspective, "no object can be adequately described in isolation from the conscious being experiencing it, nor can any experience be adequately described in isolation from its object" (Crotty, 2013, p. 45). Interaction occurring between a human and the human world results in the construction of meaning, demonstrating the interdependence between the human and the world (Crotty, 2013). Thus, in this research study the use of narrative inquiry fits naturally, as students share stories constructed in their own living and telling of their experiences which are then

shared with the researcher and the narrative is co-constructed. Multiple experiences and interactions contributed to a pluralistic and highly contextualized meaningful reality for the students, designating narrative inquiry as an appropriate methodology for this study.

Based on the views of constructionism and the emphasis of the student and the researcher constructing and co-constructing their narratives, this paradigm aligns well with my research study and my research goals. The goals of my study explored the stories lived and shared by the students about experiences of integrating best practice professional ideals during Level II fieldwork and factors identified as impacting their ability to integrate these ideals during fieldwork? I was able to be in the relational space with each student over the seven to eight-month timeframe in which they were completing their fieldwork experiences. This allowed for ample opportunities for the students and I to construct and co-construct narratives, starting the development of the field texts.

Narrative Inquiry as Methodology

Along with constructionism, I will be drawing from the methodology of narrative inquiry.

> Narrative inquiry is a way of understanding experience. It is collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus. An inquirer enters this matrix in the midst and progress in the same spirit, concluding the inquiry still in the midst of living and telling, reliving and retelling, the stories of the experiences that made up people's lives, both individual and social. (Clandinin & Connelly, 2000, p. 20)

56

Narrative inquiry as a research methodology builds a path to understand experience which embarks with a relational space between a researcher and participants(s) over various places and throughout a duration of time. As the researcher enters the relational space the participant may already be *living* the experience and the collaboration between the researcher and participant(s) begins composition of field texts as they *tell*, *relive*, and *retell* the stories of the experiences. In my study a relational space was established with each of the four students at the beginning of their first, twelve-week fieldwork experience. The students had already begun living the experience when my first meeting occurred individually with each student, in-person at an agreed upon location. This initial meeting set the stage for the construction of field texts as each student told stories about their experience and together we re-lived and re-told stories. Over the following seven to eight-months, our relational space continued but meetings occurred via technology with video and audio features rather than in-person. Throughout the next four meetings with each student the collection of field texts grew as we engaged in all four stages of narrative inquiry.

There is a well-established view of narrative inquiry as both methodology and phenomena (Clandinin, 2007). Philosophical underpinnings from John Dewey's theory of experience (1938) has informed the development of narrative inquiry as a methodology (Connelly & Clandinin, 2000). Influenced by Dewey, a Pragmatist, Connelly and Clandinin (2000) identified the term experience as both personal and social as an individual cannot be understood without regards to the social context in which they are in. This is also a direct connection to the constructionist epistemology guiding my study. While the starting point for narrative inquiry is an individual's experience, it is

also an exploration of the surrounding social, cultural, and institutional narratives which shape an individual's experience (Clandinin, 2006). In this study the starting point is the students experience during fieldwork but like Clandinin (2006) argues, it is also an exploration into the environment around them, including direct fieldwork educator, healthcare colleagues, clients, families, administration personnel, industry productivity demands, resources available, employee morale, standards of practice within the setting, etc.

Dewey's conceptualization of experience consisted of two criteria – interaction and continuity. These two criteria provide the framework for attending to the idea of narrative as experience through the dimensions of temporality, sociality, and place, constructing the three-dimensional narrative inquiry space in which a narrative inquiry begins (Clandinin, 2013). *Temporality* identifies the continuous state of transition that occurs with experiences under study. There is acknowledgement that situations and people always have a past, present, and future and it is important to understand people, places, and situations as always in transition. (Clandinin, Pushor, & Orr, 2007). *Sociality* identifies various conditions in which narrative researchers must consider, such as personal and social conditions. Personal conditions are the feelings, hopes, desires, moral dispositions, etc., of the researcher and study participants (Connelly & Clandindin, 2006) while social conditions refer to the environment, surrounding factors, people, etc., that form each individual's context (Clandinin, Pushor, & Orr, 2007). Another condition of the sociality dimension is the relationship between the participant and researcher. According to Connelly & Clandinin (2006), researchers can't remove themselves from the relationship when a participant is involved due to the assumption in narrative inquiry

that stories are co-constructed between researcher and participant when they engage in the relational space by living, telling, re-living, and re-telling stories about their experiences. The stories constructed between two people are unique to them and can't be replicated with other individuals because the three dimensional relational space established is always in transition and never static. Lastly, *place* refers to the "specific concrete, physical, and topological boundaries of place or sequence of places where the inquiry and events take place" (Connelly & Clandindin, 2006, p. 480). The dimensions of temporality, sociality, and place must remain an area of attention throughout a narrative inquiry. The people, places, and situations in the three dimensional space are constantly in transition, meaning one can't be fully understood without considering the others. Narrative inquirers need to think about the impact of each dimension in order to gain understanding of an experience. Considering the three dimensions and the uniquely relational quality of narrative inquiry, one must remember that we also enter into the midst of a story when undertaking a narrative inquiry. The story undertaken in this narrative inquiry was the exploration of occupational therapy students' experience with integrating best practice professional ideals during Level II fieldwork experiences. At the beginning of the relational space, the students had begun their first of two, twelve-week fieldwork experience.

Students

Students were recruited from occupational therapy academic programs in the states of Minnesota (MN), North Dakota (ND), and South Dakota (SD). A total of five occupational therapy programs were contacted to assist in recruitment of students. These states were selected due to the presence of academic occupational therapy programs

within them and collegial working relationships with occupational therapy faculty within programs in these states.

Students eligible for inclusion in this study were students in the identified entry-level professional occupational therapy programs, which include both Occupational Therapy Masters and Occupational Therapy Doctoral degree programs. Students had to be registered and scheduled to complete their first Level II fieldwork experience, during the time of data collection, in one of the three states identified. Students also had to be scheduled to complete the fieldwork experience with a physical rehabilitation focus occurring in a hospital setting (acute care, long term acute care, inpatient rehabilitation, or transitional care unit). The inclusion criteria were established with intention to identify occupational therapy students that were similar in terms of their occupational therapy knowledge, progress within their academic program, at a fieldwork setting within driving distance for the first interview to be conducted, and lastly, at fieldwork settings that would provide similar learning experiences within the occupational therapy process from evaluation to discharge.

Recruitment and Selection

An email message was prepared and sent to the academic fieldwork coordinators located in the targeted geographic regions asking for their assistance in disseminating my recruitment flyer to potential students on my behalf. The recruitment flyer included my name, contact information, invitation to participate and advertisement of incentive to participate. Incentive included a $15 VISA gift card provided to each student at the conclusion of the third interview. Potential students were asked to contact me if interested in participating. Once contacted by a potential student, I sent a consent form

via email informing the potential student of their rights and the voluntary nature of the study. Documents related to recruitment of students include the original Institutional Review Board (IRB) approved consent form (Appendix B), an email message (Appendix C), and recruitment flyer (Appendix D). A reminder email was sent two weeks after initial email to academic fieldwork coordinators asking them to send a reminder email to potential students. Once contact was established with potential students, I asked each student for his/her preferred contact information and set up an agreed upon date, time and location to complete the consent process and interviews.

I received email contact from six students expressing interest in participating. After further discussion with two of the students, they were not eligible to participate due to their fieldwork setting being different from what was required for inclusion in this study. The other four students all met inclusion criteria and agreed to participate. The four students represented both public and private higher education institutions in the Midwest. From the time of initial recruitment effort until students signed informed consent was approximately a two-month time period. The students all identified as white and included three females and one male. This is closely representative of occupational therapy students nationwide, which is approximately 90% female, 10% male and 80% white (AOTA, 2019).

Research Approval Process

To ensure protection of the students in my study, permission was sought and granted to study human subjects through the Institutional Review Board (IRB) at the University of North Dakota (Appendix E). The IRB approved the plan for research utilizing qualitative phenomenological methodology and corresponding consent forms

(Appendix B). The approved plan involved obtaining six to eight students and conducting three interviews over a twelve-week span. During the research process I was able to obtain four students despite several efforts to recruit additional students. At the conclusion of my twelve interviews with my four students, I asked each of them if they would be willing to continue to work with me during their next twelve-week fieldwork placement. I informed each student that a few steps would need to be completed prior to continuing our collaboration. These steps included exploring the possibility of using a research methodology that better fit my situation, receiving committee approval, and submitting and receiving an IRB protocol change. A protocol change was submitted outlining changes to my research methodology and subsequent changes to my research plan in addition to a new consent form. Approval of the protocol change (Appendix F) and consent form was received (Appendix G).

Data Collection Process

I conducted five interviews with each of the four students over a six to eight-month time frame. Each student completed two, twelve-week fieldwork placements during the time in which interviews were completed. The first interview was completed face to face and all other remaining interviews were completed using Blackboard Collaborate, a learning management system with audio and video features. Further details of the interviews can be found below in the section titled field texts. In addition, each student wrote two letters at the conclusion of their last fieldwork placement and sent to me via email attachment. Further details of the letters can also be found below.

Informed Consent Process

Prior to the first in-person meeting, I emailed each student a copy of the informed consent form for their review. At the time of our first in-person meeting I reviewed the consent form with each student informing them that participation in the study was voluntary and that if they did not wish to answer a specific question they did not have to, and if they wished to stop the interview at any time they were free to do so. Each student was informed that the interviews would be recorded and would be made available for their review if requested. Consent was obtained at the first meeting and a copy of the signed consent form was later scanned and emailed to each student. Following IRB approval of my protocol change, students were provided with updated consent forms reflecting the changes in data collection and timeframe of participation. Students were emailed a copy of the informed consent and returned signed copies to me via email attachment.

Relational Ethics

The deeply relational nature of narrative inquiry required continuous attention to the anonymity and confidentiality of the lives of the students through the entire research process and into their future. With the creation of the research texts, it was imperative that I kept in mind the ongoing concerns of anonymity, confidentiality and consideration for what the research texts say about who each of the students are and who they are becoming. Relational ethics drove my continuous consideration for how each student would read my words and how my way of seeing a story might align with or be different from how the students see the story. Strategies I used to continually consider relational ethics included pseudonyms, sharing my interim research texts, and sharing my final

research texts. Each student identified a pseudonym to be used throughout the research texts and also were able to identify names, places, or situations that were discussed during the meetings that they wanted omitted. I shared interim research texts and research texts with students and asked for comments or concerns regarding the stories written and to ensure I represented their voices and stories in resonant ways.

Justification

In narrative inquiry, Clandindin (2013) calls for researchers to justify their research undertaken using narrative inquiry as a methodology. She argues we need to answer the questions of "So what?" and "Who cares?" in order to defend the quality of our research and prevent others from perceiving our work as simplistic. She argues for three types of justification, including (1) person; (2) practical; and (3) social or theoretical (Clandinin, 2013). Personal justification describes why the research undertaken is important to me as the researcher. Practical justification refers to the difference this research may make to practice. Lastly, social or theoretical describes the difference this research might make to our theoretical understanding or to making situations more socially just (Clandinin, 2013, p. 35).

Personal justification. This inquiry is a chance for me to hear the stories of four students as they reflect on their past experiences in coursework, Level I fieldwork, and reflect on their experience while engaged in Level II fieldwork. It allows these four students the opportunity to share in greater detail their lived experiences than they would ordinarily. In my current role as an academic fieldwork coordinator, I often hear little snippets about students' fieldwork experiences however this was an opportunity for me to visit in-depth and process these experiences with these students. I want to better

understand their experiences, their frustrations, their confusions in hopes of better preparing students for what they may experience, but also to help them see ways in which they can make a difference in practice. To read my narrative beginnings in full, see appendix H.

Practical justification. Students' academic preparation emphasizing the professional ideals of practice often feels discrepant from what they experience during fieldwork and in practice. I mentioned previously the theory-practice gap that exists within the occupational therapy profession. My goal is that this inquiry would lead to greater understanding of this gap and greater understanding of how students experience their academic preparation and their fieldwork experiences. On a larger scale, is there something that I can learn through this inquiry that will help me better equip students to practice in a manner consistent with what they learned during their academic preparation? To better inspire and support occupational therapy practitioners to practice in a way consistent with our professional ideals? To better prepare students to be positive agents of change when entering a workplace where practice is not consistent with our professional ideals?

Social justification. I believe this inquiry will increase disciplinary understandings related to the theory-to-practice gap. There is some literature on this topic (Di Tommaso, Isbel, Scarvell, & Wicks, 2016; Finlay, 2001; Gupta & Taff, 2015; Morley, 2009; Ripat et al., 2013; Robertson & Finlay, 2007; Toal-Sullivan, 2006; Towns & Ashby, 2014) but not to the depth that is needed in order to impact change. The understanding gained from this inquiry will strongly represent the experiences of occupational therapy students. Perhaps this will provide greater insights into strategies

that will help bridge the gap from academics to practice. One example of a social action that may result as a recommendation from this inquiry is a restructuring of the fieldwork education model most frequently used in the United States. I see value in opening discussion on the traditional structures and methods of supervision for both Level I and Level II fieldwork, which have been predominant and in place in the United States since the beginning of occupational therapy education, dating back to the early 1900's. Over the past several decades, theorists have proposed and added to the literature related to student learning. Will the profession of occupational therapy reach a point that would spur a mandate requiring change in the area of fieldwork education? For example, would the collaborative supervision fieldwork model increase a student's ability to implement best practice professional ideals during fieldwork, thus increasing their confidence in doing so upon entering practice?

Narrative View of the Phenomenon

Reflecting on the previous consideration of justification, I began to think about my wonders and how they relate to my narrative beginnings. From the theoretical perspectives mentioned throughout my study, Vygotsky's sociocultural learning theory (Vygotsky, 1978) played an important role in my past experience as a new occupational therapy practitioner and my ability to implement best practice professional ideals into my practice. It was difficult to integrate the knowledge I had regarding professional ideals into my practice at a facility that had well-established routines and norms of occupational therapy practice. The lifeworld theory (Dall' Alba, 2004, 2009) also relates to my past experience. Reflecting back, I knew how to practice occupational therapy in the way the role of occupational therapist was defined in my place of employment. However, I didn't

truly have full understanding of what it means to be an occupational therapist until

transitioning my career from practice to academia, where the focus of my work shifted

from patient care to teaching students what it means to be an occupational therapist.

I also thought about my wonders in relation to the literature review I completed

on the history of the profession and the ongoing discussion within the profession on

occupation-based, client-centered, and evidence-based practice. Through this reflective

process I began to identify and later articulate what wonders were important to me and

what research methodology would help me explore my wonders. This in itself was a

journey, first viewing my research from a phenomenological qualitative methodology

where my research questions were focused on the students' experiences with integrating

best practice professional ideals during Level II fieldwork and the factors that support

and hinder best practice. Without achieving the number of students I set out to and

having the opportunity to lengthen my work with the four students I already had, a switch

to narrative inquiry seemed like the most appropriate fit. Additionally, the opportunity to

work with the students over both of their twelve-week fieldwork experiences, rather than

only their first as originally planned, allowed me to develop a deeper relational and co-

constructive experience with them. I was able to cultivate a deeper and more holistic

understanding of the students' experiences and the relationship (if any) the second

fieldwork had on their experiences with integrating best practice professional ideals

during fieldwork.

My research questions became wonders that I would explore rather than answers I

would set out to find (Clandindin & Connelly, 2000, p. 124). Research questions imply

that there are concrete answers whereas I do not believe I will have answers, rather I believe I will gain understanding around my areas of wonder, which are identified as:

1. What stories are shared about the experience of integrating best practice professional ideals during students' first Level II fieldwork placement?

2. What stories were shared about the impact of a second Level II fieldwork placement on students' experience of integrating best practice professional ideals?

3. What stories were shared about factors that impact students' ability to integrate best practice professional ideals during Level II fieldwork experiences?

Research wonders is also in alignment with constructionism in that the theory posits that all meaningful reality is uncertain in comparison to research questions where a clear answer is expected. A clear answer will not result from this study, rather a meaningful reality has been constructed between myself and each student.

Living the Inquiry

In narrative research it is important for the researcher to first listen to the participant's story and know that it is the participant who first tells his or her story (Connelly & Clandindin, 1990). Participants are living their story at the same time they tell their stories as they reflect upon life and explain their life to others. Despite this, narrative inquiry is a collaboration which involves storytelling and restorying by the researcher and the participant throughout the research process. Narrative becomes more complex as researchers become involved and become part of the process as two narratives, that of the participant and of the researcher, become a shared narrative that is

constructed and reconstructed through the inquiry (Connelly & Clandindin, 1990). The

narratives are constructed through field texts, which may come in different forms

including: field notes of the shared experience, journal records, interview transcripts,

observations, storytelling, letter writing, autobiographical writing, pictures, etc. In this

inquiry interview transcripts and letter writing were the source of field texts.

The Field

According to Clandinin (2013) the field in narrative inquiry refers to a relational

space that is negotiated with participants throughout the inquiry. In my study this refers

to the ongoing conversations with the four students, where they tell their stories.

Consideration is also placed on the temporal unfolding of participants lives in places. My

exploration of the students' experiences of integrating best practice professional ideals

during Level II fieldwork started during the beginning of their first 12-week fieldwork

experience and ended at the conclusion of their second 12-week fieldwork experience.

Despite completion of formal composition of field texts, the relational space continued as

I worked with each student throughout the time in which I wrote the interim research

texts to the final research texts.

Field Texts

Each meeting with a student was recorded and transcribed verbatim as a means of

creating field texts, documenting my time with the students and the specifics of our

meetings. Other field texts in my study included letters written by each student.

Interviews. A series of five semi-structured, open-ended interviews were

conducted with each student during a span of approximately six to eight months.

Composing field texts by means of interviewing is a widely used method in narrative

inquiry (Mishler, 1986). A series of personal interviews with each student provided

several opportunities to hear the stories told by the students about their experiences.

Conducting five interviews with each student allowed me to read and reflect following

each interview in preparation for the next interview. Each interview gave me further

opportunity to delve down deeper into understanding the story told by the student.

All of the first meetings with the student's occurred in-person in a one-on-one

situation in the community in which the student was living. These meetings occurred in

meetings rooms at a local library or meeting room at a local college campus. Completing

the first interviews in person really set the stage for a collaborative and trusting

relationship. In narrative inquiry the researcher sets out to collect stories through

developing a "deeply human, genuine, empathic, and respectful relationship to the

participant about significant and meaningful aspects of the participant's life" (Clandinin,

2007, p. 539). Thus, the depth of the stories shared by the participants is influenced by

the trust and rapport the researcher is able to build with the participant (Clandinin, 2007).

Clandinin and Connelly (2000) use a metaphor to describe their experience in negotiating

a relational space with participants in one of their studies. They state, "the early days felt

a bit like it does when one is trying to start a car on a cold morning, and there is just

enough power to turn the motor. Maybe it will catch and maybe it will not" (p. 72). For

my research the "motor did catch" with each student, which was a great start to

negotiating the relational space and led to an easy transition for the following interviews.

The remaining four interviews occurred using a learning management system with both

video and audio features, called Blackboard Collaborate. The technology worked well

and the collaborative partnership was able to continue growing despite using technology

in place of face to face meetings.

The first meeting occurred within the first two weeks of the fieldwork experience

and focused on exploring the lived experiences of the students reflecting on their

academic coursework and Level I fieldworks. Students also completed Questionnaire 1

in advance of the first meeting to ensure understanding of best practice concepts as

defined for this study (Appendix I). The protocol used for the first interview can be

found in Appendix J. The second meeting occurred around week 6-9 of the fieldwork

experience and focused on the students lived experiences reflecting on their fieldwork

experience in which they were participating in. The protocol used for the second

interview can be found in Appendix K. The third meeting occurred within the last week

or a week after the conclusion of the fieldwork and focused on the students lived

experiences during the fieldwork, reflecting back over the experience and thinking to the

future. The protocol used for the third interview can be found in Appendix L. The fourth

meeting focused on the student's second, twelve-week fieldwork experience and involved

reflecting back on to previous experiences as well. The protocol used for the fourth

interview can be found in Appendix M. The fifth and final meeting involved students'

reflections over their entire occupational therapy academic preparation, fieldwork

experiences, and thinking forward to their future as an occupational therapist. The

protocol used for the fifth interview can be found in Appendix N.

Together the five interviews allowed me to gain a broad understanding of a

couple topics and a more in-depth understanding of topics directly related to my research

wonders.   The first interview provided me with an overview of the students'

occupational therapy academic preparation and unique curriculum features of the two

different academic programs. The last four interviews provided me with the opportunity

to develop an in-depth understanding of each students' narrative account of their

experiences. After each interview, I reviewed the transcripts and identified any areas in

which I wanted to follow up on in the next interview to further strengthen my

understanding. At the conclusion of all five interviews I felt confident that I had

collected a comprehensive narrative account of their experiences.

     Letter writing. At the conclusion of the second fieldwork experience, each

student wrote two letters and were asked to email them to me upon completion. Students

were free to write what they wished but were also provided with a few prompts to

consider (Appendix O). The letters were not sent to the academic programs rather the

purpose was to provide opportunity to openly communicate thoughts and feelings without

threatening the professional relationship between student and academic program.

Content of the first letter focused on the students feelings and thoughts regarding their (1)

preparation for implementing best practice ideals; (2) experiences with observing best

practice ideals during Level I and Level II fieldwork; (3) ability to implement best

practice ideals during your Level II fieldworks; (4) beliefs on the biggest barriers and

biggest supports to implementing best practice ideals based on their Level II experiences;

and (5) feelings and thoughts on how the gap between academia and practice can be

better bridged. The second letter was written to the student themselves, ten years into

their clinical practice. Content of the second letter focused on (1) meaning of best

practice as learned through their education; (2) how they experienced the importance of

best practice ideals during didactic coursework; (3) how they experienced the importance

of best practice ideals during fieldwork; and (4) how they picture themselves as a

practitioner with 10 years of experience related to best practice ideals.

Field Texts to Interim Research Texts to Final Research Texts

Clandinin and Connelly (2000) describe the composition of a research text as

being completed by looking for "patterns, narrative threads, tensions, and themes either

within or across an individual's experience and in the social setting" (p. 132). The

research texts must be rich with detailed accounts of the students' experiences but also

represent the social narrative experienced by the students during their fieldwork

experiences. As I considered the stories throughout the field texts I thought back to my

research wonders. This led me to identify the conundrum of not fully being able to speak

to all three of the best practice professional ideals. It became apparent that my students

were drawn more to discussing occupation-based practice and less engrossed with

discussing client-centered and evidence-based practice. While I was initially worried

about this finding, I came to realize that finding, as such, tells a story and has meaning.

Ultimately, my research texts were shaped by meaning and social significance derived

from experiences shared by my participations, conversations between myself and my

students and from my own past experiences.

The process of moving from field texts to interim research texts to final research

texts has been complex and laborious involving several hours of reading and re-reading

the various field texts collected through interactions with my students. Interim research

texts also typically involve sharing and negotiating what has been written with each

student. I incorporated this process as part of my journey from interim research texts to

final research texts. The writings shared with my students were closer to final research texts than field texts.

The process I used to move from field texts to interim research texts was one of trial and error. My initial plan was to analyze all of my students first interviews, then go to their second interviews, and continue that process until completing all five interviews for all four students. As I did this I began to realize this strategy led me to a mode of comparing and contrasting the students' experiences rather than fully understanding each of my students' experiences individually and separate from the other students' experiences. As a result, I switched my approach and began with student one and analyzed all five interviews before moving on to student two and so forth.

Another trial and error lesson learned was my process of analysis. I began initially by identifying significant statements throughout each of my transcribed interviews. This proved to be cumbersome and lacked focused attention on the students' experiences in relation to my research wonders. As a result, I adjusted my approach by going through each transcribed interview identifying anything directly related to my research wonders. I moved these statements into a table in a column titled raw data. After identifying all raw data in each interview that directly related to my research wonders, I narrowed statements in the raw data column down to preliminary codes. From there I narrowed them down to final codes and then created categories. Once analysis was completed for the first student I began writing a synthesis which involved identifying my final categories and quotes falling within each category. I then began writing my interim research texts, which also took trial and error in order to identify a sequence of presenting the findings in a logical manner. Once finding a logical manner, I began

constructing the final research texts from the synthesis document I previously completed. The next step involved identifying a form in which to present the narratives.

Narrative Form

To remain true to the ontological commitment of narrative inquiry, the students' stories are presented as individual stories, each presented in a separate chapter rather than combined into one results chapter as in traditional dissertation presentation. This is unique from other qualitative research data presentation in that data is generally presented only following synthesis and not presented as individual accounts.

Positioning

As part of this narrative inquiry I considered how I would position my work amongst other related research exploring topics similar to the wonders I intended to explore. I read a great deal of literature about occupation-based practice, client-centered practice, evidence-based practice, therapist professional identity, historical and philosophical underpinnings of the profession, practice paradigms in occupational therapy, fieldwork education, learning theories, transition from student to practitioner, the healthcare environment, theory-practice gap, and the realities of practice. All of these topics are explored in greater detail in the first and second chapters of this dissertation. Based on my exploration of relevant readings I discovered the gap in the literature is the stories of how students experience the process of integrating their academic knowledge into practice during fieldwork. The goal of this study was to begin to fill this gap by hearing the stories that students shared about their narrative experiences while participating in fieldwork.

Trustworthiness

Narrative inquiry is distinct in the assumption that all research is based on language, whether the research is in numbers or conversations between researcher and participant, thus narrative inquirers embrace the broad construct of language and the entirety of the story. Understanding that interactions amongst people and knowing other people is a relational process involving feelings and emotions fundamentally distinguishing narrative from "scientific" objectivity (Clandinin, 2007, p. 29). Another assumption true of narrative inquiry is the deflection of positivistic understanding of validity. According to Clandinin (2007) "validity denies the variety of ways of knowing and questioning of what counts as knowledge and insists on a single kind of truth" (p. 30). The trust in validity and belief in only particular types of evidence, narrows the conception of knowing, the properties of knowledge, and the ways of knowing to things that can be measured, controlled, or manipulated (Clandinin, 2007).

Researcher Voice

Although narrative inquiry as a methodology deflects the concept of validity, my voice as the researcher can't be ignored. Beginning this research with seven years as a practicing occupational therapist and four years as an academic fieldwork coordinator, I expected to hear the students describe experiencing discrepancy during their Level II fieldwork placements. As a practicing therapist I experienced discrepancy first hand and now as an academic fieldwork coordinator, I hear stories from students about the discrepancies they experience on fieldwork. Despite having this expectation, I approached the relational space with reservation as not to interject my own opinions and experiences unless it fit within the conversation initiated by the student. Throughout the

duration of the relational space, I remained open to and interested in hearing the students'

stories as they described them. Moving to analysis, I selected only raw data spoken by

the students taken verbatim from interview transcripts as I completed analysis of the field

texts. In composing the interim research texts and final research texts I exercised

judgement in adding my voice as the researcher. My focus was on maintaining the

student as the primary voice in their narrative with my voice added to contextualize their

experience within the occupational therapy profession.

Limitations of the Study

Students

In the states of Minnesota, North Dakota, and South Dakota, there are only six

occupational therapy academic programs, five of which were included in recruitment

efforts. The students of this study represented two of the five academic programs

targeted for recruitment.

Anonymity

With the small community of occupational therapy practitioners within these three

states, there is a chance that students did not feel their responses would be anonymous

and therefore did not share experiences or chose to exclude full details of their

experiences.

Delimitations of the Study

Students

Students in this study were occupational therapy students enrolled in academic

programs in the upper Midwest. Students were all occupational therapy students. The

study does not include perspective from occupational therapy assistant students. In

addition, to provide consistency in fieldwork experiences, students all completed their first Level II fieldwork experiences at inpatient adult physical rehabilitation settings. However, there was greater diversity of settings represented in the students second Level II fieldwork experiences.

Summary

In this chapter I outlined the philosophical perspective, the narrative inquiry qualitative methodology and methods used to study the experience of integrating best practice ideals during Level II fieldwork for occupational therapy students. I utilized a qualitative narrative inquiry research design with the goal of eliciting personal stories about experiences, situations, and factors that occupational therapy students experience in the process of integrating best practice ideals during their Level II fieldwork experience. The methods of composing field texts that supported my goal and the narrative inquiry design included completion of five, one-on-one semi-structured open-ended interviews with each of the four participants in addition to two written letters by each student. The process then involved transposing the field texts into interim research texts to final research texts and a statement of how the narratives will be presented as findings in this dissertation.

CHAPTER IV

FINDINGS: MORGAN

Introduction

Morgan is a traditional aged, third year graduate student in occupational therapy (OT) at a public institution in the Midwest, although he is not originally from the Midwest. Morgan grew up the oldest of three kids. He lived in many different towns as a child in a military family. His mom is a nurse practitioner and is aunt also holds a role within the nursing profession.

By his report, being an occupational therapy student has been a huge part of his identity the last three years. By his account, he tries to balance his role as a student with healthy and fun outlets, like going for walks on trails, exercising when he can, and being with friends. He states that he "loves" the classmates he has met in the occupational therapy program; he gets along great with them and enjoys spending time with any one of them whenever he is able. He believes it has been helpful to have friends who are going through the same rigor of the program as he is and who also share the same passion for occupational therapy. He highly values his friendships he has made during OT school, both with his classmates and with others. He highly values the support network he has developed, and reports that it has allowed him to be the best student he could be. He identifies himself as someone who worked well as a team member in group assignments, helped classmates study, and felt comfortable asking others for help. Identifying as a

student in a demanding graduate program, Morgan reported that he and his classmates were under quite a bit of stress. He identified his role in response to stress as frequently trying to lighten the air and make jokes to help alleviate the class's stress levels. If Morgan had a motto for life it would be, "everything happens for a reason"!

He presents as someone who is genuinely interested in the people he meets, and who wants to know what is meaningful to them. He reports that he desires to make a difference in the lives of the clients he works with in occupational therapy. In his client interactions he calls himself awkward, often fumbling over his words while being envious of the ability of therapists to articulate their perceptions. He reports that he knows what he wants to say but it never quite comes out the way he intends. He recognizes that his awkwardness and fumbling on words will get better with practice.

Despite the awkwardness he perceives in himself, I walked away from my interactions with him having different perceptions. Through all my discussions with him I found him to be unfailingly optimistic with a keen sense of being able to identify positives even in challenging situations. He also demonstrated a strong desire to learn, which was evident in his eagerness to participate with me in this study as well as his frequent compliments on the value he found through his participation. No matter the experience he finds value and little nuggets of wisdom that he can put forward to his future. This was also true and evident throughout his Level II fieldwork experiences which took place during the summer and fall semester of 2018. Although his experiences were not perfect, he took it all in as a learning experience that contributed to him being a better therapist in the future.

Throughout this chapter I explore topics that became evident during the five interviews with Morgan, completed throughout his 24 weeks of Level II fieldwork experience. The chapter is organized first by fieldwork placement and then by general experiences, occupation-based practice experiences, and supports and barriers to occupation-based practice. I will end with summary reflection and conclusion.

Morgan's Definition of Occupation-Based Practice

Early in our discussions we talked about defining occupation-based practice. I provided him with the definition I had identified to guide my research study. In response to my question asking him to define occupation-based practice, Morgan said,

I think of treating our clients with occupation, which, when I explain occupational therapy, I always try to break the occupation down. It's like, oh, so you get people back to their jobs, literally and I thought that was like, something very few people…and I was like dang, that's happening, ok. We had a professor that said, it's what occupies people's time and so, whatever they're trying to get back to. (I1, P5)

Morgan believes that every person has occupations and if there are reasons that contribute to not being able to complete them, he believes it impacts a person. He believes that occupation-based practice involves actually implementing occupation within the treatment plan (I1, P11). For example, if a client is having difficulty with washing hair, combing hair, donning shirt, putting dishes away, etc., all due to decreased strength in both arms, an occupational therapists' treatment plan should involve incorporating these occupations as part of the treatment plan. It may also involve incorporating other occupations that would facilitate arm strength, such as, reaching into the refrigerator,

81

reaching into cupboards, reaching and hanging clothes into closet, washing windows, etc.

Morgan believes the rewarding part of occupational therapy is getting clients back to the

occupations (I1, P13) they want to do, need to do, or are expected to do.

<div align="center">

First Placement

</div>

Morgan's first placement was completed in a mid-sized city in the upper Midwest

where he was placed in a hospital setting which provided inpatient hospital and outpatient

clinic services. The facility had several occupational therapy professionals working in a

variety of areas. When he started the fieldwork placement he was uncertain as to which

setting he would be placed. He quickly discovered he would be working primarily with

clients in the hospital transitional care unit; the focus of this setting is to assist clients in

transitioning back to their prior living arrangements.

Experience on His First Fieldwork Placement

Morgan admitted that, in the beginning of his placement, he didn't know what to

expect and how much work (outside of the work day) he should be doing, as a student.

He reported that early on he was full of energy and found it easy to stay focused and

committed to searching the literature, reading case studies, and writing notes in the

evening. Looking back, he felt that halfway through fieldwork he lost steam and found it

difficult to stay committed to his prior habits.

In the first week of his placement he experienced feelings of being overwhelmed,

confused, and frustrated with the occupational therapy practice he observed at the site.

He described his experience as "a lot of strengthening exercises". His previous work as a

certified nursing assistant (CNA) and restorative therapy aide further complicated his

feelings about what he was observing. In his previous role he assisted clients with

completing some basic exercises. He became frustrated saying he felt like a "glorified aide right now" (I1, P42). He wrestled with why he was observing the repetitive strengthening and began rationalizing, trying to explain, and question what he was experiencing. "It might just be my setting that I'm in" (I1, P9) or "might just be that a lot of the clients are generalized weakness" (I1, P9), or "is it the easy thing to do" (I1, P42). His experience led him to say, "is there an academic world and a clinical world?" (I1, 33) referencing the discrepancy he was experiencing between his academic preparation and what he was experiencing in his fieldwork placement.

Morgan spoke about looking forward to the time when he would be leading the treatment sessions and creating his own interventions and in his words "change it up a bit" (I1, P38). Throughout the second week he had the opportunity to talk with other occupational therapists at the facility and he realized "they want to help me learn too" (I1, P42) and he aimed to keep a positive attitude, saying "that was just me overthinking things" (I1, P42). As he ended the second week of his fieldwork, he began feeling more "even tempered" (I1, P42) and reflected back on those first couple weeks stating, "wow I did learn quite a bit" (I1, P42).

As he took on greater independence and responsibility with the caseload he struggled with keeping his intervention ideas fresh. He felt it was more difficult because he worked with his clients at the same time each day, five days per week. He felt it was repetitive and sometimes he felt like "oh, they're here, what are we doing today?" (I2, P20). In his head he would try to think of an intervention session that was a little bit different than what was done the previous day. Despite having difficulty with planning unique intervention sessions, Morgan said he didn't plan interventions in advance

because he never felt like he really needed to. Rather he would review the clients' goals and come up with intervention ideas spontaneously that would support him in helping his client to reach the goal. However, on some occasions he had to plan ahead such as when he completed a cooking activity which required contacting the kitchen in the hospital in advance to obtain the needed ingredients. Later on in our visits he reflected on his lack of planning ahead for intervention sessions and identified that it could have caused him to miss out on some opportunities to bring occupation into his treatments with his clients. Further, he acknowledged that lack of planning likely contributed to his difficulty in implementing occupation-based treatments (I3, P18). Although he did add that even with advanced planning, reading resources, and preparing for the session, occupation-based practice can still be difficult to implement because there will always be other barriers present (I3, P18).

Experience With Occupation-Based Practice

It was clear through my visits with Morgan that in the early stages of his fieldwork that he did not observe a great deal of occupation-based practice. This seemed to be an early challenge for him as he tried to figure out what occupation-based practice looked like in his setting. He reflected on the types of interventions that he did observe the occupational therapists, including his fieldwork educator, using and said they were primarily preparatory methods, like exercise. Preparatory methods describe intervention approaches that are to be used to prepare a client for being able to participate in an occupation. He reported, "I felt it was a little bit harder, just because of maybe what the OT's did" (I3, P3). With minimal support, and lack of others modeling for him 'what

occupation-based practice looks like', he navigated the journey "generally" alone. I say "generally" because he did seem to pull support from his peers, which I will discuss later.

He started by establishing rapport with clients, visiting with them about things they enjoyed, past and present leisure pursuits, work history, things they needed to do to return home, concerns they had about returning home, and supports they would have upon discharging home. During the first week he took a stab at trying to incorporate something of interest to a client into the therapy process. He shared the following story about how he started by finding an area of interest for a client, so that he could switch from exercise to use of a motivating activity in his therapy:

> We'll be talking and one gentleman will say, you know, you watch the basketball game? And I'll say, oh, did you play basketball? There was a beach ball and I…he put some wrist weights on. It'd be basketball like that. Instead of just rote exercises. Sometimes it's kind of fun to do that. (I1, P10)

Although he made great effort in trying to identify the meaningful occupations of each of his clients, this was a significant area of challenge for him during this placement; one that he identified as the main barrier to implementing occupation-based practice. He frequently talked about the clients not being able to identify meaningful occupations that they want to work on during therapy, which made Morgan think, "maybe I need to explain to them more about what occupational therapy is" (I2, P13). Morgan often questioned whether the challenge he experienced with identifying meaningful occupations was due to the type of clients he was assigned. The clients that were on Morgan's caseload were all hospitalized at the time he was seeing them for occupational therapy service. The feelings clients may have toward participating in therapy often vary

85

depending on if the client is hospitalized or being seen as an outpatient. Often times people in the hospital do not want to be there, but need to be there for a number of different reasons. Therapy is often part of the solution to help a client progress to be released from the hospital, therefore it may feel like something the client *has* to do rather than something the client *wants* to do. Whereas in outpatient, no one is nudging you to go to therapy, rather clients may feel more freedom to choose to go to therapy. He further speculated that since his clients were primarily older adults, most of whom were retired, they may have experienced a loss in personal roles in addition to loss in overall functioning which may lead to inability to participate in previously meaningful occupations.

Morgan identified that he did try to incorporate some interventions addressing activities of daily living (ADL) and instrumental activities of daily living (IADL) into his therapy plans. Activities of daily living refers to tasks that are oriented to self-care required for daily living such as bathing, grooming, feeding, dressing, etc. Instrumental activities of daily living refer to tasks that support daily life within the home and community such as meal preparation, taking care of pets, driving, financial management, etc. Morgan introduced tasks such as dressing, cooking, laundry, use of communication device (cell phone), and kitchen mobility. When asked further about dressing he said this most often involved putting on and taking off socks and education on adaptive equipment for various aspects of dressing. I also asked about bathing and his response was clear; "no, not any bathing" and he went on to say he hadn't observed any of the occupational therapists' address bathing. He admitted that he hadn't asked and he didn't want to be like "let's do it" if the other therapists weren't doing it at the facility. Unfortunately, he

also didn't know if his clients demonstrated safety or needed assistance with bathing upon discharge from the facility. I didn't think about it at the time but now making the connection, it doesn't surprise me that bathing, grooming, toileting, were not addressed more often, because treatment rarely occurred in the client's own hospital room, rather almost always occurred in the therapy gym. This demonstrates how the therapy location impacts the scope of occupational therapy services provided in a given setting.

I asked Morgan to tell me about a situation where he provided services to a client that were reflective of best practice. As he shared the experience I was interested in the fact that he didn't initially identify the sessions he was planning and implementing as occupation-based treatment. He said, "I wouldn't have thought of it right away as occupation-based" (I3, P12), and continued by saying he didn't make that connection until the third day of working with the client. He reported that when he made the connection he said "that's when it was like this is…this is OT" (I3, P14). As he reflected on his experience, he noted the problem solving and team work that occurred between himself and the client to implement sessions that were truly occupation-based. In his words he felt like he "had skills and knowledge and that he was a skilled professional" (I3, P14).

Barriers Influencing Occupation-Based Practice

Morgan found that the realities of implementing best practice was much harder than he thought. A while later in his first fieldwork experience, he reflected back and said "sometimes it can be hard to get it to the occupation-based treatment that you want to do, that you know you should be doing" (I2, P12). He found it frustrating when he was

able to implement occupation-based interventions knowing that is an important part of occupation therapy (I3, P1). Sometimes he questioned, "Am I even doing OT?" (I2, P29).

Morgan identified the two biggest barriers to implementing occupation-based practice within his first experience as the *clients* themselves and his *fieldwork educator*. He spoke several times about the difficulty he had in trying to identify the meaningful occupations of his clients, stating "it's hard to get it out of them sometimes" (I2, P13) and how he felt like the clients themselves were not able to identify things of importance and meaning in their lives. The other barrier was his fieldwork educator who he described as being "in a habit of more strengthening type things" (I2, P24). He states, "my fieldwork educator is maybe not doing the best practice for occupation-based" (I2, P29). It leads me to question, how can it be that the person who is to be mentoring him on how to be an occupational therapist is one of the biggest barriers he experiences to actually being an occupational therapist during this fieldwork? He goes on to describe that his relationship with his fieldwork educator was impacted by poor communication. He stated, "I wish we had better communication" (I2, P26). Despite challenging communication, Morgan was quick to point out that she was always pleasant but recalled how he felt timid around her and avoided asking her questions.

Other barriers that were present during his first fieldwork placement involved the *resources available, the number of clients*, and the *social context* of the occupational therapy team. Morgan talked about how the resources that were available didn't support occupation-based practice to the extent possible. For example, he mentioned many of his clients enjoyed woodworking or fishing but they didn't have resources available that would allow him to incorporate those interests into his treatment sessions. He also

identified that while productivity pressures were not unbearable, it would have been nice to occasionally have a break from back to back clients to allow for increased planning, reading, and researching, in order to support his use of occupation-based practice. Finally, one of the members of the occupational therapy team questioned Morgan about his academic preparation and the emphasis given to occupation-based practice and lack of emphasis on exercise and manual therapy. She asked Morgan whether his educational training had focused on function and occupation. She continued by telling Morgan that she remembered having too much emphasis on the use of occupation and not enough about exercise or manual therapy techniques in her own education (I1, P12). As an occupational therapy educator it is interesting to me that a staff occupational therapist would divulge this kind of rhetoric to a student, who at that time, had just started that week at the facility.

Supports Influencing Occupation-Based Practice

Although Morgan identified several barriers that made occupation-based practice more difficult, he also identified supports that were present throughout his placement that contributed positively to his ability to implement occupation-based practice. The supports identified fit into three categories including *personal supports, physical resources*, and *social context*. Morgan had several personal factors that positively supported him throughout this fieldwork including his past experience working with older adults, his positive attitude and desire to learn, using a notebook to write down ideas, and his academic textbooks. He also identified available resources such as handouts, books, and journal articles at the site that supported occupation-based practice. Interestingly, social context was identified as both a barrier and a support for Morgan.

He spoke generally about the occupational therapy team supporting him and helping him to learn during the experience. Another student from a different academic program was also at the facility at the same time as Morgan. He identified that having another student who was in the "same boat as me" (I2, P19) was nice to have. He mentioned that they often went out to dinner each week and frequently talked about occupational therapy. Lastly, although his classmates weren't physically present at the fieldwork site, he was able to stay connected to all of them electronically by participating in discussion boards throughout the experience. He also had a few classmates that were located in the same city as he was and stated they often got together during their fieldwork placement.

Transition to His Next Placement

At the end of his first placement and before he started his second placement Morgan talked about things he would like to change going into his next fieldwork. He spoke about feeling more confident and his desire to have more open communication with his fieldwork educator. He had a goal for his second Level II fieldwork experience to set aside a certain time during the week to "stay on top of things" and he felt like having a more measureable goal would help him with that (I3, P19). He also talked about being more proactive, creative and using the resources available as much as he could.

<div align="center">

Second Placement

</div>

Morgan's second placement was also completed in a large city in the upper Midwest where he was placed in a private outpatient therapy clinic. In contrast to his previous experience, this facility only had two occupational therapy practitioners but several physical therapy practitioners. In addition to providing services to outpatient

clients who came to the clinic for treatment, services were also provided at an assisted

living facility, to clients residing within that facility.

Experience With His Second Fieldwork Placement –
Am I Doing A Lot Of PT Stuff Here?

Morgan went into his next fieldwork placement with greater confidence than his

first. What he discovered when he arrived was occupational therapy practice that

neglected occupation, even more than his previous fieldwork site. Interventions focused

on rehabilitating the body by targeting muscle strength, endurance, motion, etc. through

the use of stretching, exercises, and other modalities. The majority of the clients served

were receiving therapy for their arm, specifically shoulder, post-injury or post-surgical.

He experienced the world of protocol-driven therapy and the dependence on protocols to

progress a client through the therapy process. He stated that he felt so caught up in what

he had to do in a day that he didn't really have a chance to think about occupation-based

treatment. The opportunity to create interventions that were occupation-based was

limited due to the dependence on the protocols. Interventions frequently consisted of a

modality such as ultrasound, followed by passive range of motion in which the therapist

moves the arm through various planes of motion without assistance from the client, joint

mobilization in which the therapist provides hands-on therapy to the clients joint to

improve joint motion, and possibly strengthening exercises depending on the client's

progress in therapy. The shock of experiencing this type of biomechanical treatment

must have worn off on his first fieldwork experience although he still recognized a

discrepancy. He said, "Am I doing a lot of PT stuff here or is it that PT's are doing

shoulder type OT stuff?" (I4, P9). He talked about scope of practice (between

91

occupational therapy and physical therapy) cross-over occurring at the shoulder level but he didn't talk about what was distinct about occupational therapy and how an OT approach to treating a shoulder would be different than a PT approach to treating a shoulder.

Throughout his second fieldwork placement Morgan praised his fieldwork educator, saying he had received better communication, more education, more support, more guidance, more feedback, and more collaboration during this fieldwork placement; something that he felt was missing during his first placement. He spoke about his fieldwork educator having similar values and beliefs about occupation-based practice. Morgan shared with me that he believed that his fieldwork educator valued occupation and believed it should be a part of occupational therapy practice. He also shared that his fieldwork educator recognized that although he had these values and beliefs he didn't incorporate them directly into his practice.

Experience With Occupation-Based Practice

Morgan worked to establish rapport with each new client to better understand their occupations. He said he often started by talking about himself which often times led to him gaining information from the client about things the client enjoyed or occupations that were meaningful (I4, P4). Morgan found that implementing occupation-based intervention was difficult in this setting for different reasons than what he experienced in his first fieldwork placement, primarily due to specific protocols the occupational therapist was instructed to follow and lack of occupation-based resources. Although his fieldwork educator did not incorporate activities directly engaging clients with an occupation into treatment, he did address his clients functioning with his/her occupations

and made connection between what his treatment involved and how it would help the client improve their overall performance with occupations. His interventions and that of his supervisor often involved educating clients on ways to modify tasks to improve function, reduce pain and other symptoms.

On occasion Morgan was assigned a client for treatment due to a work related injury and in those situations, Morgan believed he was able to be more occupation-based in his treatment. For one client he described incorporating work related tasks right into the treatment sessions, thus implementing occupation-based treatment. In addition, clients that were receiving intervention due to work related injury allowed for increased creativity and client-centeredness as Morgan was able to tailor the treatment directly to the client's specific work tasks (I4, P3). It seems that the only other situations in which Morgan was able to implement occupation-based intervention was working with clients at the assisted living facility. For example, he said he was able to address safety concerns, navigating directions in the facility, and moving around within the facility and individual client apartments (I4, P4).

Barriers Influencing Occupation-Based Practice

Interestingly, Morgan experienced different barriers to being occupation-based during his second fieldwork placement. He identified the two biggest barriers as the *protocol-driven nature of occupational therapy services* at the facility and the *lack of resources* available for use with occupation-based interventions; the two actually go hand-in-hand. The dominance of the impairment focused approach emphasizing remediation of impairment and using protocols to guide treatment limited Morgan's creativity with intervention planning thus limiting occupation-based intervention (I4, P3).

93

Morgan said, "I feel like I'm so caught up in, here's what we got to do for today that I sometimes don't even really have a chance to think about it (referring to occupation-based treatment)" (I4, P5).

One client story Morgan described, involved a client who identified occupations in which he was experience difficulty with such as "reaching up for hair, shampooing, and tucking in his shirt behind the back" (I4, P12) and according to Morgan, "we didn't really address it from there" (I4, P12). He stated, "it's so hard when they mention it and then we know ahead of time what we're gonna do" (I4, P12). After reflecting on the situation in our interview Morgan said, "I don't know, I could have just done it right then and there (referring to addressing the clients' difficulties that were reported)" (I4, P12). He shared another client story demonstrating opportunity for occupation-based intervention in which the moment again was not seized. He said, "I remember we had one client who needed to return back to work and he needed to type for his job and his dexterity was limited. We could easily have done that and we never did" (I5, P3). Was part of his reservation in completing an occupation-based intervention due to his desire to "stick to the norm"? He said, "I didn't want to go against the grain of what's done" (I5, P5), "just not wanting to disrupt things" (I5, P5).

In regards to resources for occupation-based intervention, they were limited, specifically when they were treating clients in the therapy clinic. They did not have an activities of daily living (ADL) suite available to work with clients. These ADL suites include simulated environments such as a bathroom set up, bedroom set up, kitchen set up, etc. The majority of the equipment that was available was used for doing exercises. They had a little more freedom with resources when working at the assisted living facility

because they could access many things inside the facility and individual client apartments. Morgan used the phrase "out of sight, out of mind" (I4, P16) when talking about the lack of resources available in order to incorporate occupation-based practice.

Other barriers contributing to Morgan's difficulty in implementing occupation-based practice were the *size of his client caseload* and the *academic program demands* during that semester. Morgan talked about the sheer number of clients on his caseload (approximately 30) and how remembering the details about each client's diagnoses and progress limited his ability to plan sessions in advance. He also experienced a schedule in which clients were seen back to back, leaving no extra time to plan for each session. In addition to the demands of fieldwork, Morgan worked hard to meet the demands of the academic program which included two additional online classes which he felt consumed all of his time when he was not at fieldwork (I4, P22). He stated, "everyone wants to be the best student that they can and, you know, look up stuff and prepare ahead of time. Sometimes I feel like fieldwork gets placed on the back burner because I'm not getting graded for looking up stuff in the evening, which is unfortunate" (I4, P22-23).

Supports Influencing Occupation-Based Practice

Morgan did not specifically identify anything that was helpful in supporting his ability to incorporate occupation into his practice. Thinking back on his stories, one support that comes to my mind, although he didn't specifically identify it himself, was his client's ability to identify occupations that were impacted by their injury or surgery. This was something he struggled with on his first placement.

He also experienced significant support from his fieldwork educator in terms of fostering Morgan's growth as a therapist. The relationship with his fieldwork educator

during his second placement was more collaborative; he described this as having open

communication, direct feedback, and mutual exchange of skills and knowledge (I4, P14).

His fieldwork educator fostered Morgan's use of evidence based practice by asking him

to search literature on topics related to their caseload. Morgan often mentioned that

although occupation was not utilized as means of treatment, his fieldwork educator

always connected the treatment plan to the client's end goal of improving performance

with occupation. In addition, his fieldwork educator involved Morgan in the therapy

process by discussing treatment sessions in advance and asking Morgan, "what do you

think?", demonstrating the value that he placed on Morgan's opinion. Morgan always

felt like he was a valued member of the team and if he needed guidance he knew he could

count on his fieldwork educator. He always felt comfortable asking questions,

demonstrating the collaborative nature of their relationship.

Student Syndrome

In my second visit with Morgan he coined the term "student syndrome" (I2, P20)

which means being afraid to ask questions or push the envelope. After the term was

coined it was a recurrent theme throughout the remainder of our visits. On several

occasions he shared with me not wanting to step on anyone's toes, such as when he said,

"at my first one [fieldwork] I don't know if I felt like I had a place…I didn't want to step

on anyone's toes by saying, hey, can we do something like this or like that" (I3, P1). In

another example he said, "I don't know if it was me, like, being a student and just not

wanting to really rock the boat by addressing it" (I3, P15).

After working with Morgan over the span of seven months I became more aware

of the phenomenon of student syndrome. In my five years as an academic fieldwork

coordinator I always recognized the presence of a power differential between a student and a fieldwork educator but Morgan did a beautiful job in illustrating how it plays out during fieldwork. The power differential is evident in his comments related to feeling timid around his fieldwork educator, not knowing if he had a place to contribute his ideas, and not wanting to question or disrupt the already established practice. In fieldwork experiences the student's chance of passing successfully is at the mercy of their fieldwork educator, which inherently gives power to the fieldwork educator and it is a delicate balance for students to navigate the power differential. It is not surprising that student syndrome influences a student's ability to implement occupation-based practice at a fieldwork site.

Ending Reflection

Morgan's experience in his first placement led him to ask, "is there an academic world and a clinical world?" (I1, P33). At the conclusion of my third visit with him, which was at the end of his first, twelve-week fieldwork, we revisited that statement and he said, "I feel like there is some of that to an extent" (I3, P3) although he didn't have any comments as to where the discrepancy was. Throughout the placement he recognized a discrepancy between what he learned in the classroom and what he experienced on fieldwork.

He shared that he felt limited in what he could do at the facility but knew he could do so much more than what occupational therapy was currently doing at the facility. He stated, "there was times where I felt like I was limited with what scope I could do" (I3, P22) and "knowing I can do so much more than this" (I3, P22). He spoke about the dominant milieu of repetitive strengthening exercises and he said "I know OT's do this

97

(referring to exercises) but I know that OT's can do a lot more and we're not doing it" (I3, P23).

Morgan's experience can be compared to the bargaining stage of grieving. He said, "I'm just frustrated. I know this happens because I've known people who said this happens…and why do I have to be the one seeing it right now (referring to lack of occupation-based practice)" (I3, P23). He recognized a need for change and said, "a lot of times too I was like, well, how do I change it? I don't know. It was a lot of unknown (referring to role of OT at facility)" (I3, P24). Identifying the need for occupational therapy role development at the facility and the need to increase the use of occupation-based practice may have led him to question his own abilities to take on a challenge.

In typical Morgan fashion, he ended the experience on a high note by staying positive and finding the value in the learning experience. He stated, "I feel like I could have complained or I could have made it worse…but I did make the best of it" (I3, P30). It seemed like a good reminder that we often don't have a great deal of control over the situation we are in but we can control how we respond. He stated, "I feel like you can't really change the situation, but you can adapt and overcome to what's there" (I3, P30).

Halfway through his second fieldwork placement he reflected back on resources available at both of his fieldwork placement that were available to support occupation-based practice. He stated, "I would say at my first placement we did have a little bit more resources for occupation based type things like the ADL suite (simulated bathroom, bedroom, kitchen set-up) and being able to utilize some of the things from the kitchen" (I4, P18); whereas the resources available during his second fieldwork placement he described as primarily exercise equipment. At the conclusion of both of his two, twelve-

week fieldwork placements and during the last interview he said, "I feel like at my first one for inpatient, looking back now we could have done more occupation" (I5, P5).

After both of his placements, I question the influence of his fieldwork experiences on his professional identity as an occupational therapy student, specifically after comments such as, "am I doing a lot of PT (physical therapy) stuff here" (I4, P9) or "is that PTs doing shoulder type OT stuff" (I4, P9). He stated he was often called a physical therapist during his second Level II fieldwork and that he never asserted himself to inform others that he was an occupational therapy student.

When reflecting on his academic preparation he believed he was prepared pretty well but went on to say the preparation was really for optimal situations where unlimited resources were available (I3, P18). For example, when he described working on case studies he said, "we weren't actually doing it. So we were just thinking of it in our heads" (I3, P18), which eliminated the reality of how difficult it would be to implement planned interventions in authentic fieldwork experiences.

Conclusion

I am thankful for the opportunity that I had to get to know Morgan and develop a relationship with him around our common passion for occupational therapy. He helped me better understand the day to day victories and challenges experienced and two different types of occupational therapy practices. Throughout the experience, he repeatedly thanked me for the opportunity to participate in my research and reported how helpful the reflection was to his learning. He said, "doing this as well, you know, the interviews and having a chance to just, like, think. You know, while I'm talking and stuff helped too. Because it made me just more aware of what was going on. If I didn't have

that time to self-reflect, I don't know if I would have had the opportunity to even think about it" (I5, P8).

CHAPTER V

FINDINGS: SARAH

Introduction

Sarah is a traditional aged, third-year occupational therapy (OT) graduate student at a public institution in the Midwest. She grew up on a farm just outside a small Midwest town, population under 5,000. There are two children in her family; she is the youngest and she has an older brother. She is the only person in her immediate family who pursued healthcare as a profession.

She reported that she enjoys spending time with friends and family, hiking, running, reading, baking, traveling, and doing puzzles. Through my experiences getting to know her over the twenty-four weeks of her fieldwork, I found Sarah to be kind, conscientious, and somewhat reserved. Despite my perception of her being reserved, she demonstrated initiative and desire to learn through her willingness to participate in my research study. She always spoke positively about all of her experiences, both on-campus coursework and fieldwork experiences. I have a feeling it was personally challenging for her to analyze her experiences with a critical eye, which seemed to go against her ever positive mind-set.

Throughout the next chapter I will be exploring topics with Sarah that became evident during our five interviews, completed throughout her 24 weeks of Level II fieldwork experience. The chapter is organized first by fieldwork placement and then by

general experiences, occupation-based practice experiences, and supports and barriers to occupation-based practice. I will end with summary reflection and conclusion.

Sarah's Definition of Occupation-Based Practice

Early in our collaboration, I described to Sarah the definition of occupation-based practice that I used to guide my research study. I also asked Sarah to share a definition in her own words and she stated, "I think it depends on the person and what occupations are meaningful to them. It varies depending on where you're at in life and also a person's beliefs and values" (I1, P4). Sarah believes that occupation-based practice involves the following:

> Completing the occupations and working on the issues the person has, whether it is not being able to complete those occupations as fully as they want, not satisfied with their performance, or if they don't want someone helping them with those occupations. The next step is to figure out a way to get them there. (I1, P5)

Having a solid understanding of occupation, Sarah began her first twelve-week fieldwork placement.

First Placement

Sarah's first placement was completed in a mid-sized city in the upper Midwest where she was placed at an inpatient rehabilitation facility within a regional healthcare system. The facility had several occupational therapy professionals working in a variety of practice contexts including pediatrics, acute care, inpatient rehab, home health, skilled nursing facility, and outpatient. Working on the rehabilitation unit required interdisciplinary collaboration with many different professionals including physicians, social workers, nurses, physical therapists, and speech language pathologists. The goal

for most clients receiving therapy at the rehab unit was to gain as much independence as possible with daily tasks and return to their prior living arrangement.

Experience on Her First Fieldwork Placement

From the beginning Sarah spoke positively about her experience on the inpatient rehab floor. She loved the physical environment, describing it as being set up for therapy and for clients to increase their independence. She felt there were many opportunities available to her to learn from other therapists whom had many years of experience working in the rehabilitation setting. Sarah said, "I'm still learning and kind of looking at what other people do and kind of simulate that for my patient as well" (I2, P9). Sarah talked numerous times about her fieldwork educator and the support she provided her during her placement. Sarah felt the level of support and guidance that was provided helped build her confidence as she began to take on the role of occupational therapist in this setting.

One of the challenges that Sarah experienced during this fieldwork placement was the demanding schedule. She talked about often having clients scheduled back to back with a one-hour lunch break, which she often spent catching up on her documentation. She frequently referred to just trying to manage her time and her caseload and learn the basics of what is required as an occupational therapist working in this setting. She said, "for me personally, it's just trying to manage my caseload when things are still new to me" (I2, P15) and "this first one I feel like I was just trying to make it through and work on the basics" (I3, P2). She spoke often about not being able to focus on intentionally incorporating occupation-based practice until she was able to establish a routine and feel comfortable with the basic requirements in order to independently take over the caseload.

103

She mentioned "when I first started out, sometimes it's easier just to do weights or repetitions because I knew how to do that" (I3, P1). As time went on and she became more comfortable with the routine she was better able to focus on balancing her treatments with both occupation-based interventions and exercise. She said, "I think as I got more comfortable that got easier for me to balance that" (I3, P23).

Along with the demanding schedule and back to back clients, the facility had an expectation that documentation was completed at the time the service was provided, referred to as point of service documentation. In this setting, the reality is that if Sarah did not do point of service documentation, she would have been working hours and hours after her scheduled work day to catch up on notes. She talked about having to be okay with setting up a client on a therapeutic activity or exercise in order to allow her time to catch up on documentation. Many students struggle with this because it does not support the occupation-based and client-centered therapy believed to be representative of the profession. Sarah said, "just in the experience that I had, I think it's OK as long as you're still attending to the patient. You know, you're monitoring how they're doing" (I3, P26). As she became more comfortable, she reported that she was able to "multi task sometimes and kind of still keep talking to them and asking questions while I was documenting" (I3, P26).

Another area in which Sarah reflected on during interview one and ten weeks later during interview three, was gaining comfort using evidence to support interventions. Early in the placement she talked about "just trying to make it through" and "work on the basics" (I3, P2). She reported feeling like she needed to get some of the basic skills down, such as evaluating a patient, interpreting the evaluation results, and deciding what

to focus on based on the results. By the time I talked with her in interview three, she said "as that finally became more comfortable for me, I can start to say, is this effective or how can I be more effective?" She continued, "now I think I could dig a little deeper and make sure that the interventions I use have evidence to back them up" (I3, P2).

Experience With Occupation-Based Practice

From the first week of her fieldwork experience, Sarah spoke highly about the implementation of occupation-based practice at her site. She believed the therapists had a good balance between non occupation-based activities and occupation-based activities. She identified that approximately 50% of the interventions were occupation-based and 50% were not occupation-based. The role of the occupational therapist in this setting influenced the use of occupation in treatment sessions. For example, the primary goals addressed for clients in the rehabilitation unit were related to increased independence with self-cares and other activities required to return home, therefore many of the occupation-based interventions focused on these goals.

Upon admission to the rehabilitation unit each client participated in an occupational therapy evaluation to assess the client's ability to complete their activities of daily living (ADL's). Activities of daily living refers to tasks that are oriented to self-care required for daily living such as bathing, grooming, feeding, dressing, etc. This provided the occupational therapists with a baseline measurement of performance and assisted the therapist in creating goals for the client to work toward in order to be discharged. The unit also required that occupational therapists re-evaluate each client's performance with ADLs on a weekly basis in order to monitor progress and plan for

discharge from the hospital. Sarah shared with me a story that was memorable for her about working with a client on activities of daily living.

> I had been working on a lot of grooming tasks with him, like, trying to wash his face. And he has very ataxic movement so it was very hard and difficult for him. But he eventually was able to do it, with a lot of extra time and me helping move his arm where it should be at times. Then we worked on brushing his teeth the next day too and I think that was a really big accomplishment for him. He's not able to get a lot of words out but I could tell that was a big deal for him. He'd been in the hospital for how long now and he'd never been able to do any of those things for himself. I think that was a really cool client-centered, occupation-based moment for me where a lot of the other occupational therapists I think were probably doing just exercise with him. So that was one memorable moment for me. (I3, P13)

Besides ADLs, the secondary emphasis for occupational therapists at this facility was instrumental activities of daily living (IADLs). Instrumental activities of daily living refer to tasks that support daily life within the home and community such as meal preparation, taking care of pets, driving, financial management, etc. Sarah shared examples of how meal preparation was incorporated into a client's treatment plan, typically beginning with a simple cooking task with a small number of steps and gradually increasing the difficulty of the task. For example, "they microwave oatmeal…then they do a piece of toast...then they might do an egg the next time they come, and then they might make a sandwich the next time" (I1, P33). Sarah shared a

106

story with me about how she used a cooking activity to work on a client's sequencing following a stroke. She said the following:

> We made a grilled cheese sandwich. Like I had said before, her sequencing was a little off, so she'd put the cheese in the pan first instead of the bread. She realized, you know, that doesn't look right. It was kind of nice to slowly see her improve. Over the next week she was able to do some of those sequencing tasks much better as her brain healed from her stroke. (I2, P3)

Sarah also worked with this same client on medication management by using the following occupation-based activity.

> We did a pill box set up for her with cheerios in the am and pm slot and gave it to her for a week in her room to see if she would remember to take it. She did for the most part, but forgot two days. I think she realized, maybe I didn't remember to take them and family members should help me with that. (I2, P3)

> Although these examples provide a glimpse into the great possibilities of

occupation-based intervention, Sarah also experienced the challenges that often make it difficult. For example, she commented,

> I'm more prone to doing preparatory activities instead of occupation-based activities when I don't have enough time or I feel stressed out. When I have patient after patient and not a lot of time for notes, the preparatory activities give me time to catch up on some paperwork. (I2, P15)

When Sarah talks about preparatory activities, she is referring to activities that are used to prepare clients for completing occupations. Typically, these activities, such as exercises and other activities that can be completed while the client is seated at the tabletop, can be

completed without direct therapist supervision. In comparison, occupation-based

activities generally require direct therapist supervision in order to ensure client safety.

Unfortunately, Sarah had encountered the reality of the current healthcare system that

monitors productivity and efficiency, making it difficult to only complete occupation-

based interventions while also completing required client documentation on time.

Barriers Influencing Occupation-Based Practice

Early in her fieldwork experience, Sarah recognized that she had to first focus on

managing her caseload and "getting the basics down". She stated "a barrier for me right

now is just *managing my caseload and time* appropriately" (I2, P16). Until she was more

comfortable with independently managing her caseload, implementing occupation-based

practice was more difficult. Sarah never felt pressure to meet a specific productivity

level, however, her *client caseload* is what determined how busy she was and how much

time was required to work with each of her clients. She recognized that "in this type of

setting, you have no control over how many clients that you have on your caseload" (I3,

P17). The more clients she had on her caseload the more difficult it was for her to

consistently provide occupation-based treatment. She stated, "sometimes it's easier to

give them a task to do and quick catch up on your notes for five minutes as opposed to

going in the kitchen and having to monitor them the whole time they're doing the task"

(I2, P15).

In her experience, Sarah recognized how the size of a caseload impacts a

therapist's ability to implement occupation-based practice into treatment sessions (I3,

P1). She mentioned, "sometimes it was easier to do exercises. When they're doing

exercise you can catch up on the documentation from the last two patients that you did

ADLs with" (I3, P23). When completing ADLs with clients an occupational therapist

needs to provide direct supervision and often times direct hands-on assistance in order to

ensure client safety. This eliminates the ability to complete documentation while the

client is completing their ADL tasks. Sarah also commented that when she had back to

back clients it was difficult to "sit down and think about exactly what would be the best

client-centered and occupation-based practice for them" (I4, P18). With this experience

she stated, "I can see how therapists slip back into the routine of here's a dumbbell, start

doing exercises or here is theraband, here is theraputty, do your home exercise program

that we'll send home with you" (I3, P23).

Another barrier that Sarah spoke about was *therapist creativity*. Although she

didn't state that this impacted her directly, she was able to observe how occupational

therapists may get into a routine and do similar tasks for similar challenges impacting

client performance (I2, P15), decreasing a therapist's creativity and reducing the

likelihood that interventions are client-centered. She also commented how it can be

"hard to be creative when you don't always have all the resources to be super creative"

(I2, P15). In addition, although she didn't speak specifically about creativity in relation

to time constraints, one could assume that being creative with interventions is more

difficult when a therapist is limited on time.

Time also proved to be a barrier when looking for and implementing evidence into

practice. Sarah commented that she would try to do "quick google searches" or quick

searches using databases, but identified "it is hard to make that a priority" and continued,

"it's understandable therapists sometimes don't always look at the evidence for things

they're doing" (I2, P16). Another barrier, in addition to time, was that the therapists

didn't have *access to research databases* at the facility. Although that didn't directly affect Sarah as a student, she identified that therapists would need to search for evidence outside of the facility and on their own time.

Supports Influencing Occupation-Based Practice

Sarah reported that during her first fieldwork placement, *resources* were the number one support influencing her ability to provide occupation-based practice. "Having access to those resources is a huge support for me. I know I can implement occupation-based and client-centered activities with what's given to me already" (I2, P16). She stated, "I think it's a lot easier when you have the resources set up for you to incorporate a lot of those occupation-based activities" (I2, P6). She felt that if she didn't have the access to the resources, she would have been struggling to think of ideas or creative ways to simulate occupation-based activities (I2, P16).

The other resource that significantly impacted Sarah's ability to implement occupation-based practice was the *people around her*. She spoke highly of the therapy staff she was able to work with during her first fieldwork placement and noted that many of the therapists had many years of experience. She stated, "we have a lot of skilled, knowledgeable therapists that bounce ideas off of each other and really support each other" (I2, P14). Sarah spoke of the value of a *supportive workplace culture* that was welcoming of students. She said, "they're so receptive to students and learning. There's students everywhere, all the time and it's great. Everyone is so receptive and willing to teach you" (I3, P18).

Sarah also spoke specifically about her *fieldwork educator* and the impact that she had on her learning. Sarah stated, "she said she loves having students because we were

just through school and we would know some of the most updated strategies and techniques" (I3, P19). Sarah talked about how her educator was so "hungry to learn" (I3, P28) and how she "wants to know what is the best practice" (I3, P28). Sarah said, "she's an AOTA member and looks up things all the time. I think she really does more than a lot of therapists do" (I3, P28).

The last group of people that impacted Sarah's ability to implement occupation-based practice were her *classmates*. Although they were not physically present, they connected through weekly discussion boards on an electronic learning management system. Sarah viewed her classmates as resources (I2, P9) by their mutual sharing of information they have researched and the results they found regarding effective treatments for clients (I2, P9). She mentioned how it was helpful to hear about her classmates' experiences and gain knowledge from them through the discussion boards (I3, P19). This demonstrated that for Sarah, collaboration with her peers, whether it was in-person or via technology, was valuable to her learning experience.

Transition to Her Next Placement

As Sarah prepared to transition to her next fieldwork placement, she talked about having "high expectations for every setting to be as occupation-based and client-centered as this one was" (I3, P17). She had hopes of taking some of her experiences of simulating different ADLs with her to her next rotation and was hoping to find new creative ways to do occupation-based activities (I3, P17). One strategy that she somewhat utilized during her first placement and one that she thought she could build upon during her second placement was daily reflection. She said the following:

After each day I reflect on the patients I had, the interventions I did and even

keeping a log of that, just to see if I'm doing the same things over and over. How

am I making this different? How am I incorporating the evidence into it? (I3,

P29)

On her second placement she hoped to add more time to "dig into the evidence" (I3,

P29). She added,

It is easier to go back to your usual routine and do exercises and things like that.

But if you actually look at it over time, if you're always doing exercises with your

patients, maybe that'd be kind of an, ah-ha, moment, where you know, I need to

change something. Or make sure that at least what I'm doing is effective. (I3,

P29)

The habit of self-reflection that Sarah developed during her first fieldwork placement and

continued on during her second placement is a worthwhile strategy to self-assess one's

own practice and to make changes accordingly.

Second Placement

Sarah's second Level II placement was in a rural area of the Midwest in a town of

approximately 3,700 people. The sole occupational therapist covered several practice

areas including hospital, outpatient adults, home health, and outpatient pediatrics. With

this experience being quite different than her previous experience, Sarah had a new set of

unique challenges with implementing occupation-based practice.

Experience With Her Second Fieldwork Placement

The most significant difference between Sarah's first and second placement was

the client caseload. While her first placement focused on adults and older adults in need

of intensive inpatient rehabilitation, her second placement involved clients across the life span, in many different stages of recovery, thus many different settings where services were provided. "It was just so hectic...you know, in one day you see five different settings" (I4, P4). Sarah really enjoyed being able to experience the variety of different settings stating, "it's been really nice to see a lot of different settings. It's nice and it's overwhelming but it's a really good experience" (I4, P23). With the multiple different settings, an added challenge proved to be learning the different documentation systems used in the various settings, whereas in her first placement she only had to learn and use one documentation system.

Sarah experienced a quick transition into working with her first clients during her second fieldwork placement. She recognized feeling more confident and comfortable in her second placement resulting in being able to adjust more quickly to the daily demands of practice as compared to her first placement. For example, Sarah stated, "It was the second day and I was treating all of the in-patients" (I4, P11). Sarah stated, "my educator knew this was my second fieldwork so she kind of threw me in really quick" (I4, P11). Despite being thrown in rather quickly, Sarah felt comfortable with the role of occupational therapy in the hospital setting and was also able to catch on quickly to the documentation system used in the hospital setting.

One challenge Sarah faced related to the variety in caseload was working with adult outpatient clients. She stated, "outpatient is a little tougher because I'm new and I don't always know what I'm doing" (I4, P8). To help her along the way, Sarah talked about referencing as many materials as she could to become more familiar with treatment related to her outpatient clients. She also stated that because she wasn't comfortable with

some of the conditions, she would do many of the same things she saw her fieldwork

educator do (I4, P13). Sarah stated, "sometimes it just takes me a while to think about

what treatments would be appropriate" (I4, P13). She commented that after taking time

to do background research, it took additional time to digest it, think about it, and identify

what treatment method would be appropriate. In one of my interviews with Sarah she

said, "I feel like I'm trying to trudge through a really tall snowbank sometimes" (I4, P13).

She also added that while outpatient is not a lot of occupation-based practice, it does

represent evidence-based practice. Sarah commented that her fieldwork educator did a

good job of providing evidence to support the things she is doing with the outpatients (I4,

P2). As Sarah gained experience and repetition with various diagnoses and interventions,

she became more confident with her knowledge and skills.

Another challenge Sarah identified was her apprehension working with the

pediatric population, which she did share with her fieldwork educator during the first

week of her fieldwork. Sarah stated, "I had told her right off the bat that pediatrics

wasn't really my strong point and I'm nervous to work with pediatric patients" (I4, P21).

Her fieldwork educator took a steady and gradual approach to adding pediatric clients to

her caseload, adding one client each week. Sarah believes that communicating her

reservation up front with her fieldwork educator led to a slower progression providing

opportunity for Sarah to feel progressively more comfortable and gain confidence each

week of the experience.

Sarah reflected that this communication was imperative to her comfort and ability

to learn in a way that worked best for her. As an educator I also know that

communication between student and fieldwork educator is an important predictor of the

114

quality of a students' learning experience. Sarah recognized her fieldwork educators for

each placement were different in personality and style; however, both contributed to

positive learning experiences for her. In the beginning of her second placement Sarah

stated she frequently communicated with her fieldwork educator. Sarah said, "I had lots

of questions and I didn't always feel super confident going into things" (I4, P19). Sarah

described her fieldwork educator as being, "a very easy going type of person, which has

been nice because sometimes I overthink and freak out about things that I don't need to

and she's like, it's fine, let it go" (I4, P20). Throughout her second placement Sarah

eventually learned that she needed to ask her fieldwork educator to provide feedback as

she didn't always readily provide it. Sarah said, "she sits quietly in the corner for almost

all of the sessions. She really lets me run it for the most part and then she'll give me

feedback before or after, and usually not in front of the patient" (I4, P20). Sarah learned

that if she gave her educator a "heads up" of what she was planning during a session, her

educator was great at providing feedback on if the idea would work and provide

suggestions of other things to try (I4, P19).

Sarah built upon the daily reflection she completed in her first fieldwork

placement and developed a strategy to help her ameliorate some of the challenges

experienced with the variety in caseload during her second placement. She created a

document to help track her clients, their diagnoses, and each treatment session. Sarah

said, "I rely on that very heavily. I open it every morning and pick out the patients that

are on the schedule and make sure I have a plan and go from there. It's been real helpful"

(I4, P23). Sarah also described using visualization as a strategy to increase her readiness

to complete initial evaluations for outpatient clients. She said, "I've learned I really need

to be prepared and visualize like how I'm going to start it and how I'm going to progress"

(I4, P21).

Another unique aspect of this placement was a 15-minute break in between each

client on her schedule. She stated, "having a little bit of time built in between patients

has been so helpful for me" (I4, P18). The extra time during the day contributed to her

being able to complete most of her work during the work day without having a great deal

of work to do in the evening. The extra time allowed Sarah to tap into resources

available to her in the therapy department. In addition to relying on available resources,

Sarah spoke frequently about the impact of the team environment on the success of her

placement and her growing interest in using evidence. For example, Sarah stated:

> The rehab department, all the therapists are research driven. They are all a lot
>
> younger and really into looking at research studies. They always mention, oh, I
>
> read a study about this or they'll actually look up articles to back up what they're
>
> doing. (I4, P2)

Sarah recognized that this type of evidence-based practice differed from her previous

fieldwork.

She also identified that relying on other team members was the most helpful

support for her as she tried to implement best practice. She described the physical

therapists working at the facility as supportive and collaborative. Sarah reported her

direct fieldwork educator relied pretty heavily on the physical therapists at the facility (I4,

P12). Sarah stated it was helpful to be able to consult with the physical therapists who

were able to provide professional opinions and ideas in situations when Sarah and her

fieldwork educator had questions. The director of rehabilitation at the facility was also a

physical therapist whom Sarah identified as a resource to her throughout her fieldwork. Sarah identified an example in which she consulted with the rehab director regarding a client scenario because the therapist had specific expertise regarding the client's condition. Sarah stated, "she knows the latest evidence of all the different techniques" (I4, P15). From a student perspective, it was likely extremely valuable to have other practitioners available, even those from other disciplines, to supplement the learning experience.

Experience With Occupation-Based Practice

Working in a variety of settings during her second placement allowed Sarah to explore occupation-based practice throughout the continuum of care, throughout different settings, and throughout the lifespan. As she reflected on the use of occupation throughout the different settings, she found that occupation-based treatment was most easily implemented in the inpatient hospital setting, home health, and while working with outpatient pediatric clients. Clients in the inpatient hospital setting frequently were working toward increasing independence with self-care activities in order to return to their prior living arrangement. This allowed Sarah to spend a fair amount of time on occupation-based treatments working toward the clients' goals. Sarah said, "I always make sure to do functional things such as transfers, showering, short walks to the bathroom, and putting the bed to a height similar to what their bed would be at home" (I4, P8). In addition, the plan of care for inpatient hospital clients often involved transporting clients from the hospital to the connected outpatient clinic treatment area which included a simulated kitchen and bathroom environment. This allowed clients to practice skills such as cooking and transferring in and out of a bathtub.

Similarly, many of the same occupations addressed in the hospital setting were also incorporated in her treatment planning in the home health setting. She stated "I always try to focus it on them and how are they completing things. Who's helping you? How much help are you receiving compared to where you were at before you came back home" (I4, P9)? Many of the occupations addressed are part of an individual's daily routine, such as bathing, dressing, and cooking. According to Sarah, home health is a great example of occupation-based practice. She commented, "you're literally in their home, in their environment and able to see how they get around, how they transfer and give them techniques to do it easier" (I4, P3).

In contrast, Sarah's experience in outpatient did not seem to support occupation-based practice. Although occupation wasn't explicitly evident in the interventions occurring in the outpatient setting, Sarah did emphasize they often discussed a client's activities of daily living during the evaluation process. "We typically do ask about ADLs, such as any trouble getting dressed in the morning? Or cooking? Or carrying heavy pots? We ask if there's anything they've been having more difficulty completing since their injury" (I4, P22). One of the reasons Sarah believed implementing occupation-based practice in the outpatient setting was more challenging was because generally the clients were more independent. She stated the following:

> I think for the most part they're able to complete their ADLs by themselves. It just might take extra time or be a little more difficult for them than before their injury. I don't think it would challenge them enough to keep practicing zippers and buttons because they're capable of doing it. (I4, P7)

118

Hearing this perspective from Sarah, I wonder if she has come to equate occupation-based practice to only working on ADLs and IADLs, as opposed to addressing other occupational areas such as work, rest and sleep, social participation, and leisure? Could it be because of the focused attention on ADLs and IADLs in inpatient occupational therapy practice? Does this bias therapists to a narrower understanding of occupation-based practiced, rather than a comprehensive understanding? As a student with limited practice experience aside from fieldwork, it would not be unusual for her view of occupations to match those of her supervising therapist, leading to potential barriers to occupation-based practice. Although Sarah didn't identify this situation as a barrier that impacted her specifically. The following section identifies barriers she experienced.

Barriers Influencing Occupation-Based Practice

In stark contrast to her first Level II experience, the primary barrier Sarah experienced during this placement was the *lack of resources*. The lack of resources can be viewed in a few different ways, such as *lack of supplies* available, *lack of financial support* to attend continuing education courses, and *lack of occupational therapy coverage* to take days off to attend education courses. The primary factor she attributes to scarcity of resources is the rural nature of the facility. "They're a small rural clinic so sometimes they don't have the time or resources to give you to go take a week and learn about upper extremity conditions" (I4, P16). "My OT is the only occupational therapist in the clinic, so I think for her it's even harder to go to educational courses that are during the day" (I4, P16). Sarah brings up unique challenges in working as the lone occupational therapist in a rural area. There is limited availability of others to cover the client caseload for the occupational therapist to take time off to participate in continuing

education conferences. In addition, living in a rural area likely leads to the need to travel greater distances to attend these conferences, contributing to higher costs for the therapist or therapy department.

In regard to *physical resources*, it is challenging to have an adequate variety of supplies when working with clients across the life span and with various diagnoses. Sarah primarily experienced this difficulty when working with pediatric clients. She said, "I feel like we don't have a lot at all to work with; I mean there's not a lot of resources for them" (I4, P17). The *lack of supplies* in the clinic may also have limited the variety of interventions that Sarah was able to implement. For example, she said, "you only have so many supplies in the clinic so I do use some of the same things that she had done" (I4, P13), referring to her fieldwork educator. Sarah believed that limited resources was "just part of rural health care" (I4, P17) and recognized it would likely be a barrier for her if she practiced at in other rural areas. I question if Sarah's response to the lack of resources is also part of her go with the flow personality? Would her response have been the same if there had been no resources available at her first placement in the inpatient rehabilitation setting?

Other barriers Sarah experienced include *size of caseload* and *reason for therapy*. In situations where the caseload was high and clients were scheduled back to back without the standard 15-minute break in between, she found it difficult to prepare for back-to-back clients. The time available to plan for upcoming clients was significantly limited due to having to complete documentation before the next client arrived, which is not an uncommon scenario for many practitioners in the field. Lastly, Sarah identified that the reason for a client's therapy referral can limit the implementation of occupation-

based practice. For example, Sarah recalls working with clients following carpal tunnel surgery, which typically required a visit with the doctor before the therapist can progress the client to strengthening. "For the most part it's just range of motion and scar massage because that's all we're approved to do until they're farther down the line" (I4, P10). The standard of care following many surgical procedures involves following a *strict protocol* of progression, limiting a therapist's ability to incorporate occupation into the strict routine.

Supports Influencing Occupation-Based Practice

While Sarah faced some barriers to occupation-based practice, she also experienced a few supports that positively influenced her ability to incorporate occupation into her practice. One of the supports Sarah identified was the *physical set up of the clinic space*. Sarah said, "there is one OT room and that's where most of the outpatients go. We have an ADL suite with a full kitchen, bed, and recliner, to practice transfers. The bathroom set up is also pretty cool" (I4, P7).

Another support that proved to be helpful was the *15-minute break in between each client*. Sarah commented that as her documentation became more efficient, she still had time to prep for the next client and look for evidence to incorporate into her work with clients (I4, P12). Sarah also recognized the benefit of *no specific productivity requirement*. She said, "we don't really have a productivity requirement because the number of patients we have is the number of patients we have" (I4, P15). Although the caseload occasionally would rise to the point of the 15-minute break being eliminated, for the most part, this perk was beneficial and a rarity that Sarah greatly appreciated.

Lastly, Sarah used the *log to track her clients* (mentioned above), to also track client treatment sessions. She said,

> I have this huge document with client name, condition, and what we've been
>
> working on. I have an assessment portion for each client to know how I assessed
>
> them. Then treatment ideas and I put all the treatment ideas in there. At the end
>
> of each client I'll typically identify new things to try or ideas that I would like to
>
> ask my fieldwork educator about before we go in. (I4, P22)

During my time meeting with Sarah it was clear that she benefited from using a log during each of her fieldwork experiences, to track her treatment plans with her clients. The value experienced as a result of her intentional reflection will hopefully carry forward as she prepares for entry-level practice upon graduation.

Ending Reflection

These two placements were formative to Sarah's professional development as an occupational therapist. She not only learned a great deal about being a practicing therapist, she also grew personally and professionally, and began to think about her values in relation to her future success. At the start of her fieldwork placements, Sarah reflected back to the didactic portion of her coursework and recognized the emphasis on occupation-based practice and realized "sometimes it's just not realistic in the setting that you're in and the resources that you have" (I1, P9). In the beginning this was just a thought and after both placements, she realized how true this really was. In the last interview, Sarah reflected back by saying:

> In classes you always learn everything is occupation based and evidence-based
>
> and that was really drilled in school and then once you get out into practice, it's a

lot harder to apply some of those things with all of the barriers and things we'd

talked about in other sessions. (I5, P2)

In interview one Sarah stated, "I think there is a little bit of a disconnect I guess from

school to practice with occupation-based treatment because you don't know what

resources you're gonna be given" (I1, P9). Sarah identified that she thought once she

was on fieldwork that it would be obvious what to do with her clients (I3, P4) and she

thought "it would be easier to just jump in and be like, everything has to be occupation

based" (I3 P4). She quickly learned that implementing best practice was much harder

than expected, stating, "in reality there's so many other factors that you need to consider

before you can actually implement some of those things" (I3, P4).

Throughout the two placements Sarah experienced both barriers and supports

impacting her ability to implement occupation-based practice. Collectively she identified

time and *resources* as the two factors that most impacted her, either positively or

negatively. "If you don't have adequate time to set up an occupation-based activity…or

the time to develop an occupational profile and do all of those meaningful activities, I

think it's really, really hard to do occupation-based activities" (I5, P2). In regards to

resources Sarah stated:

Especially with this last one being my rural rotation, I mean resources were really

limited. She's the only OT. There's just one small little OT room and you can't

really fit a lot in there. She doesn't really have access to a lot of that. It's not in

the budget to get new fine motor occupation-based activities. (I5, P2)

During our last conversation of her first fieldwork placement, Sarah reflected

back on how she felt about her preparation going into her first and second Level II

experiences. Sarah shared with me that she felt like she was as prepared as she could be when she started her first placement although she admitted that she was very afraid of failure (I3, P21). In comparison from our first conversation at the beginning of her first placement to our third conversation at the end of her first placement, she stated, "you know, from that day compared to this day, it's no comparison" (I3, P21). Sarah reported that there were times when she felt unprepared although she believed that to be normal, even for entry-level practitioners (I3, P21). She emphasized that during those times of feeling unprepared "you just have to know where to find information, whether that's through mentorship or through text books or evidence online" (I3, P21). At the conclusion of her second placement Sarah spoke about feeling more prepared for situations you can't prepare for. For example:

> In the beginning it would be way too much if you just dumped a patient on me and didn't give me a day's warning. But towards the last 3 weeks of this last rotation, we could have had a random outpatient show up and I probably could have looked at the evaluation pretty ok, you know. (I5, P5)

This increase in confidence is likely characteristic of past successes, increased confidence, as well as strengthened clinical reasoning. Sarah easily identified the growth in her confidence from her first day of fieldwork to her last day of fieldwork (I5, P3) and reflected on her early feelings of needing approval to ensure she was on the right track. She shared the following:

> When I first started, I was like, oh, is this right? Should I do this? I always had to ask, is this right? I mean towards the end of this last fieldwork, I didn't really

have to give her my plan. She trusted me to do what I knew was right and I really

had to be on top of things and plan really well for the day. (I5, P3)

At the conclusion of her experiences Sarah was able to identify ways in which she

changed as a professional during the 24 weeks of fieldwork. She specifically identified

that her organizational skills improved greatly. For example, she shared that the strategy

she used to track her outpatient clients on a spreadsheet, including past intervention

sessions and suggestions for future sessions, was extremely valuable. She stated, "when

the patient would come, I'd just look on my document and I was already prepped" (I5,

P4). Another skill that she felt she was able to build upon was her use of evidence-based

practice. Reflecting back to her first placement Sarah reported that when she was just

learning the responsibilities involved with her role, she just wanted to treat her clients, be

done, and move on; whereas in her second placement she experienced greater ease in

trying to incorporate evidence-based practice. She stated,

> I became more interested in it and I wanted to dig and figure out what was best
>
> for these conditions, especially, as I got more comfortable treating them. I'm like,
>
> you know, what if there's something better, what if I can do something better?
>
> (I5, P4)

Sarah identified that her last fieldwork placement was a positive experience in

regards to therapists using evidence in practice. She often spoke of the therapists talking

about research articles and sharing evidence with each other. Sarah stated, "I think they

really played off of each other…they'd tell each other about articles they were reading. I

think your coworkers have a lot to do to motivate you to look up the evidence...or fill you

in on what they've been learning" (I5, P2-3). The experience of being around other

125

therapists discussing evidence seemed to be a valuable experience and different than her first experience, where the use of evidence was not as explicit. Sarah shared that her interest in evidence-based practice and desire to use evidence greatly increased during her second placement.

Conclusion

Sarah identified she believes that five to ten years down the road, it will be hard to keep up with best practice standards (I3, P28) and that having a "hunger to keep learning" and then making the time for learning will contribute to her ability to implement best practice. Sarah identified that her first fieldwork educator had a strong hunger for learning and knowing what best practice is. Sarah stated "I know she's doing that outside of clinic hours" (I3, P28), recognizing that valuing and implementing best practice may require time commitment outside of work hours.

Sarah also recognized that having adequate time and resources played an important role in her ability to implement occupation-based practice. While neither of her settings identified a specific productivity requirement, her second placement allotted a small amount of extra time in between clients, which made an impact on Sarah's experience. Conversely, her first placement had significantly more resources available to incorporate more client-centered and occupation-based practice.

When thinking about the therapist she wants to be, Sarah talked about making the time and staying motivated as the key to success (I5, P10). Interestingly, Sarah also recognized that therapist burnout is a really big factor. She stated, "I could see how you could so easily get burnt out…you get so many frequent flyers or repeats" (I5, P10). Sarah believes that finding a setting and a passion will be key for her to continue growing

as a therapist. She added that she hopes in her future setting she doesn't experience many of the barriers which we talked about throughout her 24 weeks of fieldwork. She stated, "hopefully they have a little bit of time built in to prep for patients or prep for sessions. Hopefully I have a good team that really motivates me and supports me to do continuing education or shares with me different things that they've learned. And I hope that there's a culture of learning in whatever facility I end up in" (I5, P6).

CHAPTER VI

FINDINGS: EMILY

Introduction

Emily is a traditional aged college student who attended occupational therapy school in a metropolitan area in the upper Midwest. She is the oldest of three kids, growing up in a mid-size community of approximately 60,000 people. Although the community was decent in size, it is located in a rural area of the Midwest. She spent much of her high school years in smaller community (approximately 15,000 people) where she attended high school. Growing up, Emily had others in her family in the healthcare profession. She identified her mom as a physician, aunt and cousin as nurses, and another cousin as a pharmacist. Emily reports playing piano and organ, exercising, spending time with family and friends, traveling, singing in choir, reading, and shopping for good deals are some of her most valued occupations. She places value on helping others, putting her best effort into any task she completes, supporting local or small business, and spending quality time with people she loves.

After meeting Emily in person it was easy to identify the small town girl in her. She presented as a down-to-earth person who enjoyed making connections and feeling connected to others around her. This rang true through her fieldwork experiences as well. She frequently emphasized the importance of client interactions and making personal connections with clients, families, and co-workers. For example, Emily stated, "it's just

been fun and I've really enjoyed building rapport with people and finding out more about them" (I3, P10). Once she learned information about a client, she used that information to make conversation and ultimately to build a therapeutic relationship with that person. It was apparent that Emily valued her interactions with clients and getting to know them and what was important to them. Emily stated:

It's just knowing…even remembering things about them, like, oh, how was the lake this weekend? Remembering things that they told you at the last session. Remembering things about their family or their pets, can actually make a really big difference to them. (I3, P19)

Emily's fieldwork educators also noted her ability to build relationships with others as a strength. Emily stated, "they did remark just about my interaction with clients and they felt it was a strength just because I was able to, obviously to interact with them, but also to really get to know them" (I3, P19). Emily demonstrated this same passion and interest when interacting with her co-workers and this theme was represented throughout all of my discussions with her. Emily stated, "it really helps if people get to know each other, like the coworkers, because, then people just feel more comfortable and it's a better environment if people go into work knowing that they know each other" (I3, P33) and "it makes it more enjoyable to go in every day" (I3, P29). While establishing a therapeutic relationship and being client-centered was an obvious strength and passion for Emily, she also was passionate about using occupation in treatment.

Throughout the next chapter I will be exploring topics with Emily that became evident during our five interviews, completed throughout her 24 weeks of Level II fieldwork experience. The chapter is organized first by fieldwork placement and then by

general experiences, occupation-based practice experiences, and supports and barriers to occupation-based practice. I will end with summary reflection and conclusion.

Emily's Definition of Occupation-Based Practice

In our first meeting I introduced the focus of my research and asked Emily to define in her own words the meaning of occupation-based practice. Emily said, "trying to use activities or occupations to do your therapy with the client. Stuff that they're actually interested in but things that will actually build upon your goals" (I1, P2). Emily went on to mention the importance of analyzing a task to identify the feasibility of completing a particular task in therapy to reach a specific outcome or goal. Emily shared an example of using a board game or card game in therapy to work on a skill that was needed by the client. Emily was easily able to share her experiences with occupation throughout the time I spent with her.

<div align="center">

First Placement

</div>

Emily's first placement was in the same small town (approximately 15,000 people) where she completed her high school years. She was placed in a hospital setting which provided a variety of inpatient hospital and outpatient clinic services. Being in a rural area, Emily was able to experience many different aspects of occupational therapy although most of her time was spent with adults, both inpatient and outpatient. When thinking about the variety of her clientele, she stated, "it's a ton, which, that's awesome for me. But it is a lot to try to get my head around. But it's really good. I'm glad that I get to see the variety that I do" (I2, P3).

The feelings of being a small town girl that had finally left the city to come home was reflected in many phrases that Emily stated throughout our first two interviews. She

talked about feeling a "personal connection being in my neck of the woods and home town" (I1, P24). She spoke fondly of the memories she had in "this place" (I1, P24) and the meaning she held for the town (I1, P24). It was enjoyable to see how this connection played out in client interactions during therapy as she spoke about relating to so many of the people in the town. For example, she said, "They know the local events that are going on and we can talk about that. The fair is happening so they ask, oh, did you go to the county fair this weekend?" (I2, P8-9). For Emily, the experience of completing fieldwork in her home town, where she felt personal connection to the people and the community, positively impacted her entire experience.

Experience With fieldwork

The occupational therapists at the facility worked with a variety of clients across the life span and stages of recovery, such as inpatients, outpatients, pediatrics, pulmonary rehabilitation, and inpatient psychiatry (I1, P27). Across these different areas, the facility employed two full time occupational therapists and one full time occupational therapy assistant. Emily's supervision was shared between both full time occupational therapists.

When starting her first fieldwork, Emily identified that she was excited to feel more confident in her skills (I1, P24). She discovered quickly the plethora of details she needed to learn before gaining that confidence. Emily said, "when they're trying to teach a student right away, there's a lot of logistical things that you have to learn" (I3, P16). She shared with me her experience of worrying first about the immediate here and now, referring to this time as "survival mode". "What do you have to know how to do when you walk in that room? How do you interact with somebody? How do you actually use these tools?" (I3, P18). Similarly, she reflected on the physical things that actually fill

131

the time with clients, such as evaluations, interventions, transfers, etc. Interestingly, she talked about feeling like she needed to gain confidence and competence with these pragmatic considerations before she was able to reflect from the perspective of being client-centered, occupation-based, and evidence-based in her own practice.

When Emily started fieldwork she had ideas about how she would be using her time to support her learning. She shared with me her desire to look through and refresh on her notes she had taken during school (I1, P26-27), her goal to set time aside each week to look for resources and literature for client situations she was experiencing (I1, P27), to spend time each day after fieldwork, debriefing with herself (I1, P27), and taking the time to "let it all sink in and start good habits early" (I1, P27). Despite these goals, she also had a moment of practicality, realizing it might be more difficult than she expected to keep up with all those goals. Emily said, "I feel like I'll just start to get overwhelmed with the documentation, you know, doing my stuff at the site and then going home. Who knows if I'll want...you know, what if I'm not motivated to do that?" (I1, P27). Throughout her placements though, she demonstrated her ability to be a self-directed learner. She reflected on how it would have been easier for her to ask her fieldwork educators when she had questions regarding what she should do with a client. Instead she wanted to figure it out for herself. She said, "if I don't know how to treat this, and if I was working alone, I wouldn't be able to just ask somebody" (I2, P10). She wanted to be able to use her own clinical reasoning to work with a client from start to finish (I2, P10). Recognizing this route as being more challenging, she said, "I think it's good, even though it's harder, it's really good to get into that habit" (I2, P10).

132

Despite wanting to be independent and self-directed she viewed both of her fieldwork educators in this experience as positive role models and great supports to her learning. Emily shared some examples of how her fieldwork educators supported her learning. Emily said, "if we don't have a patient, then a lot of times my supervisors will take a half hour to show me different techniques for different things" (I2, P2). Emily recognized the additional information provided her opportunities to experience additional aspects of therapy she may not have had the chance to learn without her fieldwork educators taking time to directly teach her. Another example she shared was her fieldwork educators use of the occupational therapy practice framework, as a tool to refresh their memory on the scope of practice in occupational therapy. Emily stated, "just refreshing has kind of helped me to keep focused on occupations" (I2, P9).

Experience With Occupation-Based Practice

Emily was able to experience implementing occupation-based practice into both the inpatient hospital setting and the outpatient clinical setting on her first fieldwork placement. During her time in the inpatient hospital setting she was able to experience a strong focus on the area of occupation represented as activities of daily living (ADLs). Activities of daily living refers to tasks that are oriented to self-care required for daily living such as bathing, grooming, feeding, dressing, etc. She stated, "when they're inpatient, you're really just focused on these occupations. I need to make sure you're safe doing these specific occupations so that you can go onto the next place" (I3, P8). Many of the sessions involved basic self-cares such as brushing teeth, combing hair, washing face, getting dressed, and getting to the bathroom.

133

While the use of occupation may not have been quite as obvious for Emily's outpatient clients, she was still able to incorporate occupation into treatment. She shared "even though they came with their clothes on, how long did it take them to actually get dressed with this injured hand" (I2, P9)? She also discussed activities simulating occupations such as brushing hair and opening jars, stating, "we actually have real jars or things for them to use so they can actually practice or practice with a piece of dycem or something to have better grip" (I2, P7). In addition to ADLs, Emily was also able to work with clients on instrumental activities of daily living (IADLs), such as household management and money management. Instrumental activities of daily living refer to tasks that support daily life within the home and community such as meal preparation, taking care of pets, driving, financial management, etc.

Interestingly, she felt like she was better able to understand her outpatient clients' meaningful occupations compared to her clients seen in the hospital setting. She attributed this to the primary emphasis given to activities of daily living in the hospital setting and having more time to focus on other occupations with her clients in the outpatient setting. She stated, "I feel like you just get a lot more time to understand the occupations that are really important to clients when they're in outpatient" (I3, P8). Emily identified that many of her male clients grew up on a farm and are used to do doing a fair amount of mechanical work. She talked about using activities in therapy that were more familiar and realistic for them. For example, she stated, "I think he'd prefer using something he's more familiar with and doesn't feel as therapeutic I guess and medical" (I2, P6) and "we definitely try to make it as realistic as we can and I think that helps. Just have them feel that it will translate to their home setting" (I2, P7).

134

While it wasn't as easy to maintain the occupation focus in outpatient, Emily felt support and good role modeling from her fieldwork educators. She stated, "they're very big on making sure that it's actually functional and occupation centered" (I2, P12). Her fieldwork educators helped her to understand how and why therapy goals for outpatient occupational therapy clients need to be functional. Emily reported:

> They always tell me; we need these goals to be actually functional. You know, you don't just make a goal about increasing grip strength by 10 pounds, what are they going to do? Oh, to complete cleaning tasks in their house that they haven't been able to do. (I2, P12)

Despite having positive influences, Emily reported she still felt like she had missed opportunities for actually doing an occupation with a client rather than doing an exercise. She did state that she was better able to identify those missed opportunities during her last few weeks of her first fieldwork placement (I3, P2).

Identified Barriers Influencing Occupation-Based Practice

Emily identified the barriers to occupation-based practice at her facility as *limited resources available*, *therapist's creativity*, and *not having a peer with her* to share in the experience. According to Emily, in some aspects the facility had plenty of resources, such as evidence-based practice articles and resources from continuing education courses previously attended. In terms of resources for occupation-based practice, Emily wished there were more. She said, "You know, it's like, oh, we don't have that here. I wish you could have everything you could want at a site because that would be something I would think would be important" (I3, P25). Emily shared an example of a situation in which she wanted to be creative and she wasn't able to. She said,

135

It would be really cool if I could do painting with this woman who needs to work

on right upper extremity coordination, strength and grasping; a built up paint

brush and an easel would easily work on her shoulder and that would be more fun

than stacking cones. (I3, P25)

She also hoped that her next fieldwork facility would have more resources which can also

help her to stay creative in her therapy interventions (I3, P24).

Therapist creativity was another area she felt was a barrier to implementation of

occupation-based practice at her site. In addition to more resources, she also stated, "I

hope that I'll be able to expand my repertoire when I go to the transitional care unit

(TCU) and hopefully I don't fall into that noncreative rut" (I3, P34). Emily felt like she

had good creative ideas but felt like resources and the current practice at the site limited

her ability to fully use her creativity. She said the following:

Sometimes I would suggest things that we could try with somebody, but either the

site wouldn't have stuff to do that or that's not what they do with this type of a

patient. I felt sometimes the options were a little more limited. (I3, P2)

Throughout her placement she tried to be creative or think outside the box but she wasn't

always able to due to the barriers previously mentioned. She also identified that it may

become more difficult to be creative "if you found something that works and gets you by

and you don't have to spend any more time prepping or thinking outside of the box" (I3,

P24). Emily talked about how it is easy to get stuck using the same activities or

exercises. She stated, "It's really easy to just use what your site has…so it's very easy to

get into a pattern of using the same therapeutic activities or therapeutic exercises and not

switching it up maybe as much as could be done" (I2, P19).

136

Based on Emily's experience and statements she shared with me, it seemed as if a couple factors that were identified as barriers, are related. For example, therapists' creativity was a challenge because the resources were not always available to allow for creativity. It then becomes easy to fall into a routine of completing the same activities with clients because creativity and resources are both limited, therefore therapists fall back to into their same routine. When Emily first experienced the occupational therapists using the same interventions repeatedly, she reported feeling unprepared for that experience and just went along with it. She said, "I would just go along with it because I mean, well, I don't really know any better and this must be fine" (I3, P24). She went on to say:

> I think now looking back, I think things could have gone differently. Just trying one new thing, you know. One intervention with a client or just doing something a little out of the box would have at least helped to get out of that rut. (I3, P24)

Another situation Emily faced was the indifference or non-commitment of her fieldwork educators when sharing novel intervention ideas. Emily stated, "when I was trying to feel out what they thought about my ideas, they kind of were like…oh…yeah…maybe…but you know, we're trying to…then they would kind of hem and haw a little more" (I3, P25). In contrast when Emily would simply initiate a novel treatment idea rather than sharing it first with her educators, they were more likely to be impressed with the results. She said, "I think if I just went ahead and did stuff, they were like, oh, yep, good session" (I3, P25).

The last barrier Emily shared with me was indirectly related to this fieldwork experience but reflective of her overall learning experiences during fieldwork. During a

Level I fieldwork placement, earlier in her curriculum, she was placed at the same facility as a classmate. Emily talked about this experience as an extremely positive learning opportunity. She speculated on the value of having a peer present during a Level II fieldwork experience, stating the following:

> I wonder if it would be kind of neat to have another classmate or another student at least, so both of us would be learning together and we could kind of bounce things off each other. I feel like maybe it would be cool to have that peer to peer interaction. (I2, P22)

Emily talked about it as an aspect of comfort and comradery to have a peer or another student there with her, both learning together and sharing "different new nuggets of knowledge with each other" (I2, P22).

Identified Supports Influencing Occupation-Based Practice

Although there were barriers present, Emily was also able to identify positive facility supports for implementation of best practice ideals during her first placement. Some of the supports were broad in nature and not directly related to implementation of occupation-based practice, but to best practice in general. For example, Emily spoke frequently about the *positive workplace culture* at the facility and how she really enjoyed getting to know and interact with the interdisciplinary team. She spoke about feeling welcomed and supported throughout her entire fieldwork experience. She identified her *fieldwork educators* as great supports for her learning; she really appreciated their willingness to share their skills and knowledge with her. She stated:

> I'm with them all day so even watching them interact or explain something to a client, I'm learning from that interaction as much as I'm learning from them

138

specifically teaching me a specific modality or a specific manual therapy

technique. They have been able to show me so much without explicitly teaching

me. They just have so much knowledge that I'm able to just kind of soak up as

I'm with them. Now I'm doing a lot more and they are able to guide me, but they

still have so much knowledge that when I'm stuck, they're able to point me in the

right direction and make sure that I'm able to get there myself, but they kind of

steer me the right way. (I2, P21)

This quote highlights the support Emily's fieldwork educators provided throughout her

placement, from start to finish. Early in the placement when more observation was

involved, Emily benefited from listening and watching her fieldwork educators interact

with clients. As she gained experience throughout the placement, she continued to

benefit from their skills and knowledge but less directly. Towards the end as Emily took

on more independence, she relied on her fieldwork educators more as consultants than

direct supervisors.

Transition to Her Next Placement

As Emily reflected back and anticipated the beginning of her second placement,

she was thankful for the community and the connection she was able to experience on her

first placement. Emily reported, "the other coworkers at the site were very welcoming.

The occupational therapy department was very welcoming. Even just the other members

of the rehab department that I interacted with were super friendly and very helpful" (I3,

P29). She continued saying, "it's a really, really cool culture of community there; they

really foster that community and do little events or celebrate little successes" (I2, P13).

The clients and the location were also an important aspect of this placement for her. She

enjoyed being back in an area where she has roots (I3, P30) and where the clients are "all kind of from a familiar area" (I3, P29). She even discovered that some of the clients knew her grandparents; Now that's small town living!

In addition, Emily was thankful for the quality of the learning she was able to experience during her first placement. She stated, "I'm just glad I had this site right away and I know a good routine; I've learned good habits, so we'll see how that carries over to my next site" (I2, P13). She went on to say:

> I feel a lot more confident having completed this first placement going into the next one, than I did starting my first placement. I feel I will have better footing right off the bat. At least I have a sense of how to do the documentation, how to do basic skills. I feel confident doing those things and can work on site specific things when I get there. (I3, P31)

Emily reported feeling good about her use of occupation-based practice during her first placement and identified the extra practice and thought that is required to incorporate occupation. She stated, "I'm looking forward to trying to be more intentional about that in the future" (I3, P1) but now also recognized the challenges to implementing best practice ideals.

When thinking about occupation at her next placement she said, "I think occupation-based will be interesting because now that I've seen that sites have a limited amount of supplies and they sort of have almost a list of things that…ok, this person has this…try X, Y, and Z" (I3, P3). Emily identified that the challenge to do occupation would be even greater if her next fieldwork site had a cookbook recipe, so to speak, for clients based on diagnoses. She said, "if they already have a preconceived notion of what

to do with this type of person based on whatever their diagnosis is, it might make it a little more challenging to actually do occupation as therapy" (I3, P3). She summarized by stating, "I always know the goal is to get people back to their occupations but I think there's room to do more actual occupations during the session" (I3, P3). As a whole, Emily identified having a better understanding on how occupations can be used, how to lead sessions focused on ADLs, and ways to "tweak the activity" to purposely lead into occupation when working in an outpatient setting (I3, P5-6). When thinking about her next placement she stated, "occupational therapists are adaptable and they just work with what they have and I hope that I am able to still work with what they have; think a little outside the box at least and try some new things" (I3, P10-11).

Second Placement

Emily's second placement was in a town of approximately 60,000 people in the town where she grew up. Her placement was at a local skilled nursing facility and transitional care unit. Her case load was approximately fifty percent clients in the skilled nursing facility and fifty percent clients in the transitional care unit.

Experience With Fieldwork

Emily identified a few differences in the structure of her day at her second placement as compared to her first placement. She identified less structure, different pace, and variable schedules. Her fieldwork educator on her second placement primarily worked from 10 am to 6 pm, which was different from the schedule of her first placement, which typically ranged from 7:30 am to 4:30 pm. There was no therapy schedule during her second placement, only a list with the clients needing occupational therapy services. Emily stated, "I actually really like how we at the nursing home can

141

just organically get people at a good time and just see if they're ready for therapy" (I4, P24). Emily also highlighted that this system also allows the therapists freedom to work with clients based on the client's availability and readiness for therapy as well as based upon the activity that the therapist would like to complete with the client. Although Emily enjoyed the flexibility in her second placement, she identified that having the structure and a schedule to follow during her first placement was helpful. She stated, "I was probably more nervous and hesitant so it was nice to know exactly what was coming up and you could look at the next days' schedule and kind of prepare" (I4, P25). In comparison, she said, "each day is completely different in the nursing home, so you can't prepare a ton. You just know the people you're gonna see and know what you're working towards" (I4, P25). When thinking about it she said, "that was a good progression for me, to go from more structure to less structure" (I4, P25), referring to the difference between her first and second fieldwork placement.

Emily also discussed how her first placement helped her to feel more prepared for her second placement, with both placements occurring in settings with a focus on adult physical rehabilitation. She stated the following:

> I think my first site really did prepare me and helped me a lot in this setting. I feel like whatever I did at my previous site has now just been augmented here. I did some transfers with people at my previous site and got good training and feedback from my supervisors. Now I'm doing transfers all the time, so I think I've just had a good foundation to build on and now I feel confident at this site where I'm doing it all the time. (I4, P10)

That confidence helped prepare Emily for the higher expectations she experienced on her second placement (I4, P26). For example, in the previous statement Emily shared how her first placement provided thorough training on how to transfer a client from one position to another. Such as moving a client from the bed to chair. The practice and training that Emily experienced in her first placement, prepared her to gain confidence and continue growing in her skill of assisting clients with mobility. Emily shared that her fieldwork educator promoted independence early in the fieldwork, stating, "it was a couple weeks in and I was doing a lot by myself" (I4, P26). Although she recognized that the amount of independence she had early on was "a lot", she also reported that it was good and that she felt a lot more confident during this placement (I4, P27). Emily talked about feeling supported by her fieldwork educator who Emily reported "led by example" (I4, P28). Emily also noticed drawing a lot from what she learned in school, stating, "it's just so applicable to this site that I'm able to use a lot of techniques or different things that I've learned directly with clients" (I4, P28).

One thing that stood out to Emily as different than what she learned in school was the dominance of intervention methods other than occupation. For example, Emily reported her site had standard exercise equipment including theraband, dumb bells, and weighted dowels (I4, P7). In addition, she identified the availability of various sizes of therapy balls, theraputty, playing cards, therapy stacking cones, and hand exercisers. She mentioned using these various modalities for activities including standing, tossing, strengthening, reaching, and core stability (I4, P7). Emily reported that the rehabilitation team tried to actively use the therapy equipment available to them in many different ways for therapeutic purposes (I4, P8).

Despite recognizing the value that therapeutic exercise and therapeutic activity can add to a client's plan of care, Emily identified the dominance of therapeutic activity and therapeutic exercise as a significant mode of intervention at the facility. These two types of interventions also seemed to be the occupational therapists automatic "go to" when clients arrived to the therapy gym. Emily stated, "That is the therapists default; starting them on strengthening with theraband and dowels" (I4, P9). She shared with me her feelings on the repetition of the exercises and "wishing we would mix it up and do more occupation based practice with people" (I4, P4). She identified the overall discrepancy between the dominant biomechanical methods of intervention versus the idealistic occupation-based methods learned in coursework.

Experience With Occupation-Based Practice

While Emily identified therapeutic exercise as a dominant mode of intervention, she was also able to incorporate occupation throughout her placement. She reported feeling like she had a lot of freedom during her second placement to be innovative in her therapy (I4, P2). Emily enjoyed the outdoor garden space her fieldwork educator created for the residents (I4, P8). According to Emily, the residents were able to help with all the gardening, watering, and weeding of the outdoor garden space (I4, P8). Emily shared with me that one of her clients who had sustained a stroke and had severe right sided muscle weakness, really enjoyed gardening, so "we took her outside to the garden area and had her pulling out weeds or old plants when it was time to cover all the flower beds up" (I4, P3). Although Emily wasn't able to take full advantage of the outdoor garden as much as she would have liked, due to the end of the growing season, she was able to take some of those garden ideas into the indoor space to work with clients. For example, for

the same client, Emily brought outdoor plants inside and had her client water them, requiring the client to reach up and pour water from the cup into the planter (I4, P9).

This type of therapeutic intervention seemed to truly motivate Emily as it combined both client-centered practice and occupation-based practice. She identified that she enjoyed trying to build off of a client's specific interests in order to make therapy more engaging (I4, P3). Emily stated, "with some clients I think it's (creative interventions) easier because they have such pronounced interests" (I4, P15). Another activity that Emily identified as one that several clients enjoyed was playing cards. She reported having clients with broken wrists and other deficits which made it difficult to manipulate cards. Emily said when talking about one woman who enjoyed cards, "it obviously was hard for her to manipulate the cards but she has always played cards and enjoyed that. So it wasn't a boring session for her" (I4, P3). Other activities that were done to incorporate various interests of the clients included craft activities, decorating activities, games, and baking. Emily stated, "one week we were baking apple crisp with people so we had them peel apples, mix all the ingredients together and then do the baking" (I4, P20).

In addition to the variety of creative activities Emily was able to complete with her clients, she identified ADLs as still being the "main highlight" in regards to occupation-based practice (I4, P4). Emily felt it was easier to address occupations because the clients were residents of the nursing home, even if on a temporary basis, spending comparatively more time at the facility than the hospital or outpatient clients seen on her previous fieldwork. Emily identified this as contributing to "more organic opportunities to do occupations with people" (I4, P7). Despite Emily identifying ADLs

145

as "mundane" (I4, P28) she recognized that working on ADLs is evidence-based and often what the clients need to work on in order to improve their independence or return home. On this placement Emily was able to address a variety of ADL and IADL tasks including: toileting, bathing, dressing, self-feeding, bathroom mobility, meal preparation and medication management. Emily stated, "there are so many opportunities where we're working on ADLs or occupations that I guess I should give the site more credit sometimes than I do" (I4, P28). Emily also identified that the type of setting and the flexibility in scheduling to "catch people" at natural times made it easier to address occupations. For example, Emily stated she was often at the facility over noon and evening meal which allowed her to work on feeding with clients as needed. She recognized that when going to a client's room to pick them up for therapy, she could engage the client in occupations in the room before leaving for the therapy gym. She stated, "typically when we go and get the person from their room it's easy to ask, do you want to go to the bathroom before we go" (I4, P17), giving the occupational therapist a prime opportunity to evaluate a client's performance with an ADL activity such as toileting.

Identified Barriers Influencing Occupation-Based Practice

Although Emily was sometimes able to catch clients at natural times to work on occupations, this wasn't always the case. Every now and then she ran into situations where she had to ask clients to complete an occupation that wasn't at the natural time. This most often occurred due to her *supervising therapist's schedule*, which Emily identified as one of the barriers she experienced. Her fieldwork educator had a schedule that varied day by day and while she did appreciate that for flexibility, it occasionally led

146

to challenges with incorporating occupations into her client intervention. For example, Emily reported, "dressing is always kind of weird because they're already dressed so we had them do practice pants or other things like that" (I4, P5). Another similar situation was when "we're trying to get people to go to the bathroom or something and they don't have to go or just went" (I4, P5). In my experience as an occupational therapist, neither of these two situations are unique to this specific setting, rather are somewhat common occurrences in occupational therapy in adult physical rehabilitation settings.

Other barriers Emily identified include *not having peer support*, giving into the *routine of doing exercises*, and only having *one therapy room*. Emily shared a story with me about an employee who was a certified nursing assistant (CNA) at the facility, who was also applying to occupational therapy school. The CNA shadowed with Emily's fieldwork educator for a couple weeks and Emily realized she really enjoyed that experience. She stated, "I actually really liked working with her just because it was nice to have another peer there" (I4, P21). Emily went on to say, "I wouldn't have noticed the lack of peer support had I not had her with us for a couple of weeks and I really found that helpful and cool to process with someone else who's learning with me" (I4, P22).

Another barrier Emily identified was the *routine of over-using therapeutic exercise* with clients making it difficult to branch out and be more creative with interventions. Emily recognized that therapeutic exercise was a prevalent method of intervention at this facility, making it easy to fall into this same routine of intervention. Lastly, having *only one therapy space* was seen as a barrier at times. Emily reflected on a situation in which she would have appreciated a quiet kitchen space to work on a cooking task with a client who was having difficulty with cognitive processing. A noise-

filled therapy room does not lend itself well to eliminating distractions while working

with individuals with impaired cognitive processing. She also mentioned that it made it

more difficult to address more sensitive and personal topics in therapy.

Identified Supports Influencing Occupation-Based Practice

On the same note, Emily also identified that sharing *one therapy space* can also

be a support. Use of shared space forced clients and therapists to socialize with one

another and provided greater opportunities for accessible therapist collaboration (I4,

P23). Emily identified that her *own creativity* was supported by using Pinterest as well as

having the chance to observe other *therapists implementing creative occupations*. Emily

reflected on the activities that she observed her fieldwork educator implement in therapy

and concluded that her fieldwork educator did demonstrate creativity and used a wide

variety of activities in therapy (I4, P20). Lastly, Emily believed that the *size of the*

caseload during this experience was a support to her being able to implement occupation-

based practice. She shared with me that she felt like the size of her caseload allowed her

to spend a lot of time getting to know her clients, which ultimately assisted her in

providing more occupation-based and client-centered care (I4, P19).

<div align="center">

Ending Reflection

</div>

As a person who valued personal connections, Emily described the experience of

being away from her classmates during fieldwork as feeling "a little odd" (I3, P30). She

said, "I feel like so many of us are kind of far flung; I feel like we've all….almost had

such individual experiences that it's kind of just interesting" (I3, P30). In Emily's

academic program there was only one occasion of formal connection between the

students and the academic program. Emily described having to write one blog post

<div align="center">

148

</div>

during each of her two placements, providing a summary of her placement. There was no formal dialog that occurred between the students and between the students and academic program. For Emily, she would prefer to meet in person, even if via technology, rather than engage in a discussion board with peers. She said:

> I think it would be nice to meet in person because I'm just not the type of person that wants to sit on like a discussion board and type a response. It's just more efficient and also more enjoyable to talk about your current experiences with people in person. (I3, P30)

Emily's desire for personal connection is also reflected in her interest in working with another student during her fieldwork placement and wanting the opportunity to process and share ideas with a peer to better support her Level II fieldwork learning. On the other hand, Emily demonstrated the ability to be a self-directed learner, gaining autonomy throughout her fieldwork by challenging herself to find the resources she needed, think through things she had been experiencing with her fieldwork educator, and thinking about how she could apply prior knowledge to new clients at her fieldwork sites (I3, P32).

Conclusion

In reflecting back on her experiences with implementing best practice on fieldwork, she stated, "you can just get away with so much if you have that mindset" (I3, P19). This experience brought her to say that implementing best practice has to "come from you" (I3, P19). She said, "you have to be committed to actually pursing what's best for clients and actually what's best for the profession in general" (I3, P19). She also added, "you're not gonna necessarily love every place you work but it's knowing that

things are temporary and no matter what, you're there for the clients" (I3, P34). After all,

"fieldwork is just a learning experience and a stepping stone to moving forward" (I3,

P34).

CHAPTER VII

FINDINGS: SYLVIA

Introduction

Sylvia is a traditional-aged college student who grew up in the upper Midwest, in a suburb of approximately 20,000 people. She is the youngest of three kids in her family. Growing up there were a number of neighborhood kids who played together, including Sylvia. She is the only one in her family who has pursued a profession within healthcare and reports no other immediate family members who work in healthcare. Sylvia identifies running, baking, and decorating cakes and three of her meaningful occupations.

First Placement

Sylvia's first, 12-week fieldwork experience was in a large transitional care unit (TCU) in a metropolitan city in the upper Midwest. She primarily spent her time on the stroke unit with clients who had recently or in the past sustained a stroke. Her unit employed two occupational therapists and one occupational therapy assistant as part of the interdisciplinary team. When thinking about her Level II fieldwork experiences, Sylvia was most excited about learning to be an occupational therapist and stepping out of her comfort zone (I1, P31). During the second interview, nine weeks into her experience, she stated, "I know that what I'm learning here will absolutely transfer to the places I'm going next and hopefully wherever I go in the future. I'm learning a lot and I really like what I'm learning" (I2, P19).

Experience With Fieldwork

Sylvia described the work setting as fast paced, as she was often seeing clients back to back. In the first interview Sylvia described the occupational and physical therapy team working and communicating closely together. She commented that the occupational therapists on her wing work well together and communicate with each other about best practice. She stated, "I think what they're doing is good for the patients and I do think overall that they're a pretty well functioning wing" (I2, P30-31).

Planning therapeutic intervention. As Sylvia began to take on more independence in her setting she shared with me her experience with planning therapeutic intervention. She occasionally did a little research when she got home, specifically if she was working with a new diagnosis (I2, P2) or a client with severe one-sided upper extremity weakness (I2, P3). Otherwise she used the OT Tool Kit book or asked her supervisor and "figured things out as she went" (I2, P2). She reported planning her treatment sessions at the beginning of the day, before her first client session (I2, P3). She began her planning with a general idea of what skills the client was working on and what the client's goals were. As part of her planning, Sylvia aimed to take a top down approach, first figuring out what occupation(s) the client wants to address and what is important to them and then identifying what performance skills and client factors need to be targeted to improve the client's performance with occupations. She recognized that the top down approach and being client-centered was emphasized in school although she now experienced how it can be challenging in fieldwork. She stated, "everything that we planned in school was client centered and then you get to fieldwork and it's…it's kind of missing" (I2, P39).

Client-centered care. To use the top down approach requires a therapist to be client-centered in their approach. In occupational therapy the top down approach refers to focusing first on the client's meaningful occupations as using those occupations to guide the treatment process. Sylvia identified aspects of the transitional care unit that impacted a therapist's ability to be client-centered, one of which is insurance reimbursement for services. She was quick to point out that reimbursement challenges were not specific to this site, but transitional care and skilled nursing facilities, in general. She stated, "it's just very driven by Medicare and what's reimbursable. Medicare is not going to cover leisure goals or social participation" (I2, P13). Sylvia also questioned if perhaps the goals are written specifically for reimbursement purposes rather than truly being client-centered. She states, "sometimes I feel like the minutes are inappropriate, but…ugh….it's the industry, it's not this site" (I2, P14). Clients receiving rehabilitation within transitional care units or skilled nursing facilities are identified in specific categories indicating the number of minutes per day they need to receive therapy. The greater number of minutes, the greater amount of reimbursement the facility receives. Sylvia reported,

> It is important (referring to Medicare minutes) but at the same time it shouldn't get in the way of what's best for the client. Like if you're sacrificing what's best for the client for reimbursement purposes, I think it's teetering on the line of being unethical. (I2, P15)

Unfortunately, Sylvia did share experiences she had that she felt were teetering on that line.

Another challenge to being client-centered in this setting is the unnatural

environment. She stated, "it's not the natural way they do things, so you need to just find

different ways to motivate them and make sure to do things that are meaningful to them"

(I3, P1). Sylvia identified that she worked hard to incorporate clients' interests into their

therapy sessions to make the sessions more meaningful and enjoyable. Each day she also

targeted the client's specific goals during her intervention sessions and used any

remaining time or additional sessions to work on strengthening. Sylvia identified that she

was aware of evidence that supports strengthening exercises to improve performance

with occupations, however the challenge she identified is that it was easy to get into a

routine of doing the same things every day. She stated, "it's really easy to get someone a

red theraband and do the same motions. You don't have to think too much about it, just

the routine of doing the same things every day" (I3, P3). Despite the ease of getting into

a routine, Sylvia mentioned that she liked to provide a variety of activities to her clients

rather than doing the same activities day after day (I2, P23).

Fieldwork educator. Sylvia had some freedom with therapy interventions and

felt her fieldwork educator trusted her although there were interesting dynamics that

existed between them, which became more apparent during the second and third

interviews. One of the first situations of tension that Sylvia shared with me was around

the topic of errorless learning. This teaching strategy provides cues and assistance to

clients while engaging in a task and preventing or correcting them before an error occurs.

Sylvia stated, "I know errorless learning is a good strategy and I know how to use it. My

supervisor thinks it won't work. I don't think she really knows what errorless learning

is" (I2, P11). Sylvia stated,

I was teaching 4 wheeled walker safety with a client utilizing errorless learning.

My supervisor kept saying, she's not gonna remember. Magically by discharge

she remembered what I taught her. Yes, it took a long time but she demonstrated

safety because of errorless learning. It was interesting that she's like, oh, she's

not gonna remember that, I wouldn't even try. I'm like, ok, I'm just gonna do

what I can and see where she's at and document it. I just left it at that cause I'm

not trying to argue with her because maybe she's right. Maybe she won't

remember, but in this case she did. (I2, P12)

Sylvia reported feeling like her fieldwork educator was in a rut and presented in a

way that she was not open to new ideas. Sylvia stated, "I think she is too much in a rut

of….I've been doing this for so long that I know what I'm doing" (I2, P11) and Sylvia

validated that "she is right in some sense" but Sylvia wanted to work to "bridge the gap"

between her fieldwork educators experience and new information Sylvia could share that

could help both of them provide better intervention to their clients (I2, P11). Sylvia went

on to state, "it's hard because she's not really open to it so I don't want to step on her

toes, but sometimes I just kind of do it anyway" (I2, P11). Sylvia commented that she

wanted her fieldwork educator to understand that they were on the same team (I2, P12).

Sylvia said, "she's really good at her job so I just have to be very tactful about it, which is

fine. It's kind of a line honestly" (I2, P12).

Sylvia also shared a situation resulting from differing opinions between her and

her fieldwork educator. Ultimately, Sylvia believed it was an ethical dilemma and she

did what she believed was best, although her fieldwork educator was not happy about it.

There was a patient who was in his 90's and he was getting discharged to hospice.

We only needed 15 minutes with him for the day. He slept most of the day. He

hadn't made any progress and he was going home the next day. So she's

(fieldwork educator) on her computer and she leans over and says to me, oh, just

give him a home exercise program. I said, ok, so um….I just grabbed one, just in

case. Then I thought, wow, no, I'm not giving this poor sweet old man a home

exercise program. He's in pain. He sleeps most of the day. He's getting

discharged to hospice. Which in the definition of hospice is making it most

comfortable for the client before it's time for them to go and he's not gonna go

home and do these exercises. I wouldn't. Like, no. So I was a little taken back

when she's like, oh, just give him a home exercise program, because I'm like, is it

compassion fatigue? Is it just something that is billable? Like why? Why send

him home with a home exercise program? So I just talked to him for a little bit,

only for 17 minutes. We went on a short walk in the hallway and I said, ok, this is

something we offer to everybody. Are you interested in taking a home exercise

program home? He goes, oh, sweetheart, thank you. But…ah….I'm in bad

shape. I don't think I want to do that. I'm like, oh, no worries. Instead I gave

him some educational handouts on energy conservation and said, make sure

you're using your energy for things that you really value and enjoy. If it's not

important for you to get dressed by yourself in the morning, then have someone

help you get dressed so that you can have your energy for things that are more

important to you. My supervisor was not happy about it, but I documented that he

declined the home exercise program. She was like, but you didn't give it to him?

I said, no, he didn't want to do it. That's fine, she goes, I put it in the

recommendations anyway, because if he doesn't do it, it's not our fault, because

we recommended it. I was like ugh, yeah, well he didn't want it. I didn't feel like

it was ethical for me to spend 15 minutes teaching him arm exercises that he's not

gonna do. Energy conservation is much more appropriate in that scenario.

(I2, P15-16)

During interview one, Sylvia commented that it is important not to shy away from

the dilemma but think about how to handle it professionally, while doing what you think

is best for the client, without being disrespectful to the therapist. Sylvia stated:

It's still a dilemma, especially with the student educator type of role. I think it

depends on the relationship you have with your supervisor because mine took on

an attitude that I learn directly from her, it wasn't bidirectional. It was a little bit

more challenging for me to approach that dilemma just because she didn't really

want to know what I have learned. It was just kind of a one-way street of, I learn

from her. I didn't shy away from it. I really advocated for patients when it was

necessary, but it was also kind of a pick your battles kind of thing. (I3, P6)

Throughout her 12 weeks at this facility, Sylvia learned to navigate the

relationship she had with her fieldwork educator. She found that starting communication

with an area of agreement where she demonstrated that she was listening to her fieldwork

educator and keeping suggestions focused on what is best for the client rather than "I

think versus you think" (I3, P7). Sylvia expressed wanting to have a positive relationship

with her fieldwork educator and at times she felt like her fieldwork educator wanted to

argue with her. She stated, "There were times that she just wanted to argue with me and I

157

don't really care to argue. I didn't really engage because it wasn't necessary to treat the patient. So again, kind of picking your battles" (I3, P6). Sylvia also experienced discomfort when her fieldwork educator would give her feedback, loudly and in front of others who would then snicker or laugh at her (I3, P19). Sylvia was able to maintain a well-balanced and mature demeanor throughout her fieldwork experience despite the challenges she experienced. She desired to put her best foot forward and have a professional relationship with her fieldwork educator. She was able to identify how to collaborate with her fieldwork educator to make the best of the experience, although her relationship with her fieldwork educator was just one aspect of the overall workplace culture.

Workplace culture. Throughout the second and third interviews with Sylvia it was clear the workplace culture played a significant role in her experience. She did identify positive features, but it seemed the negative features overshadowed the positive. Positive features of workplace culture identified by Sylvia include competency of the therapists (I2, P26), low level of stress among therapists (I3, P23), generally a pretty positive environment (I3, P23), and the social aspect is pretty good (I3, P23). Unfortunately, the negative features of workplace culture outnumbered the positive. She identified negative features such as therapists' superiority complex (I2, P26), therapists' frustration and blaming others (I2, P31), negativity among the team (I2, P31), therapists being critical of others (I2, P31), and gossiping about each other (I2, P31).

It took time but Sylvia was able to navigate the workplace culture and persevere through the fieldwork experience. She learned a great deal about herself and about others during the experience. One of my favorite comments she made, which really personifies

158

who she is as a person is, "you attract more bees with honey" (I3, P7). Throughout the 12 weeks she lived by that statement. Over time, Sylvia tried to break down the situations to better analyze what was happening and how she should respond, if at all. What's politics versus lack of communication? Sylvia shared the following situation between her fieldwork educator, the occupational therapy assistant, and herself.

> My supervisor said, you've got to be keeping track of the minutes. So in the mornings I would look up the minutes. Later she told me, don't worry about the minutes, because we'll probably get them anyway. I said, ok, I'm not worrying about it. I didn't check the minutes for two days. Then at the end of a client treatment session, she said across the room, "Are you good on minutes?" and I said, "What do you mean?" She goes, "Do you have enough minutes with her?" and I said, "I think so, I got 32". Then the occupational therapy assistant yelled at me and said, "Or you could ask your coworkers how many they got with them this morning"? (I2, P32)

The conversation above between Sylvia, her fieldwork educator and the occupational therapy assistant demonstrates the difficulty students can have with navigating interpersonal dynamics and fieldwork expectations. One minute the expectations seems clear, the next thing you know, the expectations have changed. Sylvia went on to state,

> It was extremely aggressive and demeaning to me, in front of the patient and 2 physical therapists. I said, ok, "How many did you get this morning?" She goes, "47!" I was like, "I got 32". Then they said, "She needs 70 for the day so she's fine". At that point I just started crying. I was just so frustrated. I'm like, why are you yelling at me for something that was never even a problem? We had the

minutes anyway. You told me not to check the minutes and it wasn't an issue so

why are you yelling at me and trying to make me feel bad about something that

was never an issue. If it was an issue, why were you mentioning it across the

room at the end of the session? An easy way to avoid that is to tell me to check

the minutes. If I didn't check the minutes, just say, "Heads up she needs 70, the

occupational therapy assistant got 47". That's a way to avoid it. I was so

frustrated. I was crying for a little while and then it irritated me a little bit more.

I didn't want to talk to her about it, I just wanted to go to lunch. (I2, P32)

Unfortunately, when situations such as these occur, students are in a difficult position in

regards to appropriate response. In the back of their mind, they know they are being

evaluated and passing their fieldwork is dependent on their fieldwork educator. Sylvia

did the best she could and reminded herself, "I can't take it personally. She was trying to

communicate that she wants me to communicate more with her, so I try to communicate

with her more and she's been warming up to me" (I2, P33).

The workplace culture and her fieldwork educator directly impacted the learning

environment for Sylvia. According to Sylvia, the aspect of the learning environment that

most hindered her learning during fieldwork was her fieldwork educators' attitudes,

beliefs, and unwillingness to hear what Sylvia had to say or let her try new intervention

methods, despite receiving feedback from her fieldwork educator to step up more often

and be confident in what she was saying. When Sylvia worked to incorporate the

feedback she received and tried to practice being more confident, she would receive a

negative reaction from her fieldwork educator. For example, Sylvia stated she would

often receive a response such as "oh, I've been doing this for so long, that's not gonna

160

work" (I3, P29-30). The inconsistency in messaging from her fieldwork educator was frustrating for Sylvia and made it difficult for her to know what her fieldwork educator wanted.

After situations such as these, Sylvia found ways to keep herself from being in the middle of the negative workplace culture. She began to distance herself from them during free time, such as lunch (I2, P34). Toward the end of the third interview, Sylvia stated she learned a lot about staying centered, doing what she thinks is best, and staying true to herself in that type of environment (I3, P23). She talked about taking initiative (I3, P27), communicating more (I3, P27), being confident in what she knows (I3, P27), asking questions when she's not sure (I3, P27), staying focused on what she was there to learn (I3, P27), practicing self-forgiveness (I3, P27), trying to bridge the gap the best she could (I3, P30), and deciding if she should or shouldn't lean into the challenge (I3, P29).

Throughout the experience, Sylvia identified and demonstrated several personal attributes that helped her in persevering through the fieldwork experience. Sylvia had a curiosity, a genuine interest in getting to know and understand her clients. She desired to keep the focus of her experience and her therapy on the clients. Above all was her ability to stay centered and demonstrate kindness, even in the most difficult of situations. Another aspect that she believed enhanced her fieldwork experience was having another student at the facility who she worked closely with. While the student was not an occupational therapy student, they were on the same interdisciplinary team, working with the same clients. Sylvia also shared with me that her and the other student spent time together during lunch, often just processing what is occurring around them in the work environment. Sylvia recognized that it was helpful to have a student peer to process the

161

experience with and to have a sense of validation about what was going on around her in the work environment (I2, P37).

Sylvia's Definition of Occupation-Based Practice

In my first interview at the beginning of Sylvia's two, 12-week fieldwork experiences, I asked her to describe what occupation-based practice meant to her based on her experience throughout the academic program. Sylvia identified occupation-based practice as something that is highly individualized, meaningful to the person, and should tie back to enhancing the function and performance of that person (I1, P2). She stated, "occupation should be the center of it and whatever you plan for treatment should be relating back to something not just doing it because it's in the gym" (I1, P7). During the first interview I also asked Sylvia if she had any experiences during her coursework or on Level I fieldwork where she had seen examples of situations in which occupation-based practice was not being demonstrated. Sylvia stated, "oh my gosh, yeah. But yes, I have and it kind of makes me cringe a little bit because I'm a student. So I'm not gonna step on their toes but some things I'm just like, why?" (I1, P25). Sylvia's broad understanding of occupation-based practice would be tested during her fieldwork placements, resulting in a greater understanding and appreciation of occupation-based practice.

Experience With Occupation-Based Practice During Fieldwork

Sylvia highlighted that occupation-based practice was more strongly represented during fieldwork than during her academic coursework. She shared with me how learning about occupation-based practice in school helped her to gain a broad, general understanding, "more buzz wordy" (I2, P40) than concrete specific examples of

162

occupation-based practice. On her first fieldwork placement, examples of occupations she addressed included: getting in and out of bed, using the bathroom, other self-care tasks, medication management, and meal preparation.

Sylvia also reflected on the activities that she observed being used during therapy sessions on her first placement. She questioned, "if a person's having issues buttoning their shirt, yeah, we can have them get beads out of putty, but does picking beads out of putty translate to being able to button your shirt? Does that make sense?" (I1, P25). Similarly, for strengthening activities she questions, "can you do something that is strengthening and functional? Like lifting stuff out of the fridge?" (I2, P25). Overall, Sylvia felt that the wing she was on did a really good job of being occupation-based and addressing occupations frequently during a client's plan of care.

Identified Barriers Influencing Occupation-Based Practice

When thinking about the barriers she experienced, she identified her top three as *workplace culture*, *attitudes and beliefs of the occupational therapy practitioners* and *expectations of others* (I2, P30); workplace culture was her biggest challenge (I2, P35). Reflecting back, it was not clear if these barriers were specific to implementation of occupation-based practice or barriers to her experience in general. More specifically to barriers impacting implementation of occupation-based practice, Sylvia shared that the *environment*, *therapists' creativity*, and *getting into a routine* impacted her experience. As for the environment, she identified that "being in a different setting and having a different routine every day made it difficult to be occupation-based" (I3, P3). Some of the things she felt were occupation-based included doing car transfers with the clients' personal car, doing home assessments with the client present, and completing clients'

activities of daily living routines (I3, P3). In terms of creativity, she reflected that she felt

like this was an area of growth for her but didn't specifically identify what her feelings

were regarding the creativity of the occupational therapy practitioners around her. Sylvia

stated, "I wish I had more creativity. I think I could grow more in that area, using

creative means, but also that are evidence-based and client-centered" (I2, P36). Lastly,

Sylvia identified the ease of getting into a routine with doing exercises or therapeutic

activities. For example, she stated, "I did theraband exercises, stacking cones, or other

things that are in the gyms that could have been expanded on. It's easier to do the

exercises, to do things that are repetitive motions and they're still useful" (I3, P3).

Identified Supports Influencing Occupation-Based Practice

Despite the barriers identified that influenced Sylvia's ability to implement

occupation-based practice, she also identified factors that supported her ability to

implement occupation into practice. The supports she identified include: *skills and*

knowledge of the therapists, therapist's confidence, productivity, and *available resources*

(I2, P29).   Sylvia believed the therapists had confidence and demonstrated strong skills

and knowledge in what they were doing as occupational therapy practitioners. Along

with the skills and knowledge of the therapists, Sylvia added the support of having

resources available and the knowledge to use the resources (I2, P37-38). She reported

that the facility had multiple gyms and other resources, such as the Occupational Therapy

(OT) Tool Kit, which is a comprehensive book providing intervention ideas for clients

with various diagnoses. She identified that the value of supports changed as she moved

throughout her placement. For example, she identified during her second interview,

week nine of her placement, she relied less on the skills and knowledge of the therapists

164

as her own skills and knowledge grew, in comparison to the value of that support earlier in her placement (I2, P36).

Transition to Her Next Placement

Sylvia's second fieldwork placement was also in a metropolitan area of the upper Midwest and took place in a community-based non-profit organization providing day programing for individuals with serious and persistent mental illness or dementia. While the role of the occupational therapist at the facility was somewhat of a non-traditional role, Sylvia valued the opportunity to be more client-centered in her care.

<div align="center">

Second Placement

</div>

Experience With Fieldwork

Sylvia's second placement was a drastic change compared to her first placement. She stated, "there's so much free time and variability that I really get to choose what I do and when I do it" (I4, P1). She experienced freedom that she didn't have on her first placement due to the nature of the two settings. She shared with me that she felt supported by her fieldwork educator and felt she was allowed to take the lead during this placement. Her day to day activities involved assisting the clients upon arrival, leading group activities, assisting with lunch, completing assessments, attending care conferences with family, providing caregiver education, and communicating with the interdisciplinary team (I4, P1).

Sylvia also experienced greater opportunity to be client-centered. The organization did not bill insurance companies for reimbursement therefore productivity requirements were non-existent and occupational therapy practitioners didn't face time pressures or expected quotas, allowing for more client-centered care. The setting also

became part of the client's natural environment which also supported client-centered care. Sylvia stated, "some of them are here 5 days a week times 6 hours; if you're spending 30 hours a week at a center for years and choosing to do so, that is your natural environment" (I4, P9). She went on to say, "that's what I really love about it because we get to know them as individuals, we know their preferences" (I4, P9). Sylvia mentioned that most clients attended the center from 9 am to 3 pm but could arrive as early as 7:30 am and stay as late as 5 pm (I4, P2). Sylvia mentioned one client had been coming to the center for 8 years (I4, P6), which she felt demonstrated how the center becomes part of the client's natural environment and staff are able to develop therapeutic relationships and truly be client-centered.

Sylvia described a positive and supportive workplace culture, sharing that she wasn't afraid to ask questions or contribute her ideas, which she felt were valued at this facility. She felt people were always willing to help one another and receive help. She identified work politics on the administrative side but nothing impacting her ability to practice (I4, P16). Sylvia experienced a good relationship with her fieldwork educator, stating it was collaborative, comfortable, and supportive. She did discover areas that were "sticky topics" with her fieldwork educator, which Sylvia stated, "I don't touch on those sticky topics that are her things, but that's fine, I don't mind" (I4, P29). For the most part, Sylvia had great things to say about her relationship with her fieldwork educator.

The support and trust she experienced from her fieldwork educator also supported her in making the most of the placement. Early on in the learning experience she recognized that it was going to be a self-driven experience and she could make of it what

166

she wanted. Sylvia identified that she didn't want to sit in the office all day, that she

would rather go out and do things that are helpful (I4, P20). She also reflected that she

believed having this as her second placement was helpful because she was more

confident in her documentation and clinical skills and it allowed her to be more

independent, which was needed for this placement. Sylvia shared this type of placement

was a good match for her because she was a self-starter and was internally motivated.

She said, "I think there are some students who need more direction and more one on

one…they're not really gonna get that out of this setting and out of this supervisor" (I4,

P31). Despite all the freedom Sylvia experienced on this placement, she remained

focused on what she was there to accomplish. Sylvia stated,

> I really try to make it a learning experience. How can I best understand the client
>
> as a person, as an individual? How do I understand how the family is
>
> functioning? What are some cultural differences and how can we care for them?
>
> How can I modify the task and communicate that tactfully with the program
>
> workers to not seem like I am condemning them but as communication to help
>
> best serve the clients? How can I increase my documentation skills so that I know
>
> how to document in a psychosocial setting because doing a monthly progress note
>
> is way different than a daily note? (I4, P19)

Evidence-based practice. In addition to opportunities for client-centered

practice, Sylvia also reflected on the presence of evidence-based practice at the facility.

She described the plethora of evidence-based resources available to her, "literally binders

and binders full of articles from 2012 to now of evidence-based practice….cooking,

baking, gardening; literally going through each and every activity and occupation that we

do here" (I4, P4). Sylvia identified that the evidence that she reviewed at the center indicated that including this client population in activities increases their quality of life, keeps them in the home longer, reduces re-hospitalizations, and reduces reliance on medications (I4, P14). From the beginning, Sylvia felt encouraged to look at the evidence. She also felt that her fieldwork educator was interested in knowing and learning if more recent evidence was available on a topic. For example, Sylvia stated, "when I ask her specific questions about things, she's like, this is what I have, you might have stuff that's more updated, so if you do, please bring it to me" (I4, P5).

Areas of discrepancy. Although her fieldwork educator valued the use of evidence and had several evidence-based practice resources available, Sylvia wasn't always in agreement with some of the practice decisions her fieldwork educator made. Sylvia shared one area of disagreement was the choice of assessments used by the occupational therapist. She didn't believe that the tools utilized did a good job of measuring what the clients gain by participating in the programming at the center. For example, the occupational therapist completed the Cognitive Performance Test (CPT) and the Berg Balance Scale, upon admission to the center and every calendar year after, on every client in the dementia program (I4, P6). Sylvia identified there wasn't an assessment completed measuring improvement in quality of life or satisfaction of programming and according to Sylvia "it's not really getting at the, so what" (I4, P15). Sylvia shared that she did see value in completing the CPT and Berg upon admission to understand initial functioning of the clients and to be able to provide education to the caregivers regarding the supports the client needs. Dementia is a progressive disease which means a client's score on the CPT will expectedly worsen over time, but it does

168

not measure the client as a whole. Sylvia stated, "shouldn't we be looking at the person and their needs, what their preferences and values are? Some assessment tools that get the best picture of the person as a whole" (I4, P14)?

It didn't take long for Sylvia to recognize the areas off limits for discussion. Her fieldwork educator was strongly passionate about and had expertise related to cognition. Sylvia commented,

> She's the expert of a few things and I do not step on her toes with those few subjects, even if I disagree, cause it's not worth it. Everything else she really does love to learn, so, I just let her be the expert of a few things and then just open up conversation for literally every other topic. It is interesting because she is a learner as long as it's not within her area of expertise, which I think is really odd. (I4, P25)

Another area of discrepancy that Sylvia identified was that of goal writing. Typically, in occupational therapy practice the occupational therapist oversees the entire occupational therapy process which involves developing client goals in collaboration with the client, following completion of the evaluation process. At this facility, the occupational therapy assistants (OTAs) drive much of the occupational therapy process including writing goals, carrying out interventions, and completing monthly client notes. In addition, the results from the assessments completed by the occupational therapists are not used to create client-centered goals, rather general goals are created. Sylvia identified that the client goals are "not really intended to be met at a specific time" (I4, P7). A couple examples of client goals are: "client will be in a safe, secure environment" (I4, P6) and "client will have opportunities for meaningful engagement" (I4, P7). Sylvia points

out that both of these goals, "if they are there on their first day, they've technically met their long-term goal, they are in a safe, secure environment" (I4, P7) and "the opportunities are there" (I4, P7). Sylvia recognized that she didn't like the system used for goals so she decided she would write her own goals because that's what she did at her prior facility. In Sylvia's words, "I kind of got the finger wag of no, we just stick to this and that" (I4, P7). Upon further reflection she stated, "it's just the system that they have and I'm not gonna come in and just change it the first time I ever write a goal" (I4, P7). Despite that, she was able to identify how she would change it if she were in this position full time, by making the goals more individualized, measuring participation, measuring quality of life, etc.

Unique value of OT

When I was visiting with Sylvia about the goal writing procedures, I couldn't help but wonder if the unique value of occupational therapy was really being demonstrated at this site, especially in the goal writing and documentation. Sylvia stated, "it kind of worries me because we continually have to advocate for OT and why OT is necessary in general" (I4, P7). She continued by saying,

> It kind of just raised the question in my mind of, how can we advocate for OT when it really is necessary in the setting, because we do have a unique role and collaboration with everyone else. Sometimes it's just not always clear and that's when you need to softly and lovingly advocate for our role, because we can do a lot more. (I4, P7)

I delved further with Sylvia to identify if she believed the unique role of occupational therapy was evident and she did confidently state:

I think she really does demonstrate…so the unique role that OT's play is…this is

how you properly transfer someone and help them in the bathroom, this is how

you grade the activity up and down; it might not be just overt said out loud but it's

definitely evident that there's a difference between how the program workers and

how the occupational therapy assistants do things. (I4, P8)

Sylvia also believed that the interventions chosen by the occupational therapy assistants

were appropriate for the group of clients. She said, "I'm very impressed by it" (I4, P13).

Another aspect of the intervention process at this facility was home modifications, which

according to Sylvia was "a big part of safety and keeping people in their homes as long as

possible so they can engage in those meaningful occupations" (I4, P11). Suggesting

appropriate home modifications required Sylvia to look at each person as a whole, see

how they are functioning in their environment, see how they are responding to their

environment, and recommend how things could be adapted and modified to improve a

client's performance or safety (I4, P10). Home modifications often in the form of client

education was one example of occupation-based intervention strategies used at this

facility that demonstrated the unique value of occupational therapy.

Occupation-Based Practice During Fieldwork

When thinking about occupation-based practice at this site, Sylvia identified that

the primary focus was on increasing leisure and social participation to improve the

clients' quality of life and support client's ability to stay in their homes longer (I4, P2).

She also mentioned that activities of daily living such as bathing, toileting, hygiene,

grooming, and dressing were often addressed with individuals in later stages of dementia

but were not solely addressed by occupational therapy practitioners (I4, P3), rather the goals could be written by any staff member (I4, P26).

Other interventions that had been incorporated into the programming at the site included a baking and cooking class, crossword puzzles, word searches, puzzles, games, gardening, exercising, and cognitive activities which involved reminiscing and historical facts. All of the interventions had an identified purpose. For example, exercising helps to improve safety with functional transfers and functional mobility. Cognitive activities completed in a group provided opportunities for leisure and social participation (I4, P11).

Identified Barriers Influencing Occupation-Based Practice

Sylvia identified two barriers that she experienced during her second placement, *workplace politics* and *therapist's confidence*. Although the barriers were present, she stated, "it's at such a small scale that I really just had to [think hard to] pick one or two" (I4, P22). They were not barriers that she felt impacted her ability to implement best practice. The workplace politics seemed to be more related to academic degree level. For example, Sylvia shared that some people had a negative perception toward OT's or other professionals; the perception of "oh, I know this because I have a Master's degree" (I4, P22). Sylvia identified that communication between her fieldwork educator and the program workers was hindered because "she doesn't spend a lot of time with clients, but she has very strong opinions about situations" (I4, P22).

The other barrier Sylvia identified was that of therapist's confidence, specifically being over confident (I4, P22). Sylvia was referring to seasoned therapists relying on their intuition and experience rather than concrete details. She said, "as a student I rely on my resources, classroom materials, and things that I can see. I believe what I see more

than what I hear. I rely more on concrete things that I see, know, read, and observe" (I4, P22-23). She identified that she didn't think this was a good or bad thing but a natural occurrence that likely happens with gained experience, but she does question where the information comes from and when does that occur? When do therapists rely more on their intuition than they do on concrete details (I4, P23)? Sylvia shared an example to demonstrate this barrier. She said, "when, you are saying that they can't do it, but I see them doing it" (I4, P23). This type of situation can lead to difficulty with communication. She states, "it's harder to communicate when they're disagreeing with you based on something that happened when you were interacting with them (the client)" (I4, P23). She went on to state,

> I'm not challenging your expertise or your career at all, I am trying to
> communicate about this client and sometimes it's hindered by, well…I've been
> doing this for a long time and you're a student, and it's like, ok, I am a student,
> but that has nothing to do with what we're talking about. (I4, P23)

Sylvia reflected on this experience and identified needing to have the skill of being tactful and knowing when to ask and when not to ask (I4, P23). According to Sylvia this type of interaction can hinder best practice but regarding her situation, she stated, "I have them figured out and I know the soft spots and when to push and when not to" (I4, P23).

Identified Supports Influencing Occupation-Based Practice

Along with barriers, Sylvia also experienced several supports throughout her second placement. The first support she felt stood out to her was *therapist's creativity*. She spoke highly of the OTA's she worked with and commented on their creativity, their ability to adapt activities, and their openness to new ideas. Sylvia also felt encouraged by

173

the OTA's when they asked her to lead an activity of her choosing. She commented that she didn't feel it was "like a challenging contest" rather she knew and they told her they were looking forward to her leading (I4, P21). The second support Sylvia identified was *client's attitudes, beliefs and values*. She felt that the clients contributed to a positive environment. She shared that the clients were always open to doing different activities, even new ones; they were appreciative, welcoming, and really enjoyed being at the center (I4, P21). Sylvia commented, "what really energizes me is people involved in their own care and that want to be there. They tell me, oh, Sylvia, I would love to do this…let's do that and I'm like, yes, let's do it" (I4, P21).

The third support she identified was *time*. Due to occupational therapy services not being billed to insurance, the time pressure was not present. She shared that her time with clients could take as long as they need to and there was "no real pressure to produce, produce, produce. It's just do what you need to do and then move on" (I4, P21). The fourth support was *workplace culture*, which she identified as being "really, really good" (I4, P21). She said, "I mean, anywhere you work there's always gonna be those things that so and so doesn't like" (I4, P21). Despite the few incidents mentioned previously it seemed that she experienced a really positive work culture during her second placement.

Questioning Practice

Throughout both fieldwork placements Sylvia was fully engaged in the learning experiences, both good and bad. One thing that Sylvia consistently demonstrated was a curiosity for learning. Throughout our five interviews, Sylvia frequently asked questions about the practice she was observing and thinking about ways she would do things different in the future. She recognized that as a student she was not always able to assert

174

her ideas for a variety of different reasons, but this didn't stop her from reflecting upon the learning experiences she was having at each site.

I wanted to gain a better understanding of the timeframe in which Sylvia was able to begin identifying discrepancies between what she learned in coursework and what she was experiencing on fieldwork. During her first placement she describes herself during the first four to five weeks as being "enthralled and a little overwhelmed and a little optimistic about everything" (I5, P8). She talked about being a "passive recipient" as she was trying to absorb everything (I5, P9). She talked about first needing to gain a better understanding about how strokes impacted people and affected daily living skills. She needed to take time to learn the frequently used interventions at the site. She stated, "when you're in that process of learning what everything is at the clinic and what you have access to…I was a little optimistic, like, oh, this is great" (I5, P8). Then around week five of her first placement, she describes having an 'ah-ha' moment.

> I was observing a therapist working with a patient who had a stroke and one of the goals was bilateral coordination. The client had a left sided stroke affecting her right side, which also impacts emotional lability. The therapist asked her to do this activity where she took both of her pointer fingers and thumbs and took a rubber band and tried to put it over pegs, like on a peg board. She's like put the rubber bands on the peg board. And I thought why? What is that even doing? I mean, the goal is bilateral coordination but there's nothing functional about it. When do you ever put rubber bands on a peg board? I've never done that before. The client got really frustrated because she couldn't do it, and she's like, I can't do this. Then the therapist is like, yeah, you can. Just do it. And then the client

refused and ended up stating, take me back to my room. I don't want to do this

anymore. That's when it kind of clicked with me. (I5, P8-9)

In the interview, Sylvia continued to reflect by saying,

> We will work on bilateral coordination. Ask her if she drinks coffee in the
>
> morning and then have her practice making a pot of coffee. Or try having her
>
> put her hair up. Or flossing her teeth. Or trimming her nails. Anything that
>
> requires your hands that you do in the morning. Like, why rubber bands over a
>
> peg board? So that was the first time that it clicked with me. Like, why? Why
>
> are you doing something that's unfamiliar and then assessing their functioning
>
> based on an unfamiliar task? Didn't make sense to me. (I5, P8-9)

This was the beginning of Sylvia questioning what she was experiencing around her.

These learning opportunities also provided her with practice in building her professional

self. For example, over time she learned how to gauge when it was okay to ask questions

and when it was best to stay quiet. This skill also came into play in the example shared

below during her second fieldwork placement.

As Sylvia started her second fieldwork placement, I was interested in knowing if

she identified discrepancies earlier in her experience, as compared to her first placement.

She shared with me that she still had time in the beginning where she was just trying to

absorb what was going on around her at her new fieldwork site. She stated, "I still had

that honeymoon phase but it was about a week or two instead of four or five weeks" (I5,

P14).

The experience of recognizing the discrepancy at her second placement was different in a

couple ways. She described having an easier transition into her second fieldwork

176

placement, where she also experienced a different openness from the staff and the occupational therapy team. She stated,

> At my first facility they were like, this is what we do and that's it. We don't want
> to know anything that you have to share. At my new site, it's just more of a
> conversation and they really wanted me to give them more information, wanted
> input from me. It was more open communication and nobody was really as
> defensive. (I5, P12)

Sylvia shared that even though she began thinking about and observing a discrepancy earlier in her second placement (week two), that was just the beginning of the process to reflect on practice. She describes starting with thinking the thoughts, then putting thoughts together, observing, seeing a pattern, and finally arriving at a place where she was able to think about "how it could be improved a little bit" (I5, P14). According to Sylvia, this process took several weeks. One of the examples she shared where she reflected on the practice and identified a discrepancy, or an area where she would make change, was related to the evaluation process.

> I thought it was a little backwards. I thought, shouldn't you be looking at the
> person as a whole and deciding what's the best way to evaluate their functioning.
> I thought it was kind of interesting that she approaches it as, these are the
> assessment tools, who can fit into that, rather than let's look at the person as a
> whole and then decide which assessment tools would be best for them. (I5, P12)

Generally, Sylvia felt free to share her input, however, not on this topic. She commented she never brought this topic up in conversation because "it's kind of a touchy subject".

177

Instead she said, "it's something I stored into my mind; this is how I want to do things a little bit differently" (I5, P13).

Ending Reflection

Initial Optimism, Then Reality

At the beginning of both fieldwork placements, Sylvia talked about the optimism she felt when starting her experiences. She had assumptions such as "everybody would always be supportive" (I5, P1), "this will be really fun" (I3, P5), but she also had an assumption that it would be really hard. She talked about being scared and nervous for her fieldwork. She experienced self-doubt, such as "Am I really cut out for this?", "Is this really meant to be for me?", "Can I be an OT?" (I5, P1). Another assumption she had was that implementing occupation-based practice would be easier than it was. She commented that "in school it seems so straight forward" and "intuitive" (I5, P2). What she found instead was that it was much harder than it seems and there were more challenges than she anticipated (I3, P5).

Factors Impacting Best Practice

Both placements brought unique challenges and supports, impacting the ability for Sylvia to implement best practice. As she thought about her two placements together, she identified the two factors that most supported or hindered her ability to implement best practice as *attitudes and beliefs of the therapists and workplace culture and environment* (I5, P6).

> My first supervisor blatantly did not care. She said to me multiple times, I don't know what they're teaching you in school, but it's not right. She set the precedent very early that I just learn from her. It's not a collaborative relationship. (I4, P24)

178

While the *workplace culture and environment* impacted her ability to implement best

practice, it also impacted Sylvia's learning as a whole during her first fieldwork

placement. During my first three interviews with Sylvia, which occurred during her first

fieldwork placement, she tried to remain optimistic and positive despite a really difficult

experience. Later in the fourth interview, reflecting back she said, "man that was just…I

really had a positive attitude because that was atrocious man. It was brutal. I won't

sugar coat it, she was pretty mean and kind of intentionally mean" (I4, P27). Sylvia

shared with me that her discomfort in the environment kept her from asking a lot of

questions. She feared that her questions might sound stupid and her fieldwork educator

would make fun of her and then talk about it in front of her co-workers when she thought

Sylvia couldn't hear her (I4, P28). Although it kept her from asking questions, it also

pushed her to look for resources and seek out information on her own, which her

fieldwork educator also recognized. Sylvia stated, "it pushed me to look for things on my

own and figure it out on my own and become more self-sustaining" (I4, P28).

Knowing yourself

One thing Sylvia found to be helpful was knowing herself and what was

important to her. In one of her academic courses prior to fieldwork they talked about

personality type, personal values, and work style preferences and what to do if the work

style is different than your preference. At the time of the course, Sylvia identified that

she believed that she would just adapt to the environment and everything would be fine,

which ultimately she was able to do. She didn't realize that what she valued in a

workplace was much more important to her than she initially thought (I2, P43). Sylvia

recognized having that discussion before starting fieldwork was valuable to her because it

179

at least got her thinking about what was important to her, what she values, and what to do if those things were challenged on fieldwork.

While every workplace environment is different, Sylvia found it helpful to know herself, know how to read others, and be able to adapt to mesh with the workplace culture around her. She commented that during fieldwork she had been working hard at practicing the skill of reading others and meeting them where they're at in order to adapt positively to the environment around her. Sylvia made a comment in the third interview that I thought was insightful. She said, "I think the workplace culture has already been shaped before you get there, but I think it can continually evolve depending on what you contribute" (I3, P37).

Conclusion

Sylvia took away several valuable lessons from her 24 weeks of Level II fieldwork experience and identified recommendations for future students as they navigate their own fieldwork experiences. The learning environment in fieldwork is "very self-driven" (I3, P36) and the work is on you, the student. Sylvia advocated for taking the initiative to "do things on your own" (I3, P36). Secondly, she identified, "be patient with yourself; you are there to learn" (I3, P36). She said, "...no matter where you go, it is a scary experience and you will feel vulnerable" (I4, P34).

As she looked forward to her first year of practice, she hoped to continue developing skills and to find an environment that worked for her. She expressed wanting to go forward as a learner, to be open to new ideas, to be curious and humble, and to collaborate with future coworkers. Sylvia hopes to have a mentor as she begins the start of her career and desires to set aside time each month or every other month to stay up to

date on resources that are relevant to her setting. She also plans to attend continuing

education events sponsored by state and national associations (I5, P22).

As a future fieldwork educator, she hopes to carry forward lessons she learned

through her own experience as a student during fieldwork. She desires to have a

collaborative relationship with future students, identifying that the collaboration is

helpful. She identified that as a fieldwork educator she will also learn from her students.

She pointed out, just because there is collaboration it doesn't mean that there isn't a

supervisor, it just means "you're sharing responsibilities and enabling the student to

really develop as their own professional" (I5, P23-24). Sylvia identified that she wants

her future students to know how to be sustainable on their own and how to ask for help.

She hopes to lead by example and help her future students feel as comfortable as possible

in order to facilitate the learning process (I5, P23-24).

CHAPTER VIII

DISCUSSION, RECOMMENDATIONS AND CONCLUSIONS

Discussion

The purpose of this study was to re-tell the individual stories shared by occupational therapy students about their experiences of integrating best practice professional ideals during their Level II fieldwork. Additional area of exploration included the perceived supports and barriers during Level II fieldwork and the impact of second Level II fieldwork, in relation to implementing best practice. The plethora of supports and barriers are one of the complicating factors of working in a healthcare environment in comparison to learning in a more controlled academic environment. Additional interest was also in understanding if students experienced increased feelings of preparedness and ability to implement best practice as they transitioned from their first fieldwork placement to their second.

This study is important due to the reported presence of a theory-to-practice gap and the difficulties experienced with transitioning into the workforce which are identified in the literature. The theory-to-practice gap is a discrepancy between what students learn during didactic coursework and what is evident in clinical practice. This gap creates a learning discrepancy as students' transition from coursework to fieldwork to practice. Literature has shown that both occupational therapy students and new graduates feel tension when discrepancy is experienced on fieldwork and in practice (Ripat et al., 2013;

182

Towns & Ashby, 2014). Additionally, Aiken et al. (2011) report that clinicians often struggle with living up to the professional ideals due to a variety of factors including: job pressures, time pressures, tight budgets, medical model paradigms, and organizational issues. To complicate experiences by both students and new graduates, literature also indicates a power differential with students and new graduates and their supervising therapists that create feelings of pressure to conform to the existing practices present at the facility (Clarke et al., 2014; Crist, 2007; Di Tommaso et al., 2016; Di Tommaso & Wilding, 2014; Pfeifer et al., 2008; Wilding & Whiteford, 2007).

The results of this study provide greater understanding into the experience of occupational therapy students as they transition to fieldwork and during the 24 weeks of required Level II fieldwork, including the supports and barriers they experienced. These results inform practice for occupational therapy academic program educators, fieldwork educators and fieldwork site coordinators, and occupational therapy students. The findings have potential to contribute to the literature by making an impact on the learning experience of students, narrowing the theory-practice gap in the profession of occupational therapy, and broader implications for curriculum development and pedagogy in occupational therapy education.

While the focus of narrative inquiry methodology is on sharing stories of each individual student rather than identifying commonalities and differences in the stories, I took the opportunity to do both. The previous four chapters were the stories of each individual student. Next, I will synthesize the stories of the four students for the purpose of identifying implications and recommendations to benefit the occupational therapy profession. I will situate the synthesized findings within my conceptual framework,

followed by the limitations of my study, recommendations, and finally concluding statements.

Synthesis of Findings

There were a number of findings that seemed to surface within the stories told by each of the students. I will explore the following four findings throughout this section: (1) *students experience of theory-to-practice gap*; (2) *student factors impacting integration of best practice*; (3) *site-specific factors impacting integration of best practice*; and (4) *academic factors impacting integration of best practice*.

Students Experience of Theory-to-Practice Gap

Each of the students identified discrepancy between what they learned during didactic coursework as being best practice and what they experienced during their fieldwork placements. This discrepancy has been identified by students and therapists alike. For example, a study conducted by Aiken et al. (2011) found the existence of two realities, one describing the way students felt occupational therapy should be practiced and the other describing the way occupational therapy is actually practiced. This same study identified various demands of practice that impacted implementation of best practice.

Activity systems from academic program to workplace. Faced with the transition from academic program to workplace, a student is faced with several challenges. Students in the study consistently expressed their need to feel comfortable with the day to day operations and responsibilities before attending to and analyzing the implementation of best practice at the site. The literature supports this, identifying that it is important for students to gain knowledge with the technical skills before they are able

to learn through reflecting on practice (Sladyk & Sheckley, 2000). According to Le Maistre and Pare's (2004) study exploring activity systems, students and new graduates often fail to integrate academic knowledge when faced with the "hurly burly" of initial practice, stating students and new graduates "adopt means that will enable them to make it through the day" (p. 48). This experience was reflected by Sarah as she talked about her first fieldwork placement. She shared with me that early in the placement she wasn't able to consider incorporating best practice into her client care because she was "just trying to make it through the day" (P2, I3, P2).

Once students were comfortable with the day to responsibilities and technical skills required, they were able to reflect on the practice and students were then able to identify discrepancies. During their first fieldwork placement, this generally occurred around week three or four, as students began to take on more independence with their caseload. Students were able to identify discrepancy earlier in their second placement. This could be due to achieving comfort with day to day responsibilities, earlier on in their placement, allowing them to critically appraise what they were experiencing. This is in alignment with the research, which states that competency areas improve with each fieldwork placement (Holmes et al., 2010).

Of the three professional ideals (occupation-based practice, client-centered practice, evidence-based practice) explored in this study, students were more likely to report the greatest discrepancy with occupation-based practice. This could be due to occupation being central to the occupational therapy identity whereas client-centered practice and evidence-based practice are central concepts to many professions.

185

Another factor that seemed to impact students' ability to recognize discrepancy was their understanding of the concepts. They each seemed to have a concrete understanding of the best practice professional ideals but corporately had little understanding of how the three concepts might be applied and generalized in practice and throughout the entire occupational therapy process. For example, there are various definitions or what it means to demonstrate occupation-based practice therefore when confronted with practice situations, students struggled with clearly identifying the parameters of what is considered occupation-based practice, despite agreeing with the definition provided at the beginning of the study.

For example, Morgan identified discrepancy with both occupation-based and client-centered practice, in both of his fieldwork experiences. Sarah did not identify any discrepancies during her first placement but did identify in her second placement, that implementation of occupation-based and client-centered practice, particularly with adult outpatient clients, was different than how it was described during coursework. Emily identified that her first placement occasionally lacked in the demonstration of occupation-based and client-centered practice ideals whereas her second placement had greater opportunities for occupation-based and client-centered practice and fewer instances of implementing evidence-based practice. Sylvia identified strong discrepancies with client-centered and occupation-based practice during her first placement. During her second placement she did not specifically identify discrepancy with any one of the three best practice professional ideals. However, she did identify discrepancy with a couple procedures, such as conducting occupational therapy evaluation and writing client-centered goals demonstrating unique value of occupational therapy.

Student Factors Impacting Integration of Best Practice

      Unique personality. Throughout my study I learned of the various factors that impact a student's ability to implement best practice while on fieldwork. The first factor identified was the unique personality of each student and their approach to stressful situations. As I listened and gained understanding of each student through their stories, it became apparent that each students' unique personality impacted their thoughts and perceptions about their experiences as well as their response to the discrepancies they faced. The role of personality in relation to how students approach new learning or navigating experiences has not been explored in the occupational therapy literature. There have been studies exploring desired characteristics in occupational therapy students. For example, Campbell et al. (2015) identified the following characteristics as essential in fieldwork students: being adaptable, clinically competent, good communication skills, ethical, responsible, and efficient (p. 6). Unfortunately, I was unable to locate any literature that directly relates students' personality and response to new learning, in this case response to discrepancy in practice. For example, Sarah's personality could be described through adjectives such as easy-going, optimistic, go with the flow, content, and reserved. Throughout my interviews with her, she rarely questioned the practice she observed and experienced, rather she seemed to accept it. If she did experience a discrepancy, she did not seem to feel distressed or uncomfortable. For example, during her second placement, she recognized that it was more difficult to be occupation-based when working with her adult outpatient clients, but instead of reflecting on ways to overcome the challenge, she went on to say "that's to be expected".

In comparison, Sylvia's personality could best be described as being confident, assertive, passionate, strong-willed, and independent. Sylvia questioned discrepant practices she observed and identified several areas of discrepancy throughout her fieldworks. Her response varied depending on her perception of the situation. For example, on her first fieldwork she experienced a situation in which she did not agree with her fieldwork educators' recommendation to complete a home exercise program with a client in his 90's who was discharging to hospice. Instead of taking the recommendation of her fieldwork educator, she provided treatment which she believed was more appropriate and more client-centered. She was able to clearly identify her own beliefs about the situation and was able to verbalize a rationale for her action, despite pressure to take the recommendation of her supervising therapist. On the other hand, Sylvia experienced a situation on her second fieldwork placement in which she didn't agree with the evaluation process used by her fieldwork educator. Instead of acting on this discrepancy, she recognized that this was a "touchy subject" for her educator and believed she would be better off not challenging the opinion of her supervising therapist. She did however, reflect on the situation and identify what she would do different in her own future practice.

Power differential. Power differential was present due to the fieldwork educator's role in evaluating the student and the student either passing or failing the fieldwork experience. While the power differential was not specifically identified by students in this study as playing a role in their ability to enact best practice ideals, several situations throughout their experiences demonstrated this dynamic. For example, Morgan self-identified "student syndrome" and gave examples of this theme in all five of our

meetings. It was evident in his comments related to feeling timid around his fieldwork educator, not knowing if he had a place to contribute his ideas, and not wanting to question or disrupt the typical milieu.

In addition, students' experiences of recognizing a discrepancy and identifying areas that may be "touchy subjects" or "off limits", highlights the presence of the power differential that exists between students and fieldwork educators. Previous literature has also identified power differentials between fieldwork students and fieldwork educators (Crist, 2007; Di Tommasso & Wilding, 2014; Pfeifer et al., 2008). The students, particularly Morgan, Emily, and Sylvia, appeared to feel pressure to conform to the modus operandi of the fieldwork site, which aligns with similar findings in the literature (Clarke et al., 2014; Di Tommaso & Wilding, 2014). As a result of this observation it became clear that the students' unique personality and what they bring to the fieldwork experience plays a role in their comfort with questioning the usual way of doing things at the fieldwork site and challenging the existing power differential dynamic.

Developmental continuum. Additionally, each student was in a different place in their journey to becoming a health care professional; impacting their knowledge and comfort in responding to discrepancies experienced. Thinking of Baxter Magolda and King's (2012) theoretical model to self-authorship in relation to the students in the study, helped me to understand how each student is an individual and at their own position within the continuum on their journey to self-authorship. The assumption that students are each on their own developmental continuum that occurs over time is supported by occupational therapy literature. Results from a study conducted by Hodgetts et al. (2007) demonstrated a developmental continuum from occupational therapy student to recent

189

graduate to longer-term graduate. Students enter and exit these phases in their own time. For example, Sylvia was able to assess the situations and determine if it was something she was able to positively impact. If she wasn't able to, she took the opportunity to consider how she would do it differently in her future practice. In Baxter Magolda and Kings (2012) model, Sylvia would be described as leaving the crossroads and beginning to listen to her internal voice over external authority. In the model this position is characterized by "actively work to *cultivate* the internal voice, which mediates most external sources. Consciously work to not slip back into former tendency to allow others' points of view to subsume own point of view" (p. 19). In contrast, Morgan was able to identify discrepancies and questioned the modus operandi at his fieldwork sites, but as he reflected in our meetings, he didn't know what he could do about it and continued to moving forward. He would be described as being in the first position within the crossroads, characterized by "relying on external sources despite awareness of the need for an internal voice; realizing the dilemma of external meaning making yet unsure how to proceed" (Baxter Magolda & King, 2012, p. 19).

Completing the fieldwork experiences in itself requires students to apply knowledge gained throughout coursework and presumably students would engage it some level of individual reflection, comparing academic knowledge to their experience in clinical practice. I argue that the students who participated in my research study likely had greater growth toward self-authorship as compared to students who did not participate. The in-depth reflection required for participation and the knowledge co-constructed through our conversations likely contributed to students individual meaning making of the experiences.

190

Site-Specific Factors Impacting Integration of Best Practice

The next factor I identified as impacting student's integration of best practice was fieldwork site considerations. When I talked with each student about factors impacting best practice, I had them each identify factors they had noticed; I also provided a list of factors that I had identified, some of which came from the literature and some from my personal experience. I found interesting the variation in factors identified and the variations in perception as to how factors identified influenced practice. What was identified as a support in one setting might be identified as a barrier in another setting. For example, both Sylvia and Emily had their first fieldwork experiences in an inpatient hospital setting. While Sylvia experienced the *workplace culture* as a barrier, Emily experienced her *workplace culture* as a support. Factors also proved to be site specific. For example, *financial resources* were only identified as a barrier by Sarah, whose second fieldwork placement was in a rural setting.

In this study there were several factors identified as either supports or barriers, also matching factors previously identified in the literature which have shown to impact therapists' ability to implement professional ideals in practice. The following factors will be discussed in greater detail below: time, resources available, physical space, therapists' creativity, workplace culture, approaches used by and expectations of other team members, size of caseload, and protocol driven nature of practice.

Time was the most commonly reported barrier to best practice, experienced by students in six out of the eight fieldwork experiences. Each student experienced at least one fieldwork setting in which time negatively impacted their ability to implement best practice. Time has also been identified as a barrier throughout the literature (Aiken et al.,

191

2011; Estes & Pierce, 2012; Kristensen et al., 2011; Lyons et al., 2011; Salls et al., 2009).

Size of client caseload often goes hand in hand with time as a barrier. For the students in this study and supported by the literature (Aiken et al., 2011), size of client caseload was identified as a barrier to best practice as well as identified as a factor that the students and supervising therapist have little control over. *Resources available* and *physical space* were identified by students in the study as both barriers and supports, depending on the fieldwork setting. Students identified available resources as a barrier in five out of the eight experiences where as physical space was mentioned as a support in three experiences and a barrier in two experiences. For example, Sarah identified both resources available and physical space as supports in her first fieldwork placement at the inpatient rehabilitation facility whereas Morgan identified both as barriers in his fieldwork placement at the outpatient clinic. The literature also identifies these two factors as barriers or supports to implementing best practice (Estes & Pierce, 2012). During fieldwork students identified that the resources available and physical space also impacted the ability for the therapists to be creative in their interventions. *Therapists' creativity* was identified by all students as being a barrier to implementing best practice. The limited number of resources decreased the students' and therapists' ability to be creative with their interventions. Three of the four students identified that even if they wanted to be creative and had an idea for a creative intervention session, they were often not able to implement it due to lack of resources. Therapists' creativity is also mentioned in the literature as a barrier to implementation of best practice (Estes & Pierce, 2012). Students had varied experiences with *workplace culture*, referring to the presence of conflict, team work, presence of comradery, power dynamics within the setting, respect

192

for each other, etc. For the most part, workplace culture was positive and identified as a support for students. Two of the students had experiences where the workplace culture positively impacted their interest in and ability to incorporate evidence-based practice into their treatment with clients. For example, in Emily's first fieldwork experience there was a culture of community that was fostered throughout the workplace, she described as welcoming, helpful, and friendly. The literature also supports this finding reflecting the importance of workplace culture, role modeling on fieldwork, and therapists demonstrating and encouraging EBP (Kellegrew, 2005; Morrison & Robertson, 2016; Stube & Jedlicka, 2007; Wenger, 2002). In one fieldwork experience, the workplace culture was recognized as the greatest barrier to implementing best practice. The literature also identifies workplace culture as a factor that impacts best practice at a site (Di Tommaso et al., 2016; Sumsion & Lencucha, 2009). Related to workplace culture but uniquely separate from, the ***approaches used by and expectations of other team members*** were recognized as factors impacting implementation of best practice. For example, in Morgan's first placement he reported the difficulty he felt in implementing occupation-based practice because of the therapy methods used by those around him. He stated, "I felt it was a little bit harder, just because of maybe what the OT's did" (P1, I3, P3). Without his fieldwork educator and other occupational therapists around him modeling occupation-based practice, it is difficult navigate that alone. This finding was supported by the literature (Aiken et al., 2011; Di Tommaso et al., 2016; Wilkins, Pollock, Rochon, & Law, 2001). The last factor that was identified was the ***protocol driven nature of practice.*** This factor was identified by three students as impacting practice at three of their fieldwork settings. For example, Morgan, Sarah, and Emily each

193

identified the impact of therapy protocols on the implementation of best practice. This typically occurred when working with adult outpatients being treated for orthopedic conditions, in which therapists follow a particular protocol or method of intervention. Protocols are required for many clients who have had surgical procedures and the surgeon identifies a particular treatment protocol. This prescriptive nature of therapy limits the ability to implement client-centered and occupation-based practice. Literature also supports this finding of protocols as a barrier to best practice implementation (Aiken et al., 2011).

Protocol driven therapy also impacts the identity of the individual who is performing the protocol driven therapy. For example, in Morgan's second fieldwork experience he reflected on the protocol driven nature of the practice by stating, "Am I doing a lot of PT stuff here or is it that PT's are doing shoulder type OT stuff?" (P1, I4, P9). Morgan was able to identify that the occupational therapy and physical therapy scope of practice cross but he was not able to speak about the distinct nature of occupational therapy and how an OT using an occupational lens would approach a shoulder injury differently than a physical therapist. In this experience, Morgan's fieldwork educator was the only occupational therapist working in an outpatient clinic with several physical therapists, which brings me to question the impact on his fieldwork educator's professional identity. In a similar situation, during Sarah's second fieldwork placement her fieldwork educator was also the only occupational therapist at the site. Sarah talked specifically about her and her fieldwork educator relying on the physical therapists for their professional opinion and ideas in treatment situations. While this level of collaboration and support is helpful, it also brings me to question if the unique role of

194

occupational therapy was displayed to the inter-professional team and the impact of reliance on the physical therapists on the occupational therapist's professional identity.

While no factor was consistent across all experiences, time was the most prevalent factor impacting best practice. It is helpful to identify the variety of potential factors that might influence practice in order to better prepare students for fieldwork and to assist fieldwork educators in recognizing barriers at their specific fieldwork sites.

Relationship with fieldwork educator. The relationship between the student and his/her fieldwork educator proved to play an important role in the overall experience of the fieldwork by the student. Generally, students reported a positive relationship with their educators and were able to identify fieldwork educator behaviors that contributed to this perception. Students reported positive experiences with fieldwork educators who were pleasant, eager to learn, and who viewed the relationship as collaborative rather than hierarchical. Additionally, the experience between student and fieldwork educator can be viewed positively even if the fieldwork educator did not model occupation-based practice. For example, during Morgan's second placement he reported his fieldwork educator was collaborative, used open communication, provided direct feedback, and engaged Morgan in mutual exchange of skills and knowledge, but did not implement the use of occupation into practice. Despite acknowledging the lack of occupation used in his fieldwork educator's treatment, Morgan strongly valued his fieldwork educator and the relationship he fostered with Morgan.

This finding is supported by Grenier's (2015) recent study which identified that students had a preference for collaborative learning models in which fieldwork educators were seen more as mentors than supervisors. Fieldwork educators who supported

195

students in trying new and creative interventions were viewed positively in comparison to fieldwork educators who held tighter control over students' decisions or "shot down" ideas students expressed. Fieldwork educators who demonstrated desire to not only teach the student but also learn from the student were viewed positively by students in comparison to educators who held an attitude of being the expert, "knowing it all", and who were closed-minded when students offered information. Fieldwork educators who mentored the students by demonstrating and implementing best practice professional ideals into their own practice, were viewed more positively than fieldwork educators who students perceived as being in a "routine" or a "rut", with less evidence of best practice incorporated into their treatment with clients.

Academic Factors Impacting Integration of Best Practice

The last factor identified was related to the academic program or academic preparation. It was interesting to find in my interviews that students felt prepared for ideal practice conditions but not specifically for managing factors that were barriers to implementing best practice ideals during fieldwork and might be barriers in their future practice. Although students reported that time and access to literature were mentioned during their academic coursework, students could not recall strategies to overcome these barriers. During my first interview with each student they shared with me a number of learning activities they participated in during their academic coursework. The activities appeared to be meaningful to the students at the time, but also may have unintentionally prepared students for practice in ideal conditions than for the realities of practice. For example, a common learning activity completed during coursework involves completion of a client treatment plan, including creating client goals and interventions to address the

goals. This activity is helpful for students to understand the occupational therapy

process, starting with evaluation and ending with outcomes. However, it may not prepare

students for environmental barriers experienced in an authentic healthcare environment

that impact the occupational therapy process. For example, when creating goals and

interventions during school, students have unlimited opportunities to be creative with

their plan, increasing ease of demonstrating client-centered and occupation-based

practice. Unfortunately, this may lead to the perception that client-centered and

occupation-based practice is easy and always possible to achieve; actually, it isn't

realistic in most occupational therapy practice arenas, where barriers such as time,

available resources, physical environment, etc. are present.

Additionally, students had difficulty demonstrating a conceptual understanding of

core concepts of the profession. For example, when talking with the students about the

evaluation process, they were apt to immediately think of specific assessment tools rather

than the broad concept of evaluation. Their concrete understanding of these core

concepts of the profession limited their ability to apply and generalize these concepts

during fieldwork. Students also seemed inclined to focus on only one professional ideal

at a time, rather than the simultaneous use of all three and how they are implemented

throughout the occupational therapy process.

Lastly, through no fault of their own, the evaluation process of students on Level

II fieldwork emphasizes achieving entry-level practice at the fieldwork site. This often

results in the fieldwork site focusing on a students' independence with a full client

caseload rather than how well the student implemented best practice. Moreover, the

fieldwork performance evaluation for the occupational therapy student, marketed by the

national professional organization, includes only eight items (out of 42) that directly

identify implementing one of the three professional ideals. None of these items evaluate

the simultaneous implementation of all three ideals, disregarding the definition of best

practice proposed by Strong (2003) and used for the purpose of this study.

　　　　Communication with academic supports. Communication between the student

and academic program surfaced as a clear academic factor. Students reported varied

levels of communication with academic supports, including academic fieldwork

coordinator, faculty, and peers. The four students represented two academic programs

leading to two different communication processes that were in place between the

academic program and students while on Level II fieldwork. For example, one academic

program facilitated weekly discussion boards with students throughout the 12-week

experience, in addition to a phone call or site visit with student, fieldwork educator, and

academic fieldwork coordinator. In comparison, the other academic program required

students to write one blog post during the 12 weeks and that was the extent of the

required communication between academic program and students. One of the students

commented on how she felt so "far flung" from her peers, after being so close during

coursework. The other student commented that during her fieldwork experiences, she did

reach out to a couple faculty members, who she viewed as mentors within her program,

demonstrating more of an informal and spontaneous mechanism of communication for

the student. Interesting to note, one of the students who had a challenging fieldwork

experience due to the workplace culture, did not reach out to her academic program

regarding the challenges. She reported that she "wasn't a fan" of her academic fieldwork

coordinator, but also that it created the potential for a more complicated dynamic at the

site, if the site was contacted about the students reporting challenges. The student commented the only time she would have contacted the academic fieldwork coordinator in that situation was if she was concerned about passing her fieldwork, which was not the case. This correlates back to the power differential dynamic previously mentioned that exists for students while on fieldwork.

The participation in weekly discussion boards provided opportunities for students to share with their peers about their experience as well as problem solve challenges encountered. Additionally, discussion boards offered opportunity for the students to reflect on their experiences. The two students with this experience seemed to value the opportunity to have frequent discussion with their peers. They also identified their peers as a support as they integrated their knowledge of best practice into fieldwork, despite their peers not being physically present at the site. The literature also supports using technology to provide opportunities for students to share ideas, collaborate on projects, and potentially reduce feelings of isolation for students distanced from peers (Daniels, 2010; Thomas & Storr, 2005).

Relatedness of Findings to Conceptual Framework

When beginning this research study, I viewed the student learning experience from the sociocultural perspective, believing that the context in which the student was learning during fieldwork would impact their learning experience. Two learning theories consistent with this perspective were helpful to understanding the students learning experience. In each of the students' fieldwork placements it was easy to see how the environment impacted their ability to implement best practice. Viewing the experiences through Vygotsky's Sociocultural Learning Theory, each student was matched with a

199

fieldwork educator who had greater expertise and knowledge within the field of occupational therapy and they (the fieldwork educators) were able to facilitate the students understanding of how to perform various activities associated with the occupational therapist role throughout the placement. What I didn't thoroughly consider before starting the study was the impact on learning when the fieldwork educator lacked expertise and knowledge related to implementing best practice ideals. In these situations, students felt confident with the day to day activities of providing occupational therapy services but did not feel confident in their abilities to provide client care aligning with the best practice professional ideals.

In addition to the learning experience resulting directly from the student-fieldwork educator relationship, the broader social context impacted the students learning experiences. Throughout each of the students' fieldwork placements the community of practice established at the facility impacted the students learning, some positively and some negatively. Early in the student's experiences, they were not able to directly contribute to the community of practice because they first had to demonstrate adequate competency and become familiar with the norms, relationships, and shared repertoire at the setting (Wenger, 1998, 2000). This includes gaining an understanding of the language, routines, and tools that are used. Once students became familiar with and felt accepted by the community of practice at each setting, they were able to look beyond day-to-day activities to consider how they might increase their participation and contributions regarding best practices. Students were strongly influenced by the specific best practice professional ideals accepted within the community of practice. For example, in Morgan's first fieldwork experience bathing/showering was not typically addressed by

the occupational therapy team within his setting. He recognized that bathing/showering was not part of the usual practice routine for therapists. Despite identifying self-care as a highly valued occupation of the client, the joint understanding, norms, and routine that had been established by the community of practice took precedent over his own ability to address this aspect of client care.

The last theory I identified prior to the start of my study was Lifeworld described by Dall' Alba (2004; 2009). What was unique about this theory is the emphasis placed on learning about practice rather than learning through practice. The previous two theories mentioned place greater emphasis on learning through practice. The value of this theory became even more evident with each interview. It was clear that a large emphasis of student learning, across all four participants, was learning particular routines and activities reflecting occupational therapy practice at a given site. The one exception to this was Sylvia's second Level II fieldwork experience. She described learning what it meant to be an occupational therapist rather than just learning the particular routines and activities at the site. She was able to discern how specific activities at the site were reflective of broader patterns or concepts of practice across sites and by doing so, she was able to understand the distinct value that occupational therapy contributed to the setting.

Hooper (2010) described the dangers of curriculum focused on the learning of specific skills needed for care for a particular diagnoses or practice setting. Specifically, students miss the bigger picture of the need to focus on occupation and instead focus on addressing impairment. This theory supports the need for academic curricula to focus on core concepts of the profession rather than content driven by specific diagnoses or practice settings. When students learn from a content driven curriculum where emphasis

201

is on understanding the role of occupational therapy with particular populations (ex. pediatrics, pediatric-adolescent mental health, adult mental health, adult physical dysfunction, gerontics), it becomes clear that students are learning to practice occupational therapy toward a particular population or practice setting. In comparison, when students learn through a curriculum that is implemented using concept-based and subject-centered pedagogy, they more easily understand how the core concepts of the profession are applied across the life span and across practice settings. Use of a concept-based curriculum model has tremendous potential to teach students to be occupational therapists rather than learn to practice occupational therapy in a specific setting.

At the conclusion of my study I reflected back on the learning experience of each student, the conceptual frameworks utilized and what I had learned through this experience and I realized something was missing. After some reflection I realized that the missing element was a conceptual understanding of the journey within each student and the student's response to learning challenges. For example, when my second student, Sarah, experienced dissonance between what she understood as best practice and the activities of her fieldwork site, she did not question the authority of the site in any way, but accepted it as normal. My first student, Morgan, recognized dissonance and was questioning the activities at the site but because he thought of himself as "only a student", he was not able to mobilize himself to speak directly with his therapist about his thoughts or ideas or take any action. In contrast my fourth student, Sylvia, recognized the problem and took steps to introduce change.

I found the theoretical model authored by Baxter Magolda and King (2012) helpful to understanding the student journey to self-authorship. The authors describe a

ten position journey which has been used to describe college student development. The continuum begins with a student relying fully on external authority for their own meaning making. Over time the student begins to recognize shortcomings in their previously accepted external authority and enters the phase referred to as *crossroads* where the student begins to question external authority and to create an internal voice as a reference point rather than relying on external authority. Within this model, with time and experience, the student gradually learns to trust their internal voice and use it when responding to external authority. As a student continues along the continuum, strengthening and trusting their own inner voice, they begin to craft their own "beliefs, values, identity, and relationship to the world into a philosophy of living to guide one's decisions actions" (Baxter Magolda & King, 2012, p. 98). The final position describes the solidifying of this new philosophy and it becoming second nature. This theoretical model also considers the students' personal characteristics, personal experiences, personal interpretation of experiences in relation to how they move along the continuum.

Through the concepts of each of the theories identified, I was able to gain a broad understanding of the students' experience during Level II fieldwork. The two sociocultural learning theories helped me to understand the outside influences on the student. The Lifeworld perspective (Dall' Alba, 2004; 2009) helped me to understand how the academic preparation influences the students conceptually understanding of the profession. Lastly, Baxter Magolda and King's (2012) theory on journey to self-authorship helped me to understand the student themselves and how that impacted their ability to implement best practice.

Contributions to the Literature

The current literature provides ample evidence that occupational therapy practitioners experience barriers with implementing best practice professional ideals into practice (Aiken et al., 2011; Di Tommaso et al., 2016; Estes & Pierce, 2012; Kristensen et al., 2011; Lyons et al., 2011; Salls et al., 2009; Sumsion & Lencucha, 2009; Wilkins et al., 2001). The literature also provides examples of practitioner's difficulty with transitioning from school to practice and the feelings of tension experienced by therapists when they realize they aren't able to live up to the best practice within the profession (Aiken et al., 2011; Ripat et al., 2013; Towns & Ashby, 2014). There is a gap in the literature regarding how students experience Level II fieldwork in relation to integration of best practice ideals into practice. This study specifically contributes to the literature regarding this wonder, in several different ways, which in turn provides some insight into why the theory-practice gap continues to exist. First, this study provides greater understanding into student-specific factors that impact student learning on Level II fieldwork. Second, this study provides greater understanding into the impact of site-specific factors, such as the sociocultural environment and resources available and how these factors impact student learning on Level II fieldwork. Third, this study provides greater understanding into the relationship between the student and the fieldwork educator during Level II fieldwork and how the relationship can impact student learning on fieldwork and students' ability to implement best practice. Fourth, this study provides insight into the factors specific to the academic program and how these factors impact student learning during Level II fieldwork. Lastly, this study contributes to the literature by providing research using narrative inquiry methodology to explore the stories of

occupational therapy students on fieldwork. While narrative inquiry methodology has been utilized within occupational therapy literature there is still work to be done to demonstrate the unique value it offers.

Recommendations and Implications

Through the completion of this study, I have identified recommendations for *occupational therapy students* who will be completing Level II fieldwork, for *occupational therapy fieldwork educators and fieldwork site coordinators* who mentor students at fieldwork settings during Level II experiences, and *occupational therapy academic programs* nationwide.

Occupational Therapy Students

Every student has a unique experience on their Level II fieldworks. The overall experience for a student results from the relationships among several factors, one of which is what the student brings to the experience. That is, the experience is a culmination of who they are, their personality, their strengths and areas of growth, their beliefs and values. These factors, along with other factors uniquely specific to the fieldwork environment and fieldwork educator come together to influence the students experience.

The following general recommendations for students are strategies to assist them in integrating their academic knowledge of the best practice professional ideals into practice during fieldwork. (1) Prior to Level II fieldwork, the student would benefit from a structured activity requiring reflection and self-assessment regarding personal strengths and areas of growth. In completion of the activity, students should identify how their personal strengths and areas of growth will impact their ability to implement best

practice, while considering common barriers identified in the literature and from this study. (2) Early in the fieldwork experience, the student and fieldwork educator would benefit from completing an environmental analysis to better understand the unique dynamics at the site. The Fieldwork Experience Assessment Tool (FEAT) (AOTA, 2001) could also be utilized to support this analysis and to foster communication to identify strategies that can be used to create the "just-right challenge". (3) Following completion of environmental analysis, the student should identify barriers and supports present at site and consider the possible impact on their learning experience and ability to implement best practice professional ideals. (4) Upon completion of previous recommendations the student should collaborate with fieldwork educator to identify specific goals targeting the students' ability to implement best practice, considering the findings from the previous environmental analysis. (5) The student should identify an action plan to overcome site specific barriers and capitalize on supports in pursuit of achieving previously established goals and implementing best practice. (6) The student would benefit from setting aside time for frequent self-reflection and self-assessment to track progress on achieving goals set. Use of a weekly rating form will help accomplish this, and is available from many academic programs and sites. For an example of such a form https://med.und.edu/occupational-therapy/_files/docs/fieldwork-level-2-weekly-review-form.pdf (University of North Dakota, n.d.). (7) The student should actively challenge themselves, push themselves, take initiative, go above and beyond in pursuit of best practice; it will not come easy.

Occupational therapy fieldwork educators and fieldwork site coordinators

Fieldwork educators and fieldwork site coordinators in the occupational therapy profession are not typically compensated financially for working with occupational therapy students, although they are awarded continuing education credits for the direct supervision. In addition, occupational therapy fieldwork educators are not provided with specific training requirements to serve as a fieldwork educator other than what the academic program may provide as resources. Although the profession now offers a course for fieldwork educator training, it entails a two-day commitment for participation. However, there are also online options that would be helpful for fieldwork educators if the two-day on site commitment is not feasible. Online options include Preceptor Education Program for the Health Professionals and Students (Kinsella et al., 2016) and ClinEdAus: Enabling Clinical Education Skills (Queensland Health, 2019). According to accreditation standards, fieldwork educators are required to be currently licensed and regulated, have one year of full time experience since certification and "adequately" prepared for the role (ACOTE, 2018).

Based on findings from this study demonstrating the importance of the fieldwork educator in the student experience on fieldwork, it is recommended that fieldwork educators participate in specific training on being a fieldwork educator prior to accepting their first Level II student. Educator training should also focus on facilitating a collaborative relationship between fieldwork student and fieldwork educator. Students in this study strongly preferred a collaborative relationship with their fieldwork educator, one who is open to learning themselves. In order for fieldwork educators to support students in a collaborative relationship and in their understanding and application of best practice during fieldwork, they must be supported in their role as an educator.

Considering the lack of incentive, lack of time allocated, and responsibilities that fieldwork educators are already required to do, it is difficult to add more responsibilities to their duties without adequately supporting them in their role.

Despite this challenge, students throughout my study recognized factors that positively impacted their fieldwork experiences leading to the identification of recommendations geared toward occupational therapy fieldwork educators and fieldwork site coordinators. Some of these recommendations can be completed prior to the arrival of a student and some can be utilized during a student's fieldwork experience.

Prior to student arrival. There is often planning involved on the side of the fieldwork educator and fieldwork site, in preparation for a student to arrive. Current accreditation standards require site-specific learning objectives to be identified prior to student arrival. Additional preparation can be incorporated to more effectively assist a student in integrating the best practice professional ideals learned during coursework, into practice while in fieldwork. The following is a list of strategies that fieldwork educators and fieldwork site coordinators might consider. (1) Reflect on occupational therapy practice at the fieldwork site and identify how best practice professional ideals are integrated into practice, including during each of the stages of the occupational therapy process. (2) Reflect on barriers and supports at the fieldwork site that impact the implementation of best practice professional ideals into client care. (3) Make an action plan to assist occupational therapy practitioners and students in overcoming previously identified barriers and strategies to capitalize on supports. (4) Identify strategies to incorporate best practice professional ideals into student learning experiences such as adding weekly reflection on best practice into the weekly meeting form. (5) Consider

how to balance student performance of demonstrating best practice with performance of entry-level competence and perceived expectation of independently managing a full case load. (6) Reflect on site-specific learning objectives and create ways to incorporate best practice professional ideals into the students specific learning objectives, thus naturally adding the focus during the learning experience. (7) Reflect on weekly learning activities and create ways to incorporate best practice professional ideals into the students learning experience. Consider what might be appropriate at week one related to best practice in comparison to what might be appropriate at week nine.

During students' fieldwork experience. Once fieldwork educators and the fieldwork site coordinator have considered the strategies recommended in the previous section, the following recommendations will be a logical extension of these efforts. (1) Orient student to how best practice professional ideals are implemented at the fieldwork site, specifically addressing each phase of the occupational therapy process. (2) Discuss with students their preferred learning style, preferred method of giving and receiving feedback, and their personality characteristics. All of these items will impact the student fieldwork educator relationship and overall student learning experience. (3) Orient student to site-specific learning objectives highlighting the importance of best practice. (4) Orient student to weekly learning activities highlight the application of best practice throughout the 12-week experience. (5) Orient student to barriers and supports they may experience at the fieldwork site which may impact their ability to implement best practice. The assumption here is that the fieldwork educator themselves have already become aware of the barriers and they can assist students in working to address them. However, if the fieldwork educators are just learning to identify the barriers, they may

209

need support from the academic fieldwork coordinator to assist in identifying unique

supports and barriers and supporting them through the process, so they are able to

supports students. (6) Facilitate students' development of a learning plan identifying

strategies to overcome barriers and capitalize on supports unique to the fieldwork site.

This particular strategy is supported by literature which suggests the need to use specific

teaching methods to bridge the theory-practice gap and to teach students to integrate

skills during fieldwork and overcome the barriers present in the real-world (Morrison &

Robertson, 2016). (7) During weekly meetings, facilitate students' reflection and self-

assessment regarding performance with implementing best practice. This would require

the best practice professional ideals to be monitored as part of a weekly meeting similar

to other areas of competency that are evaluated weekly, such as completing conducting

evaluations, selecting and documentation interventions, demonstrating time management,

etc. If a weekly meeting form is utilized, it could be adapted to include self-assessment

and feedback from the fieldwork educator on the three areas of best practice. (8)

Consider brief fieldwork assignments designed to assist the student in implementing best

practice. (9) Regularly evaluate students' ability to implement best practice and adjust

students' responsibilities accordingly to positively support continued growth. According

to Farber and Koenig (2009), increasing opportunities for students to engage in reflective

practice during the fieldwork experience is important to improve entry-level

competencies.

Occupational therapy academic programs

The academic environment is typically a student's first in-depth exposure to the

profession of occupational therapy and sets the foundation for the formation of their

professional identify as an occupational therapist. It is the goal of the academic program to prepare occupational therapists to be competent entry-level generalist practitioners who engage in client-centered, occupation-based, and evidence-based practice. College is also the time in which students move along their journey to self-authorship, a desirable achievement for occupational therapy graduates. Students who demonstrate self-authorship have the capacity to be change agents within their future occupational therapy practice and within the profession. Baxter Magolda and King (2004) authored the Learning Partnership Model as a framework for educators to facilitate the development of students' self-authorship. The three key assumptions and three key principles can be used by occupational therapy educators to build learning partnerships among students and between students and educators (Baxter Magolda & King, 2004). The following are recommendations specifically for academic preparation, fieldwork preparation, and during fieldwork experiences.

Academic preparation. Academic programs often organize curriculum around occupational therapy practice areas, such as pediatrics, mental health, and physical rehabilitation. This method of preparation places an emphasis on learning to practice occupational therapy in these specific practice contexts, which often leads to compartmentalized thinking and difficulty generalizing learning. Additionally, it appeared that the students had a concreate understanding of the core concepts of client-centered, occupation-based, and evidence-based practice. They struggled with generalizing how these core concepts might be applied throughout the occupational therapy process from evaluation, to intervention, to discharge. For example, how does one demonstrate client-centered practice during evaluation, intervention, and discharge?

211

What does that look like? What does it mean to implement occupation-based practice during the evaluation process? During my first interview with students, they struggled with answering these types of questions. For example, when I visited with the students about their understanding of how the best practice professional ideals are implemented during evaluation, they automatically spoke about specific assessment tools instead of conceptualizing evaluation broadly.

It is recommended that academic programs consider exploring subject-centered education and concept-based teaching, shifting curricular focus from emphasis on delivering specific content to a conceptual understanding which may lead to greater generalization of core concepts of the profession as well as a strengthened professional identity for students.

Fieldwork preparation. The way academic programs prepare students for Level II fieldwork presumably varies from program to program thus these recommendations are general and perhaps already present in some academic programs. It is recommended that academic programs be intentional about preparing students specifically for Level II fieldwork experiences. Intentional preparation can begin when students participate in Level I fieldwork experiences. The following are ideas that can be incorporated as methods for fieldwork preparation. (1) Facilitate students' ability to identify fieldwork site performance patterns (roles, habits, routines) during Level I and Level II fieldwork; provide opportunities to discuss the impacts these patterns had on implementation of best practice; discuss strategies to overcome any challenges that result. (2) Facilitate students' ability to analyze fieldwork site workplace cultures and power dynamics during Level I and Level II fieldwork; provide opportunities to discuss the impact of these dynamics on

212

the learning experience; discuss possible strategies to work through these situations. (3)

Facilitate students' ability to identify fieldwork site barriers and supports during Level I

and Level II fieldwork and provide opportunities to discuss strategies to overcome

barriers and capitalize on supports.

During fieldwork experiences. I previously noted in my research findings the

difference in the amount of communication that occurred between the students in my

study and their affiliated academic program, while they were on Level II fieldwork.

There are currently no mandated requirements indicating the amount of communication

the academic program should have with students while on fieldwork, leading to extreme

variability across academic programs nationwide, as evidenced in my study. Based on

the findings in my study I recommend that several opportunities for communication exist

between the student and the academic program, which may involve faculty, academic

fieldwork coordinator, students, and peers. Some of these communications should occur

face-to-face, either in person or via technology to create more authentic and intentional

learning environments. The more frequent the communication, the more opportunities

students will have to reflect on their experiences, share their experiences, and learn from

the experiences of others. Based on the experiences of the students participating in my

study, the opportunity for in-depth reflection and co-construction of knowledge between

myself and the students served as a support to propel students along their own journey to

self-authorship. While it is difficult to conjecture the appropriate frequency of

communication, I believe that one occurrence throughout 12 weeks is insufficient and

weekly occurrences may be excessive.

Academic fieldwork coordinator. Currently, the role of academic fieldwork coordinator is often seen as the position within the academic program that ensures the administrative components of fieldwork are in compliance with accreditation standards. There is very little focus in the accreditation standards that places emphasis on the role of the academic fieldwork coordinator regarding the coaching and teaching aspects of the role, both in reference to students and fieldwork educators. There are a total of 16 standards related to Level I and Level II fieldwork and there is one sentence within all of those standards that relates to the teaching responsibilities of the academic fieldwork coordinator. The statement is "document a mechanism for evaluating the effectiveness of supervision and for providing resources for enhancing supervision (e.g., materials on supervisory skills, continuing education opportunities, articles on theory and practice)" (ACOTE, 2018, p. 42-43). Resources can easily be provided through communication that is already occurring, such as emails to the site when upcoming students are scheduled to arrive. The reality is that fieldwork educators and site coordinators are busy with their day to day duties in providing client care and don't always have extra time to read resources attached to email conversations. There is a need to provide fieldwork educators and site coordinators with more intentional training that supports their educator role directly. Doing so also is difficult for individuals in the role of academic fieldwork coordinator as time allocation may not allow for more intentional and thoughtful training of fieldwork educators, despite the need.

There is a need to improve connectedness between what is occurring in the academic coursework and what students are experiencing on fieldwork. This discrepancy is best ameliorated by work that the academic fieldwork educator could do, if given

214

adequate time and resources. It is recommended that academic fieldwork coordinators nationwide continue with joint efforts in providing intentional and thoughtful training to fieldwork educators regarding the best practice professional ideals and why they matter during student fieldwork experience. It is also recommended that academic fieldwork coordinators continue to share resources in order to best support each other, best support fieldwork educators, and ultimately, best support students.

Recommendations for Future Study

As a result of the findings from this study and my own practical experiences, there are several areas of future research needed for greater understanding of the complexities surrounding occupational therapy best practice ideals, college student learning, development of professional identity, and transitions into professional life.

Future study is recommended on the concept of best practice within the occupational therapy profession. Through this study it was clear that the students lacked understanding of the concept of best practice, leading me to recommend additional research to more clearly define and operationalize the concept. It is also important to identify the viability of this concept within today's occupational therapy service delivery models. What does the concept of best practice look like across the occupational therapy process? How is best practice implemented in various occupational therapy practice contexts? What is the student learning outcome related to the concept of best practice? How do occupational therapy fieldwork educators understand and perceive the applicability of best practice within their practice setting?

Through my own recent experience serving on our departmental curriculum ad-hoc committee leading our faculty through a full curricular revision including two new

215

pedagogies, I have come to wonder the impact of specific pedagogies on students learning outcomes, ability to integrate best practice on fieldwork, and professional identity development. Future study is recommended exploring the learning outcomes for students who have experienced subject-centered and concept-based curriculum in comparison to content-driven curriculum.

The findings of this study led me to explore the concept of self-authorship as a means to describe students own developmental journey during Level II fieldwork. As a result, future research is needed to explore the concept of self-authorship and the learning partnership model in relation to occupational therapy curriculum and integration of best practice on fieldwork. In addition, research exploring the intersection between students' gender and culture in relation to their journey to self-authorship and achievement of learning outcomes would be useful.

Through my own practical experiences and related to this research, I recommend future research on student learning outcomes during fieldwork when considering approaches other than those traditionally used. For example, exploring the use of alternative fieldwork supervision models, on students' ability to integrate best practice ideals as well as on students' professional identity development. Another example is exploring the use of various structures of Level I and Level II fieldwork learning opportunities, such as simulation, faculty led experiences, pro bono clinic experiences, and other non-traditional fieldwork settings, on students' ability to integrate best practice ideals and on students' professional identity development.

Lastly, an area that was not specifically explored within my study but is important for student learning and development is student transitions. Future studies are needed

216

exploring the transitions from classroom setting to fieldwork setting to workplace while

applying various transition theories. Research is needed exploring the professional

identity development for students as they progress in and out of various transitions on

their way to being a professional.

Conclusions

The findings of this study provide greater understanding into occupational therapy

student's experiences with integrating best practice professional ideals into Level II

fieldwork. The findings demonstrate the discrepancy students experience between their

academic knowledge and their Level II fieldwork, contributing to the theory-to-practice

gap. There were a number of factors identified that impacted student's ability to

implement best practice. These factors were categorized into three groups: student

factors, site-specific factors, and academic factors. Student factors included unique

personality, power differential, and the developmental continuum. The most commonly

identified site-specific factors included time, size of client caseload, resources available,

physical space, therapists' creativity, workplace culture, approaches used by and

expectations of other team members, the protocol driven nature of practice, and the

relationship with fieldwork educator. The academic factors included preparation for ideal

practice but not the realities of practices, concrete understanding of core concepts of the

profession, fieldwork performance evaluation emphasis on achieving entry-level practice

leading to a focus on client caseload but not implementation of best practice, and

communication with academic supports throughout Level II fieldwork.

In addition to the above findings, my study raised several questions. First, what is

the impact of various curricular designs and pedagogies on student learning,

implementing of best practice, and student professional identity development? Second, what is the impact of various fieldwork supervision models and fieldwork structures on student learning, implementing of best practice, and student professional identity development? Third, what is the impact on the student's journey to self-authorship with the application of the self-authorship model (Baxter Magolda & King, 2004)? How is self-authorship related to student's ability to integrate best practice ideals into fieldwork? Fourth, how can greater understanding of transition theory lead to more effective transitions from classroom to fieldwork and fieldwork to the workplace?

This study has been a journey of personal perseverance as a qualitative researcher and advocate for occupational therapy student learning and best practice. It has taught me a great deal about the complexities of knowledge integration and the interplay of several dynamics impacting the learning experiences for students on Level II fieldwork. The identities of the students in my study, as with all of us, are always in the making, dependent on particular times and particular social and institutional narratives (Clandinin, Cave, Cave, 2011). In narrative inquiry "the stories are always partial, always contextual, and always in the relational space between researcher and participant" (Clandinin, 2013, p. 116).

APPENDICES

APPENDIX A

ACOTE C STANDARDS

SECTION C: FIELDWORK EDUCATION

C.1.0: FIELDWORK EDUCATION

Fieldwork education is a crucial part of professional preparation and is best integrated as a component of the curriculum design. The fieldwork experience is designed to promote clinical reasoning and reflective practice, transmit the values and beliefs that enable ethical practice, and develop professionalism and competence in career responsibilities. Fieldwork experiences should be implemented and evaluated for their effectiveness by the educational institution. The experience should provide the student with the opportunity to carry out professional responsibilities under the supervision of qualified personnel serving as a role model. The academic fieldwork coordinator is responsible for the program's compliance with fieldwork education requirements. The academic fieldwork coordinator will:

STANDARD NUMBER	ACCREDITATION STANDARDS FOR A DOCTORAL-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPIST	ACCREDITATION STANDARDS FOR A MASTER'S-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPIST	ACCREDITATION STANDARDS FOR A BACCALAUREATE-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPY ASSISTANT	ACCREDITATION STANDARDS FOR AN ASSOCIATE-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPY ASSISTANT
C.1.1. Fieldwork Program Reflects the Curriculum Design				
C.1.1.	Ensure that the fieldwork program reflects the sequence and scope of content in the curriculum design, in collaboration with faculty, so that fieldwork experiences in traditional, nontraditional, and emerging settings strengthen the ties between didactic and fieldwork education.	Ensure that the fieldwork program reflects the sequence and scope of content in the curriculum design, in collaboration with faculty, so that fieldwork experiences in traditional, nontraditional, and emerging settings strengthen the ties between didactic and fieldwork education.	Ensure that the fieldwork program reflects the sequence and scope of content in the curriculum design, in collaboration with faculty, so that fieldwork experiences in traditional, nontraditional, and emerging settings strengthen the ties between didactic and fieldwork education.	Ensure that the fieldwork program reflects the sequence and scope of content in the curriculum design, in collaboration with faculty, so that fieldwork experiences in traditional, nontraditional, and emerging settings strengthen the ties between didactic and fieldwork education.
C.1.2. Criteria and Process for Selecting Fieldwork Sites				
C.1.2.	Document the criteria and process for selecting fieldwork sites, to include maintaining memoranda of understanding, complying with all site requirements, maintaining site objectives and site data, and communicating this information to students prior to the start of the fieldwork experience.	Document the criteria and process for selecting fieldwork sites, to include maintaining memoranda of understanding, complying with all site requirements, maintaining site objectives and site data, and communicating this information to students prior to the start of the fieldwork experience.	Document the criteria and process for selecting fieldwork sites, to include maintaining memoranda of understanding, complying with all site requirements, maintaining site objectives and site data, and communicating this information to students prior to the start of the fieldwork experience.	Document the criteria and process for selecting fieldwork sites, to include maintaining memoranda of understanding, complying with all site requirements, maintaining site objectives and site data, and communicating this information to students prior to the start of the fieldwork experience.
C.1.3. Fieldwork Objectives				
C.1.3.	Document that academic and fieldwork educators agree on established fieldwork objectives prior to the start of the fieldwork experience, and communicate with the student and fieldwork educator about progress and performance throughout the fieldwork experience. Ensure that fieldwork objectives for all experiences include a psychosocial objective.	Document that academic and fieldwork educators agree on established fieldwork objectives prior to the start of the fieldwork experience, and communicate with the student and fieldwork educator about progress and performance throughout the fieldwork experience. Ensure that fieldwork objectives for all experiences include a psychosocial objective.	Document that academic and fieldwork educators agree on established fieldwork objectives prior to the start of the fieldwork experience, and communicate with the student and fieldwork educator about progress and performance throughout the fieldwork experience. Ensure that fieldwork objectives for all experiences include a psychosocial objective.	Document that academic and fieldwork educators agree on established fieldwork objectives prior to the start of the fieldwork experience, and communicate with the student and fieldwork educator about progress and performance throughout the fieldwork experience. Ensure that fieldwork objectives for all experiences include a psychosocial objective.

STANDARD NUMBER	ACCREDITATION STANDARDS FOR A DOCTORAL-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPIST	ACCREDITATION STANDARDS FOR A MASTER'S-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPIST	ACCREDITATION STANDARDS FOR A BACCALAUREATE-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPY ASSISTANT	ACCREDITATION STANDARDS FOR AN ASSOCIATE-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPY ASSISTANT
C.1.4. Ratio of Fieldwork Educators to Students				
C.1.4.	Ensure that the ratio of fieldwork educators to students enables proper supervision, and provides protection of consumers, opportunities for appropriate role modeling of occupational therapy practice, and the ability to provide frequent assessment of student progress in achieving stated fieldwork objectives.	Ensure that the ratio of fieldwork educators to students enables proper supervision, and provides protection of consumers, opportunities for appropriate role modeling of occupational therapy practice, and the ability to provide frequent assessment of student progress in achieving stated fieldwork objectives.	Ensure that the ratio of fieldwork educators to students enables proper supervision, and provides protection of consumers, opportunities for appropriate role modeling of occupational therapy practice, and the ability to provide frequent assessment of student progress in achieving stated fieldwork objectives.	Ensure that the ratio of fieldwork educators to students enables proper supervision, and provides protection of consumers, opportunities for appropriate role modeling of occupational therapy practice, and the ability to provide frequent assessment of student progress in achieving stated fieldwork objectives.
C.1.5. Sufficient Fieldwork Agreements				
C.1.5.	Ensure that fieldwork agreements are sufficient in scope and number to allow completion of graduation requirements in a timely manner, in accordance with the policy adopted by the program as required by Standard A.4.7.	Ensure that fieldwork agreements are sufficient in scope and number to allow completion of graduation requirements in a timely manner, in accordance with the policy adopted by the program as required by Standard A.4.7.	Ensure that fieldwork agreements are sufficient in scope and number to allow completion of graduation requirements in a timely manner, in accordance with the policy adopted by the program as required by Standard A.4.7.	Ensure that fieldwork agreements are sufficient in scope and number to allow completion of graduation requirements in a timely manner, in accordance with the policy adopted by the program as required by Standard A.4.7.
C.1.6. Level I and II Fieldwork MOUs				
C.1.6.	The program must have evidence of valid memoranda of understanding in effect and signed by both parties from the onset to conclusion of the Level I fieldwork and the Level II fieldwork if it involves an entity outside of the academic program. (Electronic memoranda of understanding and signatures are acceptable.) Responsibilities of the sponsoring institution(s) and each fieldwork site must be clearly documented in the memorandum of understanding.	The program must have evidence of valid memoranda of understanding in effect and signed by both parties from the onset to conclusion of the Level I fieldwork and the Level II fieldwork if it involves an entity outside of the academic program. (Electronic memoranda of understanding and signatures are acceptable.) Responsibilities of the sponsoring institution(s) and each fieldwork site must be clearly documented in the memorandum of understanding.	The program must have evidence of valid memoranda of understanding in effect and signed by both parties from the onset to conclusion of the Level I fieldwork and the Level II fieldwork if it involves an entity outside of the academic program. (Electronic memoranda of understanding and signatures are acceptable.) Responsibilities of the sponsoring institution(s) and each fieldwork site must be clearly documented in the memorandum of understanding.	The program must have evidence of valid memoranda of understanding in effect and signed by both parties from the onset to conclusion of the Level I fieldwork and the Level II fieldwork if it involves an entity outside of the academic program. (Electronic memoranda of understanding and signatures are acceptable.) Responsibilities of the sponsoring institution(s) and each fieldwork site must be clearly documented in the memorandum of understanding.
	IF A FIELD TRIP, OBSERVATION, OR SERVICE LEARNING ACTIVITY IS USED TO COUNT TOWARD PART OF A LEVEL I FIELDWORK, THEN A MEMORANDUM OF UNDERSTANDING IS REQUIRED. IF A FIELD TRIP, OBSERVATION, OR SERVICE LEARNING ACTIVITY IS NOT USED TO COUNT TOWARD PART OF THE LEVEL I FIELDWORK, THEN NO MEMORANDUM OF UNDERSTANDING IS REQUIRED. *WHEN A MEMORANDUM OF UNDERSTANDING IS ESTABLISHED WITH A MULTISITE SERVICE PROVIDER (E.G., CONTRACT AGENCY, CORPORATE ENTITY), THE ACOTE STANDARDS DO NOT REQUIRE A SEPARATE MEMORANDUM OF UNDERSTANDING WITH EACH PRACTICE SITE.*			
C.1.7. Fieldwork in Behavioral Health or Psychological and Social Factors				
C.1.7.	At least one fieldwork experience (either Level I or Level II) must address practice in behavioral health, or psychological and social factors influencing engagement in occupation.	At least one fieldwork experience (either Level I or Level II) must address practice in behavioral health, or psychological and social factors influencing engagement in occupation.	At least one fieldwork experience (either Level I or Level II) must address practice in behavioral health, or psychological and social factors influencing engagement in occupation.	At least one fieldwork experience (either Level I or Level II) must address practice in behavioral health, or psychological and social factors influencing engagement in occupation.

222

STANDARD NUMBER	ACCREDITATION STANDARDS FOR A DOCTORAL-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPIST	ACCREDITATION STANDARDS FOR A MASTER'S-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPIST	ACCREDITATION STANDARDS FOR A BACCALAUREATE-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPY ASSISTANT	ACCREDITATION STANDARDS FOR AN ASSOCIATE-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPY ASSISTANT
		The goal of Level I fieldwork is to introduce students to fieldwork, apply knowledge to practice, and develop understanding of the needs of clients. The program will:		
C.1.8. Qualified Level I Fieldwork Supervisors				
C.1.8.	Ensure that personnel who supervise Level I fieldwork are informed of the curriculum and fieldwork program design and affirm their ability to support the fieldwork experience. This must occur prior to the onset of the Level I fieldwork. Examples include, but are not limited to, currently licensed or otherwise regulated occupational therapists and occupational therapy assistants, psychologists, physician assistants, teachers, social workers, physicians, speech language pathologists, nurses, and physical therapists.	Ensure that personnel who supervise Level I fieldwork are informed of the curriculum and fieldwork program design and affirm their ability to support the fieldwork experience. This must occur prior to the onset of the Level I fieldwork. Examples include, but are not limited to, currently licensed or otherwise regulated occupational therapists and occupational therapy assistants, psychologists, physician assistants, teachers, social workers, physicians, speech language pathologists, nurses, and physical therapists.	Ensure that personnel who supervise Level I fieldwork are informed of the curriculum and fieldwork program design and affirm their ability to support the fieldwork experience. This must occur prior to the onset of the Level I fieldwork. Examples include, but are not limited to, currently licensed or otherwise regulated occupational therapists and occupational therapy assistants, psychologists, physician assistants, teachers, social workers, physicians, speech language pathologists, nurses, and physical therapists.	Ensure that personnel who supervise Level I fieldwork are informed of the curriculum and fieldwork program design and affirm their ability to support the fieldwork experience. This must occur prior to the onset of the Level I fieldwork. Examples include, but are not limited to, currently licensed or otherwise regulated occupational therapists and occupational therapy assistants, psychologists, physician assistants, teachers, social workers, physicians, speech language pathologists, nurses, and physical therapists.
C.1.9. Level I Fieldwork				
C.1.9.	Document that Level I fieldwork is provided to students and is not substituted for any part of the Level II fieldwork. Ensure that Level I fieldwork enriches didactic coursework through directed observation and participation in selected aspects of the occupational therapy process, and includes mechanisms for formal evaluation of student performance. The program must have clearly documented student learning objectives expected of the Level I fieldwork. Level I fieldwork may be met through one or more of the following instructional methods: • Simulated environments • Standardized patients • Faculty practice • Faculty-led site visits • Supervision by a fieldwork educator in a practice environment All Level I fieldwork must be comparable in rigor.	Document that Level I fieldwork is provided to students and is not substituted for any part of the Level II fieldwork. Ensure that Level I fieldwork enriches didactic coursework through directed observation and participation in selected aspects of the occupational therapy process, and includes mechanisms for formal evaluation of student performance. The program must have clearly documented student learning objectives expected of the Level I fieldwork. Level I fieldwork may be met through one or more of the following instructional methods: • Simulated environments • Standardized patients • Faculty practice • Faculty-led site visits • Supervision by a fieldwork educator in a practice environment All Level I fieldwork must be comparable in rigor.	Document that Level I fieldwork is provided to students and is not substituted for any part of the Level II fieldwork. Ensure that Level I fieldwork enriches didactic coursework through directed observation and participation in selected aspects of the occupational therapy process, and includes mechanisms for formal evaluation of student performance. The program must have clearly documented student learning objectives expected of the Level I fieldwork. Level I fieldwork may be met through one or more of the following instructional methods: • Simulated environments • Standardized patients • Faculty practice • Faculty-led site visits • Supervision by a fieldwork educator in a practice environment All Level I fieldwork must be comparable in rigor.	Document that Level I fieldwork is provided to students and is not substituted for any part of the Level II fieldwork. Ensure that Level I fieldwork enriches didactic coursework through directed observation and participation in selected aspects of the occupational therapy process, and includes mechanisms for formal evaluation of student performance. The program must have clearly documented student learning objectives expected of the Level I fieldwork. Level I fieldwork may be met through one or more of the following instructional methods: • Simulated environments • Standardized patients • Faculty practice • Faculty-led site visits • Supervision by a fieldwork educator in a practice environment All Level I fieldwork must be comparable in rigor.

STANDARD NUMBER	ACCREDITATION STANDARDS FOR A DOCTORAL-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPIST	ACCREDITATION STANDARDS FOR A MASTER'S-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPIST	ACCREDITATION STANDARDS FOR A BACCALAUREATE-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPY ASSISTANT	ACCREDITATION STANDARDS FOR AN ASSOCIATE-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPY ASSISTANT
	The goal of Level II fieldwork is to develop competent, entry-level, generalist occupational therapists. Level II fieldwork must be integral to the program's curriculum design and must include an in-depth experience in delivering occupational therapy services to clients, focusing on the application of purposeful and meaningful occupation and research, administration, and management of occupational therapy services. It is recommended that the student be exposed to a variety of clients across the lifespan and to a variety of settings. The program will:		**The goal of Level II fieldwork is to develop competent, entry-level, generalist occupational therapy assistants. Level II fieldwork must be integral to the program's curriculum design and must include an in-depth experience in delivering occupational therapy services to clients, focusing on the application of purposeful and meaningful occupation. It is recommended that the student be exposed to a variety of clients across the lifespan and to a variety of settings. The program will:**	
C.1.10. Length of Level II Fieldwork				
C.1.10.	Require a minimum of 24 weeks' full-time Level II fieldwork. This may be completed on a part-time basis, as defined by the fieldwork placement in accordance with the fieldwork placement's usual and customary personnel policies, as long as it is at least 50% of an FTE at that site. The student can complete Level II fieldwork in a minimum of one setting if it is reflective of more than one practice area, or in a maximum of four different settings.	Require a minimum of 24 weeks' full-time Level II fieldwork. This may be completed on a part-time basis, as defined by the fieldwork placement in accordance with the fieldwork placement's usual and customary personnel policies, as long as it is at least 50% of an FTE at that site. The student can complete Level II fieldwork in a minimum of one setting if it is reflective of more than one practice area, or in a maximum of four different settings.	Require a minimum of 16 weeks' full-time Level II fieldwork. This may be completed on a part-time basis, as defined by the fieldwork placement in accordance with the fieldwork placement's usual and customary personnel policies, as long as it is at least 50% of an FTE at that site. The student can complete Level II fieldwork in a minimum of one setting if it is reflective of more than one practice area, or in a maximum of three different settings.	Require a minimum of 16 weeks' full-time Level II fieldwork. This may be completed on a part-time basis, as defined by the fieldwork placement in accordance with the fieldwork placement's usual and customary personnel policies, as long as it is at least 50% of an FTE at that site. The student can complete Level II fieldwork in a minimum of one setting if it is reflective of more than one practice area, or in a maximum of three different settings.
C.1.11. Qualified Level II Fieldwork Supervisors				
C.1.11.	Document and verify that the student is supervised by a currently licensed or otherwise regulated occupational therapist who has a minimum of 1 year full-time (or its equivalent) of practice experience as a licensed or otherwise regulated occupational therapist prior to the onset of the Level II fieldwork. Ensure that the student supervisor is adequately prepared to serve as a fieldwork educator prior to the Level II fieldwork. The supervising therapist may be engaged by the fieldwork site or by the educational program.	Document and verify that the student is supervised by a currently licensed or otherwise regulated occupational therapist who has a minimum of 1 year full-time (or its equivalent) of practice experience as a licensed or otherwise regulated occupational therapist prior to the onset of the Level II fieldwork. Ensure that the student supervisor is adequately prepared to serve as a fieldwork educator prior to the Level II fieldwork. The supervising therapist may be engaged by the fieldwork site or by the educational program.	Document and verify that the student is supervised by a currently licensed or otherwise regulated occupational therapist or occupational therapy assistant (under the supervision of an occupational therapist) who has a minimum of 1 year full-time (or its equivalent) of practice experience as a licensed or otherwise regulated occupational therapist or occupational therapy assistant prior to the onset of the Level II fieldwork. Ensure that the student supervisor is adequately prepared to serve as a fieldwork educator prior to the Level II fieldwork. The supervising therapist may be engaged by the fieldwork site or by the educational program.	Document and verify that the student is supervised by a currently licensed or otherwise regulated occupational therapist or occupational therapy assistant (under the supervision of an occupational therapist) who has a minimum of 1 year full-time (or its equivalent) of practice experience as a licensed or otherwise regulated occupational therapist or occupational therapy assistant prior to the onset of the Level II fieldwork. Ensure that the student supervisor is adequately prepared to serve as a fieldwork educator prior to the Level II fieldwork. The supervising therapist may be engaged by the fieldwork site or by the educational program.
C.1.12. Evaluating the Effectiveness of Supervision				
C.1.12.	Document a mechanism for evaluating the effectiveness of supervision (e.g., student evaluation of fieldwork) and for providing resources for enhancing supervision	Document a mechanism for evaluating the effectiveness of supervision (e.g., student evaluation of fieldwork) and for providing resources for enhancing supervision	Document a mechanism for evaluating the effectiveness of supervision (e.g., student evaluation of fieldwork) and for providing resources for enhancing supervision	Document a mechanism for evaluating the effectiveness of supervision (e.g., student evaluation of fieldwork) and for providing resources for enhancing supervision

STANDARD NUMBER	ACCREDITATION STANDARDS FOR A DOCTORAL-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPIST	ACCREDITATION STANDARDS FOR A MASTER'S-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPIST	ACCREDITATION STANDARDS FOR A BACCALAUREATE-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPY ASSISTANT	ACCREDITATION STANDARDS FOR AN ASSOCIATE-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPY ASSISTANT
	(e.g., materials on supervisory skills, continuing education opportunities, articles on theory and practice).	(e.g., materials on supervisory skills, continuing education opportunities, articles on theory and practice).	(e.g., materials on supervisory skills, continuing education opportunities, articles on theory and practice).	(e.g., materials on supervisory skills, continuing education opportunities, articles on theory and practice).
C.1.13. Level II Fieldwork Supervision				
C.1.13.	Ensure that Level II fieldwork supervision is direct and then decreases to less direct supervision as appropriate for the setting, the severity of the client's condition, and the ability of the student to support progression toward entry-level competence.	Ensure that Level II fieldwork supervision is direct and then decreases to less direct supervision as appropriate for the setting, the severity of the client's condition, and the ability of the student to support progression toward entry-level competence.	Ensure that Level II fieldwork supervision is direct and then decreases to less direct supervision as appropriate for the setting, the severity of the client's condition, and the ability of the student to support progression toward entry-level competence.	Ensure that Level II fieldwork supervision is direct and then decreases to less direct supervision as appropriate for the setting, the severity of the client's condition, and the ability of the student to support progression toward entry-level competence.
C.1.14. Fieldwork Supervision Where No OT Services Exist				
C.1.14.	Document and verify that supervision provided in a setting where no occupational therapy services exist includes a documented plan for provision of occupational therapy services and supervision by a currently licensed or otherwise regulated occupational therapist with at least 3 years' full-time or its equivalent of professional experience prior to the Level II fieldwork. Supervision must include a minimum of 8 hours of direct supervision each week of the fieldwork experience. An occupational therapy supervisor must be available, via a variety of contact measures, to the student during all working hours. An on-site supervisor designee of another profession must be assigned while the occupational therapy supervisor is off site.	Document and verify that supervision provided in a setting where no occupational therapy services exist includes a documented plan for provision of occupational therapy services and supervision by a currently licensed or otherwise regulated occupational therapist with at least 3 years' full-time or its equivalent of professional experience prior to the Level II fieldwork. Supervision must include a minimum of 8 hours of direct supervision each week of the fieldwork experience. An occupational therapy supervisor must be available, via a variety of contact measures, to the student during all working hours. An on-site supervisor designee of another profession must be assigned while the occupational therapy supervisor is off site.	Document and verify that supervision provided in a setting where no occupational therapy services exist includes a documented plan for provision of occupational therapy assistant services and supervision by a currently licensed or otherwise regulated occupational therapist or occupational therapy assistant (under the direction of an occupational therapist) with at least 3 years' full-time or its equivalent of professional experience prior to the Level II fieldwork. Supervision must include a minimum of 8 hours of direct supervision each week of the fieldwork experience. An occupational therapy supervisor must be available, via a variety of contact measures, to the student during all working hours. An on-site supervisor designee of another profession must be assigned while the occupational therapy supervisor is off site.	Document and verify that supervision provided in a setting where no occupational therapy services exist includes a documented plan for provision of occupational therapy assistant services and supervision by a currently licensed or otherwise regulated occupational therapist or occupational therapy assistant (under the direction of an occupational therapist) with at least 3 years' full-time or its equivalent of professional experience prior to the Level II fieldwork. Supervision must include a minimum of 8 hours of direct supervision each week of the fieldwork experience. An occupational therapy supervisor must be available, via a variety of contact measures, to the student during all working hours. An on-site supervisor designee of another profession must be assigned while the occupational therapy supervisor is off site.
C.1.15. Evaluation of Student Performance on Level II Fieldwork				
C.1.15.	Document mechanisms for requiring formal evaluation of student performance on Level II fieldwork (e.g., the AOTA *Fieldwork Performance Evaluation for the Occupational Therapy Student* or equivalent).	Document mechanisms for requiring formal evaluation of student performance on Level II fieldwork (e.g., the AOTA *Fieldwork Performance Evaluation for the Occupational Therapy Student* or equivalent).	Document mechanisms for requiring formal evaluation of student performance on Level II fieldwork (e.g., the AOTA *Fieldwork Performance Evaluation for the Occupational Therapy Assistant Student* or equivalent).	Document mechanisms for requiring formal evaluation of student performance on Level II fieldwork (e.g., the AOTA *Fieldwork Performance Evaluation for the Occupational Therapy Assistant Student* or equivalent).

STANDARD NUMBER	ACCREDITATION STANDARDS FOR A DOCTORAL-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPIST	ACCREDITATION STANDARDS FOR A MASTER'S-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPIST	ACCREDITATION STANDARDS FOR A BACCALAUREATE-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPY ASSISTANT	ACCREDITATION STANDARDS FOR AN ASSOCIATE-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPY ASSISTANT
C.1.16. Fieldwork Supervision Outside the U.S.				
C.1.16.	Document and verify that students attending Level II fieldwork outside the United States are supervised by an occupational therapist who graduated from a program approved by the World Federation of Occupational Therapists and has at least 1 year of experience in practice prior to the onset of Level II fieldwork.	Document and verify that students attending Level II fieldwork outside the United States are supervised by an occupational therapist who graduated from a program approved by the World Federation of Occupational Therapists and has at least 1 year of experience in practice prior to the onset of Level II fieldwork.	Document and verify that students attending Level II fieldwork outside the United States are supervised by an occupational therapist who graduated from a program approved by the World Federation of Occupational Therapists and has at least 1 year of experience in practice prior to the onset of Level II fieldwork.	Document and verify that students attending Level II fieldwork outside the United States are supervised by an occupational therapist who graduated from a program approved by the World Federation of Occupational Therapists and has at least 1 year of experience in practice prior to the onset of Level II fieldwork.

226

For the full list of ACOTE accreditation standards (2018), please access here:
https://www.aota.org/~/media/Corporate/Files/EducationCareers/Accredit/StandardsReview/2018-ACOTE-Standards-Interpretive-Guide.pdf

APPENDIX B

GRAVES – INFORMED CONSENT

ORIGINAL

The University of North Dakota
Consent to Participate in Research

TITLE: *Integrating "best practice" on fieldwork: A phenomenological study of occupational therapy student's fieldwork experiences*

PROJECT DIRECTOR: *Cherie Graves*

PHONE # *701-777-6086*

DEPARTMENT: *Educational Leadership – Higher Education*

STATEMENT OF RESEARCH
A person who is to participate in the research must give his or her informed consent to such participation. This consent must be based on an understanding of the nature and risks of the research. This document provides information that is important for this understanding. Research projects include only subjects who choose to take part. Please take your time in making your decision as to whether to participate. If you have questions at any time, please ask.

WHAT IS THE PURPOSE OF THIS STUDY?
You are invited to be in a research study to explore integration of "best practice" professional ideals during Level II fieldwork because you are a current occupational therapy student completing your first Level II fieldwork experience.

The purpose of this research study is to explore the experience of occupational therapy students as they integrate "best practice" professional ideals during Level II fieldwork. According to the literature there is a gap between theory and practice in the field of occupational therapy. Little is known about occupational therapy students experience during Level II fieldwork and how they describe their experience with integraring "best practice" professional ideals during fieldwork.

HOW MANY PEOPLE WILL PARTICIPATE?
Approximately six to eight people will take part in this study at the University of North Dakota.

HOW LONG WILL I BE IN THIS STUDY?
Your participation in the study will last approximately 4 months. You will be need to meet in-person, one time, with the project director at an agreed upon time and location. You will also need to complete two other meetings with the project director, which will occur via technology, at an agreed upon time. Each visit will take about 60-75 minutes.

WHAT WILL HAPPEN DURING THIS STUDY?
Once consent is obtained, Questionnaire 1 will be sent electronically to you at the beginning of your fieldwork placement and will be due back to project director prior to Interview 1. Interview 1 will occur within the first 3 weeks of fieldwork and will be a 1:1 in-person interview that will

Approval Date:	MAY 3 2018
Expiration Date:	MAY 2 2019
University of North Dakota IRB	

Date: _____
Subject Initials: _____

be completed at an agreed upon time and location. Questionnaire 2 will be sent electronically to you during the middle of your fieldwork placement and will be due back to project director prior to Interview 2. Interview 2 will occur between weeks 7-9 of fieldwork and will be a 1:1 interview conducted via use of technology. Questionnaire 3 will be sent electronically to you toward the end of your fieldwork placement and will be due back to project director prior to Interview 3. Interview 3 will occur during week 12 or within two weeks of completing fieldwork and will be a 1:1 interview conducted via use of technology.

The questionnaires will consist of open-ended statements and/or questions to prompt your reflection on your past and current experiences and how you make meaning of your experiences. You are free to skip any questions that you prefer not to answer. Each questionnaire will require approximately 20-30 minutes to complete. Each interview will require approximately 60-75 minutes to complete.

WHAT ARE THE RISKS OF THE STUDY?
There are no foreseeable risks to participating.

WHAT ARE THE BENEFITS OF THIS STUDY?
You may not benefit personally from being in this study. However, we hope that, in the future, other people might benefit from this study. The results of this study may inform practice for occupational therapy educators by identifying strategies that may ease the transition from didactic coursework to fieldwork. Results may inform practice for fieldwork educators by identifying strategies to assist fieldwork educators in helping students to integrate "best practice" professional ideals during fieldwork. Lastly, the results of this study may provide insight regarding past student experiences, challenges, and successes, for future students prior to Level II fieldwork.

ALTERNATIVES TO PARTICIPATING IN THIS STUDY
You are free not to participate.

WILL IT COST ME ANYTHING TO BE IN THIS STUDY?
You will not have costs for being in this research study.

WILL I BE PAID FOR PARTICIPATING?
You will be paid for being in this research study. At the completion of the three interviews, participants will be mailed a $15 VISA gift card. Mailing address will be needed for each participant in order to the project director to provide the gift card.

WHO IS FUNDING THE STUDY?
The University of North Dakota and the research team are receiving no payments from other agencies, organizations, or companies to conduct this research study.

Approval Date:	MAY 3 2018
Expiration Date:	MAY 2 2019
University of North Dakota IRB	

Date: _____
Subject Initials: _____

CONFIDENTIALITY

The records of this study will be kept private to the extent permitted by law. In any report about this study that might be published, you will not be identified. Your study record may be reviewed by Government agencies and the University of North Dakota Institutional Review Board.

Any information that is obtained in this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. You should know, however, that there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court or to tell authorities if we believe you have abused a child, or you pose a danger to yourself or someone else.

Confidentiality will be maintained with anonymous transcripts of all interviews. Consent forms will be kept in a locked and secure location with only the project director having access to the consent forms and personal data.

If there is a written report or article about this study, we will describe the study results in a summarized manner so you cannot be identified.

You have the right to review and provide feedback on all interview transcripts. Only the project director will have access to the audio files and interview transcripts. The audio files and transcripts of the data will be stored electronically on a password secure drive. The transcripts will be stored indefinitely while the audio data files will be destroyed properly after three years.

IS THIS STUDY VOLUNTARY?

Your participation is voluntary. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. Your decision whether or not to participate will not affect your current or future relations with the University of North Dakota. If you decide to leave the study early, we ask that you inform the project director, Cherie Graves.

CONTACTS AND QUESTIONS?

The researcher conducting this study are Cherie Graves. You may ask any questions you have now. If you later have questions, concerns, or complaints about the research please contact Cherie Graves at 701-777-6086 during the day and at 605-941-3875 after hours. The student advisor for this project is Joshua Hunter and he can be reached at 701-777-3582.

If you have questions regarding your rights as a research subject, you may contact The University of North Dakota Institutional Review Board at **(701) 777-4279** or **UND.irb@research.UND.edu.**

Approval Date:	MAY 3 2018
Expiration Date:	MAY 2 2019
University of North Dakota IRB	

Date: _____
Subject Initials: _____

- You may also call this number about any problems, complaints, or concerns you have about this research study.
- You may also call this number if you cannot reach research staff, or you wish to talk with someone who is independent of the research team.
- General information about being a research subject can be found by clicking "Information for Research Participants" on the web site: http://und.edu/research/resources/human-subjects/research-participants.cfm

I give consent to be audio recorded during this study.

Please initial: _____ **Yes** _____ **No**

I give consent for my quotes to be used in the research; however, I will not be identified.

Please initial: _____ **Yes** _____ **No**

Your signature indicates that this research study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a copy of this form.

Subjects Name: _____

_____   _____
Signature of Subject   Date

I have discussed the above points with the subject or, where appropriate, with the subject's legally authorized representative.

_____   _____
Signature of Person Who Obtained Consent   Date

| Approval Date: ____ MAY 3 2018 ____ |
| Expiration Date: ____ MAY 2 2019 ____ |
| University of North Dakota IRB |

Date: _____
Subject Initials: _____

APPENDIX C

EMAIL MESSAGE FOR RECRUITMENT

Dear potential participants,

As an Academic Fieldwork Coordinator I have heard a variety of comments from students about their experience, both positive and negative, with the use of "best practice" professional ideals (evidence-based, occupation-based, client-centered) during Level II fieldwork. There is currently limited research in the field regarding students' experiences during Level II fieldwork, and even less targeting their experience with integrating "best practice" professional ideals. The purpose of this research study is to explore the experience of occupational therapy students as they integrate professional ideals during Level II fieldwork.

I am currently seeking occupational therapy students who will be completing their first Level II fieldwork over the summer months. The fieldwork must be with a focus on physical rehabilitation and must be located within MN, ND, or SD. Participation in this study would involve reviewing and signing the informed consent followed by completion of three questionnaires and participation in three, one-on-one interviews, each lasting approximately 60-75 minutes. Questionnaires and interviews will occur throughout your 12-week fieldwork placement. An incentive for participation is provided which includes a $15 VISA gift card that will be given to participants at completion of the final interview.

I would greatly appreciate your participation in my study. Through your participation my research may inform practice for occupational therapy educators by identifying strategies that may ease the transition from didactic coursework to fieldwork. Results may inform practice for fieldwork educators by identifying strategies to assist fieldwork educators in helping students to integrate "best practice" professional ideals during fieldwork. Lastly, the results of this study may provide insight regarding past student experiences, challenges, and successes, for future students prior to Level II fieldwork.

If you are interested in participating in this study, please contact me directly at the email address or phone number indicated below. I would like to thank you for your time and I look forward to beginning my research.
Thank you very much.

Sincerely,

Cherie

Cherie Graves, MOT, OTR/L
PhD Candidate
University of North Dakota
Cherie.graves@med.und.edu
701-777-6086

APPENDIX D

RECRUITMENT FLYER

PARTICIPANTS NEEDED!!!

Seeking OT Students for a Research Study

Level II fieldwork this summer?
Fieldwork focus in phys dys?
Fieldwork in MN, ND, or SD?

CONTACT ME TO SEE HOW YOU CAN HELP:

Cherie Graves, PhD candidate

cherie.graves@med.und.edu

701-777-6086

Participants will receive a $15 VISA gift card!

Research for partial fulfillment of PhD in Higher Education.

APPENDIX E

IRB APPROVAL

ORIGINAL

DIVISION OF RESEARCH & ECONOMIC DEVELOPMENT

May 8, 2018

Principal Investigator:	Cherie Graves
Project Title:	Integrating "Best Practice" on Fieldwork: A Phenomenological Study of Occupational Therapy Student's Fieldwork Experiences
IRB Project Number:	IRB-201805-306
Project Review Level:	Expedited 7
Date of IRB Approval:	05/03/2018
Expiration Date of This Approval:	05/02/2019
Consent Form Approval Date:	05/03/2018

The application form and all included documentation for the above-referenced project have been reviewed and approved via the procedures of the University of North Dakota Institutional Review Board.
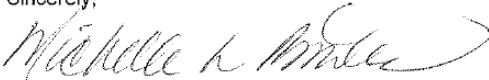
Attached is your original consent form that has been stamped with the UND IRB approval and expiration dates. Please maintain this original on file. *You must use this original, stamped consent form to make copies for participant enrollment. No other consent form should be used.* It must be signed by each participant prior to initiation of any research procedures. In addition, each participant must be given a copy of the consent form.

Prior to implementation, submit any changes to or departures from the protocol or consent form to the IRB for approval. No changes to approved research may take place without prior IRB approval.

You have approval for this project through the above-listed expiration date. When this research is completed, please submit a termination form to the IRB. If the research will last longer than one year, an annual review and progress report must be submitted to the IRB prior to the submission deadline to ensure adequate time for IRB review.

The forms to assist you in filing your project termination, annual review and progress report, adverse event/unanticipated problem, protocol change, etc. may be accessed on the IRB website:
http://und.edu/research/resources/human-subjects/

Sincerely,

Michelle L. Bowles, M.P.A., CIP
IRB Manager

MLB/sb
Enclosures

Cc: Joshua Hunter, Ph.D.

APPENDIX F

IRB PROTOCOL CHANGE APPROVAL

UND UNIVERSITY OF NORTH DAKOTA.

Institutional Review Board
Twamley Hall, Room 106
264 Centennial Drive Stop 7134
Grand Forks, ND 58202-7134
Phone: 701.777.4279
Fax: 701.777.6708

October 16, 2018

Principal Investigators:	Cherie Graves
Project Title:	Integrating "Best Practice" on Fieldwork: A Phenomenological Study of Occupational Therapy Student's Fieldwork Experiences
IRB Project Number:	IRB-201805-306
Project Review Level:	Expedited 7
Date of IRB Approval:	10/13/2018
Expiration Date of This Approval:	05/02/2019
Consent Form Approval Date:	10/13/2018

The Protocol Change Form and all included documentation for the above-referenced project have been reviewed and approved via the procedures of the University of North Dakota Institutional Review Board.

Attached is your revised consent form that has been stamped with the UND IRB approval and expiration dates. Please maintain this original on file. *You must use this original, stamped consent form to make copies for participant enrollment. No other consent form should be used.* It must be signed by each participant prior to initiation of any research procedures. In addition, each participant must be given a copy of the consent form.

You have approval for this project through the above-listed expiration date. When this research is completed, please submit a termination form to the IRB. If the research will last longer than one year, an annual review and progress report must be submitted to the IRB prior to the submission deadline to ensure adequate time for IRB review.

The forms to assist you in filing your project termination, annual review and progress report, adverse event/unanticipated problem, protocol change, etc. may be accessed on the IRB website: http://und.edu/research/resources/human-subjects/

Sincerely,

Michelle L. Bowles, M.P.A., CIP
IRB Manager

MLB/sb

Enclosures

Cc: Joshua Hunter, Ph.D.

APPENDIX G

Graves - Informed Consent

Following Protocol Change

THE UNIVERSITY OF NORTH DAKOTA
CONSENT TO PARTICIPATE IN RESEARCH

TITLE: *Integrating "best practice" on fieldwork: A narrative study of occupational therapy student's fieldwork experiences*

PROJECT DIRECTOR:	*Cherie Graves*
PHONE #	*701-777-6086*
DEPARTMENT:	*Educational Leadership – Higher Education*

STATEMENT OF RESEARCH
A person who is to participate in the research must give his or her informed consent to such participation. This consent must be based on an understanding of the nature and risks of the research. This document provides information that is important for this understanding. Research projects include only subjects who choose to take part. Please take your time in making your decision as to whether to participate. If you have questions at any time, please ask.

WHAT IS THE PURPOSE OF THIS STUDY?
You are invited to be in a research study to explore integration of "best practice" professional ideals during Level II fieldwork because you are a current occupational therapy student completing a Level II fieldwork experience.

The purpose of this research study is to explore the experience of occupational therapy students as they integrate "best practice" professional ideals during Level II fieldwork. According to the literature there is a gap between theory and practice in the field of occupational therapy. Little is known about occupational therapy students experience during Level II fieldwork and how they describe their experience with integrating "best practice" professional ideals during fieldwork.

HOW MANY PEOPLE WILL PARTICIPATE?
Four people will take part in this study at the University of North Dakota.

HOW LONG WILL I BE IN THIS STUDY?
Your participation in the study will last approximately four months.

WHAT WILL HAPPEN DURING THIS STUDY?
Once consent is obtained, participants will be contacted to schedule interview 4 and 5. Interview 5 will occur between weeks 6-8 of fieldwork and will be a 1:1 interview conducted via use of technology. Interview 5 will occur during week 12 or within one week of completing fieldwork and will be a 1:1 interview conducted via use of technology. Each interview will require approximately 75-90 minutes to complete.

Approval Date:	**OCT** 1 3 **2018**
Expiration Date:	MAY 2 **2019**
University of North Dakota IRB	

Date: _____
Subject Initials: _____

Participants will be asked to write two letters during the 12-week placement. The participants will be provided with a few prompts to consider in writing both letters. The time to complete each letter will vary depending on the participant although it is estimated that each letter can be written within 1 hour of time.

WHAT ARE THE RISKS OF THE STUDY?
There are no foreseeable risks to participating.

WHAT ARE THE BENEFITS OF THIS STUDY?
You may not benefit personally from being in this study. However, we hope that, in the future, other people might benefit from this study. The results of this study may inform practice for occupational therapy educators by identifying strategies that may ease the transition from didactic coursework to fieldwork. Results may inform practice for fieldwork educators by identifying strategies to assist fieldwork educators in helping students to integrate "best practice" professional ideals during fieldwork. Lastly, the results of this study may provide insight regarding past student experiences, challenges, and successes, for future students prior to Level II fieldwork.

ALTERNATIVES TO PARTICIPATING IN THIS STUDY
You are free not to participate.

WILL IT COST ME ANYTHING TO BE IN THIS STUDY?
You will not have costs for being in this research study.

WILL I BE PAID FOR PARTICIPATING?
You will be paid for being in this research study. At the completion of the two interviews (interviews 4 & 5) and two written letters, participants will be mailed a $15 VISA gift card. Mailing address will be needed for each participant in order to the project director to provide the gift card.

WHO IS FUNDING THE STUDY?
The University of North Dakota and the research team are receiving no payments from other agencies, organizations, or companies to conduct this research study.

CONFIDENTIALITY
The records of this study will be kept private to the extent permitted by law. In any report about this study that might be published, you will not be identified. Your study record may be reviewed by Government agencies and the University of North Dakota Institutional Review Board.

Any information that is obtained in this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. You should know, however, that there are some circumstances in which we may have to show your

Approval Date: **OCT 13 2018**	
Expiration Date: **MAY 2 2019**	
University of North Dakota IRB	

Date: _____
Subject Initials: _____

APPENDIX H

MY NARRATIVE BEGINNINGS

This inquiry for me is personal as I reflect back on my own experience as an occupational therapy student, occupational therapy practitioner, and now an occupational therapy educator. As a student I remember the professional values of client-centered, occupation-based, and evidence-based be emphasized in many ways through my eight semesters of training. I remember going to fieldwork and trying to incorporate the use of occupation into my treatments with clients. Now, I have to be honest, I don't remember my experience as a student on fieldwork and how I tried to incorporate evidence or focus on my skill of being client-centered. I can however speak clearly to my experience as a practitioner and how easy it was to just fall into the patterns of practice that were already occurring at my place of employment. I remember how easy it was to just fall into the habit of going to work each day and leaving my work when I went home at the end of the day. Unfortunately, this meant, the habits and values that I had established as a student related to client-centered, evidence-based, and occupation-based practice, easily went to the wayside and became less important. But why? How did I get to that point?

Now reflecting back to that time, I easily realize that I didn't reflect on my practice. I didn't consider how my practice impacted others around me including clients, families, other occupational therapists, my interdisciplinary team members, and even occupational therapy students that I worked with. For that, I am sorry. I am sorry that I wasn't reflecting the professional ideals. I am sorry that I know I could have done better. I am sorry that I practiced in that way for seven years and didn't even realize it until it was too late to change my practice. I am sorry in the way that I contributed to the continuing of uninspiring and unauthentic practice at my workplace. I am sorry for the

245

number of students who observed what I did and felt discrepancy from their academic knowledge. I am even more sorry for the students who then tried to exemplify what I did because I was their supervisor. Now I want to be clear that even though I am not proud of the way that I practiced, thankfully the lives of clients were never in harm's way despite practice that was not consistent with the professional ideals of occupational therapy.

I think back to the time when I decided that I wanted to start a journal club amongst the occupational therapy team at my workplace. I can't remember what occurred that would have precipitated my desire to start that. Thankfully, other therapists around me were also interested and so began one strategy that supported the use of evidence in practice. I do often wonder if the journal club continued once I left the workplace for another career opportunity. Five years ago I left my job as an occupational therapist in a large hospital system, mostly working in acute care and inpatient rehabilitation. Looking back, I often thinking about my desire to leave and try something new. Where did that come from? Was it my dissatisfaction with my job? Was it the lack of challenge that I felt? Maybe it was that I felt uninspired to make change? One thing I know for sure was that I didn't see opportunities for my career to move beyond my role as an acute care or inpatient rehabilitation therapist. I guess I wanted more opportunity.

Reflecting back, I see there was great opportunity to make change in the way that the occupational therapists practice, changes to be more consistent with the professional values, but I was not conscious of that need. How could I not have been conscious of the need to change practice? How could I not have been conscious that my practice was not consistent with the professional values? Was it because no one told me that my practice

was not consistent? Was it because the other occupational therapist around me were

practicing in a similar manner? Maybe it was because by that point I was apathetic to the

reason why I chose to be an occupational therapist, apathetic to the unique value that

occupational therapists contribute to the healthcare team. Was I worn down by the

organizational demands of working within a large healthcare system where change was

constant? Or maybe it was the productivity demands pushing me to work faster but not

better. It could also have been due to the frequent changes in the healthcare environment

which made it difficult to attend to your own practice as a therapist because of the need to

constantly monitor and make changes required by the healthcare environment.

Eventually I decided that my career was not moving and I was looking for

something different. I began exploring the possibility of beginning my studies for a PhD.

I truly only remember one thought I had about that decision and that was, "There really is

never going to be a better time to go back to school". By that time was married to my

husband and had one child who had just turned three. I was right by the way. Now I

have a husband, eight-year old and a three-year old and I am still trying to wrap this up. I

did balance my first semester of PhD coursework while still practicing full time on the

inpatient rehabilitation unit. One semester into my coursework, I was informed of a job

opening at my alma mater, how could I not jump in? I always told myself that if I was

going to teach, I wanted my career to begin there. It wasn't until I left my role as a

practicing therapist and entered my role in occupational therapy education that my

reflection began.

And so it began, my experience as an educator and not only a faculty but also an

academic fieldwork coordinator. I plunged into this world with people who eat, breathe,

247

and sleep occupational therapy. It was so new to me. I remember thinking, "wow, there are so many opportunities here". I remember feeling supported, encouraged, and inspired by all those around me. At the time, it was exactly what I needed, what I was looking for. My passion for the occupational therapy profession re-ignited as if it had been stomped downed to smoldering coals. My greatest joy in my new life as an academic came through mentorship provided and inclusion that I felt when working alongside my colleague Dr. Debra Hanson. Her passion for all things related to occupational therapy practice, theory, and professional identity inspired me to build my competence by soaking in opportunities, even if I felt intimidated. In a way I felt like a shriveled up sunflower when I started my career as an educator. My roots in occupational therapy were still hanging on but they weren't deep and the soil around me was dry and crumbling. I gradually began to soak in the vast knowledge and thriving passion around me and my roots began to hydrate. Although my stalk was weak, mentorship and support began to strengthen me. I still withered in the strong North Dakota wind but I didn't topple over. As I was invited to engage in teaching, working with fieldwork sites, and writing short articles for practice journals, my stalk grew stronger, my leaves became more plentiful, and roots grew deeper. I could withstand the wind in the North Dakota prairie as my confidence continued to grow. Overtime I began to feel like the other sunflowers in the field. I was competent. I was strong. I was confident. I was passionate. I was an occupational therapy educator.

Now in my role as an educator and fieldwork coordinator I work in the space between the occupational therapy students and the fieldwork sites. I try to balance the professional values emphasized in coursework that define authentic occupational therapy

with the realities of practice experienced by practitioners at our fieldworks sites. Realities that I am all too familiar with. I hear the student's frustration and confusion when they return from fieldwork with experiences far from the authentic occupational therapy they were expecting. While I don't frequently hear from the fieldwork sites or fieldwork educators directly about their experience or feelings, I often wonder what they feel after working with an occupational therapy student for a week or longer. Once students graduate, I see what happens, heck I have experienced it first-hand.

APPENDIX I

QUESTIONNAIRE 1 – PRE-INTERVIEW

Participants Initials: Click or tap here to enter text.
Name of Academic Program: Click or tap here to enter text.
Master or OTD Program: Click or tap here to enter text.
How many semesters have you completed? Click or tap here to enter text.
How many semesters do you have remaining? Click or tap here to enter text.
Name of Level II fieldwork placement facility:Click or tap here to enter text.
Type of setting: Click or tap here to enter text.

Concept Clarification

Best practice: Strong (2003) identified best practice ideals of the profession as the integration of client-centered, evidence-based, and occupation-based care. All three elements are required to be considered best practice.

- Evidence-based practice: requires that decisions about health care are based on the best available, current, valid, and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources (Dawes et al., 2005, p. 4).
    - Is this your understanding of the concept from your own education background? ☐ Yes ☐ No
    - If no, please clarify:Click or tap here to enter text.

- Occupation-based practice: Practice must enable the performance or engagement in an occupation that a client wants to, needs to, or is expected to do (Polatajko & Davis, 2012, p. 259).
    - Is this your understanding of the concept from your own education background? ☐ Yes ☐ No
    - If no, please clarify:Click or tap here to enter text.

- Client-centered practice: refers to "service that incorporates respect for and partnership with clients as active participants in the therapy process. This approach emphasizes clients' knowledge and experience, strengths, capacity for choice, and overall autonomy" (Boyt-Schell et al., 2014a, p. 1230).
    - Is this your understanding of the concept from your own education background? ☐ Yes ☐ No
    - If no, please clarify:Click or tap here to enter text.

APPENDIX J

INTERVIEW 1 PROTOCOL

1) Review questionnaire to ensure understanding of information and concepts. Do you have any points of clarification?

Academic program coverage on best practice concepts

Occupation-based practice

2) We are going to start by talking about occupation-based practice. How and when did your academic program first introduce you to occupation-based practice?
   a) What have you learned about OBP?
   b) What activities and/or assignments do you recall from class to learn about OBP?
   c) What memorable experiences do you recall when learning about OBP?
   d) How was OBP brought in when you were learning about assessment?
   e) How was OBP brought in when you were learning about treatment planning?
   f) How was OBP brought in when you were learning about implementing intervention?
   g) How was OBP brought in when you were learning about discharge planning?

Client-centered practice

3) How and when did your academic program first introduce you to client-centered practice?
   a) What have you learned about CCP?
   b) What activities and/or assignments do you recall from class to learn about CCP?
   c) What memorable experiences do you recall when learning about CCP?
   d) How was CCP brought in when you were learning about assessment?
   e) How was CCP brought in when you were learning about treatment planning?
   f) How was CCP brought in when you were learning about implementing intervention?
   g) How was CCP brought in when you were learning about discharge planning?

Evidence-based practice

4) How and when did your academic program first introduce you to evidence-based practice?
   a) What have you learned about EBP?
   b) What activities and/or assignments do you recall from class to learn about EBP?
   c) What memorable experiences do you recall when learning about EBP?

d) How was EBP brought in when you were learning about assessment?
e) How was EBP brought in when you were learning about treatment planning?
f) How was EBP brought in when you were learning about implementing intervention?
g) How was EBP brought in when you were learning about discharge planning?

Level I fieldwork experiences related to best practice concepts

5) How did the learning experiences you have had in the classroom, related to the best practice ideals, influence your expectations going into your Level I fieldwork?
   a) What did you think you might do?
   b) What were your expectations?
6) Describe the types of settings you experienced for your Level I fieldworks.
   a) Experiences with OT vs experiences with no OT
   b) Participation vs observation

7) What did you observe on your Level I fieldwork placements, in relation to best practice?

8) Were you able to do anything on Level I fieldwork where you incorporated any best practice in what you did?

9) Describe experiences of observing and/or participating in best practice ideals.
   a) Identifying appropriate assessment methods and implementing assessment
   b) Evaluating a new client and identifying treatment priorities
   c) Documenting evaluation report
   d) Identifying and implementing appropriate intervention sessions
   e) Documenting intervention session
   f) Patient and/or family caregiver education
   g) Discharge planning
   h) Team meeting or interdisciplinary communication

10) How did the learning experiences you had during Level I fieldwork, related to the best practice ideals, influence your expectations going into your Level II fieldwork?
   a) What were you most excited about?
   b) What were you concerned about?
   c) What were your expectations?

Level II fieldwork experiences related to best practice concepts

11) Before starting this fieldwork, rate your confidence level from 1-10 (1 – lowest, 10 – highest) regarding your ability to implement each of the best practice ideals.

12) What were your hopes for implementing best practice in your Level II fieldwork?

13) What were your emotions regarding implementing best practice in your Level II fieldwork?

14) Tell me about the context of your current Level II fieldwork experience.

15) What have you noticed so far?
   a) What have you observed/not observed about your site?
   b) Have you been able to see others incorporate best practice ideals? If so, what does that look like?

16) How are best practice ideals evident at your fieldwork site when working with clients?
   a) How are best practice professional ideals incorporated into assessment?
   b) How are best practice professional ideals incorporated into treatment planning?
   c) How are best practice professional ideals incorporated into intervention implementation?
   d) How are best practice professional ideals incorporated into discharge planning?

Summary

17) Is there anything else that you would like to tell me that has influenced your experience of thinking about best practice ideals at this stage in your fieldwork?

APPENDIX K

INTERVIEW 2 PROTOCOL

1) I'd like to understand a typical day for you at your fieldwork site. What is your schedule? What do you do? What areas of occupation are commonly addressed?

2) Describe what you do with a typical client or two. I'd like to know the whole process from beginning to end. (assessment, treatment planning, intervention, documentation, discharge planning)

3) How are you implementing best practice ideals into your work? Describe ways and/or strategies you have used to keep the focus of your therapy on your clients. Describe ways and/or strategies you have used to keep the occupational lens when providing care to clients. Describe ways and/or strategies you have used to apply evidence in your day to day therapy.

4) What resources have you used to implement best practice?

5) Compare what you are trying to do with what you see other OTs doing at your site. How are they incorporating occupation based, client-centered, evidence-based practice? Or not? (listen for how ideals are addressed in the OT process)

6) What are the factors that support implementation of best practice ideals at your site?
   a. Physical environment, social environment, temporal context, personal context, cultural context, virtual context

7) What are the factors that get in the way of best practice ideals at your site?
   a. Physical environment, social environment, temporal context, personal context, cultural context, virtual context

8) Of the challenges that we have discussed for implementing best practice, what has been the biggest challenge for you? Why?

9) Of the supports discussed, what has been most helpful for you? Why?

10) What additional supports do you wish you had right now?

11) How is your reality of fieldwork similar to what you learned in school? How is it different? If you could go back to school right now and ask a question about how to incorporate occupation-based, client centered, and evidence-based into your present reality, what would it be?

APPENDIX L

INTERVIEW 3 PROTOCOL

You went into the fieldwork with intent to be client-centered, occupation-based, and evidence-based in your practice. What are you thinking now? What conclusions did you come to about enacting these ideals into fieldwork? How about into your next Level II fieldwork?

In interview 1 (at the beginning of fieldwork) I had you rate your confidence level with your ability to implement occupation-based, client-centered, and evidence-based practice during your Level II (1 - lowest confidence and 10 - highest confidence). Let's look at the numbers you provided me in interview 1 and talk about if they are different now than before.

Compare for me how you expected you would do with implementing best practice with your actual performance with implementing best practice. Was it easier or more difficult than expected? How so?
Thinking about your work day, walk me through the skills/processes you would identify as being important for a person to know at your FW site to be entry-level? (*write these down as they are said*)

Describe your ability to do these things? What activity would you want to engage in to get better at these things?

I am going to list a number of skills/processes that occur during Level II fieldwork. I want to better understand the importance of these skills/processes at your fieldwork site. Will you put these in order of importance at your site based on your perceptions.

(*Demonstrating safety, completing evaluation, documentation, developing treatment plan, providing skilled intervention, discharge planning, productivity standards, billing codes, interdisciplinary team work, being client-centered, incorporating occupation into therapy, using evidence to support treatment*)

What insights did you gain about the importance of best practice ideals at your site? Thinking about the skills/processes you identified in the previous question, where do best practice ideals fit in terms of importance in comparison to the other identified skills? Why do you think that is? Did your fieldwork educator provide you any feedback related to your ability to implement best practice? Was your ability to implement best practice ever evaluated on this fieldwork?

Tell me about an experience during fieldwork where you were working with a client and you thought back on best practice ideals. What was happening? What were you thinking? What were you feeling? What meaning do you make of that now?

I'm going to review with you, challenges mentioned in Interview 2 that you identified as playing a role in your ability to implement best practice. Were any of these challenges considered and talked about during your coursework? Describe. Looking back, do you feel you were prepared/unprepared to deal with the challenges with implementing best

practice? Do you have suggestions for ways that you could have been more prepared by your academic program to work with the challenges? How about suggestions for ways that your fieldwork educator could have better supported your ability to deal with the challenges of implementing best practice during practice?

What message would you tell the next cohort of OT students going on their first Level II fieldwork regarding implementing best practice?

What did you learn from your experience implementing best practice professional ideals on your fieldwork, that you will take forward to your next Level II? How about into future practice?
How did the social experience impact you? From your site? From academic program? What connections did you have with your academic program and your peers throughout the fieldwork experience? In what ways were the connections supportive of your ability to implement best practice? Looking back can you think of other connections from the academic program/peers that would have strengthened your ability to implement best practice?

Describe to me what you think it means to be an occupational therapist? Now describe to me what it means to practice occupational therapy at your fieldwork site? Which of these two explanations is more representative of your experience on your fieldwork? What do you see as the differences? How do you feel about your ability to be an occupational therapist at your next fieldwork site?

APPENDIX M

INTERVIEW 4 – SAMPLE PROTOCOL

1) Describe to me a typical day/week at your setting. Describe to me how you see best practice being used at your fieldwork site.

2) In interview 3 you mentioned that you thought applying occupation-based during this fieldwork would be interesting. You mentioned that you have seen now that some sites have limited supplies available and that there is somewhat of a typical list of activities that would be completed based on diagnosis. You stated, "Ok, this person has this, try X, Y, and Z. Like they already kind of have a preconceived notion of what to do with this type of person or whatever they're diagnosis is. It might make it a little more challenging to do occupation as therapy. I always know the goal is to get people back to their occupations. But I think there's just room to do more actual occupations during the session". How do you feel your experience is with this in your new fieldwork? Tell me about the supplies available to you. Do you feel this site also has a typical list of activities to complete? Do you feel you have been able to try things that are outside the box?

3) How are you implementing best practice ideals into your work? Do you feel like you have been able to carry over your great experience from your previous fieldwork into this experience with implementing best practices?

4) Describe ways and/or strategies you have used to keep the focus of your therapy on your clients. Describe ways and/or strategies you have used to keep the occupational lens when providing care to clients. Describe ways and/or strategies you have used to apply evidence in your day to day therapy.

5) In Interview 3 you mentioned feel like you have learned to be creative and to think of fun things to do with clients that are also therapeutic. You stated you hope that on your next fieldwork you would be able to expand your repertoire and not fall into the noncreative rut. Do you feel you have been able to do that?

6) What resources have you used to implement best practice?

7) Compare what you are trying to do with what you see other OTs doing at your site. How are they incorporating occupation based, client-centered, evidence-based practice? Or not? (listen for how ideals are addressed in the OT process)

8) What are the factors that support implementation of best practice ideals at your site?
   a. Physical environment, social environment, temporal context, personal context, cultural context, virtual context (S28 in framework)

9) What are the factors that get in the way of best practice ideals at your site?
   a. Physical environment, social environment, temporal context, personal context, cultural context, virtual context

10) Of the challenges that we have discussed for implementing best practice, what has been the biggest challenge for you? Why?

11) Of the supports discussed, what has been most helpful for you? Why?

12) What differences do you notice between this fieldwork and your past in terms of a typical day/week and implementation of best practices.

13) How would you describe the communication between your FWE and yourself? How is your relationship with your fieldwork educator different than previous? How is it the same? How does that impact your ability to provide best practice? You mentioned that your previous fieldwork experience you had two supervisors and that on your current fieldwork experience you will only have one. How has that impacted your experience?

14) Tell me about your fieldwork educators expectations of you? Do you have duties to complete outside of work day?

15) In the last interview you stated, "I think that in my next fieldwork it will be more difficult to do evidence based practice. Cause from what I've gather, at least just from conversing with my next site. I think they're a little more scattered or disorganized than my current site. So I highly doubt they're gonna have any like drawer filled with all these best of practice articles. So maybe it'll just be a little more work on my end.   To actually like access current research about whatever I'm doing". Has this rung true for your fieldwork experience? Has it been more difficult? Has it been more work on your end to incorporate evidence?

APPENDIX N

INTERVIEW 5 PROTOCOL

1) Explore with me your initial assumptions about Level II fieldwork

2) What do you believe about those assumptions now?

3) Reflecting back on all 24 weeks of your fieldwork experience what environmental aspects, do you believe best support and hinder best practice?

4) Reflecting back on all 24 weeks of your fieldwork experience, explore with me your developmental progress from day 1 to the last day.

5) Thinking of that developmental progression you talked about, what do you predict for yourself in the next year and within the first year of practice?

6) Thinking about your 24 weeks of Level II fieldwork experience what recommendations do you have for the academic program?

7) Reflecting on all that you have learned and experienced, what do you believe is needed to create the best plan to be the practitioner you want to be?

8) Now you are a fieldwork educator, tell me how your experience as a student will inform your future work and decisions as a fieldwork educator working with students.

APPENDIX O

REFLECTION LETTER PROMPTS

Describe to your academic program:

*your feelings and thoughts regarding your preparation for implementing best practice ideals (client-centered, occupation-based, and evidence-based) in occupational therapy practice.

*your feelings and thoughts regarding your experiences with observing best practice ideals (client-centered, occupation-based, and evidence-based) during Level I and Level II fieldworks.

*your feelings and thoughts about your own ability to implement best practice ideals (client-centered, occupation-based, and evidence-based) during your Level II fieldworks.

*your feelings and thoughts on what you believe to be the biggest barriers and biggest supports to implementing best practice ideals (client-centered, occupation-based, and evidence-based), based on your Level II experiences.

*your feelings and thoughts on how the gap between academia and practice can be better bridged.

The second letter you will be writing to yourself, ten years into your occupational therapy practice. The following are prompts you could consider when writing your second letter.

 Describe to your future self:

*the meaning of best practice ideals learned through your academic program and describe what best practice looks like.

*how you experienced the importance of best practice ideals (client-centered, occupation-based, and evidence-based) during your coursework and during your Level I and Level II fieldwork.

*the similarities and differences between what you learned during coursework and what you experienced during your Level I and Level II fieldwork.

*how you picture yourself as a practitioner with 10 years of experience related to implementing best practice ideals (client-centered, occupation-based, and evidence-based).

*strategies to incorporate and words to live by, in order to provide best practice in your occupational therapy practice.

REFERENCES

Accreditation Council for Occupational Therapy Education. (2018). *Accreditation Council for Occupational Therapy Education standards and interpretive guide*. Retrieved from: https://www.aota.org/~/media/Corporate/Files/EducationCareers/Accredit/StandardsReview/2018-ACOTE-Standards-Interpretive-Guide.pdf

Adams, K., Hean, S., Sturgis, P., & Clark, J. (2006). Investigating the factors influencing professional identity of first-year health and social care students. *Learning in Health and Social Care, 5*(2), 55-68.

Aiken, F. E., Fourt, A. M., Cheng, I. K. S., & Polatajko, H. J. (2011). The meaning gap in occupational therapy: Finding meaning in our own occupation. *Canadian Journal of Occupational Therapy, 78*, 294-302, http://doi.org/10.2182/cjot.2011.78.5.4

American Occupational Therapy Association, Task Force on External Issues. (2019). *Report of the AOTA Task Force on External Issues*. Retrieved from https://www.aota.org/~/media/Corporate/Files/AboutAOTA/BOD/Special-Task-Force-February-2019-Summary-Report.pdf

American Occupational Therapy Association. (2017). *Decades: OT's important events*. Retrieved from: http://www.otcentennial.org/events/events-by-decades

American Occupational Therapy Association. (2017). Philosophical base of occupational

therapy. *American Journal of Occupational Therapy, 71*(Suppl. 2), 7112410045.

http://doi.org/10.5014/ajot.2017.716S06

American Occupational Therapy Association. (2017). Vision 2025. *American Journal of*

Occupational Therapy, 71, 7103420010. http://doi.org/10.5014/ajot.2017.713002

American Occupational Therapy Association. (2016). Occupational therapy fieldwork

education: Value and purpose. *American Journal of Occupational Therapy,*

70(Suppl. 2), 7012410060. http://dx.doi.org/10.5014/ajot.2016.706S06

American Occupational Therapy Association. (2015). Philosophy of occupational therapy

education. *American Journal of Occupational Therapy, 69*(Suppl. 3),

6913410052. http://dx.doi.org/10.5014/ajot.2015.696S17

American Occupational Therapy Association. (2014). Occupational therapy practice

framework: Domain and process (3rd ed.). *American Journal of Occupational*

Therapy, 68(Suppl.1), S1-S48. http://dx.doi.org/10.5014/ajot.2014.682006

American Occupational Therapy Association. (2007). AOTA's Centennial Vision and

executive summary. *American Journal of Occupational Therapy, 61*, 613-614.

American Occupational Therapy Association. (2001). Fieldwork Experience Assessment

Tool [Measurement instrument]. Retrieved from

https://www.aota.org/~/media/Corporate/Files/EducationCareers/Accredit/FEAT

CHARTMidterm.pdf

Ashby, S. E., Adler, J., & Herbert, L. (2016). An exploratory international study into occupational therapy students' perceptions of professional identity. *Australian Occupational Therapy Journal, 63*, 233-243. http://dx.doi.org/10.1111/1440-1630.12271

Ashby, S., & Chandler, B. (2010). An exploratory study of the occupation-focused models included in occupational therapy professional education programs. *British Journal of Occupational Therapy, 73*(12), 616-624. https://doi.org/10.4276/030802210X12918167234325

Ashby, S. E., Ryan, S., Gray, M., & James, C. (2013). Factors that influence the professional resilience of occupational therapists in mental health practice. *Australian Occupational Therapy Journal, 60*, 110-119. http://dx.doi.org/10.1111/1440-1630.12012

Baxter Magolda, M. B. (2014). Self-authorship. n P. S. Meszaros (Ed.), *New Directions for Higher Education*, (Vol. 166, pp. 25-33). San Francisco, CA: Jossey-Bass. http://dx.doi.org/10.1002/he.20092

Baxter Magolda, M. B. (2008). Three elements of self-authorship. *Journal of College Student Development, 49*(4), 269-284, http://dx.doi.org/10.1353.csd.0.0016

Baxter Magolda, M. B. (2001). *Making their own way: Narratives for transforming higher education to promote self-development*. Sterling, VA: Stylus.

Baxter Magolda, M. B. (1999). Constructing adult identities. *Journal of College Student Development, 40*(6), 629-644.

Baxter Magolda, M. B. (1992). *Knowing and reasoning in college: Gender-related patterns in students' intellectual development*. San Francisco, CA: Jossey-Bass.

Baxter Magolda, M. B., & King, P. M. (2012). Nudging minds to life: Self-authorship as

    a foundation for learning [Monograph]. *ASHE Higher Education Report.*

    http://dx.doi.org/10.1002/aehe.20003

Baxter Magolda, M. B., & King, P. M. (Eds.). (2004). *Learning partnerships: Theory and*

    models of practice to educate for self-authorship. Sterling, VA: Stylus.

Bennett, S., Tooth, L., McKenna, K., Rodger, S., Strong, J., Ziviani, J., Mickan, S., &

    Gibson, L. (2003). Perceptions of evidence-based practice: A survey of Australian

    occupational therapists. *Australian Occupational Therapy Journal, 50*, 13-22.

Bockoven, J. S. (1971). Occupational therapy – A historical perspective. Legacy of Moral

    Treatment – 1800's to 1910. *American Journal of Occupational Therapy, 25*,

    223-225.

Boehm, J., Tanner, B., Lowrie, D, Bonassi, M., Brown, N., Thomas, Y., & Cordier, R.

    (2015). Exploring emerging occupational therapy identity and the development of

    graduate attributes among occupational therapy students. *British Journal of*

    Occupational Therapy, 78(8), 499-507.

    https://doi.org/10.1177/0308022614562585

Boyt-Schell, B. A., Gillen, G., & Scaffa, M. E. (2014a). Glossary. In B. A. Boyt Schell,

    G. Gillen, & M. Scaffa (Eds.). *Willard and Spackman's occupational therapy*

    (12th ed.), pp. 1229-1243. Philadelphia, PA: Lippincott, Williams, & Wilkins.

Brown, J. S., Collins, A., & Duguid, P. (1989). Situated cognition and the culture of

    learning. *Educational Researcher, 18*(1), 32-42.

Burke, J. P., & Cassidy, J. C. (1991). Disparity between reimbursement-driven practice
and humanistic values of occupational therapy. *American Journal of
Occupational Therapy, 45*(2), 173-16.

Cameron, K. A. V., Ballantyne, S., Kulbitsky, A., Morgolis-gal, M., Daugherty, T., &
Ludwig, F. (2005). Utilization of evidence-based practice by registered
occupational therapists. *Occupational Therapy International, 12*(3), 123-136,
http://dx.doi.org/10.1002/oti.1

Campbell, M. K., Corpus, K., Wussow, T. M., Plummer, T., Gibbs, D., & Hix, S. (2015).
Fieldwork educators' perspectives: Professional behavior attributes of level II
students. *The Open Journal of Occupational Therapy, 3*(4), 1-13.
http://dx.doi.org/10.15453/2168-6408.1146

Canadian Association of Occupational Therapists. (1997). *Enabling occupation: An
occupational therapy perspective*. Ottawa, ON: CAOT Publications ACE.

Chisholm, D., & Boyt Schell, B, A., (2014) Overview of the occupational therapy process
and outcomes. In B. A. Boyt Shell, G. Gillen, M. E. Scaffa, & E. S. Cohn (Eds.),
Willard & Spackman's Occupational Therapy (12 ed.) (pp. 266-280). Baltimore,
MD: Lippincott Williams & Wilkins.

Christiansen, C. (2007). Adolf Meyer revisited: Connections between lifestyles,
resilience, and illness. *Journal of Occupational Science, 14*(2), 63-77.

Christiansen, C., Clark, F., Kielhofner, G., Rogers, J., & Nelson, D. (1995). Position
paper: Occupation. *American Journal of Occupational Therapy, 49*, 1015-1018.

Christiansen, C. H., & Haertl, K. (2014). A contextual history of occupational therapy. In

    B. A. Boyt-Shell, G. Gillen, & M. E. Scaffa (Eds.), *Willard and Spackman's*

    occupational therapy (pp. 9-34). Philadelphia, PA: Lippincott, Williams, &

    Wilkins.

Clandinin, D. J. (2013). *Engaging in narrative inquiry*. Walnut Creek, CA: Left Coast

    Press, Inc.

Clandinin, D. J. (Ed.). (2007). *Handbook of narrative inquiry: Mapping a methodology*.

    Thousand Oaks, CA: Sage Publications, Inc.

    http://dx.doi.org/10.4135/9781452226552

Clandinin, D. J. (2006). *Narrative inquiry: A methodology for studying lived experience*.

    Research Studies in Music Education, November 27, 44-54.

Clandinin, D. J., Cave, M. T., & Cave, A. (2011). Narrative reflective practice in medical

    education for residents: Composing shifting identities. *Advances in Medical*

    Education and Practice, 2, 1-7, http://dx.doi.org/10.2147/AMEP.S13241

Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry: Experience and story in*

    qualitative research. San Francisco: Jossey-Boss.

Clandinin, D. J., Pushor, D., & Orr, A. M. (2007). Navigating sites for narrative inquiry.

    Journal of Teacher Education, 58(1), 21-35.

Clarke, C., Martin, M., de Visser, R., & Sadlo, G. (2015). Sustaining professional identity

    in practice following role-emerging placements: Opportunities and challenges for

    occupational therapists. *British Journal of Occupational Therapy, 78*(1), 42-50.

    https://doi.org/10.1177/0308022614561238

Clarke, C., Martin, M., Sadlo, G., & de Visser, R. (2014). The development of an

    authentic professional identity on role-emerging placements. *British Journal of*

    Occupational Therapy, 77(5), 222-229.

    http://dx.doi.org/10.4276/030802214X13990455043368

Cole, M. B., & Tufano, R. (2008). *Applied theories in occupational therapy: A practical*

    approach. Thorfare, NJ: Slack Inc.

Collins, A. (1991). Cognitive apprenticeship and instructional technology. In L. Idol & B.

    F. Jones (Eds.), *Educational values and cognitive instruction: Implications for*

    reform. Hillsdale, NH: Lawrence Erlbaum Associates.

Collins, A., Brown, J. S., & Newman, S. E. (1989). Cognitive apprenticeship: Teaching

    the craft of reading, writing, and mathematics. In L. B. Risnick (Ed.), *Knowing,*

    learning, and instruction: Essays in honor of Robert Glaser. Hillsdale, NJ:

    Erlbaum.

Connelly, F. M., & Clandinin, D. J. (2006). Narrative inquiry. In J. L. Green, G. Cailli, Pl

    Elmore (Eds.), *Handbook of complementary methods in education research* (3rd

    ed., pp. 477-487). Mahwah, NJ: Lawrence Erlbaum.

Connelly, F. M., & Clandinin, D. J. (2000). Narrative understandings of teacher

    knowledge. *Journal of Curriculum and Supervision, 15*(4), 315-331.

Connelly, F. M., & Clandinin, D. J. (1990). Stories of experience and narrative inquiry.

    Educational Researcher, 19(5), 2-14.

Copley, J., & Allen, S. (2009). Using all the available evidence: Perceptions of pediatric

    occupational therapists about how to increase evidence-based practice.

    International Journal of Evidence Based Healthcare, 7(3), 193-200.

    http://dx.doi.org/10.1111/j.1744-1609.2009.00137.x

Crabtree, J. L., Justiss, M., & Swinehart, S. (2012). Occupational therapy master-level

    students' evidence-based practice knowledge and skills before and after

    fieldwork. *Occupational Therapy in Health Care, 26*(2-3), 138-149,

    http://dx.doi.org/10.3109/07380577.2012.694584

Craig, G., Robertson, L., & Milligan, S. (2004). Occupational therapy practice in acute

    physical health settings: A pilot study. *New Zealand Journal of Occupational*

    Therapy, 51(1), 5-13.

Crist, P. A. (2007). Commentary: Realizing the vision through fieldwork education.

    Occupational Therapy in Health Care, 21(1/2), 313-318.

Crotty, M. (2013). *The foundations of social research: Meaning and perspective in the*

    research process. Thousand Oaks, CA: Sage.

Dall' Alba, G. (2009). *Learning to be professionals*. Dordrecht, The Netherlands:

    Springer.

Dall' Alba, G. (2004). Understanding professional practice: Investigations before and

    after educational program. *Studies in Higher Education, 29*, 679-692.

Daniels, N. (2010). Peer interactions and their benefits during occupational therapy

    practice placement education. *British Journal of Occupational Therapy, 73*(1),

    21-28. https://doi.org/10.4276/030802210X12629548272664

Davis, J. (2006). The importance of the community of practice in identity development. *The Internet Journal of Allied Health Sciences and Practice, 4*(3), 1-8.

Dawes, M., Summerskill, W., Glasziou, P., Cartabellotta, A., Martin, J., Hopayian, K., …, Osborne, J. (2005). Sicily statement on evidence-based practice. *BMC Medical Education*, *5*(1), p. 4. http://dx.doi.org/10.1186/1472-6920-5-1

Diasio, K. (1971). The modern era – 1960 to 1970. *American Journal of Occupational Therapy, 25*, 237-242.

Di Tommaso, A., Isbel, S., Scarvell, J., & Wicks, A. (2016). Occupational therapists' perceptions of occupation in practice: An exploratory study. *Australian Occupational Therapy Journal, 63*, 206-213, http://dx.doi.org/10.1111/1440-1630.12289

Di Tommaso, A., & Wilding, C. (2014). Exploring ways to improve descriptions of occupational therapy. *New Zealand Journal of Occupational Therapy, 61*(1), 27-33.

Dopp, C. M. E., Steultjens, E. M. J., & Radel, J. (2012). A survey of evidence-based practice among Dutch occupational therapists. *Occupational Therapy International, 19*, 17-27. http://dx.doi.org/10.1002/oti.324

Dubouloz, C., Egan, M., Vallerand, J., & von Zweck, C. (1999). Occupational therapists' perceptions of evidence-based practice. *American Journal of Occupational Therapy, 53*(5), 445-453.

Egan, M., Dubouloz, C.J., von Zweck, C., & Vallerand, J. (1998). The client-centered evidence-based practice of occupational therapy. *Canadian Journal of Occupational Therapy, 65*(3), 136-143.

Estes, J. & Pierce, D. E. (2012). Pediatric therapists' perspectives on occupation-based

practice. *Scandinavian Journal of Occupational Therapy*, *19*, 17-25.

http://dx.doi.org/10.3109/11038128.2010.547598

Evenson, M. E., Roberts, M., Kaldenberg, J., Barnes, M. A., & Ozelie, R. (2015).

National survey of fieldwork educators: Implications for occupational therapy

education. *American Journal of Occupational Therapy, 69*(S2), 6912350020.

http://dx.doi.org/10.5014/ajot.2015.019265

Fange, A., & Ivanoff, S. D. (2009). Integrating research into practice: A challenge for

local authority occupational therapy. *Scandinavian Journal of Occupational*

Therapy, 16, 40-48. http://dx.doi.org.10.1080/11038120802419357

Farber, R. S., & Koenig, K. P. (2008). Facilitating clinical reasoning in fieldwork: The

relational context of the supervisor and student. In B. A. Boyt Schell & J. W.

Shell (Eds.), *Clinical and professional reasoning in occupational therapy*

(pp. 335-367). Philadelphia: Lippincott Williams & Wilkins.

Finlay, L. (2001). Holism in occupational therapy: Elusive fiction and ambivalent

struggle. *American Journal of Occupational Therapy, 55*, 268-276,

http://dx.doi.org/10.3109/11038128.2015.1020866

Fisher, A. G. (2014). Occupation-centered, occupation-based, occupation-focused: Same,

same or different? *Scandinavian Journal of Occupational Therapy, 21*, 96-107.

http://dx.doi.org/10.3109/11038128.2012.754492

Fortune, T. (2000). Occupational therapists: Is our therapy truly occupational or are we

merely filling gaps? *British Journal of Occupational Therapy, 63*(5), 225-230.

Fortune, T., & Kennedy-Jones, M. (2014). Occupation and its relationship with health

and wellbeing: The threshold concept for occupational therapy. *Australian*

Occupational Therapy Journal, 61, 293-298. http://dx.doi.org/10.1111/1440-

1630.12144

Giddens, J. F., Caputi, L., Rodgers, B. (2015). *Mastering concept-based teaching: A*

guide for Nurse Educators. St. Louis, MO: Elsevier.

Gillen, G. (2014). Occupational therapy interventions for individuals. In B. A. Boyt

Shell, G. Gillen, M. E. Scaffa, & E. S. Cohn (Eds.), *Willard & Spackman's*

Occupational Therapy (12 ed.) (pp. 322-341). Baltimore, MD: Lippincott

Williams & Wilkins.

Gilman, I. P. (2011). Evidence-based information-seeking behaviors of occupational

therapists: A survey of recent graduates. *Journal of the Medical Library*

Association, 99(4), 307-310. http://dx.doi.org/10.3163/1536-5050.99.4.009

Graham, F., Robertson, L., & Anderson, J. (2013). New Zealand occupational therapists'

views on evidence-based practice: A replicated survey of attitudes, confidence,

and behaviors. *Australian Occupational Therapy Journal, 60*, 120-128.

http://dx.doi.org/10.1111/1440-1630.12000

Gray, J. M. (1998). Putting occupation into practice: Occupation as ends, occupation as

means. *American Journal of Occupational Therapy, 52*(5), 354-364.

Grenier, M. L. (2015). Facilitators and barriers to learning in occupational therapy

fieldwork education: Student perspectives. *American Journal of Occupational*

Therapy, 52(2), 143-149. http://dx.doi.org/10.5014/ajot.2015.015180

Griffin, S. D. (1993). Short bed stays: their effect on occupational therapy services in

   teaching hospitals. *Archives of Physical medicine and Rehabilitation, 74*,

   1087-1090.

Guile, D., & Young, M. (2003). Transfer and transition in vocational education: Some

   theoretical considerations. In T. Tuomi-Grohn, Y. Engestrom (Eds). *Between*

   school and work: New perspectives on transfer and boundary-crossing. Oxford:

   Elsevier Science, 63-81.

Gupta, J., & Taff, S. D. (2015). The illusion of client-centered practice. *Scandinavian*

   Journal of Occupational Therapy, 22, 244-251.

   http://dx.doi.org/10.3109/11038128.2015.1020866

Hasselkus, B. R. (2000). New offerings in AJOT. *American Journal of Occupational*

   Therapy, 54, 7.

Hinojosa, J., Kramer., P., & Brasic Royeen, C. (2017). *Perspectives on human*

   occupation: Theories underlying practice (2nd ed.). Philadelphia, PA: F. A. Davis

   Company.

Hitch, D. P. (2016). Attitudes of mental health occupational therapists toward evidence-

   based practice. *Canadian Journal of Occupational Therapy, 83*(1), 27-32.

   http://dx.doi.org/10.1177/0008417415583108

Hobson, J., & Morrison-Saunders, A. (2013). Reframing teaching relationships: From

   student centered to subject-centered learning. *Teaching in Higher Education,*

   18(7), 773-783. http://dx.doi.org/10.1080/13562517.2013.836095

Hodgetts, S., Hollis, V., Triska, O., Dennis, S., Madill, H., & Taylor, E. (2007). Occupational therapy students' and graduates' satisfaction with professional education and preparedness for practice. *Canadian Journal of Occupational Therapy, 74*(3), 148-160.

Holmes, J. D., Bossers, A. M., Polatajko, H. J., Drynan, D. P., Gallagher, M. B., O'Sullivan, C. M., …, Denney, J. L. (2010). 1000 fieldwork hours: Analysis of multi-site evidence. *Canadian Journal of Occupational Therapy, 77*, 135-143. http://dx.doi.org/10.2182/cjot.2010.77.3.2

Hooper, B. (2010). On arriving at the destination of the centennial vision: Navigational landmarks to guide occupational therapy education. *Occupational Therapy in Health Care, 24*(1), 97-106. http://dx.doi.org/10.3109/07380570903329636

Hooper, B. (2006). Beyond active learning: A case study of teaching practices in an occupation-centered curriculum. *American Journal of Occupational Therapy, 60*, 551-562.

Hooper, B., & Wood, W. (2014). The philosophy of occupational therapy. In B. A. Boyt-Shell, G. Gillen, & M. E. Scaffa (Eds.), *Willard and Spackman's occupational therapy* (pp. 35-46). Philadelphia, PA: Lippincott, Williams, & Wilkins.

Ikiugu, M. N., & Rosso, H. M. (2003). Facilitating professional identity in occupational therapy students. *Occupational Therapy International, 10*(3), 206-225.

Kegan, R. (1994). *In over our heads: The mental demands of modern life*. Cambridge, MA: Harvard University Press.

Kellegrew, D. H. (2005). The evolution of evidence-based practice: Strategies and resources for busy practitioners. *OT Practice, 10*(2), 11-15.

Kielhofner, G. (2009). *Conceptual foundations of occupational therapy practice* (4th ed.). Philadelphia, PA: F.A. Davis Company.

Kinsella, E. A., Bossers, A., Ferguson, K., Jenkins, K., Bezzina, M. B., MacPhail, A., Moosa, T., Schurr, S., Whitehead, J., & Hobson, S. (2016). *Preceptor education program for health professionals and students*. (2nd ed.). London, ON: The University of Western Ontario. Available at www.preceptor.ca

Korner, M., & Modell, E. (2009). A model of shared decision-making in medical rehabilitation. *Rehabilitation, 48*, 160-165.

Kristensen, H. K., Borg, T., & Hounsgaard, L. (2011). Facilitation of research-based evidence within occupational therapy stroke rehabilitations. *British Journal of Occupational Therapy, 74*(10), 473-483. http://dx.doi.org/10.4276/030802211X13182481841949

Law, M., Baptiste, S., & Mills, J. (1995). Client-centered practice: What does it mean and does it make a difference? *Canadian Journal of Occupational Therapy, 62*(5), 250-257.

Law, M., & Baum, C. (1998). Evidence-based occupational therapy. *Canadian Journal of Occupational Therapy, 65*(3), 131-135.

Law, M., & MacDermid, J. C. (2014). *Introduction to evidence-based practice. In Evidence-based rehabilitation: A guide to practice* (3rd ed.). Thorofare, NJ: SLACK, Inc.

Le Maistre, C., & Paré, A. (2004). Learning in two communities: The challenge for universities and workplaces. *Journal of Workplace Learning, 16*(1/2), 44-52, http://dx.doi.org/10.1108/13665620410521503

Lyons, C., Brown, T., Tseng, M. H., Casey, J., & McDonald, R. (2011). Evidence-based

practice and research utilization: Perceived research knowledge, attitudes,

practices and barriers among Australian pediatric occupational therapists.

Australian Occupational Therapy Journal, 58, 178-186.

http://dx.doi.org/10.1111/j.1440-1630.2010.00900.x

Lyons, C., Casey, J., Brown, T., Tseng, M., & McDonald, R. (2010). Research

knowledge, attitudes, practices and barriers among pediatric occupational

therapists in the United Kingdom. *British Journal of Occupational Therapy,*

73(5), 200-209. http://dx.doi.org/10.4276/030802210X1234991664147

McCluskey, A. (2003). Occupational therapists report a low level of knowledge, skill and

involvement in evidence-based practice. *Australian Occupational Therapy*

Journal, 50, 3-12.

McKenna, K., Bennet, S., Dierselhuis, Z., Hoffman, T., Tooth, L., & McCluskey, A.

(2005). Australian occupational therapists' use of an online evidence-based

practice database (OTseeker). *Health Information and Libraries Journal, 22*,

205-214.

Meyer, A. (1922/1977). The philosophy of occupational therapy. *American Journal of*

Occupational Therapy, 31, 639-642. (Original work published 1922).

Mishler, E. G. (1986). *Research interviewing: Context and narrative.* Cambridge, MA:

Harvard University Press.

Morley, M. (2009). Contextual factors that have an impact on the transitional experience

of newly qualified occupational therapists. *British Journal of Occupational*

Therapy, 72(11), 507-514.

http://dx.doi.org/10.4276/030802209X12577616538753

Morrison, T., & Robertson, L. (2016). New graduates' experience of evidence-based

practice: An action research study. *British Journal of Occupational Therapy,*

79(1), 42-48. http://dx.doi.org/10.1177/0308022615591019

Nielson, C. (1998). The issue is: How can the academic culture move toward occupation-

centered education? *American Journal of Occupational Therapy, 52*, 386-387.

Ottenbacher, K., & Petersen, P. (1985). Quantitative trends in occupational therapy

research: Implication for practice and education. *American Journal of*

Occupational Therapy, 39(4), 240-246.

Palinscar, A. S. (1998). Social constructivist perspectives on teaching and learning.

Annual Review of Psychology, 49, 345-375.

Palmer, P. J. (1997). Teaching and learning in community. *About Campus*, Nov-Dec,

4-13.

Pfeifer, T., Kranz, P., & Scoggin, A. (2008). Perceived stress in occupational therapy

students. *Occupational Therapy International, 15*(4), 221-231,

http://dx.doi.org/10.1002/oti.256

Pierce, D. (2003). How can the occupation base of occupational therapy be strengthened?

Australian Occupational Therapy Journal, 50, 1-2.

Pierce, D. (1998). The issue is: What is the source of occupation's treatment power?

American Journal of Occupational Therapy, 52, 491-491.

Plewnia, A., Bengel, J., & Korner, M. (2016). Patient-centeredness and its impact on

    patient satisfaction and treatment outcomes in medical rehabilitation. *Patient*

    Education and Counseling, 99, 2063-2070.

    http://dx.doi.org/10.1016/j.pec.2016.07.018

Polatajko, H. J., & Davis, J. A. (2012). Advancing occupation-based practice:

    Interpreting the rhetoric. *Canadian Journal of Occupational Therapy, 79*,

    259-263. http://dx.doi.org/10.2182/cjot.2010.79.5.1

Price, P., & Miner, S. (2007). Occupation emerges in the process of therapy. *American*

    Journal of Occupational Therapy, 61, 441-450.

Queensland Health. (2019). ClinEdAus: Enabling clinical education skills. Retrieved

    from http://www.clinedaus.org.au/

Reagon, C., Bellin, W., & Boniface, G. (2008). Reconfiguring evidence-based practice

    for occupational therapists. *International Journal of Therapy and Rehabilitation,*

    15(10), 428-436.

Rebeiro, K. L. (2000). Client perspectives on occupational therapy practice: Are we truly

    client-centered? *Canadian Journal of Occupational Therapy, 67*(1), 7-14.

Restall, G., Ripat, J., & Stern, M. (2003). A framework of strategies for client-centered

    practice. *Canadian Journal of Occupational Therapy, 70*(2), 103-111.

Richard, L. F. (2008). Exploring connections between theory and practice: Stories from

    fieldwork supervisors. *Occupational Therapy in Mental Health, 24*(2), 154-175.

Ripat, J., Wener, P., & Dobinson, K. (2013). The development of client-centeredness in

    student occupational therapists. *British Journal of Occupational Therapy, 76*(5),

    217-224. https://doi.org/10.4276/030802213X13679275042681

Robertson, C., & Finlay, L. (2007). Making a difference, teamwork and coping: the

    meaning of practice in acute physical settings. *British Journal of Occupational*

    Therapy, 70(2), 73-80.

Sackett, D. L., Straus, S. E., Richardson, W. S., Rosenberg, W., & Haynes, R. B. (2000).

    Evidence-based medicine: How to practice and teach evidence-based practice

    (2nd ed). Edinburgh: Churchill Livingstone.

Salls, J., Dolhi, C., Silverman, L., & Hansen, M. (2009). The use of evidence-based

    practice by occupational therapists. *Occupational Therapy in Health Care, 23*(2),

    134-145. http://dx.doi.org10.1080/07380570902773305

Sandberg, J., & Dall' Alba, G. (2009). Returning to practice anew: A life-world

    perspective. *Organization Studies, 30*(12), 1349-1368.

    http://dx.doi.org/10.1177/0170840609349872

Shannon, P. (1977). The derailment of occupational therapy. *American Journal of*

    Occupational Therapy, 31, 229-234.

Sladyk, K., & Sheckley, B. (2000). Clinical reasoning and reflective practice:

    Implications of fieldwork activities. *Occupational Therapy in Health Care, 13*(1),

    11-22.

Strong, J. (2003). Seeing beyond the clouds: Best practice occupational therapy.

    Canadian Journal of Occupational Therapy, 70(4), 197-199.

Stube, J. E., & Jedlicka, J. S. (2007). The acquisition and integration of evidence-based

    practice concepts by occupational therapy students. *American Journal of*

    Occupational Therapy, 61, 53-61.

Sumsion, T. (2006). *Client-centered practice in occupational therapy: A guide to implementation*. 2nd ed. Philadelphia: Churchill-Livingstone.

Sumsion, T. (1999). A study to determine a British occupational therapy definition of client-centered practice. *British Journal of Occupational Therapy, 62*(2), 52-58.

Sumsion, T., & Law, M. (2006). A review of the evidence on the conceptual elements informing client-centered practice. *Canadian Journal of Occupational Therapy, 73*(3), 153-162.

Sumsion, T., & Lencucha, R. (2009). Therapists' perceptions of how teamwork influences client-centered practice. *British Journal of Occupational Therapy, 72*(2), 48-54.

Sweetland, J., & Craik, C. (2001). The use of evidence-based practice by occupational therapists who treat adult stroke patients. *British Journal of Occupational Therapy, 64*, 256-260.

Thomas, A., & Storr, C. (2005). WebCT in occupational therapy clinical education: Implementing and evaluating a tool for peer learning and interaction. *Occupational Therapy International, 12*, 162-179.

Tickle-Degnen, L. (1999). Organizing, evaluating, and using evidence in occupational therapy practice. *American Journal of Occupational Therapy, 53*(5), 537-539.

Toal-Sullivan, D. (2006). New graduates' experiences of learning to practice occupational therapy. *British Journal of Occupational Therapy, 69*(11), 513-524.

Towns, E., & Ashby, S. (2014). The influence of practice educators on occupational

   therapy students' understanding of the practical applications of theoretical

   knowledge: A phenomenological study into student experiences of practice

   education. *Australian Occupational Therapy Journal*, 61, 344-352.

   https://doi.org/10.1111/1440-1630.12134

Trede, F., Macklin, R., & Bridges, D. (2011). Professional identity development: A

   review of the higher education literature. *Studies in Higher Education, 37*,

   365-384. http://dx.doi.org/10.1080/03075079.2010.521237

Trombly, C. A. (1995). Occupation: Purposefulness and meaningfulness as therapeutic

   mechanisms. 1995 Eleanor Clarke Slagle Lecture. *American Journal of

   Occupational Therapy, 49*, 960-972.

Turpin, M. J., Rodger, S., & Hall, A. R. (2012). Occupational therapy students'

   perceptions of occupational therapy. *Australian Occupational Therapy Journal,

   59*(5), 367-374. https://doi.org/10.1111/j.1440-1630.2011.00988.x

University of North Dakota. (n.d.). Occupational therapy student weekly review form.

   Retrieved from https://med.und.edu/occupational-therapy/_files/docs/fieldwork-

   level-2-weekly-review-form.pdf.

Vygotsky, L. (1978). *Mind in society: The development of higher psychological

   processes*. Cambridge, MA: Harvard University Press.

Waghorn, G., Lloyd, C., & Clune, A. (2009). Reviewing the theory and practice of

   occupational therapy in mental health rehabilitation. *British Journal of

   Occupational Therapy, 72*(7), 314-323.

Wenger, E. (2002). Communities of practice and social learning systems. In: Reeve F,

    Cartwright M, and Wedwards R (Eds.) *Supporting Lifelong Learning*. London:

    Routledge Falmer, pp. 160-179.

Wenger, E. (2000). Communities of practice and social learning system. *Organization, 7*,

    749-771.

Wenger, E. (1998). *Communities of practice: Learning, meaning, and identity*.

    Cambridge, New York: Cambridge University Press.

White Jr., J. A. (2019). Disability, community, culture, and identity. In B. A. Boyt-Shell

    & G. Gillen (Eds.), *Willard and Spackman's occupational therapy* (pp. 256-282).

    Philadelphia, PA: Wolters Kluwer.

Whiteford, G., Townsend, E., & Hocking, C. (2000). Reflections on a renaissance of

    occupation. *Canadian Journal of Occupational Therapy, 67*(1), 61-69.

Wilding, C., & Whiteford, G. (2007). Occupation and occupational therapy: Knowledge

    paradigms and everyday practice. *Australian Occupational Therapy Journal,*

    54(3), 185-193, http://dx.doi.org/10.1111/j.1440-1630.2006.00621.x

Wilkins, S., Pollock, N., Rochon, S., & Law, M. (2001). Implementing client-centered

    practice: Why is it so difficult to do? *Canadian Journal of Occupational Therapy,*

    68, 70-79.

Wilkinson, S. A., Hinchliffe, F., Hough, J., & Chang, A. (2012). Baseline evidence-based

    practice use, knowledge, and attitudes of allied health professionals. *Journal of*

    Allied Health, 41(4), 177-184.

Wood, W., Nielson, C., Humphry, R., Coppola, S., Baranek, G., & Rourk, J. (2000). A

    curricular renaissance: Graduate education centered on occupation. *American*

    Journal of Occupational Therapy, 54, 586-595.

Yerxa, E. J. (1998). Occupation: The keystone of a curriculum for a self-defined

    profession. *American Journal of Occupational Therapy, 52*, 365-372.

Yerxa, E. J. (1993). Occupational science: A new source of power for participants in

    occupational therapy. *Journal of Occupational Science, 1*, 1-9.

Yerxa, E. J. (1967). Authentic occupational Therapy, Eleanor Clarke Slagle lecture.

    American Journal of Occupational Therapy, 21, 1-9.

Zimmerman, L., Michaelis, M., Quaschning, K., Muller, C., & Korner, M. (2014). The

    significant of internal and external participation for patient satisfaction.

    Rehabilitation, 53, 219-224.