The Identification of Domains and Competencies for Community Practice Occupational Therapy

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THE IDENTIFICATION OF DOMAINS AND COMPETENCIES FOR COMMUNITY PRACTICE OCCUPATIONAL THERAPY

by

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Literature shows evidence of a shift in occupational therapy from traditional institutional settings to community-based settings. As increasing numbers of new and expert occupational therapists enter community-based practice, the need for competency identification for practice, education, and reimbursement becomes paramount. This qualitative research study sought to identify domains and competencies of community-based occupational therapy practice by interviewing three expert occupational therapists using the critical incident method in which each therapist described one therapeutic intervention with a client. This method, as seen in nursing studies (Benner, 1982, 1984), serves to elicit competencies embedded in expert practice. Thirty-nine competencies were described in these interviews which were clustered into five domains: (1) content-related knowledge, (2) interpersonal skills, (3) educational pathways, (4) clinical reasoning, and (5) spirit of community. The five domains and thirty-nine competencies described in this study can critically impact the education and training of occupational therapy professionals for entry into community-based practice.
# TABLE OF CONTENTS

ACKNOWLEDGMENTS ................................................................................... ii  
LIST OF TABLES ................................................................................................ vi  

CHAPTER  
I. INTRODUCTION ................................................................................... 1  
II. LITERATURE REVIEW ........................................................................ 6  
   Shift Into Community Practice .............................................................. 6  
   Occupational Therapy Workplace Data ............................................... 9  
   Domains and Competencies ................................................................ 9  
   Critical Incident Survey ...................................................................... 13  
   Five Stages of Skill Acquisition .......................................................... 14  
      Novice Stage .................................................................................... 15  
      Advanced Beginner Stage .............................................................. 15  
      Competent Stage ........................................................................... 16  
      Proficient Stage ............................................................................ 17  
      Expert Stage .................................................................................. 18  
   Differences Between Practical and Theoretical Knowledge ............. 18  
   Clinical Reasoning ............................................................................. 19  
   Therapist With a Three-Track Mind .................................................. 20  
   Multiple Intelligences Theory .............................................................. 22
### Table of Contents-Continued

**CHAPTER**

OT Application of the Dreyfus Model of Skill Acquisition ........................................... 23

Summary ......................................................................................................................... 24

### III. DESIGN AND METHODOLOGY ........................................................................ 26

Research Design ........................................................................................................... 26

Instrumentation ............................................................................................................. 27

Critical Incident Survey Guide ..................................................................................... 27

Demographic Data Form ............................................................................................... 28

Participants .................................................................................................................... 28

Procedures ..................................................................................................................... 29

### IV. RESULTS ......................................................................................................... 31

Participant Description ................................................................................................. 31

Competency Identification ............................................................................................. 32

Content-Related Knowledge ......................................................................................... 33

Interpersonal Skills ......................................................................................................... 36

Educational Pathways ..................................................................................................... 41

Clinical Reasoning .......................................................................................................... 42

Spirit of Community ....................................................................................................... 46

### V. DISCUSSION ..................................................................................................... 49

Implications for the Future of the OT Profession .......................................................... 50

Implications for the Future of OT Education ................................................................. 53
Table of Contents-Continued

CHAPTER

Implications for Future OT Research ............................................... 54

APPENDICES

A. Protocol Clearance From the Human Subjects Institutional Review Board ................................................................. 56
B. Script for Initial Phone Contact .................................................. 58
C. Follow-Up Letter ........................................................................ 61
D. Scope of the Study ....................................................................... 63
E. Demographic Data Form .............................................................. 65
F. Critical Incident Survey Guide ...................................................... 67
G. Consent Form .............................................................................. 69
H. Permission to Reproduce Statement .............................................. 72
I. Interview Summaries ................................................................... 74

BIBLIOGRAPHY ............................................................................... 98
## LIST OF TABLES

1. Emergence of Content-Related Knowledge Competencies .................................. 36
2. Emergence of Interpersonal Skill Competencies .............................................. 40
3. Emergence of Educational Pathways Competencies ...................................... 42
4. Emergence of Clinical Reasoning Competencies .......................................... 45
5. Emergence of Spirit of Community Competencies ....................................... 48
CHAPTER I

INTRODUCTION

Occupational therapy (OT), defined as the "therapeutic use of self-care, work and play activities to increase independent function, enhance development, and prevent disability" (Dictionary definition of occupational therapy, 1986, p. 852), has evolved into a recognized profession over the course of this century. From the beginning of this century through the mid-1970s, occupational therapists largely practiced in medical and institutional settings, such as children's, general, psychiatric, and state hospitals, rehabilitation centers, and residential schools for children with special needs. But, as a result of public demand, legislative changes, and health care reform, OT settings and service provision have been evolving over the past twenty-five years.

Literature shows evidence of a shift in OT, as well as in other areas of health care, from traditional institutional settings to community-based practice. OT's shift into public school systems, community mental-health centers, sheltered workshops, developmental disability centers, home health care, and private practice allows occupational therapists to take full advantage of the therapeutic benefits of the individual's natural environment. These benefits are seldom available to therapists working in traditional institutional settings as the environment is often restrictive and unnatural, and large caseloads and brief treatment sessions limit a therapist's time and
energy for making the treatment purposeful.

As community OT practice expands, occupational therapists need to answer fundamental questions about its development, its practitioners, and its effectiveness. While there is a wealth of literature concerning occupational therapy in its traditional settings, there is very little dealing with OT in community-based practice. A handful of OT authors, in the past decade, have begun to create a blueprint for the future of community-based OT practice, yet this is only a fraction of the information needed about this evolving practice area.

Yerxa (1991), in “Seeking a Relevant, Ethical, and Realistic Way of Knowing for Occupational Therapy,” advocated the use of qualitative research methods in efforts to expand OT’s knowledge base. Responding to Yerxa’s call for suitable research methods, this study employed a qualitative method known as the critical incident survey (CIS). This method, used by Benner (1982, 1984) in her nursing studies, facilitated the interview process of a purposive sample of occupational therapy experts in order to identify the competencies and domains for community-based occupational therapy practice.

Yerxa (1991) stressed that “knowledge in occupational therapy needs to emphasize skills and capacities of the whole person and include the experience of engagement in occupation” (p. 201). She believed qualitative research, a generic term for several research approaches, allows one to tap into this knowledge. Qualitative research, descriptive by its nature, uses the natural setting as the primary data source, focuses on both the process and the outcome, and analyzes data
inductively. This type of research is also interested in meaning from the participants' perspective and deals with the complexity of a situation in its context (Yerxa, 1991). Yerxa asserted that traditional quantitative methods reduce humans into measurable units and therefore do not represent the person's reality. Qualitative research methods are congruent with occupational therapy's philosophical assumptions and offer a "goodness of fit for what is worth knowing in occupational therapy" (Yerxa, 1991, p. 200).

Berg (1998), a social science researcher, distinguished between qualitative and quantitative research by noting that the former deals with the nature of things (who, what, where, and when) and the latter with the amount of something (counts and measures). Qualitative techniques allow researchers to examine and understand how people organize and make sense of their surroundings (Berg, 1998).

Qualitative research is subjected to considerable rigors of authenticity and trustworthiness. Authenticity and trustworthiness, analogous to validity and reliability respectively, exist when the research findings are true and represent reality (Holloway & Wheeler, 1996). Commonly used qualitative research methods include ethnography, systems theory, oral history, historical research, single case study, interview, and focus group interview (Berg, 1998; Holloway & Wheeler, 1996; Yerxa, 1991). The CIS, while not a commonly used qualitative research method, draws from the oral history and interview methods to serve as a worthwhile tool for uncovering this particular area of the occupational therapy knowledge base.

Dunn and Hamilton (1986) defined the critical incident technique as "a rather
sophisticated method for collecting behavioral data about the ingredients of competent behavior in a profession” (p. 208). The CIS originated during World War II from John C. Flanagan’s frustration with the lack of suitable data on why pilots failed training programs (Flanagan, 1954). Flanagan interviewed experienced pilots to determine the behaviors that made them successful and then based his training program on this information to ensure that the new pilots would have the necessary competencies for flying (Dunn & Hamilton, 1986; Flanagan, 1954).

Dunn and Hamilton (1986) defined an incident as “any observable activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act” (p. 209). An incident is critical when the purpose of the act is clear to the observer and the consequences are definite enough to leave almost no doubt about its effects. For each incident/description, one gathers information about the details of the setting where the event occurred, precisely what occurred, an account of the incident’s outcome, and why it was considered effective or ineffective practice. The concern in such a survey is always with the incident, never with the practitioner, for the purpose is not to identify incompetent professionals (Dunn & Hamilton, 1986).

The first step in conducting a CIS is to identify the profession of interest. One then determines from whom the incidents will be collected. Having established these steps, one proceeds to the interviews (Dunn & Hamilton, 1986). Dunn and Hamilton (1986) stated, “As the individually described incidents are collected, what happens is that they tend to fall into natural clusters and the areas of essential competence within
a profession begin to emerge” (p. 214). Further breakdown of the incidents reveals competencies within each main area of activity. An expert panel from the profession can be created to assist with this task of identifying competencies, which serves to take pressure off the research team and guarantees support from the profession under study (Dunn & Hamilton, 1986).

This research study sought to expand the blueprint for the future of community-based OT practice by identifying the knowledge, skills, and abilities needed to practice OT in community-based settings and to stimulate their further development. This study followed similar research methodology that Benner used in nursing practice. Benner (1982, 1984), using the CIS, interviewed expert nurses about an experience the nurses found significant or ordinary, or captured the essence of nursing practice. From these narratives, she extracted the knowledge, skills, and abilities used in expert nursing practice, which also defined what makes a nurse an expert. Benner then used this information to acknowledge the expertise necessary for effective nursing practice and to foster a nurse’s progression from novice to expert. This study, using Benner’s techniques, aimed to identify the knowledge, skills, and abilities of successful occupational therapists already in community-based practice. This information can have a crucial impact on the occupational therapy profession and occupational therapy curricula as increasing numbers of new and expert occupational therapists enter community-based practice.
CHAPTER II

LITERATURE REVIEW

Shift Into Community Practice

A review of the literature reveals a significant shift in occupational therapy (OT) practice from traditional medical and institutional settings to community-based settings over the past twenty-five years. But even before this shift, OT, although traditionally practiced in institutional settings, had branched into the community throughout the history of the profession. Although lacking prominence as a practice area, community-based practice settings date back to the profession’s inception in the early 1900s, with the first example being the sheltered workshop. OT’s further expansion into community settings began in the 1950s as a byproduct of the polio era, when occupational therapists became involved in prevocational exploration and training (Reed & Sanderson, 1992). During the massive deinstitutionalization movement of the 1960s, many occupational therapists expected increased opportunities for employment in community mental health centers, but few positions materialized (Gibson, 1993; Reed & Sanderson, 1992). Grady (1995) noted that, beginning in the 1960s, the independent living movement for people with disabilities provided additional impetus toward community OT practice.

It was not until the mid-1970s that occupational therapists began to work in
community-based settings in significant numbers. Hopkins (1993) noted that the passage of key federal education legislation created many new OT positions in community-based settings. Both Public Law 94-142 of 1975, which requires that all children receive free and appropriate educational services, and Public Law 94-457 of 1986, which provides for early intervention services, list OT as a related service (Hopkins, 1993). Other legislation, such as the Americans with Disabilities Act of 1990, and the advent of managed care have further shifted OT practice into community settings (Grady, 1995). The most recent shift of OT into community settings is in the provision of home health care, including hospice care (Devereaux, 1991; Hopkins, 1993).

Health Policy Alternatives (1996) noted that there is an unmistakable trend toward changing the service delivery system so that it is supportive of individuals with low levels of disabilities and their ability for independent living. While most Medicaid spending for persons with disabilities requiring chronic care goes for institutional support, spending for home- and community-based care is rising more quickly than the growth of expenses for institutional services (Health Policy Alternatives, 1996). According to the Pew Health Professions Commission (1993), allied health professionals play a pivotal role in helping people with disabilities function in chronic care, home, and school environments. Relating these concepts to occupational therapy, Baum and Law (1998) stated:

Changes in the health care system require occupational therapy practitioners to focus on the long-term health needs of clients in order to help them develop
healthy behaviors to improve their health and to minimize the health care costs associated with disabling conditions. (p. 8)

This information appears to suggest that government, as well as the public, is beginning to recognize the benefits, many of which are financial, of providing services to people in their natural environments.

According to the Pew Health Professions Commission (1993), the emerging trends in allied health professions (i.e., occupational therapy, physical therapy, speech therapy, etc.) are: (a) changing demography, (b) changing patterns of disease, (c) refocusing on health promotion, (d) advancing medical information and technology, (e) ensuring quality care, and (f) declining access and growing cost of health care.

Responding to the trend of health promotion, the Commission (1993) wrote:

The best locations for wellness activities are those that are most accessible to the community needing the services: worksites, schools, and aging centers. Allied health professionals predominate in community-based settings and are key players in wellness and prevention. Their participation will only increase in the future by virtue of both the locations of their practices and the content of their skills. (p. 38)

Several sources predict that health care reform will continue to serve as impetus for the allied health professions’ expansion into community-based settings (Health Policy Alternatives, 1996; Pew Health Professions Commission, 1993). The Pew Health Professions Commission (1993) wrote, “As the health services delivery system becomes more rational, selected allied health services in alternative settings could substitute well for more expensive forms of medical and institutional care, a much-needed response to justifiable pressures for cost containment” (p. 39).
Occupational Therapy Workplace Data

Data from the early and mid 1990s reflect a shift in occupational therapy workplace settings. As cited in “Health Care and Market Reform: Workforce Implications for Occupational Therapy,” the 1991 and 1995 American Occupational Therapy Association (AOTA) membership workplace surveys demonstrate a marked decline in the proportion (20.6 percent) of occupational therapists working in hospital settings. In the same period, a dramatic increase occurred in the proportion of occupational therapists working in skilled nursing/intermediate care facilities (170.6 percent) and home health agencies (106.2 percent). The survey showed that private practice is experiencing modest continued growth, while the proportion of occupational therapists working in school-based practices remains largely unchanged (Health Policy Alternatives, 1996). From this data, it is apparent that increasing numbers of occupational therapists are working in community-based settings.

Domains and Competencies

The Pew Health Professions Commission (1993) wrote that health professions, in spite of all their efforts to establish their professional identity, must now redefine themselves and “what they will contribute within the context of the needs of a rapidly changing health care world” (p. 8). The Commission appeared to suggest that it is critical for health professions to identify their competencies and to examine if they
meet not only the needs of clients and patients but also the demands of a rapidly changing health care system.

The Pew Health Professions Commission (1993) defined competencies as "skills, attitudes, and values" (p. 5). Benner (1984), in a less clear manner, defined a competency as "an interpretively defined area of skilled performance identified and described by its intent, function, and meanings" (p. 292). She defined a domain as "a cluster of competencies that have similar intents, functions, and meanings" (p. 293). Benner’s definitions, although somewhat convoluted, appear to suggest that competencies are the specific knowledge, skills, and abilities one possesses, and that domains are the clustering of those competencies. The domains, once identified, can serve as a guide to practice for a profession.

In anticipation of meeting shifting health care demands, the Commission (1993) provided a summary of competencies for the health professions for the year 2005: (a) to care for the community’s health, (b) to provide contemporary clinical care, (c) to participate in the emerging system and accommodate expanded accountability, (d) to ensure cost-effective care and use of technology appropriately, (e) to practice prevention and promote healthy lifestyles, (f) to involve patients and families in decision-making process, and (g) to manage information and continue to learn.

Research efforts in the nursing profession also suggest that competencies play a pivotal role in meeting the demands of patients as well of those of a changing health care system (Benner, 1984). Benner (1982, 1984) interviewed nurses ranging in ability from novice to expert to identify the knowledge embedded in expert nursing
practice. Her studies allowed her to define the competencies and domains of nursing practice as well as to document the progression of skill acquisition. She extracted the competencies from the nurses' descriptions of critical incidents that occurred in their nursing practice. From the critical incidents, thirty-one competencies emerged, which Benner clustered into seven domains of nursing practice.

A review of OT literature revealed one article related to competencies in OT practice. Case-Smith (1994) surveyed pediatric occupational therapists regarding their skill level in competencies that define pediatric practice. An analysis of the surveys identified six constructs that described the respondents' related areas of skills. The study also revealed that the advanced occupational therapy practitioners rated themselves higher than the inexperienced practitioners in 73 of 80 competencies (Case-Smith, 1994).

Striving to meet the demands of a shifting health care world and ensuring quality in OT in community-based settings requires developing a list of domains and competencies. Studies conducted in nursing and also in OT pediatric practice have delineated competencies important to practice. However, no literature exists which defines competencies for OT in community-based settings. Therefore, the identification of domains and competencies in this evolving area of OT practice is the basis for this study.

The Pew Health Professions Commission (1993) made a call for health profession educators to address competencies in their curriculum so that they are in line with American's health care needs and with the changing health care systems. The
Commission (1993) noted that this will “require a balance with the individual, organ-
based, disease-specific model that has been the driving force in many of the health
professions, especially medicine, for several decades” (p. 1). The Commission (1993)
continued:

Reform in health care is emerging as an important national, political, and
economic issue. As leaders from government and business are challenged to
device creative solutions to address this complex issue, they must also respond
to an increasing pressure to provide health care workers with the skills
necessary to work in a different type of health care world. This push for
general reform will motivate educational change. (p. 9)

Support for educational change in occupational therapy is noted in the
literature. Baum and Law (1998) appeared to support adapting curriculum when they
stated, “What is required are fundamental changes in the preparation of practitioners
and in continuing education opportunities for acquiring new competencies for
community programs...” (p. 8).

It appears that the value of competencies lies not in the specific information
identified but in how that information is used. The above sources (Benner, 1984; Pew
Health Professions Commission, 1993) suggest that competencies are a rich source for
delineating a profession’s knowledge, skills, and abilities and for responding to the
needs of a rapidly changing health care environment. With this information, health
educators can adapt curriculum so that students enter health professions with the
minimum competencies needed to practice in that field and with domains to guide their
practice.
A review of the literature shows several health care professions using the CIS method as a means for acknowledging professional expertise and identifying what knowledge, skills, and abilities are needed for successful practice in a field (Dunn & Hamilton, 1986; Sim, Kamien & Diamond, 1996). Studies done in Australia with general practitioners show that this technique and the critical incident narratives serve as a valuable resource “as a vocational training tool to reinforce good practice, avoid problem areas and rehearse methods of dealing with areas of recurrent difficulty” (Sim, Kamien & Diamond, 1996, p. 64). According to Dunn and Hamilton (1986), the main values of the critical incident technique lie in three areas: (1) competency-based education, (2) priority areas in education, and (3) problem-solving materials. Lending support to the problem-solving approach in education, Dunn and Hamilton (1986) further asserted:

Critical incidents provide the ideal basis for such problems in that they detail true-life events in professional activity which the members of a profession regard both as important and factual evidence of good and bad practice. The critical incident survey can provide the framework for problem-solving courses which, in turn, can guarantee educational programmes relevant to a profession’s needs. (p. 210)

This approach fits with the problem-based learning method that many OT educators are now starting to embrace.

Benner (1983) asserted that “a wealth of untapped knowledge is embedded in the practices and the know-how of expert nurse clinicians, but this knowledge will not expand or fully develop unless nurses systematically record what they learn from their
own experience” (p. 41). This idea holds for occupational therapy as well.

Five Stages of Skill Acquisition

Benner (1982, 1984), in her studies to further explore nursing expertise and competency, interviewed 130 nurses who practiced in the intensive care units of eight hospitals. Clustering the nurses into groups based upon expected level of practice, she used the CIS method to extract narratives from these different levels of practice. In order to describe how skill acquisition occurs in nursing and to identify the types of practical knowledge used in expert practice, Benner used a model of skill acquisition developed by Hubert and Stuart Dreyfus to categorize her findings.

The Dreyfus Model of Skill Acquisition, inspired by the brothers’ passion for the game of chess and refined through their study of pilots, states that one progresses through five stages of proficiency in the acquisition and development of a new skill (Dreyfus & Dreyfus, 1986). The five stages are: (1) novice, (2) advanced beginner, (3) competent, (4) proficient, and (5) expert (Dreyfus & Dreyfus, 1986). Benner, Tanner, and Chesla (1992) asserted:

This model holds that in learning a practice, changes in four general aspects of performance are reflected: (1) movement from a reliance on abstract principles and rules to use of past, concrete experiences; (2) shift from reliance on analytic, rule-based thinking to intuition; (3) change in the learner’s perception of the situation from one in which it is viewed as a compilation of equally relevant bits to an increasingly complex whole in which certain parts are relevant; and (4) passage from detached observer, standing outside the situation, to one of a position of involvement, fully engaged in the situation. (p. 15)
Novice Stage

Dreyfus and Dreyfus (1986) described the novice stage as marked by beginners who, having little or no experience with the situations in which they must perform, rely on rules to guide their actions. Because the novice learns rules outside of a situational context and has no prior experience to link them to, the novice will apply these rules regardless of the situation (Benner, 1982; Dreyfus & Dreyfus, 1986). Benner et al. (1992) found that the novice nurse has difficulty recognizing the most relevant tasks in real situations and making exceptions to the rules when needed.

Advanced Beginner Stage

The novice moves into the advanced beginner stage after she accumulates considerable experience in dealing with real situations, begins to take notice of meaningful recurrent aspects of situations (Benner, 1982), and links them to theoretical knowledge (Benner et al., 1992). The advanced beginner, performing at a marginally acceptable level, still operates from general guidelines and cannot reliably identify the most integral components of a complex situation (Benner, 1982; Dreyfus & Dreyfus, 1986). Because the advanced beginner nurse is just starting to perceive meaningful recurrent patterns in practice, she often needs assistance in setting priorities (Benner, 1982). Benner et al. (1992) wrote that the advanced beginner nurse is more accepting of her limited understanding of a situation and feels it can be remedied through consultation or further reading. Another major aspect of this stage
is that the nurse perceives the situation in terms of what it demands of her, rather than in terms of what the patient needs and the situation’s outcomes (Benner et al., 1992).

Benner et al. (1992) asserted:

This self-consciousness arises because advanced beginners are constantly working at the edges of their safety and knowledge. In addition, they are deliberately taking on the role of the nurse, acting like a nurse, even though they cannot fully inhabit the role. (p. 17)

**Competent Stage**

As the advanced beginner nurse progresses into the competent stage, typically after practicing two to three years, she begins to see her actions in terms of goals. Her goals or plans dictate which aspects or components of a situation she addresses (Benner, 1982; Dreyfus & Dreyfus, 1986). As a result of this conscious planning, the competent nurse has greater organization and efficiency (Benner, 1982). During this stage, the competent nurse often develops a sense of hyperresponsibility as her confidence in her ability increases and as she questions the assessments and judgments of experienced clinicians (Benner et al., 1992). The competent nurse develops a desire to limit the unexpected. This self-imposed order might limit the competent nurse’s ability to perceive the demands of the situation and recognize changing relevance (Benner et al., 1992).

Benner described the competent stage as a pivotal time for nurses to receive further support and training as she feels many nurses question whether they want to stay in the profession, largely as a result of the hyperresponsibility they feel (Villaire,
1992). She (1982) wrote that many nurses remain at this level of skill acquisition because their employers greatly value their organization and efficiency and do not encourage development of further expertise.

**Proficient Stage**

The proficient nurse has an increased ability to see changing relevance in a situation and to respond to it. The nurse’s response to this relevance often results from analytical planning and problem-solving instead of instantly seeing the most appropriate response (Benner et al., 1992). Benner et al. (1992) wrote:

> What is new at the proficient level is the nurse’s ability to read the situation and to notice when the patient’s condition has changed sufficiently to warrant a redefinition of the situation, a change in perspective and action. The skill of seeing has become direct recognition through association, although the proficient nurse may have to figure out what action to take in response to the pattern recognition. (p. 24)

The proficient nurse perceives the situation as a whole rather than its isolated parts (Benner, 1982). Decision-making becomes less cumbersome because the proficient nurse more readily identifies the salient aspects of a situation (Benner et al., 1992; Dreyfus & Dreyfus, 1986). She thinks analytically by using previously learned rules and guidelines to make her decisions, and she can comfortably make modifications (Benner, 1982; Dreyfus & Dreyfus, 1986). The proficient nurse no longer feels anxious about having left a step out because she has more confidence in her ability to see the most important aspects of a situation. Even though the proficient nurse has
gained this recognition, she often still relies on analytical planning and deliberate problem solving (Benner, 1982).

**Expert Stage**

The expert stage is marked by a decreased reliance on analytical processes to formulate a plan of action for a situation (Benner et al., 1992; Dreyfus & Dreyfus, 1986). Dreyfus and Dreyfus (1986) wrote that an expert, from a mature and practiced understanding, has an intuitive sense of what to do in most situations. They further added, "When things are proceeding normally, experts don't solve problems and don't make decisions, they do what normally works" (Dreyfus & Dreyfus, 1986, p. 30). The expert's intuitive sense seems to flow from the similarities and pattern recognition that she has accumulated throughout her experiences. In new situations, the expert nurse might need to summon her analytical skills from the background; however, her pattern recognition and intuitive sense will allow her to quickly narrow in on the essence of the situation at hand without wasting time considering unfruitful options (Benner, 1982; Dreyfus & Dreyfus, 1986). Benner et al. (1992) wrote, "The expert is at home managing rapidly changing situations and is able to attend to many other aspects of care that go unnoticed by the less experienced clinician" (p. 26).

**Differences Between Practical and Theoretical Knowledge**

In their writings on novice to expert issues, Benner (1983) and Dreyfus and Dreyfus (1986) made a distinction between practical and theoretical knowledge.
Practical knowledge is "knowing how"; theoretical knowledge is "knowing that" (Benner, 1983; Dreyfus & Dreyfus, 1986). Both Benner and Dreyfus and Dreyfus noted that people often possess many skills (knowing how) that they learned through practice without ever acquiring the rules or facts (knowing that) behind that skill, for example, such as riding a bike. Furthermore, one's know-how of many common activities cannot always be accounted for theoretically (Benner, 1983). "Knowing that" results from theory and concepts, whereas "knowing how" results from experience. The expert, through the course of her professional development, incorporates "knowing that" into "knowing how" (Benner, 1993; Dreyfus & Dreyfus, 1986).

Clinical Reasoning

Mattingly (1991), in occupational therapy literature, wrote that use of clinical reasoning is what distinguishes the novice from the expert and is the tool one uses to become an expert. For a novice, using clinical reasoning is a deliberate, conscious process, while it becomes automatic for experts (Mattingly, 1991). She wrote that as an occupational therapist gains more experience, the gap between what one knows and what one can say grows. This idea relates to the previously highlighted distinctions made between "knowing how" and "knowing that" (Benner, 1983; Dreyfus & Dreyfus, 1986). Mattingly (1991) asserted that clinical reasoning is more than the application of theory to the treatment process; she described clinical reasoning as being meaning-centered, that is the culmination of what one knows and learned through
academia with what one has gained through doing and interacting with the client.

Burke and DePoy (1991) stated:

Clinical reasoning addresses many of the unstated thoughts and formulations that therapists develop when they work with patients. The therapist’s ability to decide which of the patient’s needs to address and how to construct the most meaningful treatment opportunities often depends on more than a set of explicit rules. Intuition, judgment, empathy, and common sense, all aspects of the clinical reasoning process, are among the many strategies a therapist may use to develop and evaluate individualized treatment plans. (p. 1027)

Mattingly (1991) noted that clinical reasoning does not fit under the medical model and basic science because the procedures used cannot be uniformly applied in all situations.

Therapist With a Three-Track Mind

Three types of clinical reasoning emerged from the American Occupational Therapy Association/American Occupational Therapy Foundation Clinical Reasoning Study: (1) procedural reasoning, (2) interactive reasoning, and (3) conditional reasoning. Fleming (1991) described these three styles of reasoning as “different operations interacting with each other in the therapist’s mind. We referred to these operations as different tracks for guiding thinking. Thus, we developed the notion of the occupational therapist as a therapist with a three-track mind” (p. 1008). Each type of reasoning seemed to address different aspects of the whole problem; therapists attended to patients on multiple levels: (a) the physical ailment, (b) the patient as a person, and (c) the person as a social being in the context of family, environment, and culture (Fleming, 1991). Regardless of the type of reasoning used or the concerns
addressed, the therapists’ main goal was to promote a full life for the patient (Fleming, 1991).

Fleming (1991) wrote that procedural reasoning is the style of reasoning used when the occupational therapist thinks about the disabling condition and decides on treatment approaches to “remediate functional performance problems” (p. 1008). This reasoning deals with problem identification and treatment selection (Fleming, 1991). Experienced occupational therapists seemed to quickly identify and search within the problem areas; novice therapists appeared to have more difficulty with this task (Fleming, 1991).

Interactive reasoning is the face-to-face interaction the occupational therapist has with a patient in an effort to better understand him or her as an individual. Through this type of reasoning, Fleming (1991) asserted that the therapist might be attempting to better understand the individual’s experience of having a disability. Interactive reasoning can be used to find ways to engage patients and/or clients in therapy. Fleming suspected that procedural reasoning guides treatment while interactive reasoning guides therapy.

In conditional reasoning, Fleming (1991) wrote that the therapist “interprets the meaning of therapy in the context of a possible future for the person. The therapist imagines what that future would be like. This imagined future is a guide to bringing about a revised condition through therapy” (p. 1012). The therapist tries to imagine what the patient was like before the disabling condition in order to match treatment selections to the person’s specific interests, capabilities, and goals (Fleming, 1991).
From the Clinical Reasoning Study, Fleming (1991) observed that the therapists shifted rapidly from one form of thinking to another, noted subtle cues and responded to them, and then resumed another task and thinking mode without apparently skipping a beat. Fleming (1991) believed that these three types of reasoning allow therapists to "put it all together" and to "treat the person as a whole" (p. 1013).

Multiple Intelligences Theory

Several occupational therapy authors (Fleming, 1991; Schwartz, 1991) have taken notice of Gardner’s theory of multiple intelligences and have drawn upon it when examining the clinical reasoning processes therapists use. Gardner (1993b) defined "intelligences" as the human cognitive abilities, talents, and mental skills we all possess. The theory of multiple intelligences posits that seven intelligences exist: (1) verbal/linguistic: intelligence of words; examples: reading, writing, analyzing, and organizing; (2) logical/mathematical: intelligence of numbers and reasoning; examples: strategies, games, science, and problem solving; (3) visual/spatial: intelligence of pictures and images; examples: diagrams, charts, and schemata; (4) bodily/kinesthetic: intelligence of moving the body and manipulating objects; examples: building models and dramatizing events; (5) musical: intelligence of tone, rhyme, and timbre; examples: composition, singing, and learning in rhythmical ways; (6) interpersonal: intelligence of social understanding; examples: clubs, group projects, and cooperative learning; (7) intrapersonal: intelligence of self-knowledge; examples: diaries, meditation, self-
esteem, research, and reflection (Gardner, 1993a; Melton & Pickett, 1997).

Fleming (1991) suggested that when an occupational therapist engages in interactive reasoning, he or she uses interpersonal intelligence. Gardner (1993b), further defining this concept, wrote:

Interpersonal intelligence builds on a core capacity to notice distinctions among others; in particular, contrasts in their moods, temperaments, motivations, and intentions. In more advanced forms, this intelligence permits a skilled adult to read the intentions and desires of others, even when these have been hidden. This skill appears in a highly sophisticated form in religious or political leaders, teachers, therapists, and parents. (p. 23)

Gardner’s theory appears to give validation to the refined skills, talents, and abilities occupational therapists possess and utilize when working with clients and patients.

OT Application of the Dreyfus Model of Skill Acquisition

Slater and Cohn (1991) integrated the findings of the American Occupational Therapy Association/American Occupational Therapy Foundation Clinical Reasoning Study with the Dreyfus Model of Skill Acquisition to design a framework for a staff development program which serves to foster an occupational therapist’s professional growth from novice to expert as well as to validate the expertise of the experienced occupational therapist. The authors (1991), describing one hospital’s experience of using case stories and analysis of therapy sessions as a means of staff development, found:

Clinicians who had been videotaped articulated tangible ways in which they thought videotaping and analyzing practice in reflective study groups changed their thinking and their approach to practice. Changes noted among clinicians included increased personal insights into their response to patients, increased
ability to take a reflective stance toward their practice, different approaches to analyzing and labeling observation, and improved ability to hypothesize about therapy outcomes. (p. 1042)

Slater and Cohn (1991) proposed that such reflection, through videotaping therapy sessions as well as pretherapy and posttherapy interviews followed up by analysis, affords experienced occupational therapists opportunities to serve as role models and mentors to novice therapists while at the same time reinforcing their enthusiasm for the profession. Slater and Cohn’s staff development program is not only a method for validating expertise in occupational therapy practice but is also a valuable tool for fostering the clinical reasoning skills of newer therapists.

Summary

With literature showing evidence of a shift in occupational therapy practice from traditional institutional settings to community settings, the need for more information about this evolving practice area is ever present. To date, little is documented about community-based occupational therapy practice. In a constantly changing health care world, it is crucial that health care professionals have the necessary knowledge, skills, and abilities to meet the demands of clients and the evolving health care system. As seen in nursing, uncovering the knowledge embedded in practice is one strategy for increasing a profession’s knowledge base. Through her critical incident survey (CIS) interviews with nurses varying in levels of expertise from novice to expert, Benner identified the competencies and domains of nursing practice as well as expertise in practice. It appears that Benner views the CIS process as an
ongoing approach to competency identification due to the dynamic nature of professional practice. Several authors have noted that the CIS serves as an excellent tool for tapping into a professional’s clinical reasoning process and knowledge base. Literature shows that the expert, through linking theoretical knowledge with experience, can quickly problem solve and reason through a situation with an intuitive sense. This study values the extensive knowledge and experience the expert occupational therapist has to offer. In an effort to increase the knowledge base about this practice area, this study aimed to identify the competencies and domains of successful occupational therapists already in community practice.
CHAPTER III

DESIGN AND METHODOLOGY

Research Design

To facilitate the identification of competencies and domains for community-based occupational therapy practice, this study employed a qualitative research method known as the critical incident survey (CIS). A qualitative design was chosen in response to Yerxa’s (1991) assertion “...that qualitative research approaches have a goodness of fit with finding out what is worth knowing for occupational therapists” (p. 200). The CIS is subject to the considerable rigors of authenticity and trustworthiness. Analogous to validity and reliability respectively, authenticity and trustworthiness exist when the research findings are true and represent reality (Holloway & Wheeler, 1996).

According to Holloway and Wheeler (1996), trustworthiness is established through: (a) credibility, which exists when the subjects are accurately identified and described; (b) transferability, which is judged by the reader who determines if the information from the study can be transferred to other settings; (c) dependability, which is evidenced when the research process follows the accepted standards; and (d) confirmability, which is ensured when the reader assesses the adequacy of the research processes and judges that the findings arose from the data. Credibility for this design resulted from the identification and selection of occupational therapists that qualified
as experts, per this study’s criteria, to serve as participants. Transferability of information uncovered in this study to other community-based OT settings is feasible due to the agreement that emerged on the competencies described by participants who met the “expert” criteria and practiced in community settings. To ensure dependability of the research process, this study was conducted with strict adherence to its research design as approved by Western Michigan University’s Human Subject Institutional Review Board. In addition, the student researcher and primary investigator met regularly to discuss the research process and assure that the design was followed. Confirmability was assured in this design as the participants reviewed, edited, and approved the use of the interview summary before its inclusion in this study. A triangulation process, in which two OT graduate students assisted the student researcher, confirmed the authenticity of the results.

Instrumentation

The CIS guide and the demographic data form served the purpose of organizing the interviewer, the interviewee, and the overall interview as well as the data collection and analysis procedures.

Critical Incident Survey Guide

The CIS guide (see Appendix F) was adapted by Ben Atchison, Ph.D., from Eastern Michigan University, for use in OT from research methodology used by Patricia Benner, Ph.D., in her expert nursing studies. The purpose of this guide was to
facilitate and organize the CIS interview. The guide defines a critical incident as any of the following: (a) an incident in which the practitioner feels his/her intervention made a difference in the patient’s outcome; (b) an incident that captures the quintessence of what OT is all about; (c) an incident that is typical and ordinary; and (d) an incident that was particularly demanding. The CIS guide contains a variety of probes the interviewer can use to elicit further information about the critical incident.

Demographic Data Form

The demographic data form (see Appendix E), also created by Ben Atchison, Ph.D., was used to obtain the practitioner’s name, contact number, employment history, professional education profile, special certifications/credentials, and any other significant information the practitioner wanted included.

Participants

The purposive sample for this study consisted of three community-based occupational therapy practitioners. Initially, faculty in Western Michigan University’s Occupational Therapy Department identified occupational therapists they considered experts in community-based occupational therapy practice. Of the three occupational therapists interviewed for this study, the OT Department identified two; another therapist who participated in the study suggested one. To be identified as an expert for this study, the occupational therapist needed to have at least five years of continuous experience in the profession, be regarded as one who incorporates
expert by colleagues in the field. An additional criterion for participation was employment in a community-based setting.

Procedures

After the Human Subjects Institutional Review Board of Western Michigan University approved the study (Appendix A), the student researcher contacted each expert occupational therapist by telephone using a verbal script (Appendix B). Upon giving verbal consent to participate in the CIS interview, each occupational therapist received a packet a week prior to the interview containing a follow-up letter (Appendix C); the scope of the study, created by Ben Atchison, Ph.D., (Appendix D); the demographic data form (Appendix E); the CIS guide (Appendix F); and the consent form (Appendix G). Initially, the student researcher contacted two therapists who practice in community mental health centers. The first therapist contacted expressed interest in participating in the study but was unable due to time constraints. She offered several names of community-based occupational therapists that she felt met the expert criteria. The second therapist contacted had consented to participate in the study but did not want to have the interview recorded; the student researcher felt that the absence of audio-recording would limit the fluidity and spontaneity of thought the CIS method elicits and therefore did not interview this therapist. Three additional therapists were identified and contacted. All three volunteered to serve as participants and had experience working in home health care. The OT Department faculty recommended two of the participants who were selected; the third participant was
recommended by one of the other participants interviewed. Participants were asked to review the CIS guide before the interview to stimulate thoughts for the interview. It was suggested that they wait to sign the consent form until the interview so they would have an opportunity to have any questions addressed. The student researcher met with the participants individually to conduct the audio-taped interview. After each interview was transcribed, the student researcher prepared an interview summary. Each participant was then provided with a copy of the interview summary in order to review, discuss, edit, and approve of its use in this study. The student researcher then analyzed the content of the three interviews looking for similarities in order to derive the competencies and domains. Two OT graduate students assisted the student researcher in confirming the authenticity of the results.
CHAPTER IV

RESULTS

Participant Description

Three occupational therapists, identified as experts in the area of community-based OT practice, were interviewed using the critical incident survey (CIS). During the interview, each occupational therapist described, in narrative form, a critical incident of her choice. The interviews were transcribed and summarized. Each therapist reviewed her summary, made revisions, and approved of its use for inclusion in this study. (See Appendix I for interview summaries.)

All three participants were female and provided occupational therapy services in home health care settings. Participant 1 had a bachelor’s degree in liberal arts, a master’s degree in occupational therapy (OT), and 16 years experience as an occupational therapist. This participant also held adult neurodevelopmental treatment (NDT) certification. Participant 2 had a bachelor’s degree in OT and 12 years experience as an occupational therapist. Participant 3 had both a bachelor’s and master’s degree in OT and had 19 years experience as an occupational therapist.

Participant 1 chose to describe a critical incident that she believed was typical and ordinary within her scope of OT. During this interview, the interviewer relied heavily upon the CIS guide and used few follow-up questions. Voice-to-voice
contact with the first participant was not achieved until three weeks after she had received the interview summary. This participant said she saw a few items she wanted to change but could only remember one, which was the spelling of a product. She then gave her approval for the summary's inclusion in this study.

Participant 2 selected an incident that she felt was very demanding. In fact, it was the most demanding one she has had in her 12 years as an occupational therapist. After reviewing the summary, the participant spent approximately two hours via telephone discussing her revisions of the interview summary. These revisions improved the overall clarity and richness of the interview.

Participant 3 also selected an incident which she felt was demanding. This participant, after having an opportunity to review the interview summary, met with the student researcher and elaborated on points needing further clarification. She did not request additional changes.

Competency Identification

Critical points of each interview were drawn from the summaries and placed in a grid to identify similarities. To help classify these similarities, competencies were identified from the literature review that matched the therapists' statements. Some competencies emerged directly from the therapists' statements, for example, "knowledge of body mechanics." Some competencies resulted from interpretation of the critical points that emerged from the interviews, for example, understanding the client's disability experience. Although the latter competency type
was not directly stated, two research associates and the student researcher agreed that each therapist, through her narrative, had expressed an attempt to understand the client’s disability experience. The triangulation process, with two other OT graduate students, in the data analysis confirmed the student researcher’s classification categories.

Thirty-nine competencies emerged from the three interviews. These competencies were then clustered into five domains: (1) content-related knowledge, (2) interpersonal skills, (3) educational pathways, (4) clinical reasoning, and (5) spirit of community. The presentation of the domains and corresponding competencies is for organizational purposes only; priority and/or rank are not implied. To summarize the domains and competencies, each of the five domains are presented with a list of competencies, a domain description, excerpts from the interview summaries, and a table of agreement.

**Content-Related Knowledge**

The content-related knowledge domain consists of eight competencies: (1) knowledge of disabilities, (2) knowledge of adaptive equipment, (3) knowledge of activities of daily living (ADL) teaching and retraining, (4) ability to perform functional ADL evaluations, (5) ability to adapt the environment to meet the client’s needs, (6) knowledge of body mechanics, (7) knowledge of home safety issues, and (8) knowledge of work simplification.

During the interviews, the participants described a complex and varied body
of knowledge they felt they needed in order to make a difference in those critical incidents. Their descriptions highlighted much of what an occupational therapist needs to know in order to be an effective therapist. The majority of this knowledge does not appear specific to a particular client. Much of it relates to the signs, symptoms, and effects of a disability, and then knowing what to do to minimize the effects of the disability. One participant, who has treated many people with hip fractures, described this type of knowledge when she elaborated:

...They’ve got a broken hip. They’re going to have some range of motion difficulties as far as reaching their feet. They’re going to have some standing problems, maybe some balance problems standing at the sink or bending their leg to get in the tub....Knowing the diagnosis, what types of problems are going to be, and then how that is translated into a functional task....Some of that I guess I feel is from experience but, hopefully, I did learn some of that up front....So I guess that is knowledge that hopefully people get from a curriculum...

Some of the assessment and treatment procedures discussed in the interviews have a particular set of rules, which do not change from person to person; two examples are body mechanics and seating position. They are not context specific. The participants also possessed the basic tenets of knowledge about performing functional ADL assessments, adapting environments, and teaching ADLs, which sometimes have a loosely structured set of rules. One participant, speaking directly of her knowledge of adaptive equipment, stated she had “...a lot of knowledge of adaptive equipment-big stuff, little stuff, walker trays or trays that she could carry things from one place to another, different ways to build up a chair to make it a higher height.”
The participants were able to and did individualize the components of occupational therapy to meet the needs of their clients. According to these three experts, an occupational therapist must know about many disabilities or know where to go to learn about them, know how to assess the client within the scope of his or her environment, and then adapt the environment to meet the client’s needs. Much of the information clustered into this domain appeared to be content-based, not context specific.

The next excerpt illustrates seven competencies clustered into this domain: (1) knowledge of disabilities, (2) knowledge of adaptive equipment, (3) knowledge of ADL teaching and retraining, (4) ability to perform functional ADL evaluations, (5) ability to adapt the environment to meet the client’s needs, (6) knowledge of body mechanics, and (7) knowledge of work simplification. Elaborating on the events of the critical incident she chose, this participant explained:

...I had her actually show me how she stood in the kitchen, show me how she would put things into the laundry. I...made suggestions as far as getting a stool to sit on to put things into the dryer or to take things out of the dryer so that she would be in a better position. I showed her how to get in and out of the bathtub an easier way. We talked about some equipment for her kitchen so that she could feed the dog, so that she could pick up the newspapers. You know, suggested her sitting on a stool so that she could bend over from the waist, from the hips, so that she wouldn’t have so much back pain or neck pain or headaches. I could tell from that initial visit that this woman needed more. There were psychological overlays to what was happening....She had no awareness of her own body mechanics.

Table 1 shows agreement on the emergence of content-related knowledge competencies among the three interview summaries.
Table 1
Emergence of Content-Related Knowledge Competencies

<table>
<thead>
<tr>
<th>Competency</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of disabilities</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Knowledge of adaptive equipment</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Knowledge of ADL teaching and retraining</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ability to perform functional ADL evaluations</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ability to adapt the environment to meet the client’s needs</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Knowledge of body mechanics</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Knowledge of home safety issues</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Knowledge of work simplification</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Interpersonal Skills

The following 13 competencies form the interpersonal skills domain: (1) engaging the client in treatment; (2) offering alternatives versus giving commands; (3) understanding the client’s disability experience; (4) seeing the client as a social being in the context of family, environment, and culture; (5) treating the person as a whole; (6) utilizing therapeutic use of self; (7) drawing upon one’s interpersonal
intelligence; (8) matching treatment selections to the client’s specific interests, capabilities, and goals; (9) being assertive; (10) detaching emotionally; (11) establishing a rapport with the client and his/her family; (12) communicating openly with the client; and (13) persevering through difficult situations.

Through their descriptions, the participants identified a variety of skills and abilities that are context specific, which relate directly to encounters one has with clients. They described the skills and abilities they felt they possessed which allowed them to be successful in that incident. Each competency clustered into this domain relates to the participants’ interaction with the client. Describing the competency of seeing the client as a social being in the context of family, environment, and culture, one participant asserted:

...I think looking at that person with that deficit or disability in a functional environment is always what you have to do, whether that functional environment is just a nursing home room or their own apartment or a job or a school....When you get somebody in their environment, the differentness [sic] of those diagnoses come up.

Another participant, capturing the essence of this domain, stated, “You have to try to not step on toes and...your interpersonal skills are very important.” These participants, especially those who described demanding incidents, demonstrated the multitude of skills an occupational therapist must use in order to be effective with a client and to address all the demands of the situation. According to these participants, utilizing therapeutic use of self is one critical component of working effectively with clients. Therapeutic use of self consists of understanding, neutrality (sometimes called empathy), and caring (Schwartzberg, 1993) and facilitates the therapeutic
The following excerpt depicts one participant’s struggle to develop a therapeutic relationship with her client’s spouse who felt threatened by the OT intervention, as their auto insurance company initiated the OT services. She explained:

I was real quiet and I listened at first because he was so angry, so upset. It was like any input from me would have been on deaf ears and just agitated him more... I had to try to develop a rapport with him and to make him feel that I was listening to what he had to say. And so I repeated a lot of things that he said to me and I validated things that he said to me. Then I would give input, you know, start to talk about what we were going to do with his family and how things were going to be, and it was okay.

The participants used these skills to develop an understanding of the client’s experience, to connect with the client, to motivate the client to participate in the treatment process, to find out what is important to the client, and to develop respect for the client and his or her environment. Another participant addressed this notion by stating, “You have to use yourself and the techniques that you learn, but a lot of it is just understanding what’s going on with the other person.”

One participant highlighted several components of interpersonal intelligence when she described how she deals with clients who are angry. She explained:

If they’re assaulting me, I will ask them not to do that. I will try to divert them or listen to them. Usually they just need to blow off steam and it’s not verbally assaulting me. I usually don’t end up in those kinds of situations. But it’s just that they’re angry and you feel that, and I just accept that and usually let them vent and then they start to quiet down because I don’t argue with them. I don’t try to make them change their mind. I let them feel how they feel. I guess that’s my approach with it and I try to approach everyone that way, that you have a right to those feelings. And we can’t be... telling people how to feel or how to interpret something. We can give them...
information, we can educate them, but we have to be careful about...the timing of that.

Another relevant competency a participant spoke of was emotional detachment. She stated:

I think a skill that I need to further develop is...to not get caught up into the emotions of the patient...I stayed calm, but there were times I was almost at my limits with this person....I need to work on not letting myself get too involved emotionally. I am a very sensitive person and I have...to block that out so that I don’t have a negative impact on the patient’s behavior.

In the interviews, each participant stressed the importance of matching the treatment selections to the client’s specific interests, capabilities, and goals. One participant noted that sometimes a client does not accept recommendations, even though they would help him or her be more independent. She explained:

...Sometimes patients don’t choose the choices we do. I say, ‘Oh, you can learn to do this with this long-handled shoehorn,’ and they’re like, ‘No, I hate this thing. I don’t know how it works. It’s in my way. I’d rather...just get up early in the morning and have my daughter do it everyday before she leaves or some other alternative.’...I think as OTs we need to always listen to the patient’s idea of how to do this.

Another participant, describing the importance of this competency when she spoke of trying to find an appropriate chair for her client who had a stroke, said:

Another big factor was that he lives right on a river and he wanted to see the view from a window behind him, ...which made total sense. Normally I would not recommend a client who had a CVA...sit in a swivel chair because it’s just not safe....But with him you just...have to work with what he has and what his goals are and wishes. That was definitely a priority for him to be able to swivel in the chair.

Table 2 shows agreement on the emergence of interpersonal skill competencies among the interview summaries.
Table 2
Emergence of Interpersonal Skill Competencies

<table>
<thead>
<tr>
<th>Competency</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaging the client in treatment</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Offering alternatives versus giving commands</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Understanding the client’s disability experience</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Seeing the client as a social being in the context of family, environment, and culture</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Treating the person as a whole</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Utilizing therapeutic use of self</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Drawing upon one’s interpersonal intelligence</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Matching treatment selections to the client’s specific interests, capabilities, and goals</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Being assertive</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Detaching emotionally</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Establishing a rapport with the client and his/her family</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Communicating openly with the client</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Persevering through difficult situations</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
**Educational Pathways**

Three competencies emerged from the interviews that pertain to education and form this cluster of educational pathways: (1) client and family education, (2) community education, and (3) continued professional learning. Each of the participants described in their incident educating the client and their family members. One participant stated, “For me to look at that environment… there were a lot of good answers… I could teach her. I could teach her niece.” Another participant described, “My visit was… spent educating the patient and his wife on… why we recommended a different chair and the different choices he had.”

According to these participants, community education is an ongoing responsibility of all occupational therapists. One participant said:

> I’ve done career workshops on OT actually several times. You know, that kind of overlaps. That general educating and interacting with people usually does involve something about your personal life and your work. There’s always that chance to educate people on your profession, what it is you do. And that’s come up a lot.

In describing her responsibilities to her community, this participant stated, “I also have a responsibility to educate coworkers in other disciplines and people in the community regarding what OT is and what it can do for people.”

Another theme that emerged related to the participants’ continued professional learning. This included an awareness of issues affecting the OT profession. The participants found themselves in an atmosphere where continual learning and teaching was commonplace. A participant asserted, “Keeping educated clinically by
going to workshops and conferences is really important.” Related to her intervention
with a client, another participant stated:

I had to learn to do the training... as far as her body mechanics because that
was not my specialty area. I had to learn from other therapists and I did
that.... I know how to do an ADL assessment, but when you’re looking at it
compared to body mechanics, there’s a whole protocol on that. So I needed to
learn that protocol.

Table 3 shows agreement on the emergence of educational pathway
competencies among the three interview summaries.

Table 3
Emergence of Educational Pathways Competencies

<table>
<thead>
<tr>
<th>Competency</th>
<th>Interview Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Client and family education</td>
<td>X</td>
</tr>
<tr>
<td>Community education</td>
<td>X</td>
</tr>
<tr>
<td>Continued professional learning</td>
<td>X</td>
</tr>
</tbody>
</table>

Clinical Reasoning

Eleven competencies form the clinical reasoning domain: (1) ability to
hypothesize about treatment outcomes, (2) ability to analyze and label observations,
(3) ability to recognize and respond to changing relevance, (4) intuitive sense, (5)
problem-solving, (6) judgment, (7) confidence, (8) ability to perceive situations as a whole, (9) awareness of personal safety, (10) self-awareness, and (11) pattern recognition.

Each of the participants described several cognitive processes that occur while working with a client. Skills such as pattern recognition, clinical reasoning, judgment, and intuitive sense all work together to allow the occupational therapist to make good decisions and effectively treat clients. The participants implied that these skills all occur quite rapidly and are reinforced through experience. These skills involve the ways in which a therapist views a situation, thinks about it, and reasons through it. As was stated in several of the interviews, clinical reasoning skills develop further as one gains experience.

Describing her clinical reasoning process, one participant said:

I was trying to think ahead about what I was going to do next, I mean as far as from the therapy standpoint. But I always do that. I mean, you always are thinking about what you’re going to do next. You’re listening at the same time that you’re observing at the same time as you’re planning. You kind of do it all together.... The critical thinking, critical reasoning, clinical reasoning.... And you have choices and those choices flip through your head and you say, ‘Well, which way do I want to go now?’.... Sometimes you... make that decision and you go that way and then you back off if it’s not working and you go another way and you do that right in the session if something doesn’t work.

Each participant indicated that problem solving is an integral component of working with clients. A participant illustrated her problem solving skills through the following description:

Sitting there with her I could show her pictures in catalogs that I brought with me because I happened to know...that she had a hip fracture.... She’s in her
home, she may need some adaptive equipment. I want to show her pictures of what it might look like, what the cost might be. And then right away I knew who to call and how long it would take to find out the price. I could do all that very quickly.

According to the participants, the ability to recognize and respond to changing relevance is another critical competency in community-based occupational therapy practice. Demonstrating this notion through her description of an initial home evaluation, one participant stated:

So when we got there and actually had to work in that bedroom and in that bathroom, in working through these things what had been previously planned didn’t work. So I had to suddenly change some of the equipment needs and how she’d been told to do things and do them differently because it didn’t translate to this environment.

Confidence in one’s ability as a therapist and in the knowledge one possesses surfaced as a competency. This competency was inferred from the following description one participant gave on the demanding aspects of her critical incident:

I guess it was demanding at the time when I went in...because, again, I thought it was a pretty typical situation coming out of rehab with a hip fracture...I hadn’t expected to go through the number of things I went through. I had much more cursory things in mind. And I went in and we actually had to go through every aspect of parts of dressing, toileting, bathing, and cooking. Not that we did them all in the visit, but I had to look at aspects of all that in filling out an assessment that I just hadn’t expected....But it ended up that a lot of the details added up into enough areas that we had to address every area....So I guess that was demanding, but again...it was motivating because they were things that I could figure out how to address....There are certainly cases that I go in on that are demanding and you really aren’t sure you can fix it...especially if there’s a paralysis or something....In this I very much felt like I had concrete ways I could come up with and alternatives and education, so I could be a success, and she could be a success...I guess that made it a lot more motivating, even to why I remember it as a critical incident.
Table 4 shows agreement on the emergence of clinical reasoning competencies among the three interview summaries.

Table 4

<table>
<thead>
<tr>
<th>Competency</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to hypothesize about treatment outcomes</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ability to analyze and label observations</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ability to recognize and respond to changing relevance</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Intuitive sense</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Problem-solving</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Judgment</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Confidence</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Ability to perceive situations as a whole</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Awareness of personal safety</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Self-awareness</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Pattern recognition</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
**Spirit of Community**

The spirit of community domain consists of four competencies: (1) team approach with the client, (2) ability to incorporate the client’s family into the team, (3) interdisciplinary cooperation, and (4) community networking.

Through interpretation of the participants’ statements, several forms of community emerge when an occupational therapist works with clients in their natural environments. One form of community is the team created between the client and the occupational therapist. This includes direct interactions with the client. In order to create this team, the therapist clearly communicates with the patient and listens to and respects the client’s feelings and desires. A participant described:

You’re in their environment. I think you have to be very aware of that interaction. It is very important or you’re going to walk out the door and it’s their living room, if they don’t like that cushion on that chair even though it helps them get in and out, the cushion is going to go. So I think being very open and interactive with the patient as a team effort to come up with alternatives to take care of problems and let them be part of that choice in that treatment.

The participants also discussed the importance of including the client’s family members as part of the team. Often family members play a pivotal role in a person’s recovery process, so it is crucial that family members be treated as part of the team. In doing so, the therapist needs to also consider family member’s desires and wishes. The following statement shows how one participant incorporated a family member into the team:

...Her niece was very dedicated to be sure this worked because the niece wanted to go home....When I came in and we started going through things
this niece was, I think, quite relieved to feel that we were addressing the actual problems she had been told were taken care of at the rehab hospital....So really the niece and I thought she was independent coming out of rehab and she wasn’t.

Another form of community included working with other professionals on behalf of the client in order to meet his or her needs. This spirit of community extends into the wider community and occurs when the occupational therapist networks and establishes ties with others, which then serves to efficiently and effectively provide the client with what he or she needs.

According to the participants, networking within one’s community is a pivotal task for occupational therapists. One participant asserted:

You do have to be knowledgeable about the resources in your community, where you can rent equipment, where you can get things on loan from senior centers. You really have to be up to date on that. I’m calling…stores a lot to order equipment or to find out prices.

Another participant highlighted the importance of this competency by stating:

So I think we have a lot of responsibility to all our communities and that we network and educate within those communities….There’s so much that then your community is servicing you and it makes your life a lot easier and quicker in problem solving. You can get through the community quick that way or know who to call to problem solve.

Each participant was active in her community through volunteer activities and expressed a sense of belonging with her community. This can be seen through the following description of one participant’s responsibilities to her community:

To provide a healthy environment, to teach what I know, to be a teacher, to be a role model, to be a support, to be there, to be present, to be connected because we’re all connected. I truly believe that and to show that, to demonstrate that, in everything that I do, that I am connected with everything
and everybody. I mean, not in a grandiose way...that's part of being in the community.

Table 5 shows the agreement on the emergence of spirit of community competencies among the three interview summaries.

Table 5
Emergence of Spirit of Community Competencies in the Interview Summaries

<table>
<thead>
<tr>
<th>Competency</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team approach with the client</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ability to incorporate the client’s family into the team</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Interdisciplinary cooperation</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Community networking</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>


CHAPTER V

DISCUSSION

Several of the competencies identified in this study match those in Benner’s novice to expert studies and Fleming’s clinical reasoning study. Benner et al. (1992) described the expert’s ability to reason through situations and the changes in performance that occur as one passes through the five stages of skill acquisition. The occupational therapists interviewed in this study used past experience and intuition to guide their practice instead of strict adherence to rules and analytical processing. They viewed situations as a whole and were able to quickly focus in on the relevant aspects of the situation. They were fully involved in the incidents they described. From analysis of the three interviews, each occupational therapist used the three types of clinical reasoning that Fleming (1991) described: (1) procedural reasoning, (2) interactive reasoning, and (3) conditional reasoning. From her study, Fleming (1991) wrote that therapists attended to patients on multiple levels: “(a) the physical ailment, (b) the patient as a person, and (c) the person as a social being in the context of family, environment, and culture” (p. 1007). The occupational therapists interviewed, experts in their area of practice, demonstrated a clinical reasoning process that appeared not only fluid and automatic but holistic as well, considering the clients on these multiple levels. These therapists, through many years in practice, have
developed a vast repertoire of competencies that they use in their daily practice. Because of the rich knowledge and experience expert occupational therapists possess, it is logical for researchers to turn to them for further definition of practice through the process of competency identification.

From this study, thirty-nine community-based occupational therapy (OT) competencies emerged which were clustered into the following five domains: (1) content-related knowledge, (2) interpersonal skills, (3) educational pathways, (4) clinical reasoning, and (5) spirit of community.

Implications for the Future of the OT Profession

As the shift in OT from traditional institutional settings to community-based settings continues, the OT profession will need to take a proactive stance to meet the challenges in this evolution of practice. This process will involve seeking answers to fundamental questions about community OT practice development, its practitioners, and its effectiveness. Several sources (Benner, 1984; Pew Health Professions Commission, 1993) have described competency identification as a valuable method of examining if a profession is meeting the demands of clients and the evolving health care system. This study was designed to begin the process of competency identification for the OT profession as it is evolving further into community practice. Competency identification holds many positive implications for the future of the OT profession. The profession will benefit from competency identification through further definition of what its practitioners do in community-based practice. This type
of information is greatly needed in OT and holds the potential to increase the profession’s credibility with clients, other professions, and reimbursement parties. In addition, the identified competencies and domains can serve as guides to best practice for OT in community-based settings. Dissemination of the results of this study to OT practice, education, and research forums is essential. Through dissemination, this information can be used to acknowledge the expertise necessary for effective OT practice in community-based settings and to foster an occupational therapist’s progression from novice to expert.

A point of interest in this study is that two out of the three occupational therapists interviewed expressed discomfort over being referred to as an expert. Not viewing oneself as an expert likely resulted from the occupational therapist’s continual need to learn new information, to follow trends in the profession as well as in health care, and to self-monitor one’s effectiveness as a therapist. Currently, the American Occupational Therapy Association recognizes expertise in OT through the esteemed Fellow of the American Occupational Therapy Association (FAOTA) distinction. However, in reality this recognition typically merits those who contribute to the profession not only through expertise in practice but through publication efforts and service to the national professional association. It will be critical for the OT profession to develop a formal system for recognizing the vast expertise that exists in practice, which appears to serve as a driving force for the continued existence of the profession.

Occupational therapists entering community practice need to recognize the
diverse collection of skills that one must possess or develop in order to be an effective therapist. It appears that OT practice in community-based settings elicits use of a vast number of competencies across the five identified domains. Occupational therapists in traditional institutional settings tend to specialize in their skill development and practice in an environment that is largely predictable and routine. Perhaps, as a result of this specialization and a controlled environment, these therapists might only need to use a small number of competencies in their practice. However, in community-based settings, the occupational therapist has very little control over the environment and must be competent in a multitude of areas so that she can effectively deal with unexpected changes and occurrences.

Another point of interest in this study was the emotional intensity that surfaced in the two participants who described demanding incidents. This intensity might have resulted from the nature of the demanding incident or from individual differences in the participants. The two participants described a greater number of affective competencies than did the participant who described a typical and ordinary incident. It is possible that demanding incidents elicit a greater number of affective competencies than do the typical and ordinary situations. This point merits further study.

As the demands of practice continually change, so will the competencies needed to practice in community-based OT settings. Therefore, the identification of competencies is a fluid process and needs to be continually updated.

Competency identification also presents challenges to the OT profession. The
profession will need to formulate a plan for both recognizing and incorporating competencies into the education, certification, and accreditation processes.

Implications for the Future of OT Education

The Pew Health Professions Commission (1993) described the pivotal role allied health professions can play in community settings. As previously stated, the Commission urges health profession educators to address competencies in their curriculum so that new graduates enter their professions with the minimum competencies needed to practice in that field (Pew Health Professions Commission, 1993). The results of this study have positive implications for the future of OT education as they identify the knowledge, skills, and abilities needed to successfully practice occupational therapy in community-based settings.

As changes in practice occur, it will be critical that OT educators consider the competencies needed for successful community-based OT practice and recognize their fluid nature. Curriculum in community OT practice should reflect the following five domains: (1) content-related knowledge, (2) interpersonal skills, (3) educational pathways, (4) clinical reasoning, and (5) spirit of community. Educational programs should attempt to develop curriculums that help students develop the competencies described in this study and provide continuing education for post-professional graduates entering community practice.

Most of the identified competencies in this study are built on the traditional mode of content learning, for example, knowledge of adaptive equipment. However,
the identified competencies also include affective learning, for example, therapeutic use of self. Building curriculum design to assure appropriate affective learning will be the challenge for OT educators. It will be critical for the future of education in OT to identify and construct learning strategies to ensure future graduates will begin to develop these skills at the novice level. Preparing students to enter community-based OT practice with the necessary competencies not only meets the profession's needs but also those of the client's and the ever-changing health care system.

Implications for Future OT Research

Through the richness and depth of information that emerged from the interviews, it is clear that many of the competencies match those stated in the literature review and that the compilation of this information fits nicely into those categories. The literature review and richness of this data have implications for both OT education and practice. Strengths of this study include the design and the agreement achieved on the identified competencies. The critical incident survey (CIS) method successfully provided rich and detailed information, just as it did in nursing studies. Another strength of this study is that these competencies emerged from two types of critical incidents, two described as demanding and one as typical and ordinary.

Due to limited time, the results of this study were not subjected to an expert panel for further review and elaboration. This could be an additional step in the research process should this design be implemented in the future. Another limitation
in this study was the differing levels of personal investment the therapists took in the research process. Each therapist took interest in this study but due to work and personal commitments they were not able to invest the same amount of time to review and clarify the interview summary. Again if this study were replicated, successful strategies for clarifying the interview summaries would include embedding questions and requests for clarification within the summary to save the therapist time as well as building into the design a follow-up meeting with the therapist to discuss the revisions.

The CIS method is an important process in gathering qualitative data. It captured the essence of qualitative research by looking at meaning from the therapists' perspective and did so in a descriptive manner. The CIS succeeded in delivering rich perspective of the knowledge, skills, and abilities needed to effectively practice occupational therapy in community-based settings. As with all qualitative research, this method involves an extensive time commitment. Researchers, particularly student researchers, will need to take this into consideration when deciding to use this method in future research.

Future research into competency identification is critical for the OT profession. This type of research should be viewed as an ongoing process due to the dynamic nature of OT practice and the demands on practitioners. Continued collaborative efforts between OT educational programs to gather a broad spectrum of qualitative data on community practice will be essential for future research into competency identification.
Appendix A

Protocol Clearance From the Human Subjects
Institutional Review Board
Date: 13 January 1998

To: Richard Cooper, Principal Investigator
   Lisa Werner, Student Investigator

From: Richard Wright, Chair

Re: HSIRB Project Number 97-12-02

This letter will serve as confirmation that your research project entitled "The Identification of Domains and Competencies for Community Practice Occupational Therapy" has been approved under the expedited category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: 13 January 1999
Appendix B

Script for Initial Phone Contact
Script for Initial Phone Contact

Hello, my name is Lisa Werner and I’m a graduate student in the Occupational Therapy Department at Western Michigan University. I am working with Dr. Richard Cooper who is interested in studying how occupational therapists in community-based practice make treatment decisions by interviewing experts in the field. Your name was suggested by O.T. faculty as someone who may be interested in participating in this study. If you’d like to hear more about it, it’ll only take about three minutes of your time. Shall I continue?

If not interested: Thank you for your time and have a nice day.

Purpose of this study:
The primary purpose of this study is to identify the current and emerging domains and competencies of occupational therapy practice in community-based settings. Community-based settings include public schools, home health care, community mental health, and private practice facilities not tied solely to traditional medical institutions.

How this study is being conducted:
This is a qualitative research study which will employ the use of a descriptive interview approach to practice analysis. The description of practice is provided by the completion of a Critical Incident Survey. This is a method used by many disciplines to better understand the elements of practice. In this study, the descriptions of practice are those of expert occupational therapists who work in community-based practice. These descriptions are recorded (during a 45-60 minute interview), analyzed, and synthesized for the purpose of delineating sets of practice domains and competencies.

How the information from this study will be used:
The information from this study will be used to identify and stimulate further development of domains and critical competencies needed to practice occupational therapy in community-based settings. This information will be disseminated through professional presentations and publications both on local and national levels. Names of the therapists interviewed will not be identified. In addition to using this information for practice development, it will be used to recognize the excellence which exists in current practice.

Why this study is being conducted:
There is evidence, both in general health care literature as well as the occupational therapy literature, of a shift from traditional settings of practice to so called “nontraditional” settings, referred to as community-based settings. As new graduates of occupational
therapy programs, as well as those seasoned practitioners from traditional settings enter these arenas, there is a need to identify the practice domains and competencies. In addition, there is a need to identify those areas which are emerging which require our proactive attention and responsiveness.

We are seeking occupational therapists who are willing to be interviewed. The initial interview will take approximately 45 minutes to an hour of your time. Would you be interested in participating in this study?

If “no” response: Thank you very much for your time and have a nice day.

If questions arise: Answer them as completely as possible.

If response is “yes”: Thank you for your willingness to participate in this study. I will mail you a package containing the study’s pertinent documents. I would ask that you read the information carefully, particularly the informed consent, which I will have you sign at the interview site. Also, please read the critical incident survey guide as it will help you to prepare for the interview.

When and where would you be available for the interview?

Again, thank you for your participation. I will mail the information out to you in one to two days and will call you the day before the interview to confirm the time and location.

Have a nice day!
Appendix C

Follow-Up Letter
Dear Expert:

Thank you for your expressed interest in participating in this study. I am particularly interested in discovering and documenting the professional excellence which exists in community-based occupational therapy practice. Specifically, I expect to identify domains and competencies related to this practice environment through the descriptions of the work done by expert practitioners. The method selected, the Critical Incident Survey, is largely based on the comprehensive studies of nursing practice done by Patricia Benner. Through the dissemination of her studies, Benner has documented the expertise of nurses whose excellence in practice often goes undocumented. It is my hope that this research will spur similar recognition of professional excellence in community-based occupational therapy practice as well as have positive implications for practice and curricula development.

Enclosed you will find the following: (1) Scope of the purpose, objectives, methodology, and proposed dissemination of this research; (2) Consent Form; (3) Demographic Data Form; and (4) Critical Incident Survey Guide (to be used in preparation for the audio-taped interview).

Please carefully review the consent form. I will have you sign it at the interview site so that you will have another opportunity to have any questions addressed. Also, please think about the questions posed in the Critical Incident Survey Guide. You may respond to any of the items. You will receive a call the day before the interview to confirm your participation. Again I thank you for your interest in this project.

Sincerely,

Richard G. Cooper, EdD, OTR, FAOTA
Appendix D

Scope of the Study
Why is this study being conducted?
There is evidence, both in general health care literature as well as the occupational therapy literature, of a shift from traditional settings of practice to so called "nontraditional" settings, referred to as community-based settings. As new graduates of occupational therapy programs, as well as those seasoned practitioners from traditional settings enter these arenas, there is a need to identify the practice domains and competencies. In addition, there is a need to identify those areas which are emerging which require our proactive attention and responsiveness.

What is the purpose of this study?
The primary purpose of this study is to identify the current and emerging domains and competencies of occupational therapy practice in community-based settings. Community-based settings include public schools, home health care, community mental health, and private practice facilities not tied solely to traditional medical institutions.

How is this study being conducted?
This is a qualitative research study and employs the use of a descriptive approach to practice analysis. The description of practice is provided by the completion of a Critical Incident Survey. This is a method used by many disciplines to better understand the elements of practice. In this study, the descriptions of practice are those of expert occupational therapists who work in community-based practice. These descriptions are recorded, analyzed, and synthesized for the purpose of delineating sets of practice domains and competencies.

How will the information from this study be used?
The information from this study will be used to identify and stimulate further development of domains and critical competencies needed to practice occupational therapy in community-based settings. This information will be disseminated through professional presentations and publications both on local and national levels. In addition to using this information for practice development, it is used to recognize the excellence which exists in current practice.
Appendix E

Demographic Data Form
Demographic Data Form

Name: _______________________________

Contact me at: _______________________________
(Used only for follow up interview contact by student investigator)

A. Chronology of employment as an occupational therapist:

<table>
<thead>
<tr>
<th>Dates</th>
<th>Facility Name</th>
<th>Position Held</th>
</tr>
</thead>
<tbody>
<tr>
<td>(most recent first)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. Professional Education:

- Bachelor’s Degree in _______________________
- Master’s Degree in _______________________
- Specialist’s Degree in _______________________
- Doctoral Degree in _______________________

C. Special Certifications/Credentials: (In addition to those that directly relate to O.T., include those that are not specifically related)

D. Other significant information you wish to add:
Appendix F

Critical Incident Survey Guide
The Identification of Domains and Competencies for Community Practice
Occupational Therapy

The Critical Incident Survey Guide

For the purposes of this study, a critical incident is defined as an event that significantly describes the nature of occupational therapy in a community based setting. A critical incident can be any of the following:

- an incident in which you feel your intervention made a difference in patient outcome, either directly or indirectly.

- an incident that captures the quintessence of what occupational therapy practice is all about.

- an incident that is typical and ordinary.

- an incident that was particularly demanding.

You will be asked, by way of an audio-taped interview, to describe a Critical Incident (CI) in detail. I will ask you to elaborate on the CI by use of various probes such as:

- Describe in detail the Critical Incident.

- Context of the incident: time of day, who was there, related events at the time, etc.

- Why the incident is critical to you.

- What your concerns were at the time of the incident.

- What you were thinking about as it was taking place.

- What you were feeling during and after the incident.

- What, if anything, you found most demanding about the situation.

- What particular skills, abilities, and knowledge do you feel were engaged in this incident which enabled you to make a difference?

- What particular skills, abilities, and knowledge do you feel you needed to make more of a difference?

- Describe the communities that you are a member of.

- What do you see as your responsibilities to those communities?

You will have the opportunity to review, discuss, edit, and approve the use of the summary of your interview.
Appendix G

Consent Form
Consent Form

PROCEDURES:

If you agree to participate in this study, you will be requested to:

(1) complete a Demographic Data Form which provides information about your education, professional experience, and special credentials beyond OTR certification.

(2) participate in a 45-60 minute audio-taped interview conducted either by telephone or on site. This interview will follow the outline of information in the Critical Incident Survey (CIS) which is defined by the researcher and provided to you.

(3) review the interview summary. The researcher will then contact you by phone for your clarification, additions, and approval.

RISKS AND CONFIDENTIALITY:
There are no known risks to you in participating in this study which is part of a thesis project being done by the student investigator, Lisa Werner. The results of this research will be shared with each participant. Dissemination of this research will be conducted in professional forums including professional public presentations and publications. You will not be identified by name, place of employment, or any other form of possible identification in either my field notes or in the interview transcriptions. The only place your name will occur is on this signed consent form which along with all data will be kept in a locked file in the primary investigator’s office for three years. All audio-taped recordings will be erased once the transcriptions are completed. Each transcript and demographic recording form will be assigned a number only.

Your participation in this study is entirely voluntary. If at any time you wish to withdraw, you may contact me at the provided address or telephone number. There is no consequence to you if you refuse to participate or withdraw your participation.

BENEFITS:
There are no proven benefits of participation.
COMPENSATION:
As in all research, there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or additional treatment will be made available to the subject.

QUESTIONS:
If you have questions concerning your participation in this study now or in the future or if any problems arise, you may contact the Chair of Human Subjects Institutional Review Board at 616-387-8293, the Vice President for Research at 616-387-8298, Richard Cooper at 616-387-3857, or Lisa Werner at 616-385-4761.

Thank you for your participation,

Richard G. Cooper, EdD, OTR, FAOTA
456 Hoekje Hall
Western Michigan University
Kalamazoo, MI 49008
616-387-3857

CONSENT TO PARTICIPATE IN RESEARCH STUDY

I have read or had read to me all of the above information about this research study, including the research procedure, possible risks, and the likelihood of any benefits. The content and meaning of this information has been explained and is understood. All of my questions have been answered. I hereby consent and voluntarily offer to be interviewed as part of this study. I will receive a signed copy of this consent form.

Name (print) Signature Date

Dr. Richard G. Cooper
Principal Investigator Signature Date

Lisa Anne Werner
Student Investigator Signature Date
Appendix H

Permission to Reproduce Statement
September 4, 1998

Ms. Lisa Werner
5407 Old Mill Lane
Rolling Meadows, Ill 60008

Dear Lisa,

You have my permission to use the following items in the publication of your masters thesis:

- Critical Incident Survey Form
- Demographic Data Form
- Statement: Scope of Study

Best wishes to you in your continuing professional development.

Sincerely,

[Signature]
Ben Atchison, PhD, OTR, FAOTA
Associate Professor
Coordinator, Graduate Program in Occupational Therapy
Appendix I
Interview Summaries
Interview Summary #1

Q Can I have you describe in detail the critical incident you’ve chosen?

A I have chosen an incident with an 84-year-old female who lives in a senior independent apartment. She fell and broke her hip as the moving men were literally moving furniture in. And the incident is an initial assessment home visit in her senior apartment where she came directly from a rehab hospital where she’d had therapy. There was another family member there. I think a niece who was living in the apartment for a brief period of time to help with this transition from hospital to home. The first day the niece had realized things weren’t working.

So when we got there and actually had to work in that bedroom and in that bathroom, in working through these things what had been previously planned didn’t work. So I had to suddenly change some of the equipment needs and how she’d been told to do things and do them differently because it didn’t translate to this environment. And her niece was very dedicated to be sure this worked because the niece wanted to go home. When I came in and we started going through things this niece was, I think, quite relieved to feel that we were addressing the actual problems she had been told were taken care of at the rehab hospital.

So really the niece and I thought she was independent coming out of rehab and she wasn’t. It became just a very complete home assessment of a lot of areas that I think she and her niece came home to and kind of thought she’d done well in rehab, that these things were taken care of and didn’t realize the extent of just the details of life that she couldn’t address if she was literally alone. I mean literally alone, if her niece wasn’t there. And so I think they sent her home with the impression that from their perspective she was kind of done and that she was independent. OT was only referred in because the PT went in and said, “Whoa, there’s a bunch of other things happening,” and she requested the OT order to address socks, shoes, tubs, beds, kitchen, and chair height.

...She was also in a very new environment where she had not figured out her routine. And I think when you work with people who lived in settings, they tell you, “Well, this is how I do it. I get up and I go to the bathroom first and then I get my clothes out from here.” They have little routines. But I don’t think she’d figured that out and so it was even harder because now she had a broken hip. Her assessment as a hip fracture became a much more comprehensive assessment than I thought I was doing just because there were a lot of details that just hadn’t been addressed for that environment for her to be really independent.

Q Why is this incident critical to you?
A ... For me to look at that environment...there were a lot of good answers....I could teach her. I could teach her niece. I could adapt the environment. I could adapt her clothing needs, her routines. We could set up...a routine of how she’s going to get out of bed at night. So I think it was critical to me for OT because right there were all those functional things that made such a difference to this person’s life.

...It’s critical to me to look at those environments and say, “What are our options?” Our options are she learns to do it herself or we find somebody to come in and do it. And then we find out what our resources are....I mean, those choices I think always come up and sometimes patients don’t choose the choices we do. I say, “Oh, you can learn to do this with this long-handled shoehorn,” and they’re like, “No, I hate this thing. I don’t know how it works. It’s in my way. I’d rather...just get up early in the morning and have my daughter do it every day before she leaves or some other alternative.”... I think as OTs we need to always listen to the patient’s idea of how to do this.

...In her case, she saw that she was getting better and in all cases that doesn’t necessarily happen. If it’s not an orthopedic problem you may not be looking at something that’s getting better. She was an orthopedic problem that we knew...was actually going to get easier because she would be full weight-bearing, she would be able to bend down. You know that things would get better as she went on. But there was still a period of time that she needed to know she could take care of herself, whether it was getting in the tub which actually ended up being sort of the most complicated issue..., because I had almost untrained her how to do it and she was very hesitant and worried about that. But I think...that those things really, really matter and that’s what OT is.

Q What were your concerns at the time of the incident?

A My concerns...were how to adapt this person to her environment....There were more needs unmet than I expected going in....So I thought I was going in on a pretty quick...eval only type...and it didn’t end that way...

Q What were you thinking about as it was taking place?

A ...As I got into it, I was thinking...about how many resources I could pull quickly and what I had to go through and thinking about the options for her in that environment which there were plenty of....I hadn’t from having been handed the case ...necessarily initiated those up front.

Q What were you feeling during and after the incident?
A ...I was feeling actually really positive because this woman was actually a very motivated lady. Her niece was wonderful....And I really felt like I could meet her needs. It was a very positive interaction because I right away could see it was going to work, that she was certainly going to be able to function in this environment....It was positive and motivating for me too because I felt like, okay, I can do this and here are these options, and she can do this. We’re going to get through this....I was very glad that OT had been referred in and that the PT had made the call on that...

Q  What, if anything, did you find most demanding about the situation?

A  ...I guess it was demanding at the time when I went in...because, again, I thought it was a pretty typical situation coming out of rehab with a hip fracture...I hadn’t expected to go through the number of things I went through. I had much more cursory things in my mind. And I went in and we actually had to go through every aspect of parts of dressing, toileting, bathing, and cooking. Not that we did them all in the visit, but I had to look at aspects of all of that filling out an assessment that I just hadn’t expected....But it ended up that a lot of the details added up into enough areas that we had to address every area....So I guess that was demanding, but again...it was motivating because they were things that I could figure out how to address....There are certainly cases that I go in on that are demanding and you really aren’t sure you can fix it...especially if there’s a paralysis or something....In this I very much felt like I had concrete ways I could come up with and alternatives and education, so I could be a success, and she could be a success....I guess that made it a lot more motivating, even to why I remember it as a critical incident.

Q  What particular skills, abilities, and knowledge do you feel were engaged in this incident which allowed you to make a difference?

A  ...I knew the diagnosis....I knew hips and so I knew I could anticipate a lot of things. Again, that comes from experience....And a lot of knowledge of adaptive equipment -- big stuff, little stuff, walker trays or trays that she could carry things from one place to another, different ways to build up a chair to make it a higher height....I could do a lot of that research very quickly....Sitting there with her I could show her pictures in catalogs that I brought with me because I happened to know, again, I anticipated knowing that she had a hip fracture....She’s in her home, she may need some adaptive equipment, I want to show her pictures of what it might look like, what the cost might be. And then right away I knew who to call and how long it would take to find the price. I could do that all very quickly. I knew my community, I knew my vendors, that there were options of different vendors and prices if money was an issue. So I think that helped a lot.

...I knew...to think, “Boy they’ve got a broken hip, they’re going to have some range of motion difficulties as far as reaching their feet. They’re going to have
some standing problems, maybe some balance problems standing at the sink or bending their leg to get in the tub.”...Knowing the diagnosis, what types of problems are going to be, and then how is that translated into a functional task that, again, some of that I guess I feel is from experience but, hopefully, I did learn some of that up front....So I guess that is knowledge that hopefully people get from a curriculum...of diagnoses and what problems are presented by them and what functional task they’ll show up in. And then obviously with experience it comes pretty rapidly as far as then what you do about them or what’s worked or not worked for other patients. Where, when, and how you take care of it, you know. A lot of that I think comes from experience....But in your mind as an OT, hopefully you know several of those options and you can relate them to that situation. Are they going to work or does the patient accept them? I mean, they have to accept the intervention...

And I guess that maybe another ability to me is being very open-minded towards the patient and their environment. This is their environment, their home, as far as how they think they need to function in that home. Now she didn’t have routines built in, but it still was her home. And I think being open and respectful as well as a team effort with that patient to say, “How do you feel comfortable in your environment doing this?” and offering alternatives versus...being real directive. It’s different than when you have them in the clinic on a mat and you’re saying you’ll do ten reps or sit up, lie down, whatever. You’re in their environment. I think you have to be very aware of that interaction. It is very important or you’re going to walk out the door and it’s their living room, if they don’t like that cushion on that chair even though it helps them get in and out, the cushion is going to go. So I think being very open and interactive with the patient as a team effort to come up with alternatives to take care of problems and let them be part of that choice in that treatment.

Q What particular skills, abilities, and knowledge do you feel you needed to make more of a difference?

A ...Well, actually this one I really can’t think of any. I mean, as far as I think the situation where...that would come in more would be not so much the typical and ordinary, in those other situations where OT makes such a difference that you do feel kind of frustrated. You wish you knew more. And I think in this case, I felt pretty positive because I felt like I had lots of alternatives and I knew them, ...knew some of them would work. I felt pretty positive about it, so I don’t know that there were other areas I needed in this particular incident. It’s not to say I have all the answers on this. This was a hip fracture, I can do this.

Q Sounds like it’s something that was very familiar.

A Yeah, right, more than familiar. But I think it was nice that in some ways it’s a very routine, familiar thing, but when you get somebody in their environment the
differentness [sic] of those diagnoses come up. But in the clinic a million hip fractures look a lot more similar than when you take them down to their room or in their apartment…. It may look more like a hip is a hip is a hip. And I know we know that’s not true about our patients. But I think seeing them in individualized environments shows up more about… either how they handle their hip fracture or how their hip fracture really makes a difference in their life, which usually means their environment…. I think that’s an internal thing about a patient and where they’re at with you in handling their disability. But I also think that it can be an environment thing that some environments translate into hip fractures being a lot bigger deal than other environments.

Q You’re right, and in her situation it might have been very different had she lived in that apartment for years.

A Right, so then she would have been a different hip fracture… and maybe the questions would have been slightly different, where she would have been adamant about how to fix them or not letting me…. You don’t know but that’s where I think looking at that person with that deficit or disability in a functional environment is always what you have to do, whether that functional environment is just a nursing home room or their own apartment or a job or a school. Whatever it is that translating that into environments where people function versus into clinics where they practice, I guess. You know, I think you’re practicing things in clinics but you’re not functioning in a clinic. And I think that’s the importance of the community-based OTs being able to frequently be the ones that do that translation because it is so function based.

Q Describe the communities that you are a member of.

A I’m a member of AOTA and I think I’m a member of MOTA currently. Most of the volunteering I have to do now doesn’t have anything to do with OT right now in my life. It has to do with my kids, some volunteering in schools and on field trips and at soccer games and in all of those capacities is more and more where my volunteering is versus with my professional life.

Q What do you see as your responsibilities to these communities?

A I guess that’s two different questions for me, one being the professional community…. I think is important to my profession that I’m at least a member of some organizations and at different points in my career I’ve been more involved and sat on boards…. Just right now that’s not what I’m doing. But I think it’s important to at least peripherally be involved to be able to identify myself in that community and know what the issues are in the bigger group, whether they’re my issues or not or I have time to take care of them or not right now, to know what those issues are and what’s
happening because...it probably will affect me whether I take an active role or a passive role.

And the responsibilities in my other community involvements that have to do with my family have to do a lot with the community in the bigger sense that I live where I also work....I work in this community but my family is here, my kids, and being involved in their school. I've done career workshops on OT actually several times. You know, that it kind of overlaps. That general educating and interacting with people usually does involve something about your personal life and your work. There's always that chance to educate people on your profession, what it is you do and that's come up a lot....So I just think we have a lot of responsibility to all our communities and that we network and educate within those communities....There's so much that then your community is servicing you and it makes your life a lot easier and quicker in problem solving. You can get through the community quick that way or know who to call to problem solve.
Interview Summary #2

Q Could you describe in detail the critical incident you’ve chosen?

A Sure. The client that I’ve chosen to tell you about...had a right CVA with left hemiparalysis and he is a...very demanding man. He...was on the rehab unit at our facility here....They had recommended that he be discharged because he had progressed to the point where his insurance wasn’t going to pay any more. He decided to stay on the unit and private pay despite recommendations to be discharged to home or outpatient services. So he went to a rehab, another rehab facility in a different town, ... I’m not sure how long he was there but they discharged him and recommended two weeks of home care-occupational therapy, physical therapy, speech, and nursing.

The patient at first was quite insistent that we go five times a week and it just...was not what I recommended and it was hard to explain to him,...but finally he and his wife went along with the fact that three times a week was what he was going to get....After evaluating this patient and seeing how difficult he was going to be, I did call the OT that worked with him at the previous facility...so I could have continuity of care....He had recommended...OT home care for two weeks...with a plan of getting the patient as safe as possible in his home environment...and then...his hemiplegic upper extremity would be addressed in outpatient OT....I explained to the patient that I had spoken with the OT at the previous facility and what our overall plan was. I discussed it with the patient to make sure that this was what he wanted too. We came up with a plan that we were going to make sure he was safe in and out of the shower, bathroom, and around in his bedroom. We were going to work on dressing and the basic self-care activities to make sure he’s safe at home. And it was quite difficult at first....He wanted me to work on his arm and he had...no return in his arm yet. I had to explain to him that he had to continue with the home exercise program that his previous OT gave to him, and I would work on the home safety issues.

The incident that I was going to talk about is one day I arrived at my scheduled time and...two nurses were there. It was brought to my attention by one of the nurses that the patient was having some back pain. The nurse also pointed out the patient’s poor posture in the chair. It was quite obvious that he did need to have a different chair to sit in to improve his posture. What I had originally planned to go in for had to be deferred, which was fine. The issue was something that was important at that moment. Once...you addressed a new problem, he wanted to work on it until it was resolved.

....My visit was...spent educating the patient and his wife on...why we recommended a different chair and the different choices that he had. My first choice
was that we build up the chair that he was sitting in so it would be higher. Sit to stand was difficult for the patient and when sitting in the chair, he demonstrated poor posture because his knees were higher than his hips. He did not want anything to do with building up the chair, even though that would have worked. Another big factor was that he lives right on a river and he wanted to be able to swivel 360 degrees in his chair to see the view from a window behind him, which made total sense. Normally I would not recommend a client who had a CVA sit in a swivel chair because it’s just not safe. But with him you just have to work with what he has and what his goals are and wishes. That was definitely a priority for him to be able to swivel in the chair.

We began looking for other chairs in the home that would work and found a leather recliner that also did swivel. It was a more appropriate chair for him. The only problem was he couldn’t get the leg rest up and down himself. He did actually do it when I was there, but it was with difficulty. This was frustrating for the patient. There was another recliner exactly like it in another part of the house. I got in that chair and the reclining mechanism seemed to work better. So then he wanted to go and try that. It wasn’t that easy, though, because there was a lot going on in this house. They were remodeling to make it wheelchair accessible. His wife had a lot of stress because of the demands of her husband and everything that was going on in the home.

In the meantime, his wife was trying to take care of some other things, and any time she’s not attending to him, he’s raising his voice and needs her attention. We rearranged some things so we could get him to the other chair nearby. By this time an hour had passed and it was getting time to where I had to go, but we got him in the other chair and that seemed a little bit better. He was going to have the hired assistant put the chair where it needed to be. I had thought we had accomplished the goal that we had set out after. He liked the chair and he felt comfortable in it. He was able to manipulate the leg rest, but with difficulty.

The next time I came and until I discharged him he still was sitting in the original chair. Because he couldn’t get the reclining legs, he just disregarded everything we had worked on because he couldn’t do that by himself, even though it made his posture better and he was more comfortable. So his wife was going to call the furniture store and see if they could exchange the chair for something similar. That was basically what had happened on that visit.

... The chair issue is an example of how you really have to be flexible with in-home care and when you’re in somebody else’s home. You may have a plan of action and it may just change completely once you get into the patient’s home and start working with the patient. It makes a big difference depending on the patient’s character. If somebody is cooperative, it’s a lot less difficult. But with somebody that is very demanding and very frustrated and has a lot of anger, it’s really hard.
really still feel that the patient should be sitting in the other leather chair, but he just
didn’t follow through with it. You know where you have to draw your limits…and
how hard you push and this is an area where I wasn’t going to push too hard because
this man would get upset easily.

Q ...Why is this incident critical to you or does it stand out in your mind?

A I think because of the example of how flexible you do need to be in home care
and how important it is to consider the patient’s needs and desires and their goals and
what’s important to them in their own home....As difficult as he was, still I was there
for him, and I needed to consider what his feelings were about things too, not just say,
“Well I think you need this chair and this is where you should be.”...He didn’t want to
build up the first chair, so I kept working to meet his needs and make it safe, as safe as
possible for him. Also you have to consider the wife’s feelings. The incident stood
out in my mind because it was...out of the ordinary, like I said, he was the most
difficult person I have worked with in the twelve years I’ve been an OT. That made it
different.

Q ...I can see how that would stand out. What were your concerns at the time of
the incident?

A Well, at first I think my concern was...well I had planned to work on this...and
at first I thought the nurse maybe should have brought this to my attention outside of
the patient’s home. But in the long run, now that I look back, it was good that it
happened that way because we could address it right away and...try...to meet the
patient’s needs without causing too much more stress....That was one of my biggest
concerns. And just to try to improve the quality of his life. I mean, if he’s going to be
sitting in a better chair with better posture, he’s going to have less back pain and it’s
going to help his overall tone. He was getting some spasticity...in his left hand, so
that had to be considered.

Q That makes sense and was safety also a concern...with the swivel chair?

A Yes...definitely. But...at this point he’s not going to be unsupervised. If he
was going to be getting in and out of the chair by himself, I would recommend more
strongly to the client and his wife that the chair not swivel, but that was, like I said,
...very important to him....That was his goal to be able to do that. I did discuss with
him the fact that as long as he wore his gait belt and had supervision, then the swivel
chair was okay. And chances are, he’s going to need the supervision for a long time.

Q That probably added to his wife’s stress, knowing that she needed to provide
pretty constant supervision.
A  Right....And a lot of uncertainties. Will he able to work again and how much help will he need. At least they were financially very stable, so they could afford to do any home modifications. And they were pretty receptive. A lot of homes, places I go, I recommend they have equipment but...financially they can’t do it, so we have to find alternatives. But he was pretty receptive to those kinds of things....They had all the adaptive equipment and the durable medical equipment that they needed.

Q  ...I was thinking as you were talking, it sounded like not only in this situation did you have to deal with his physical needs and his safety needs, but you also had his emotional needs to take into consideration as well as the interaction between him and his wife.

A  Right, you do, and you have to try to not step on toes and...your interpersonal skills are very important. You have to be able to know when and how to say things in a tactful way so that the patient and his family will be receptive....For example, there was a piece of furniture that needed to be moved so that he could get around in his wheelchair more safely and he wanted me to bring it up to his wife because his wife wasn’t taking care of it....and in that whole situation with the chair, trying to keep him calm so that he wasn’t shouting at his wife. You just have to be really calming and not let your emotions be affected....That’s very difficult for me to do, but you really have to learn to do it. I’m not saying that I’m real great at it all the time but...when you get upset, then the patient is going to get more upset and it’s just a...vicious cycle. So that’s real important.

Q  Yes, that makes sense. It sounds like you have to do a lot of thinking and do a lot of checks and balances on yourself all in that short span of time.

A  Right. And it’s that way with most people. I mean, it’s not just with the difficult ones. You have to really establish a rapport....You’re in their home; That’s the biggest thing. You can’t come into their home and say this has to be done this way....You just make recommendations and encourage as much as possible....You really have to explain things and why you think they need a certain piece of equipment....I do a lot of demonstration and bring equipment in and show people how to use it so that they understand why it’s important.

        ...And a lot of what I do in the home is address home safety issues. I’ve found that it’s really gone more that way in the past eight years that I’ve been doing home health care. A lot of it is geared toward the safety with ADLs in the home.

Q  That makes sense. Sounds very important and relevant. And how nice that you can do that in the home. I imagine a lot of that would be hard to have transfer over if they hear about it in the hospital.
A Yes, and in rehab settings they address a lot of those issues, but it’s not the same as addressing the problem in the patient’s home environment. Most patients’ bathrooms aren’t set up like they are in rehab. OTs in a rehab setting attempt to simulate a patient’s home environment, but it’s not easy to do. It’s so much more pertinent in the home. That’s why I really like it, because it’s so much more function oriented.

...Right, and it’s very difficult in some situations because... a lot of bathrooms are so small that it’s impossible. Sometimes there’s nothing you can do, and that’s hard.

Q That makes sense because then the client might not have the funds to either remodel or to get in a lot of the equipment that they would need.

A ...I work a lot with the social workers and we do have ways that we can get equipment for our people that can’t afford it. If they really need it, then we have a fund that can buy tub benches or shower chairs and sometimes we loan them equipment. You do have to be knowledgeable about the resources in your community, where you can rent equipment, where you can get things on loan from senior centers. You really have to be up to date on that. I’m calling... stores a lot to order equipment or to find out prices.

Q And how nice because then when you’re with a client you probably can just whip a lot of that information out right then and there.

A Yes, I try to or I make the calls right from the patient’s home....They don’t know where to call, so I usually just do it for them.

Q What were you thinking about as the incident was taking place?

A I pretty much covered that. Just meeting the patient’s needs and keeping the frustration level down as low as possible and really trying to get him in a chair that was more appropriate for him because the nurse really had brought up a very pertinent point....But also I tried, really with this man, to keep my composure...I’ve never had anybody that just got under my skin like him. Really it took a lot of energy to keep myself from being totally stressed out in this situation.

...He respected me a lot more if I did say, “This is how I feel about it, but it’s your choice.” If I was direct with him, he did respond. Even if he didn’t agree with me, if I really stuck with how I felt about something and why it was safe or why it wasn’t safe, he respected that.
Q ... It sounds like as you were dealing with him you had to think about how you needed to present the information so he would hear you and understand you and not just blow it off.

A Right, exactly. If I did that, he did listen, but he did not always follow through in the long run.

Q ... What were you feeling during and after the incident?

A I think I have already covered my feelings during the incident. Afterwards I felt relief to be done with that visit. Almost every visit with him was like that. There was always some kind of problem we were addressing that caused stress for him. But I learned a lot....I’ve had difficult patients in the past, but you always learn every time how to handle situations better and how important it is to keep the patients’ goals and their wishes in mind.

Q What if anything did you find most demanding about the situation?

A The patient himself. The emotional and psychological aspect of working with him was much more demanding than the physical aspect....He wasn’t that difficult to treat otherwise.

Q What particular skills, abilities, and knowledge do you feel were engaged in this incident which allowed you to make a difference?

A Many different skills. The ability to establish rapport and stay within the realm of what is important to the patient. My skills were in observing and understanding body mechanics and posturing and other components of the patient with a CVA and...knowing about the safety issues and just considering all those factors. There is a lot to look at, even with something as simple as which chair in your house to sit in and understanding how sitting in a bad posture could affect pain in your back, in your hemiplegic side, and tone. Understanding all the components and knowing how to deal with them.

...You definitely have to have all those skills and they definitely develop further as you experience situations like this. I think a lot of it comes from experience and...the clinical reasoning definitely comes from experience. You can learn a lot in the classroom setting about, for example, CVAs and what they do to people and how to treat them. But experience is, I feel, how you best learn how to deal with issues such as being flexible, clinical reasoning, and how to establish rapport with the patient.

Q What particular skills, abilities, and knowledge do you feel you needed to make more of a difference?
A I think a skill that I need to further develop is...to not get caught up into the emotions of the patient....I stayed calm, but there were times when I was almost at my limit with this person....I need to work on not letting myself get too involved emotionally. I am a very sensitive person and I have...to block that out, so that I don’t have a negative impact on the patient’s behavior. That did happen a couple times when I would get upset with this particular patient. To an extent, some of that was very practical and appropriate. For example, one day...we were working on dressing and he asked, “How do I get up out of this bed by myself?” I was teaching him techniques to increase his independence with this task, but he physically couldn’t perform it independently. His response was, “Why can’t you show me? You should know it.” And I said, “…I am not going to make you better in one visit. That is not going to happen. It’s going to take practice.” I was very firm with him and he did respect that, so like I said, some of the time it was appropriate, but there were a few times when I got upset and fed into his frustration further....That’s...the biggest thing I could have done to improve this situation.

...I’m trying to think of what other knowledge would have made it better....At first he wanted me to go to a furniture store and pick out a chair for him. I told him that was not within... my responsibility to do that. I could have possibly been more educated regarding the...leisure chair retailers in this area and what is available. But I usually just make recommendations on how to modify furniture in the home.

Q One thing I’m curious about is earlier you’d said that when you’re working in a person’s home you need to make sure you’re very sensitive and take into consideration their wants and desires and goals. Do you feel that’s a greater issue when you’re working in home health care versus working with the client in an inpatient rehab unit?

A Actually no, I think it’s important in every setting. I often see a problem with patients that come...from a rehab facility. The OT may have been working on something that they thought should be important to the client. The OT may then recommend that I continue to address the issue at home. I often find it’s not what the patient wants. Maybe...the OT...feels they should be able to put their sock on with the sockdonner. I get to their home and find that the patient’s wife does it. The patient is not interested in being independent and the wife is totally satisfied with doing it for the patient. I feel that...one of the most important things that you should always consider is the patient’s and family’s goals. If the wife doesn’t want to put the sock on for the patient, then that’s something that you should definitely address. You should try to encourage it. But yes, I think no matter what setting you’re in, that is very important. You have to be sensitive to it.

Q Could you describe the communities that you’re a member of?
A I'm a member of AOTA... I'm a member of the YMCA... I go to a Bible study. I have in the past volunteered for the handicapped horseback riding program... I'm a very active person. I do triathlons and I am involved in a triathlon club. I also do occasional talks to local school children to tell them about my upper extremity prosthesis and how I use it to perform my job duties and athletic pursuits... I'm a member of the advisory board for home care. I'm on a... home exercise program task force where we are trying to get all the OT home exercise programs standardized so that all the OTs in our system are using the same forms.

Q And then lastly, what do you see as your responsibilities to those communities and memberships you're involved in?

A My responsibility within my work setting is to see the patients within the scope of our policies and procedures. For example, seeing them in a timely manner, meeting their goals, and discharging them when appropriate. As far as being on the advisory board, ... I have to do chart reviews and I'm responsible for keeping all my charting up to date. I also have a responsibility to educate co-workers in other disciplines and people in the community regarding what OT is and what it can do for people.

... My responsibility to AOTA is to pay my dues and to try to keep up to date with what's going on in the OT field. Keeping educated clinically by going to workshops and conferences is really important. My responsibilities to the triathlon group are mainly just participating and training with local triathletes. It's important for me to just be involved and support others in the group. My responsibility with the Bible study is to do the lessons, attend the lectures, and participate in my group. This is a great support system for me.
Interview Summary #3

Q Can I have you describe your critical incident that you’ve chosen?

A Well, this... was a 46-year-old female who had been involved in a motorcycle accident. She was a passenger on a motorcycle and they were hit from behind by a car. She was complaining about low back pain and neck pain and headaches. Her major issues were low back pain and the neck pain. The doctors had diagnosed it as just strained muscles and spasms. They couldn’t find anything on the x-rays... There was nothing structurally wrong.

Q Did she spend any time in the hospital?

A She did not.... Her husband was involved.... They both went and were treated and released.... By the time I got her it was probably eight months post. She also had a psychiatric diagnosis, major depression. I think she had some substance abuse background, too.... I think she did have alcoholism and... she had quit smoking about six months before I saw her. Her husband was not working yet either. He was still complaining of problems from the accident, severe physical problems, although... neither one of them were using a cane or anything to walk. She was on disability prior to the accident... due to mental problems. She had worked years and years before, but... was not working. I’m trying to think of where to start.

Q You can tell me some of the details of the visit....

A The husband was there, and I was actually... called in... by the insurance company.... I think it’s something that OTs are getting called in to do more and more.... Auto insurance is very good for auto accidents in this state, and it varies from state to state. They were paying for her to... have somebody do things in the home for her.... It’s standard... that the auto insurance pays for things that you’re not able to do due to the auto accident. Like some people can’t mow their lawn. Some people can’t go shopping because it’s too much physically for them. Some people, depending on what happened, can’t do some of their activities of daily living, like even taking care of their house or maybe they need an aide to help them. Those kinds of things are paid for. It’s up to $20 a day, I believe, if you’re having somebody do things that you had to do before. These people had somebody coming in to do this for them, who was a relative, which you can designate a relative.... But they were clocking about 30 hours a week, and they lived in a trailer. So the case manager called to have an OT come and evaluate because most of us don’t take 30 hours a week to clean their house, do their shopping, make meals, all that kind of thing. It was a little bit, they felt, unreasonable. What I was called in to do was to find out how much help she actually did need. I was called in to do an evaluation.
...Even before I went into the home, ...the case manager said, “You can have somebody go with you, if you want. They’re very angry that this is happening. They feel very defensive about it. They have an attorney involved.... The husband gets real angry. You may be in some sort of harm’s way if you do go.” I said, “Well, I can run pretty fast and if both of them have physical problems, they can’t get around. I can run faster than they can.” I have psych background, so I...thought, I’ll just get out of there if there’s a problem.

I called and made an appointment and went out there. The woman was very defensive when I got there....She ended up...crying because she and her husband were having marital problems because she couldn’t give him sex. She was so depressed because she couldn’t do...anything physically herself. He was real angry....He was out in the kitchen area, and then he was listening in to our conversation and then he had to put his two cents in...He said the thing about sex when I got in there and I was asking her some questions about what kinds of things she was having problems with. He said that was an issue, and she agreed with that. She also agreed with the fact that their relationship just wasn’t very good because they were both in so much pain and neither one of them could do anything. There were obviously a lot of outlying things, other things, that needed to be looked at when you go into that kind of situation. The reason I thought of it was because it was a pretty complicated case. It was kind of a dual diagnosis case, and I thought that would be an interesting thing for this study...

...I had her show me around her house. I had her rate her pain levels from...zero to ten, ten being the worst you could imagine, and...her pain levels were about a nine, even at the time that I saw her. When I saw her, I did a lot of observation. Obviously you can see so much in the home. She was sitting slouched in a chair, in a cushiony chair that had no support. She was sitting with her legs up underneath her and so I could tell that she...had problems with body positioning and with her ability to know what proper positioning was. I...had her show me around the house and actually do certain activities and tell me what she was not able to do....First she listed all the things that she had this other person do.... It was things like laundry. It was washing dishes. They have two little pug dogs that use newspapers in the kitchen...and then the floor would need to be mopped....She had this person feeding the dogs because she couldn’t bend down far enough to get to the floor. She had the person doing some cooking for her because she could not tolerate standing for any length of time to do cooking, or the same thing with doing dishes. She had the person doing all their grocery shopping....

She basically wasn’t going out of the house....She was able to do all her dressing. It was difficult getting her socks and shoes on. That’s what she had the most trouble with as far as dressing....She was able to get in and out of bed okay. Able to bathe herself all right. It was mainly the housekeeping things. That and also
house. It was on her. It was not on him....They were putting down cleaning out the
car once a week because she always...was very meticulous beforehand, and so
she...wanted the same lifestyle that she had before.

We went through that whole list and wrote everything down. Then I had her
actually show me how she stood in the kitchen, show me how she would put things
into the laundry. I...made suggestions as far as getting a stool to sit on to put things
into the dryer or to take things out of the dryer so that she would be in a better
position. I showed her how to get in and out of the bathtub an easier way. We talked
about some equipment for the kitchen so that she could feed the dog, so that she could
pick up the newspapers. You know, suggested her sitting on a stool so that she could
bend over from the waist, from the hips, so that she wouldn’t have so much back pain
or neck pain or headaches. I could tell from that initial visit that this woman needed
more. There were psychological overlays to what was happening....She had no
awareness of her own body mechanics.

...I came back and compiled all the information and...wrote up an evaluation.
We came up with 13 hours out of the 30 that she may need somebody to do
something. That the client and her husband would be willing to work with and we
agreed to pare it down from there. And when you do that, you have to negotiate with
the client. You have to be very open about what you’re doing so that they don’t get
suspicious, because you don’t want that. You want them to work with you because
there’s obviously some problem. The person’s in pain. And then there’s a
discrepancy in what they’re perceiving...they need versus what the insurance
company is seeing. I was kind of in the middle....So I got back to the office and I
talked it over with my supervisor about what we could do, what we could offer. She
suggested doing an ADL assessment where we assess her body posture and then start
training her in body mechanics. She...had gone to physical therapy prior to...her
coming to see me. This was, I was kind of..., one of the last steps....The woman was
also having trouble just...riding in a car....Her husband was driving her places
because she would have increased back pain.

So what we did was I had her come in. We set up an eight-time visit to do this
ADL checklist and to say where she was with each thing to teach her good body
mechanics. Get her some equipment so that she could begin to do more things for
herself, like a dustpan that she could stand up...when she had to sweep the kitchen.
That was a big area that we could knock down some hours in....She would come in
twice a week for eight weeks. Oh, very important. We also categorized her pain and
I had her keep a diary of her pain at home for different activities. I would connect the
activities to pain levels, and it was not only just pain levels in general: it was
headache; it was neckache; and it was lower back....In that way we were able to
isolate...what was going on a little bit because...the pain tended to move around.
“Well, today I can’t do anything because I have a severe headache. Then I can’t do
anything because I did too much yesterday and now my low back is hurting.” So we
can’t do anything because I have a severe headache. Then I can’t do anything because I did too much yesterday and now my low back is hurting.” So we had to try to get as much objective information as we could about what was going on at home.

Q … It sounds like she had a lot of issues going on.

A She did, and then I needed to deal with her husband also, with just learning to trust and to understand…that I wasn’t there just to please the insurance company. That was not my job. My job was an objective view of what needed to happen as far as her supportive living expenses.

Q Yes, that makes sense. Can you tell me about some of the strategies you used with the husband to try to… work through his suspicions?

A I was real quiet and I listened at first because he was so angry, so upset. It was like any input from me would have been on deaf ears and just agitated him more…. I had to try to develop a rapport with him and to make him feel that I was listening to what he had to say and that I was empathetic to what he had to say. And so I repeated a lot of things that he said to me and I validated things that he said to me. Then I would give my input, you know, start to talk about what we were going to do with his wife and how things were going to be, and it was okay. And encouraged them to call me. Does that make sense?

Q Oh, it sure does. It sounds like it was effective as well.

A Yeah, I felt pretty good about it and, you know, it was… use of self. You have to use yourself and the techniques that you learn, but a lot of it is just understanding what’s going on with the other person.

Q That makes sense, taking it in and using it with your observation skills…. Why is this incident critical to you?

A … I was very pleased with the outcome at the end of her treatment because we were able to diagnose or at least tell that most of the things were not due to her neck and back pain. Most of her problems were due to headaches that she had even beforehand. Not that it was all premorbid, but maybe this accident had just exacerbated the headaches more. But we were able to say, “Look, if you can get your body feeling better and do some of these exercises then it’s going to be easier for you.” We were able to separate the headaches from the neck and back pain. So I guess that’s why and because it was a difficult case. It wasn’t a cut and dry case…. You had to get involved. I mean, you had to be yourself… and be very straight with her…. I really had to dig deep… some cases you do and some cases you don’t.
Some cases you really get to know your clients a lot more personally, and this was one of those and that's why it sticks out to me.

Q ... You said most of why she wasn't able to do things was due to the headaches. Do you think that came about as a result of having her keep the diary?

A ... Yes, and just her reports, having her keep the diary and be more aware of the area because I don't think she was really aware. All I think was she was just overwhelmed because she had pain, so it helped her to write down when the headaches were preventing her from participating in an activity and when it was her back or neck. She also kept track of her medicine intake. Even though it was not a very successful case because we didn't get her off of everything—we didn't get her back functioning. Well, she wasn't before either. She hadn't worked previously. The goal of her therapy wasn't for her to return to work. I think it clarified things more and helped her to go on... It wasn't that she didn't want treatment. She was very open to treatment, but she just had many issues. Does that answer the question?

Q Yes. Can you tell me what your concerns were at the time of the incident?

A Well, I was definitely anxious because I was going into a potentially dangerous situation. I didn't know what I was really getting into....I had gotten several phone calls before I even went there about why I was going there, both from her husband and from her....So I was obviously anxious and very alert to my own safety. Once I figured out that he was more verbal, he wasn't going to be physical, I knew I could handle that. And she was just crying. I mean, she was quite upset....I had to deal with all that, so I guess one of my concerns was am I going to get this eval done and get enough information...

Q ...Wow, it sounds like a good strategy. What were you thinking about as this incident was taking place?

A I was trying to think ahead about what I was going to do next, I mean as far as from the therapy standpoint. But I always do that. I mean, you always are thinking about what you're going to do next. You're listening at the same time that you're observing at the same time as you're planning. You kind of do it all together....The
critical thinking, critical reasoning, clinical reasoning... And you have choices and those choices flip through your head and you say, “Well which way do I want to go now?”... Sometimes you... make that decision and you go that way and then you back off if it’s not working and you go another way and you do that right in the session if something doesn’t work. I guess I view a situation like that as you go with your gut, and it’s based on experience. It’s not something that I would want somebody just out of school to go into. You need to have experience going into something like that.

Q ... It sounds like it was something you felt comfortable doing with your previous experience and then with the information that you had gathered.

A Right. And I’ve had a lot of psych experience, too, so that I felt pretty comfortable. I mean, I can handle... people being verbal. And I haven’t ever had anybody be physical with me, even on the psych ward so that way I felt pretty comfortable... with my skills.

Q Can you tell me a little bit more about how you deal with the verbal assaults in that kind of a challenging situation?

A If they’re assaulting me, I will ask them not to do that. I will try to divert them or listen to them. Usually they just need to blow off steam and it’s not verbally assaulting me. I usually don’t end up in those kinds of situations. But it’s just that they’re angry and you feel that, and I just accept that and usually let them vent and then they start to quiet down because I don’t argue with them. I don’t try to make them change their mind. I let them feel how they feel. I guess that’s my approach with it and I try to approach everyone that way, that you have a right to those feelings. And we can’t be... telling people how to feel or how to interpret something. We can give them information, we can educate them, but we have to be careful about... the timing of that.... You have to make sure when you’re a therapist that you don’t take anything personally. And know that it’s just them and what’s going on with them. It has nothing to do with you. You’re just there.

Q It sounds like your approach really helps defuse the situation instead of fueling it...

A I don’t know if that’s a theoretical approach, but that’s what I do.

Q It sounds like you found it effective. What were you feeling during and after the incident?

A During the incident, as I say, I was anxious but I knew that I wanted to stick it out and to try. I wasn’t... trying to get out of there. I wanted to get to the bottom of it. I wanted to somehow get some resolution. It ended up that I ended up going out
and looking at this gentleman’s cars and everything. He has these old cars out in the barn and so we walked out there to look at them... I felt I had gained good rapport if they’re showing me around... So eventually... he was drawn into what we were doing, once he understood what we were doing...

Q  It sounds like because you took time and let him vent his emotions that you were able to then find a way for him to buy into your purpose for being there...

A  ...I guess once he knew that... I wasn’t there to take anything away from him, then he could relax a little bit and open up.

Q  Yeah, that makes sense. Did you feel he was also more supportive of her need for the therapy?

A  Yes. In fact, he brought her to the outpatient therapy because she wasn’t able to drive. And he actually was coming in to Kalamazoo for his own therapy so he would bring her in. We fixed it up so that they could coordinate it.

Q  Can you tell me what you were feeling after the incident?

A  Oh, after. I was feeling really tired, really drained. I mean, it was quite an intense session. I felt good about it because I thought that we had established a good rapport and I had all these thoughts going on in my head about what we were going to do. I had a lot of questions. How were we going to get her from here to there? How were we going to get her doing more things? I was thinking about all the questions that I had and the treatment plan.

Q  ...What, if anything, did you find most demanding about the situation?

A  I guess the attitude of her husband was probably the most difficult to try to work with at first.... When I walked in he was very negative and out in the kitchen and listening. He was already on the defensive.

Q  It sounds very demanding.... What particular skills, abilities and knowledge do you feel... that you used in this incident which allowed you to make a difference?

A  ...My knowledge of activities, my knowledge of pain levels and muscle problems, range of motion... It’s a perfect place for an OT to be because you are doing activities of daily living. You’re talking about somebody’s life. You’re taking a history of what they do during the day. I mean, I wanted to know everything that this lady did from the time she got up to... how her sleep pattern was. What kind of medication she was taking, that was important.... My training was perfect for that kind of thing. Knowing work simplification. Well, definitely the psychological issues. I
know what major depression is. I know...what abuse is. She said she had been abused when she was a child and there was alcoholism in her family. I was trained in those areas. The whole gamut.

Q It sounds like...you brought a lot of very valuable skills into that situation to make it a success....What particular skills, abilities and knowledge do you feel you needed to make more of a difference?

A ...I had to learn to do the training...as far as her body mechanics because that was not my specialty area. I had to learn from other therapists and I did that....That is what I was lacking in, and I had to learn this assessment, the ADL assessment. I know how to do an ADL assessment, but when you’re looking at it compared to body mechanics, there’s a whole protocol on that. So I needed to learn that protocol. Not that I couldn’t do it. I just needed to get familiar with it and then it’s a checklist, so it was pretty easy. That was looking at a person from a little different aspect than I’m used to, just a little twist on it. That’s much more cut and dry, I think.

Q It sounds like maybe it was something a little more technical...than personal types of skills and abilities.

A Right.

Q That’s great. It sounds like you felt confident. Can I have you describe the communities that you’re a member of?

A The communities? Can you elaborate?

Q Sure. Basically by communities, we define that as any group that you belong to. It could be your family group, your work group, any volunteering activities, social.

A ...Well, I’m a mother of three children and I have a husband....My number one is my family. In my job I have to set priorities because I’m so busy. I am a member of a church and I teach Sunday school. Extended family, that’s very important to me, husbands, sisters, and parents. I don’t have time for a whole lot else right now.

Q Do you belong to any professional associations?

A Yeah, AOTA. And I think I belong to MOTA too...

Q ...What do you see as your responsibilities to those communities that you just mentioned?
A To provide a healthy environment, to teach what I know, to be a teacher, to be a role model, to be a support, to be there, to be present, to be connected because we’re all connected. I truly believe that and to show that, to demonstrate that, in everything that I do, that I am connected with everything and everybody. I mean, not in a grandiose way, ... that’s part of being in the community.
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