

End of intervention or discharge

If a person has been in hospital or other temporary residential care, discharge planning precedes resettling her/him back into the community. If someone has remained in her/his own environment during the intervention, discharge may mean recognising that s/he has achieved her/his goals, or is unable to achieve them. It is not always possible to reach agreement between the occupational therapist, the multidisciplinary team and the client or carer about the optimum time for discharge.

Discharge can be to a variety of locations, including some form of further care. It usually takes place when the client is able to maintain her/himself within the home, workplace and/or wider community.

When someone is seen by an occupational therapist before discharge from hospital, her/his daily living skills are assessed and attention is given to her/his strategies for maintaining or improving those skills. These strategies include liaison with colleagues and may include transfer to a therapist in another part of the health and social care services.

The therapist usually writes a short report on discharge, for inclusion in the client's notes. A detailed report will be produced if specifically requested.

Follow-up visits or telephone calls can be made once, an agreed number of times or on a regular basis for a specified period of time. In some cases, the therapist does not discharge the client but keeps the case open.

Review

The occupational therapist reviews and evaluates the occupational therapy service in order to safeguard good standards of practice. This is done through:

- self appraisal and reflection
- supervision and peer review
- client feedback via discussion, the use of an evaluation form or a consumer questionnaire
- audit.

5. The occupational therapist

What the occupational therapist does is influenced by many factors that s/he brings to the therapeutic encounter. These include:

- professional experience
- professional beliefs and values
- understanding of and commitment to client-centred practice
- occupational therapy's domain of concern
- goals and desired outcomes
- occupational therapy knowledge base
- professional skills
- thinking skills
- legitimate tools for occupational therapy practice
- roles, responsibilities and duties.

All these factors change both qualitatively and quantitatively, consequent on the length and quality of the therapist's experience.

Professional experience

Professional experience influences the pattern of client-related activity and each therapist has her/his own style of working with clients which is developed, practised and honed over time. The experienced occupational therapist generally uses a wider range of activities than her/his less experienced colleagues and is likely to use techniques that appear to work rather than appraising the research evidence or relying on information gained from other sources. These techniques are learned from other therapists and via post-graduate training courses. The experienced therapist is unlikely to change long-established practice unless for a compelling reason.

Reasoning strategies result from the interaction between the experience of the practitioner and the nature of the task. The quality, depth and efficacy of clinical reasoning differentiate the novice from the competent practitioner and the competent practitioner from the expert. For example, perceptions of the complexity of practice are connected with the ability of the therapist rather than depending on the length of the intervention or the amount of data available. The experienced clinician does not follow each stage of the occupational therapy process in a linear pattern but uses it in a much more complex way.

The factors that the occupational therapist brings to the therapeutic encounter are described here as they would be seen in an experienced therapist.

Professional beliefs and values

Beliefs about the nature of people

The occupational therapist believes that the drive to act is a basic human need. The performance of tasks and activities places demands on the individual to learn, adapt and respond, therefore, action facilitates change and personal development. Through being active people learn about themselves, develop skills and coping strategies, maintain physical and mental health, improve their quality of life, experience well being and realise their fullest potential. The sense of being in control and of striving towards reaching one's potential are crucial for physical and mental health, well being and quality of life.

People are active and social beings who learn a repertoire of roles, rules and appropriate responses to patterns of physical, social or symbolic information in the human and non-human environments. It is natural for people to strive to be like everyone else, to make a contribution to society, to feel valued and to maintain a sense of dignity, self-respect and achievement.

Key routines and occupations support the individual's sense of self. Choices of occupation, and the ways in which people perform their chosen or required range of occupations, are influenced by individual biology, spirituality, sexuality, personal history, skills, problems, needs, motives, family and the physical, social, cultural, economic and political environments. Changes in any of these aspects affect occupation and occupational performance.

Beliefs about the nature of health

Participation in a variety of activities and openness to new challenges are indicators of health. A healthy person is one who is able to perform her/his daily occupations to a satisfying and effective level and to respond positively to change by adapting her/his activities to meet changing needs. This means that a person can be healthy as a result of occupation despite severe impairment. Health can also be expressed in terms of adaptation to the environment rather than freedom from disease.

Conversely, people who are unable to participate in their choice of occupations, for whatever reason, can suffer from occupational imbalance, deprivation and alienation. Occupational imbalance refers to a loss of balance between work, rest and play. Occupational deprivation is the denial of opportunity for expressing one's occupational nature. Occupational alienation describes a complex concept of separateness from the harmonious relationship between occupation, health and the environment. Occupational imbalance, deprivation and alienation have a negative impact on health.

There is an intrinsic relationship between occupations, activities, health and well being, therefore, activities can be used to regain health and to promote good health.

Beliefs about the nature and purpose of occupational therapy

The occupational therapist provides part of the total care of the client as a member of a multidisciplinary team. Her/his specific concern is with the client's experience of illness or disability and with how impairment affects function in the physical, cognitive, emotional, spiritual and social domains of life. The role of the occupational therapist is to inform, support, facilitate and provide opportunities for clients to perform activities in order to promote function, quality of life and the realisation of potential. Her/his legitimate tools are occupations, activities and tasks which are adapted for use as therapeutic media.

The four core processes of occupational therapy are:

- therapeutic use of self
- assessment of individual ability, potential and needs
- analysis and adaptation of activities
- analysis and adaptation of environments.

The client's engagement in the process of therapy is the most important aspect of intervention, therefore, occupational therapy is most effective when it is a partnership between the client and therapist. The therapist-client interaction is a dynamic, collaborative process in which choice and control are negotiated and shared and in which the client participates actively in setting and realising goals. In order to achieve this partnership, the therapist has to balance conflicts of professional power, legal requirements, social pressure and client rights.

Values

The occupational therapist values individual experience, cultural diversity, religious beliefs and lifestyle diversity in her/his clients, within the occupational therapy profession and in colleagues. S/he accords equal respect to all, acknowledging that each person has rights.

The expression of these values means that occupational therapy is essentially a flexible process in which the therapist listens to the client in order to understand and respond to her/his needs, values, interests and aspirations. For intervention to be integrated into the life and context of the individual, the family and carers, it must be culturally sensitive and culturally relevant.

Respect for the client is expressed through taking steps to ensure that, whenever possible, the client understands the nature, purpose and likely effects of proposed interventions. Information is given in an accessible form so that the client is able to make informed choices about her/his care, occupations and life with a full understanding of the possible outcomes and risks of her/his decisions. The informed client has the right to make seemingly unsafe choices, including the right to refuse treatment, even when those choices conflict with professional opinion.

Client-centred practice

A client-centred approach places the client and her/his wishes, goals and perceptions at the centre of therapy and promotes collaborative relationships with clients, their families and carers. The occupational therapist gives precedence to the needs of people who use her/his services so that the client directly influences the purpose and course of therapy. This means that occupational therapy intervention is not standard but, for each client, a package of care and therapy is designed to meet her/his individual needs. General principles, processes, theories and approaches form a background that can be used as required and can be enmeshed with the client's needs.

The principles of client-centred practice include:

- respecting diversity
- recognising that the client has rights
- clarifying role expectations within the therapeutic encounter
- building collaborative therapist-client relationships
- focusing on the client's needs, problems and priorities
- negotiating problems and goals with the client and/or carer
- incorporating the client's perspective at all stages of intervention
- sharing power and decision making with the client and/or carer
- promoting client autonomy and choice through providing information
- ensuring that interventions are congruent with the client's life world context.

Ideally, client-centred occupational therapy is a partnership between the client and the therapist in which both participate actively, thus increasing the client's responsibility, choice, autonomy and control over her/his care. Throughout the process of intervention, the therapist listens to and respects the client's values, adapts interventions to meet the client's needs and enables the client to make informed decisions. The therapist becomes aware of her/his own values through reflection and refrains from imposing these on the client.

In cases where the client has intellectual or emotional disabilities that make her/him less competent to make rational decisions, the therapist may at times have to take responsibility for making decisions on her/his behalf. The therapist continues to work towards increasing client understanding, autonomy and choice

Inequalities of power exist in the client-therapist relationship, no matter how much the aim of facilitating the former's interests is brought to the fore. The occupational therapist has power over her/his clients because of her/his technical skills and clients' vulnerability. Clients and their relatives may have the power to demand services or refuse treatment, sometimes against the therapist's professional judgement. The therapist's autonomy can be compromised by the power of others, by shortage of resources or by legal pressures. These factors make it more difficult for her/him to give the client opportunities to exercise choice and control.

Occupational therapy's domain of concern

Occupational therapy personnel work with people of all ages with physical, mental and social impairments and learning disabilities, who have problems spanning social, educational, functional, economic and cultural difficulties. Intervention may concentrate on people with long-term problems or be at an early stage to prevent any long-term problems. The occupational therapist also works with people who have minor coping difficulties and those who are functioning well and wish to maintain and promote their well being.

Occupational therapy is a profession that focuses on the nature, balance, pattern and context of occupations in individuals' lives, therefore, it is often concerned with multiple and complex long-term needs and problems. Occupational therapy is not just concerned with impairment or diagnosis but with the meaning and purpose that clients place on activities and occupations and with the impact of illness or disability on their ability to carry them out. Occupational therapy intervention is designed to restore or create a beneficial fit between the abilities of the person, the demands of her/his occupations and the demands of the environment.

The role of the occupational therapist includes both assessment and treatment. The focus may be on different levels of problem, from occupational dysfunction through difficulties with tasks or activities to skills deficits. The occupational therapist is also concerned with issues that cut across all levels, such as quality of life, general independence and coping in the community. The therapist assists the client to change, if the client wishes to do so, in ways that the client finds acceptable.

The occupational therapist may provide professional support and guidance to carers or care staff who oversee the daily occupations of clients. The occupational therapist is concerned with making the task of caring easier, therefore the occupational therapy brief includes providing equipment and adaptations.

Goals and desired outcomes of occupational therapy

The occupational therapist engages with people in the context of occupations to bring about something in the client that has been lost or has never been there, or to enable a process of adjustment to occur. Goals may be to do with the therapeutic process or with client outcomes.

The main process goal of occupational therapy is to provide an appropriate, effective and sensitive service. This involves developing a therapeutic relationship, helping the client to take an active role in all aspects of therapy, providing appropriate activity and monitoring the therapeutic environment.

Outcome goals are expressed on different levels, from developing skills, through performing tasks and engaging in activities, to performing occupations and enabling social participation. Short-term outcome goals are goals on the way to achieving the main desired outcome. They are concerned with maintaining, developing, enhancing or compensating for loss of skills in the sensori-motor, cognitive, affective and social

domains. Skills are used for the performance of tasks which can be built into a range of activities to support the client's expected occupations. Where there are environmental barriers to occupational performance, a goal of therapy would be to remove or bypass them.

The main long-term outcome goal of occupational therapy is for the client to achieve a satisfying performance and balance of occupations, in the areas of self care, productivity and leisure, that will support recovery, health, well being and social participation.

The desired outcomes of intervention depend on the individual needs, goals and preferences of each client, therefore outcome goals may be expressed in terms of benefits to the client or of client well being, satisfaction and sense of achievement.

Occupational therapy knowledge base

The knowledge base of occupational therapy is a synthesis of knowledge adopted from many different disciplines together with concepts and theories developed within the profession and the experience of individual practitioners. Areas of knowledge include theory, research, policy, legislation, education, continuing professional development and practice. The occupational therapist needs to make explicit links between all these areas.

The most basic level of occupational therapy knowledge is concepts. These form the basis of theories which, in turn, can be organised into frames of reference, models and approaches to practice.

Concepts

Concepts are mental representations of objects or ideas. A concept is a principle of classification that can be a guide in determining whether an entity belongs in one class rather than another. Words are used to express concepts. For example, *activity* is a concept. The occupational therapist is able to identify diverse events such as cleaning one's teeth, walking a dog or writing a letter as activities.

Key concepts within occupational therapy are occupation, activity, task, skill, motivation, volition, autonomy, creativity and temporal adaptation. These are discussed here and the relationships between them explored.

Occupation is a synthesis of doing, being and becoming that is central to the everyday life of every person and that provides longitudinal organisation of time and effort. Occupation is complex and multifaceted, incorporating physical, social, psychological, emotional and spiritual dimensions. It occurs in the interaction between persons and their environments so that the things that people do every day form the bridge between their inner and outer worlds and contribute to their sense of personal and social identity.

Occupation is a basic need for people of all ages and is necessary for adaptation and survival. It has evolutionary, biological and social functions. Occupation serves to meet bodily, social and cultural needs, to give a sense of control, to build and maintain social networks, to validate social identity and to maintain emotional equilibrium. It influences childhood development, enables exploration and learning about the environment and

about one's own and others' potential, and provides opportunities to test one's perceptions of the world. Occupations are adapted in response to, and in order to facilitate, periods of transition during people's lives.

Occupations can be divided into three broad areas: self-maintenance, productivity and leisure. However, many occupations fall into more than one category or move between categories.

The occupations that people engage in have social, cultural, symbolic and spiritual significance for them. People adapt their occupations to reflect their values, commitments, meanings and social context. The initiation, expression and carrying out of occupation is, therefore, mostly unique to the individual.

Activity is any mental or physical action that is performed voluntarily and directed towards a goal or end result, while non-activity is either voluntary inaction or involuntary action. The value that an individual ascribes to an activity influences her/his commitment to spend time on it. Most of the activities an individual performs daily are so routine that s/he carries them out automatically.

Activity meets basic needs, enables self-expression, may give pleasure or ensure comfort, enables relationships with others, encourages adaptive behaviour, meets specific objectives and fosters active involvement by the individual in addressing her/his specific problems and needs. Through activity, a person not only develops skills but also learns about her/his strengths and weaknesses, because every activity involves the interplay of three factors: the demands of the task, the demands of the environment and the abilities of the individual to respond.

People are more likely to choose to engage in activities that they can visualise themselves doing and that fit their self-image. In turn, the activities performed shape how people feel about themselves. When a person feels good about her/himself and about the activity, s/he is more likely to be active and to be successful in that activity. When someone has a poor self-concept and does not see an activity as valuable, s/he is less likely to engage in that activity and more likely to perform it badly.

People give meanings to the activities they do and these meanings have an emotional content that is bound up with feelings, beliefs, attitudes and values. Meanings develop, in part, from the experiences of activity that the individual has had and the associations that have been formed by those experiences. Meanings also develop through interaction with other people, since all human activity takes place within the context of social relationships. The social meaning of an activity is developed through learning the shared cultural knowledge base of the activity, that is, the acceptable techniques, context, materials, rules, sanctions and norms associated with the activity. Shared meanings become internalised and help to create a sense of social and individual identity.

Tasks are constituent parts or self-contained stages in an activity. A single task achieves little unless it is related to a set of other tasks that are sequenced to form an activity. Task analysis involves breaking down an activity into its component stages or tasks.

Skills are specific abilities, or integrated sets of abilities, which evolve with practice. They have to be learned and practised to a standard that will enable the effective performance of a task.

Occupations, activities, tasks and skills relate to each other in a hierarchy in which occupation is the highest category. The individual must convert potential abilities into useable skill components, which are the precursors to and foundations for skilled performance. Skills are built into blocks of performance which contribute to the completion of task stages which can be chained together in short sequences to complete a task. Tasks are performed in sequences that make up activities, which relate to other activities which, together, support occupations.

Motivation is the conscious or unconscious stimulus, incentive or motives for action towards a goal. Intrinsic motivation is the basic drive to be active that is a characteristic of human beings and that must be satisfied. Extrinsic motivation is triggered by external circumstances, such as danger, or by internal circumstances, such as hunger.

Volition is the mental action of consciously willing or resolving something or of making a choice or decision regarding a course of action. It is not a precursor or trigger to action but is the conscious awareness, during an activity, of its being performed voluntarily. Volition can be treated as a skill that is necessary for the performance of activity and that can be learned or improved.

Autonomy is the capacity to make choices or to exercise freedom of the will. In order to choose to do something, the individual has to be aware of what options are available and how to access them. The ability to make choices depends on three types of autonomy: autonomy of thought, of will and of action. Autonomy is not an all or nothing capacity but may vary at different times of life.

Creativity is the capacity of each individual to meet and engage fully with the environment, making something that is uniquely her/his own out of the materials, events, people and circumstances of her/his life. Creative activities require the individual to incorporate something of her/himself into the production of an idea or an end product.

Creativity is an ability that can be developed, and everyone has the ability to be creative to some extent. A capacity for thinking and acting creatively will influence the way in which problems are approached and enhance the ability to find solutions, therefore, creativity is an important aspect of any occupational therapy intervention.

Temporal adaptation is the term given to an individual's general use of time. People need to fill their time with activity that has purpose and meaning or the brain slips into confusion and chaos. When circumstances allow it, people make conscious decisions about what they want to do and organise their choices in time and space so that they engage each day in a blend of occupations which contributes to their sense of well being and perception of the quality of their life.

The experience of doing things within time provides a perspective on the past, a structure for the present and a means of planning for and influencing the future. In order to use time adaptively, the individual needs to remember past experiences and act on them, to be aware of the future consequences of those actions, to plan ahead, to act on those plans and to monitor the effects of actions.

Theories

A theory is a system of assumptions and principles devised to analyse, predict or explain phenomena. The occupational therapy knowledge base incorporates theories of occupation, biological sciences, developmental theory, medical and psychiatric theory, psychology and sociology. Theories of occupation include: the nature, classification and functions of occupations; the evolution and ontogenesis of occupations; the occupational brain; occupational role theory; occupational form and performance; occupational behaviour; occupational choice, and the relationship between occupation and health.

The occupational therapist uses theory at a number of levels:

- as a guide to practice, to encourage coherent and systematic treatment
- to suggest alternative treatment strategies
- to enable effective communication
- to provide a rationale for practice
- to provide a basis for researching practice.

Different theories define problems differently and suggest alternative treatment strategies, therefore, the more theories an occupational therapist understands the more flexible s/he can be in her/his approach to intervention.

Frames of reference

A frame of reference is the therapist's general orientation, a collection of ideas or theories which provide a foundation for practice. Examples of frames of reference used by the occupational therapist include: biomechanical, human developmental, perceptual motor, psychodynamic, psychosocial, sensory integrative and sensori-motor.

Models

A model is a simplified representation of a phenomenon that can account for certain data or relationships. If a therapist has a repertoire of models at her/his disposal, and if they are used judiciously in particular settings, they can be very useful tools, particularly at the beginning stages of professional learning. However, adhering to one model without critical thought and evaluation can lead to routine practice rather than reasoned and reflective practice.

Each therapist develops a personal model made up of theoretical knowledge and innate or tacit knowledge learned from experience and embedded in practice. The therapist needs to review this model at intervals to check that it has not deviated from currently accepted practice or become out of date.

Approaches to practice

An approach is the methods by which theories are put into practice and treatment is administered. Examples of approaches used by the occupational therapist include: adaptive, behavioural, biomechanical, compensatory, habilitative, rehabilitative and neurodevelopmental.

If an approach or theoretical structure is selected before intervention commences, it can function as a conceptual lens. Such theory-driven therapy provides a coherent and consistent basis for practice and eliminates unnecessary deliberation. However, it affects and limits subsequent actions and could be restrictive. Selection of an approach after the problem has been named, or the desired outcome identified, is called process-driven therapy. The approach acts as a tool for the job, ensuring that intervention is appropriate and coherent.

Skills of the occupational therapist

The core skills of the occupational therapist are built around occupation and activity. These are complex skills made up of many component sub-skills which include, for example, cognitive skills and group leadership skills. The occupational therapist's core skills are:

- **Collaboration with the client:** building a collaborative relationship with the client that will promote reflection, autonomy and engagement in the therapeutic process
- **Assessment:** assessing and observing functional potential, limitations, ability and needs, including the effects of physical and psychosocial environments
- **Enablement:** enabling people to explore, achieve and maintain balance in their activities of daily living in the areas of personal care, domestic, leisure and productivity
- **Problem solving:** identifying and solving occupational performance problems
- **Using activity as a therapeutic tool:** using activities to promote health, well being and function by analysing, selecting, synthesising, adapting, grading and applying activities for specific therapeutic purposes
- **Group work:** planning, organising and leading activity groups
- **Environmental adaptation:** analysing and adapting environments to increase function and social participation.

Some of the core skills of the occupational therapist are described here in more detail.

Assessment involves gathering information, observing, measuring, recording, analysing the results and evaluating against a norm or outcome. Assessment results are used in planning interventions. The basic skills of assessment include:

- being sensitive to the client as an individual, not as an object
- selecting what is to be assessed
- selecting or designing appropriate assessment methods
- maintaining an objective stance
- making accurate observations
- producing consistent, accurate and replicable results
- communicating results clearly to others.

The therapeutic use of activity is complex, with the same activity being used for diverse purposes in differing contexts. Activity may be directed towards developing a skill, clarifying a relationship or creating an end product. To be of value, the activity must be selected to suit the individual's needs, skills and readiness in relation to her/his stage of life and her/his social and cultural values.

The occupational therapist selects the best activity to engage the client and meet therapeutic goals by analysing potential activities, selecting appropriate activities, synthesising new activities and adapting chosen activities. During an intervention, activities may be graded and sequenced to maintain the client's interest and increase or decrease the level of skills required.

Activity analysis is a process of dissecting an activity into its component parts and task sequence in order to identify its inherent properties and the skills required for its performance. Analysis allows the therapist to evaluate the therapeutic potential of an activity and manipulate it to increase that potential.

An activity can be analysed in terms of:

- types of performance skills needed - the physical, cognitive, intrapersonal and interpersonal demands
- time required for performance, number of sessions required and any issues of timing
- physical and human environments required, including space, tools, equipment and number of participants
- degree of complexity
- inherent structure
- degree of predictability
- cultural and social associations, purpose, meaning and value
- potential personal associations, purpose, meaning and value
- age and sex appropriateness, related to the cultural context
- risk factors and safety precautions
- potential for evoking interest and attention
- potential effect on individual identity
- potential for having an impact on the human and non-human environment
- potential for enabling exploration, repetition and practice
- potential for learning to solve problems
- potential for promoting personal development
- potential for gratification of needs
- potential for learning specific knowledge, skills or attitudes
- potential for learning about the self
- potential for grading in terms of the materials, equipment, environment and method
- related activities that could be used for sequencing.

Conducting a full analysis of all the skills or sub-skills required to perform a particular activity can be complex and time consuming. Task analysis allows the therapist to identify the particular task with which a client is having problems and to carry out a detailed analysis of that task.

Activity synthesis involves combining activity components and features of the environment to produce a new activity that will enable a particular performance to be assessed or will achieve a specific therapeutic outcome.

Activity adaptation is the process of changing the demands of an activity for a specific therapeutic purpose. Changes may be made to tools, position of equipment, materials, speed of performance, repetition, specific movements, strength and resistance, sequence of tasks, simplicity or complexity, instructions, context, location, number of participants and degree of choice.

Activity grading means manipulating the factors required for the performance of a task or activity in stages so that the activity becomes progressively more difficult or easier to carry out. An activity can be graded to increase or reduce social, emotional, cognitive, perceptual or physical demands. The environment can also be graded, for example to add more stimulation, pressure or stress.

Sequencing activities means finding or designing a sequence of different but related activities that will incrementally increase the demands made on the individual as her/his performance improves or decrease them as her/his performance deteriorates. It is used as an adjunct or alternative to activity grading.

Analysis of the environment may provide information about the causes of problems for the individual, explanations for behaviour or ideas for therapeutic modifications.

Environmental analysis includes:

- objective observation and recording of who and what is there (content analysis)
- appraisal of the effects of the environment on people and their perceptions, behaviours and participation in occupations and activities (demand analysis)
- identification of elements which need to be altered and the means by which this may be done (adaptive analysis).

Environmental adaptation means making temporary or permanent changes to the client's physical, cultural, institutional or social environments in order to influence her/his level of motivation and/or facilitate occupational performance. Occupation shapes, and is shaped by, space therefore changes in any aspects of the environment will affect occupation and occupational performance. The therapist needs to appreciate how existing spaces are perceived and used before recommending any adaptation.

Thinking skills of the occupational therapist

The skills which the occupational therapist uses in thinking about her/his work include, in addition to the analytical skills described earlier, clinical reasoning and reflection.

Clinical reasoning

Clinical reasoning involves a range of mental strategies and high level cognitive processes which enable the therapist to reach decisions about the best course of action. Clinical reasoning ensures that the occupational therapist practises occupational therapy and not some other form of intervention. Strategies include scientific, narrative, interactive, conditional, pragmatic and ethical reasoning.

Scientific reasoning is systematic, logical thinking based on hypothesis testing, scientific model making and the use of research-based theory and techniques.

Narrative reasoning is a phenomenological process involving empathy, improvisation and attention to values and beliefs, in which stories are used to build a picture of the client's particular needs and situation.

Interactive reasoning arises out of the interaction between the therapist and client. The therapist acts on subtle cues in order to assess the individual's motivation and engage her/him in treatment. Interactive reasoning uses primarily intuitive strategies.

Conditional reasoning involves the therapist considering the client and her/his illness, family, social environment, physical environment and past, present and future life. Reasoning can consider the future as well as the present and this type of conditional reasoning guides the way that the therapist shapes the immediate situation.

Pragmatic reasoning incorporates consideration of practical constraints and wider social factors.

Ethical reasoning is the process of thinking about an ethical dilemma in order to reach a decision on a course of action.

Clinical reasoning is influenced by a multitude of factors including the socio-cultural context, the setting of the intervention, practical constraints and the therapist's own life experiences. The style of reasoning used is dependent on the content of the tasks being thought about and their characteristics. Complex situations cause the reasoning process to move around in circles before it moves forwards again and periods of reasoning can be reiterated.

Reflection

Reflection involves the therapist standing back from practice, analysing what is being or has been done and challenging her/himself to justify it and seek improvements. Reflection can aid the gaining of knowledge and skills and guard against practice becoming over-automated. It can ensure that interventions are cost-effective while retaining purpose and meaning for clients. Even the experienced therapist's professional

knowledge becomes deeper as further understanding and appreciation are achieved through reflection.

Reflection in action involves the therapist thinking about her/himself within the therapy process and acting upon feedback from the environment. Reflection after the event involves returning to, recalling and re-evaluating the experience.

Legitimate tools for occupational therapy practice

The occupational therapist carries out assessment, treatment and outcome measurement.

Assessment tools

Occupational therapy assessment tools need to be sensitive to change, be user-friendly and provide accurate information from which the therapist can devise therapeutic plans based on the needs of the client. The occupational therapist needs to be familiar with, and experiment with, different assessment tools so that s/he can make an informed choice of the most appropriate tool in a particular situation.

Assessments can be formal and specifically focussed or informal and unstructured. Specifically focussed assessments promote a clear understanding of particular issues or needs and facilitate focused treatment. The stronger the research base backing an assessment, the more credibility it has as a tool.

The occupational therapist uses standardised assessment tools such as the Assessment of Motor and Process Skills (AMPS), the Barthel Index, the Nottingham Stroke Dressing Assessment and the Structured Observation Test of Function (SOTof).

Non-standardised methods of assessment include clinical observations, interviews, listening, reviews of case notes, performance tests, home visits, measurements of function and questionnaires. The client can be asked to perform an action, complete a task or complete a self-rating form. Some assessments are designed to elicit the client's understanding of her/his problem.

The occupational therapist also uses individualised assessments such as the Canadian Occupational Performance Measure (COPM) and the Westcoates Individualised Outcome Measure.

Procedures for collating and evaluating assessment information include: rating scales, checklists, record forms, charts, grids, graphs, statistical formulae and profiles.

Treatment tools

Treatment tools are the media, agents or techniques employed by the occupational therapist in-face to-face contact with her/his clients and in work on behalf of her/his clients.

Activities used as treatment media must have significance and purpose for the client, be perceived by her/him as interesting and worthwhile, relate to her/his personal, social, cultural and economic needs and take account of environmental factors that govern her/his life. These can be art and craft activities, creative activities, self-care activities, work activities, leisure activities, lifestyle activities (such as gardening or routine walking), community outings or social activities. The occupational therapist converts them into therapeutic media by using activity analysis, synthesis and grading which allow the component parts of the activity to be matched with specific, desired performance outcomes.

The occupational therapist uses activity to enhance, facilitate and/or remove barriers to occupational performance. For clients whose capacity will not increase further, other means of facilitating occupational performance may be used, such as adaptation of the method, environment, equipment or performance of the activity.

The environment in which the activity takes place is part of the treatment medium, for example, a friendly, supportive and encouraging atmosphere, or a relaxing environment or social contact within a group. Locating a group within the community may enable clients to maintain their own social networks.

Visits to the home, workplace, living space or school can be used as interventions to encourage the client's sense of control and involvement in the treatment process. Items of equipment or adaptations may be provided, or the environment may be used as a tool for intervention. For example, extraneous objects or hazards are removed and visual cues can be provided to aid orientation.

Risk management means having a strategy for managing potential risks and reducing the likelihood and effect of untoward incidents in order to allow positive risk taking to take place. Risk management involves collecting information, assessing and analysing risk factors, implementing strategies and monitoring.

The therapist works with individuals, with groups and with organisations.

Outcome measurement tools

An outcome measurement tool for occupational therapy should measure changes in levels of achievement, feelings and attitudes over specified time periods. The direction of change to be measured can be improvement, maintenance, reduction, prevention, development/maturation, recovery or delay. Tools for outcome measurement should complement existing documentation and communication, enhance clinical reasoning and decision making, make use of existing resources and motivate staff to use the system. In addition, it should be reliable and valid.

Some outcome measurement tools are standardised and others are individualised. Individualised measures are more sensitive to small changes that may be important to the client. They capture what it is that the client wants out of therapy and what therapists achieve in day-to-day practice. The simplest method of measuring achievements is to measure whether a goal has been achieved or not.

Roles, responsibilities and duties

Professional roles are the attributes and behaviours expected of someone in a professional job. These attributes and behaviours will be different for different professions. Occupational therapy does not have a role that carries inherent expectations which can be understood clearly in a literal sense, nor is it grounded in a statutory role, therefore, the roles taken by each occupational therapist are influenced by a complex interplay of internal and external factors. These factors are discussed in more detail in part 6: external influences on the occupational therapy process

Examples of the types of role that an occupational therapist might take on include:

- a clinical role
- a managerial role with a limited caseload
- a consultancy role, enabling clients through working with other key staff
- a care manager or care co-ordinator role
- a role at a strategic, planning or organisational level.

In a community team, the occupational therapist often combines a generic role with her/his unique professional role or, alternatively, s/he maintains a specialist role. In some teams, the occupational therapist's role is restricted, for example, s/he carries out discharge facilitation in an acute surgical setting.

Professional responsibility means being accountable for one's own actions and for adhering to the standards of practice and ethical conduct set by the professional body and other bodies, such as the Health Professions Council. The individual occupational therapist is responsible for her/his own clinical practice, for taking reasonable care of her/his clients, for providing a high quality service that meets the client's needs and does no harm, for evaluating the treatment process and for monitoring her/his own performance. The occupational therapist must only provide services and use techniques for which s/he is qualified by education, training and/or experience and which are within her/his professional competence.

When the occupational therapist delegates treatment or other procedures, s/he must be satisfied that the person to whom these are delegated is competent to carry them out. The occupational therapist retains ultimate responsibility for her/his clients.

The occupational therapist is responsible for contributing to the day-to-day management of risk. This includes being aware of the risk of violence from clients, being aware of the risk management strategy of the employing organisation and maintaining safe working practices.

Each occupational therapist has a personal responsibility to maintain and develop her/his professional competence and establish her/his fitness to practice by obtaining relevant

training and information, being proactive and assembling evidence of continuing professional and personal development.

It is the professional responsibility of every occupational therapist to participate in the education of occupational therapy students, particularly in the area of fieldwork education.

The occupational therapist has a responsibility to engage with research activity, at least as a critical consumer or user of knowledge.

Professional duties are what the professional is legally or morally obliged to do, or ought to do, to fulfil her/his professional role. The occupational therapist has a duty to act in the client's best interests. This duty should not be influenced by any commercial or other interest that conflicts with it. The occupational therapist must not engage in or condone behaviour that causes mental or physical distress, for example through neglect, intentional acts, indifference to the suffering of others and other malpractice. The occupational therapist has a responsibility to inform her/his employer and line manager if s/he is aware of any resource and service deficiencies which may have implications for clients and carers.

The occupational therapist has a duty to record accurately all information relating to professional activities. These records should include professional interventions, advice given and the outcomes of decisions taken. Subjective opinion should always be identified as such and should be clinically relevant.

The occupational therapist is ethically and legally obliged to safeguard confidential information relating to clients. Confidential information may normally be disclosed only with the client's consent, or where there is legal justification or it is considered to be in the public interest. All records must be kept securely.

6. External influences on the occupational therapy process

What the occupational therapist does is affected by many factors that are external to the occupational therapy process and to her/his professional role. These factors often exert a powerful influence on the therapist's actions. They include:

- the social context of the intervention
- government policy
- local policy
- the context in which the occupational therapist is working
- the requirement to base practice on the best available evidence
- demands for continuing professional development
- personal accountability for the process and outcomes of intervention.

The social context of the intervention

Everyday life in the UK is changing, altering the nature, balance, pattern and context of many individuals' lives. Demographic patterns are changing, leading to different patterns of need. Social values are changing, often leading to conflicting values and ethical stances.

Social changes and technological advances are affecting the ways in which health and social care are delivered, including shortened hospital stays and increased community care provision. This has also led to changes in the structural and philosophical environments in which the occupational therapist works. In addition, the occupational therapist sometimes finds that her/his clients have more knowledge about aspects of disability and service delivery than s/he does and there is an increasing fear of litigation.

Social factors have the potential to change radically the range and types of activities in which individuals habitually engage, therefore, the occupational therapist adapts to social change by amending the range of activities in her/his repertoire.

The home is increasingly becoming the ideal or preferred location for a huge range of daily activities that previously occurred outside its boundaries, for example, home working, the hospital at home, community care, distance learning and the home cinema. It is part of the occupational therapist's role to recommend physical and functional adaptations to the home in order to facilitate the performance of these activities.

Government policy

There is an evolving policy background to health and social care services that includes changes in both the law and central directives on the organisation of practice. These changes are directed towards increased accountability, cost containment, increasing speed of access to services and completion of intervention, quality assurance and the effective balancing of safety, capacity and compulsion issues.

Alongside the drive to make health and social care services more efficient overall is the goal of putting the needs of the client first in order to secure high quality, effective interventions.

In order to achieve these potentially conflicting goals, new models of service delivery are being implemented, including closer working practices both between professions and across traditional service delivery divisions. Health and personal social service budgets are being pooled, health improvement programmes are being established and primary care groups are being set up.

Services are moving from existing hospital provision towards a community-based, day treatment model, 365-day services and crisis management provision. The average length of hospital stay has decreased significantly and patients may be discharged home before they are fully rehabilitated, necessitating home-based services. The provision of home-based therapy is likely to increase.

Local policy

The occupational therapist is influenced by health and social care policy at both national and local levels. The culture of health and social care is continually changing in response to policy changes, so that the occupational therapist has continually to respond to new models of service provision and delivery, managerial initiatives, increasing workloads, funding constraints and a shortage of personnel and resources.

The occupational therapist is required to work in accordance with local protocols and procedures in order to meet service objectives. S/he is expected always to adhere to local procedures, for example, in reporting incidents, keeping records or protecting client confidentiality

The context in which the occupational therapist is working

The clinical situation has a significant influence on occupational therapy practice. This includes the field of practice, the therapeutic environment, constraints inherent in the environment, the expectations and demands of other professions, a desire to make best use of support staff, the perceived difficulty of justifying activities to medical colleagues and the therapist's acquisition of new responsibilities outside her/his traditional role.

Working in a team is a major factor determining what the occupational therapist does. This means that s/he needs to take account of current unit philosophy and management style in order to work effectively, as the impact of occupational therapy often depends critically on team working. For example, where nursing staff are not involved in the occupational therapy programme, the therapist may struggle to prompt clients to attend groups without nursing support.

The occupational therapist is often working single-handed and her/his role is often not fully understood by other professionals. The occupational therapist is likely to feel more comfortable where the team has a clear knowledge of her/his role and skills. However, there is a danger of the therapist becoming more concerned with her/his role and status than with the best interest of the client. Also, a more clearly defined role can become a more restricted one.

The occupational therapist's knowledge is greatly influenced by working with other team members, by their approaches and attitudes. When other team members hold different

views on what should be the focus of intervention, the occupational therapist can find her/himself focusing on self-care activities in order to meet team goals, or comply with service constraints, to the neglect of other client-identified activities and needs.

Time constraints are a major problem for the occupational therapist, due to heavy case loads, rapid client turnover, vacant posts, waiting lists, sickness and holiday leave. This can mean that the occupational therapist is unable to take time to get to know her/his clients as individuals so that they are discharged from therapy services when basic functional skills have been addressed, regardless of whether these are their priorities or other goals have been achieved.

Another problem that arises from working in highly pressured workplaces is that practice can become habitual or repetitive because the therapist does not have time to learn and implement new skills in order to change her/his practice.

In order to sustain the emotional and physical demands inherent in work, the therapist needs support and opportunities for learning. The working environment can provide managerial support, support from colleagues, resources, time and training or, alternatively, create demands that reduce the time available for learning and discussion.

The requirement to base practice on the best available evidence

Each occupational therapist has a responsibility to ensure that the assessed needs of her/his clients are met effectively and cost-effectively and that, wherever possible, her/his professional practice is evidence-based and consistent with established research findings. Evidence-based practice must be flexible enough to include the information gained from professional training, client input, colleagues, continuing education and clinical experience.

In order to implement evidence-based practice, the occupational therapist requires a range of skills. S/he must be able to: find relevant evidence; critically appraise evidence for its applicability within occupational therapy; decide the extent to which the client's preference can guide decision-making, in the light of evidence that may contradict what s/he wants, and use or apply evidence in practice. To acquire these skills, the occupational therapist needs training and support. S/he also needs appropriate resources and time to read research papers and implement findings.

Demands for continuing professional development

Each occupational therapist has a responsibility to embrace continuing professional development. S/he must be proactive in enhancing her/his skills and knowledge, in increasing her/his repertoire of tools and techniques and in planning and assembling evidence of continuing development.

Supervision can be used as part of continuing professional development to provide feedback, to give information, support and guidance, to increase confidence, to explore problematic issues and to discuss appropriate assessments and treatment plans.

Personal accountability for the process and outcomes of intervention

Clinical governance is a National Health Service development but it has implications for every occupational therapist wherever s/he works. It is a framework that encompasses a range of quality initiatives through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. These initiatives include quality, financial responsibility, building on good practice, professional self-regulation and assessing and minimising risks. Clinical governance aims to improve practice and professional accountability, promote continuing professional development, safeguard the quality of service provision and minimise the risk of adverse events.

Aspects of clinical governance which affect the practice of the occupational therapist include: supervision, continuing professional development, professional self-regulation, risk avoidance, risk management, performance management, quality improvement, outcome measurement, critical incident responses, dealing with complaints, evidence-based practice, culture, infrastructure and coherence.

The occupational therapist is expected to be able to justify her/his interventions against recognised standards in order to demonstrate continuing competence to practise. Clinical standards can be used to provide evidence of effectiveness and ensure quality through clinical governance.

Clinical audit focuses on the standards that are set within an organisation concerning the delivery of care. Audit identifies areas where improvements are required and highlights good practice. It involves collecting information about what is happening and comparing it with standards in order to check that those standards are being met. The five stages in an audit cycle are design, measure, present and analyse, act to improve and repeat audit. The audit cycle is completed when improvements are seen to have been implemented.

7. References

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8. Glossary

The definitions in this glossary are taken from literature published in the UK, with the exception of definitions taken from the International Classification of Functioning, Disability and Health (WHO 2001). Some definitions are taken from a single source, although the wording may have been changed slightly to fit this context. Most are compiled from more than one source. Every attempt has been made to indicate all the sources of each definition, which are given in brackets. However, in some cases, the wording has been changed so much, in order to incorporate a number of ideas and capture the full complexity of a concept, that it is not possible to identify the original sources.

If a source has been used in the study of occupational therapy as a complex intervention, the appendix in which it appears is indicated by letter A, B or C. Otherwise, the reference is given in full at the end of the glossary. Two dictionaries have been used: The New Shorter Oxford Dictionary (1993) and The Cambridge Dictionary of Philosophy (1999). These dictionaries are not included in the reference list.

Action plan (treatment plan): Specification of the approach to be used and the actions to be taken by the therapist and client towards solving identified problems or reaching agreed goals. (Foster 2002; Hagedorn 2001, C)

Action planning (treatment planning): A collaborative endeavour between the therapist, the client, the carer and the treatment team to devise a unique approach that meets the needs of the individual client under a particular set of circumstances. (Creek 2002c, C; Di Bona 2000, B; Finlay 1997, C; Perrin 2001, A; Stewart & Neyerlin-Beale 2000, B)

Activities of daily living: Basic activities required to maintain personal health and well being. (Hagedorn 2001, C)

Activity: A series of linked episodes of task performance by an individual which takes place on a specific occasion during a finite period for a particular reason. Activity is characteristic of and essential to human existence. (Creek 1998b, C; Finlay 1997, C; Green & Cooper 2000, B; Hagedorn 2000, 2001, C; Johnson 1996, C; Turner et al 2002; WHO 2001)

Activity analysis: A process of dissecting an activity into its component parts and task sequence in order to identify its inherent properties and the skills required for its performance, thus allowing the therapist to evaluate its therapeutic potential. (Creek 2002c, C; Drew & Rugg 2001, A; Foster & Pratt 2002, C; Hagedorn 2000, C; Holder 2001, Johnson 1996, C)

Activity grading: Manipulating the component parts of an activity, or the factors required for the performance of a task or activity, to meet therapeutic goals. (Creek 2002c, C; Foster & Pratt 2002, C; Hagedorn 2000, C)

Activity synthesis: Combining activity components and features of the environment to produce a new activity that will enable performance to be assessed or achieve a desired therapeutic outcome. (Creek 2002f, C; Holder 2001, A; Hagedorn 2002, C)

Aim: A brief statement of the general purpose which treatment or intervention will be planned to achieve. (Hagedorn 2001, C)

Appraisal (critical appraisal): A systematic way of considering the truthfulness of a piece of research, the results and how relevant and applicable they are, in order to make a decision about whether any flaws are important enough to raise doubts about the conclusions arising from the research. (Bury & Jerosch-Herold 1998)

Approach: The methods by which theories are put into practice and treatment is administered. (Creek 2002f, C; Hagedorn 2001, C; Turner et al 2002)

Assessment: The process of collecting accurate and relevant information about the client in order to set baselines and to monitor and measure the outcomes of therapy or intervention. (Creek 2002e, C; Finlay 1997, C; Hagedorn 2000, 2001, C)

Audit: The systematic and critical analysis of the quality of clinical care including diagnostic and treatment procedures, associated use of resources, outcomes and quality of life for clients. (COT 1998; DOH 1993)

Autonomy: Personal freedom; freedom of the will; the capacity to make choices; the ability to govern one's own actions. (Creek 1998b, C; Turner et al 2002)

Belief: Disposition to accept, under certain conditions, a statement, fact, doctrine or thing as true or existing. (The Cambridge Dictionary of Philosophy 1999; The New Shorter Oxford Dictionary 1993)

Choice: The power, right or faculty of deciding between possibilities; a scope or field of possibilities. (The New Shorter Oxford Dictionary 1993)

Client: A person using the services of an occupational therapist. The client may be an individual, a group of people (such as client and carers) or an organisation. (The New Shorter Oxford Dictionary 1993)

Client-centred practice: A partnership between the therapist and client in which the client's occupational goals are given priority during assessment and treatment. The therapist listens to and respects the client's standards and adapts the intervention to meet the client's needs. The client actively participates in negotiating goals for intervention and making decisions. (Chia et al 2000, B; Lane 2000, B; Sumsion 1999, 2000, B)

Clinical governance: A framework that encompasses a range of quality initiatives through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. Clinical governance aims to improve practice and professional accountability, promote continuing professional development, safeguard the quality of service provision and minimise the risk of adverse events. (Clarke 2000, B; Cook & Spreadbury 2002, C; McAdam, et al 2001, A)

Clinical reasoning: The mental strategies and high level cognitive patterns and processes that underlie the process of naming, framing and solving problems and that enable the therapist to reach decisions about the best course of action. Clinical reasoning translates the knowledge, skills and values of the therapist into action and ensures that occupational therapists practise occupational therapy and not some other form of intervention. (Finlay 1997, C; Hagedorn 2001, C; Harries & Harries 2001, A; Ryan 1998, C)

Clinical standards: Broad statements relating to the organisation and delivery of occupational therapy services (rather than clinical interventions, which are the subject of clinical guidelines). Standards provide a defined level of excellence and form a basis for evaluating or auditing services. (COT 2000a)

Cognitive skills: The ability to bring past experience to bear on current situations, to reason, to plan and to solve problems. Cognitive skills include knowledge acquisition, transformation, organisation, storage and retrieval, sensation and perception. (Gardner 2002)

Community: A body of people living in the same locality. Engagement in community life means taking part in the social and civic life of the community, such as engaging in charitable organisations, social clubs, professional associations and social ceremonies. (The New Shorter Oxford English Dictionary 1993; WHO 2001)

Concept: A mental representation of an object or idea; a principle of classification that can be a guide in determining whether an entity belongs in one class rather than another. (Creek 1998b, C; The Cambridge Dictionary of Philosophy 1999)

Context: A set of circumstances or surrounding conditions. (The New Shorter Oxford English Dictionary 1993)

Continuing professional development: Movement along the continuum of competence required by practitioners, educators, managers and researchers to provide services based upon evidence of effectiveness and best value. This can be achieved through informal and formal learning. (COT 2002b)

Core skills: Skills common to all occupational therapists; the expert knowledge at the heart of the profession. The core skills of the occupational therapist are complex, made up of many component sub-skills. (Creek 2002d; COT 1994)

Creative activity: Activity which involves imagination and has a novel, worthwhile product. Creative activities require the individual to incorporate something of her/himself into the production of an end-product, which may be concrete or may be an original idea or train of thought. (Creek 2002a, C)

Creativity: A process, taking place over time, which is characterised by originality and has some value to the individual and/or society; the emergence of a new and tangible product from the uniqueness of the individual and the materials, events, people and circumstances of her/his life; the capacity to meet and engage fully with the environment, making of it something that is uniquely personal. (Creek 2002a, C; Perrin 2001, A)