Occupational Therapist Managers’ perceptions of the impact of Continued Professional Development activities on their staff’s Clinical Competence

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Declaration

This dissertation has been submitted in partial fulfillment of the requirements for the degree of Master of Science in Health Services Management at the University of Dublin, Trinity College. It has not been submitted as an exercise for any other degree at this or any other University.

This dissertation is entirely my own work.

I agree that the library of the University of Dublin, Trinity College, may lend or copy this dissertation on request.

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Summary

Introduction
This study is set against the background of the establishment of the Health & Social Care Professionals Council, whose function it is to protect the public by promoting high standards of professional conduct, education and competence. Unlike medical professions in Ireland, there is no standardised competency based framework from which to evaluate practitioners’ fitness to practice. It is envisaged that the Council will place an onus on occupational therapists to demonstrate their engagement in CPD activities and competence to practice as part of the incoming state registration for occupational therapists.

Research indicates that occupational therapist managers support staff engagement in CPD activities, but it is unknown whether occupational therapist managers perceive this engagement in CPD activities to impact on their staffs’ clinical competence.

Thus in the context of the Irish healthcare system, the objectives of this study are:

- To understand if occupational therapist managers believe that engagement in CPD activities materialises in new clinical skills, which enhance clinical competence, and if not why not.
- To explore the availability and frequency with which staff engage in CPD activities.
- To explore and compare the availability of organisational supports within the HSE, voluntary organisations and private services.
- To explore methods of monitoring and assessing competence.

Methodology
This study adopted a mixed method research approach using a sequential design. It incorporated an exploratory qualitative focus group from which a quantitative survey instrument was developed and circulated to occupational therapist managers nationally. The sample population (n=98) consisted of members of the National Occupational Therapist Managers Group. Fifty six responses were received from therapists working in the HSE and voluntary organisations, yielding a 57% response rate.
Findings & Conclusions

Qualitative findings suggest that there is a good understanding of the relationship between CPD and competence.

Respondents rated formal CPD activities (e.g. attending lecturers, post-graduate education) as superior to informal CPD activities (e.g. on-the-spot demonstration, shadowing), but they reported that staff engaged in informal CPD activities more frequently than formal activities, and they perceived these informal activities to be more effective than formal activities. Activities which were perceived to be very effective in enhancing staff members’ clinical competence included: education of students, information sharing, on-the-spot demonstrations and professional conversations with colleagues. Journal clubs and attending lecturers were perceived to be the least effective CPD activities. Engagement in CPD activities which may be beyond the learning capacity or scope of practice for the staff member were not supported, nor were those which qualified staff to pursue other career paths.

88% of respondents agreed that the organisation has a role to play in supporting OTs to engage in CPD activities. There was a discrepancy between the supports available to services within the HSE and voluntary organisations. HSE services had greater access to a training budget on request and access to external supervision, while voluntary organisations had greater access to a dedicated annual training budget and an in-service co-ordinator. No responses were received from private organisations.

The findings indicate that the majority of respondents value and facilitate regular supervision as a CPD activity and as a means of assessing competency. The majority of respondents would welcome a national competency assessment tool, to assist in evaluating staff’s clinical practice. This revelation supports the need to explore standardised assessment tools and in view of imminent state registration.

While, presenting real challenges, it should be possible to develop a framework that through its focus on learning achievements enables individuals to pursue their lifelong learning, whilst meeting external expectations to demonstrate their competence.
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Glossary

AOTI    Association of Occupational Therapists of Ireland
CEO    Chief Executive Officer
COT    (British) College of Occupational Therapists
CPD    Continual Professional Development
CPR    Cardio Pulmonary Resuscitation
DATHs  Dublin Academic Teaching Hospitals
DoHC   Department of Health and Children
FEC    Faculty Ethics Committee of Trinity College Dublin
HSE    Health Service Executive
I.D.   Intellectual Disability
LHO    Local Health Officer
NOTMG  National Occupational Therapists in Management Group
OHM    Office for Health Management
OT     Occupational Therapy / Therapist
OTM    Occupational Therapy Manager
Paeds  Paediatrics
PCCC   Primary Continuing and Community Care
PDP    Personal Development Portfolio
SPIG   Special Interest Group / Advisory Group
SPSS   Statistical Package for Social Sciences
UK     United Kingdom
USA    United States of America
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1 Introduction

1.1 Background

Rapid societal change has dictated new constraints in the practices of health care practitioners, some legislated and others imposed by institutional and economic considerations (Brockett et al, 1998). These factors include; greater customer awareness and knowledge, high-profile scares about the quality and variability of health care, the growing body of research knowledge and new emphasis on the importance of evidence-based practice. This has placed the onus on professionals to keep up-to-date and to demonstrate that their practice is informed by research-based thinking on what is clinically effective (Gosling, 1999). Health care professions and professionals are under increasing pressure to demonstrate that they have developed structures and processes for Continued Professional Development (CPD) and are attentive in establishing, maintaining and demonstrating competence. CPD arguably provides the vehicle for professionals to maintain their competence; thus competence forms a primary rationale for CPD (Gosling, 1999).

The growing interest in competence assurance within the occupational therapy (O.T) profession stems from a number of developments, including:

- An increase in the number of overseas occupational therapists practising in Ireland. The Department of Health and Children, in an effort to standardise the competence of overseas practitioners requires all occupational therapists to have their qualifications validated in line with the World Federation of Occupational Therapists.

- Incoming State Registration. In March 2007, the Health and Social Care Professionals Council was entrusted to establish a national state register for twelve health care professions including occupational therapy. This register will maintain a list of those therapists whose qualifications are validated and
who demonstrate their continued competence. It is as yet, undecided how therapists will demonstrate this competence.

- The introduction of accreditation within work settings has seen employers sharing the responsibility for continuing professional competence in their employees by promoting professional excellence and upholding standards of care within the organisation.

- Professional organisations have historically taken the role of policing themselves on the premise that they are best qualified to set standards for competence within their own discipline (Cork, 1992). Professional organisations such as the Association of Occupational Therapists of Ireland (AOTI) are internally motivated to be proactive and develop programmes that demonstrate that occupational therapists continue to meet the professional standards established by their peers; while being mindful of the disadvantages of self regulation.

- In Ireland, there is currently no statutory requirement for occupational therapists to engage in CPD after graduation. Registration or licensure of occupational therapists is not required, unlike in the United States, United Kingdom and Australia. Although CPD is voluntary now, it may become mandatory within the next few years. In a recent publication, Proposals for the Way Forward 2000, the Department of Health and Children outlined their proposal on the necessity of CPD to maintain State registration of therapists, and also on the requirement of the professional bodies, including the AOTI to assist therapists in maintaining their CPD.

The proposal states that:

“Competency-based CPD must be a compulsory element of statutory registration ...it is difficult to envisage how a registration scheme which seeks to maintain high standards of practice could operate effectively without it.”

(Department of Health & Children, 2000:2)
The implications of this proposal are significant, as CPD will affect the Department of Health and Children, the occupational therapy profession and the entire education and training system.

In the absence of this pending registration, occupational therapists are governed by the profession’s Code of Ethics, which states that:

"An OT will keep up-to-date in his/her OT practice and participate in professional development through life long learning to maintain a high standard of professional competence”.

(AOTI, Professional Competence and Standards, 2002, Section 5:1)

The linkage between CPD and competence is therefore explicit within this key statement relating to conduct and practice.

The need to assess competence, is made all the more urgent by the implementation of the “Learning and Development Needs Analysis Toolkit” developed by The Office for Health Management (2002), as part of the Action Plan for People Management. The toolkit aims to ensure that through practitioners’ personal development portfolios, competencies and skills can be evaluated in accordance with the organisations’ strategic goals. The Action Plan for People Management is measurable and includes identifiable key performance indicators, but as the toolkit is in pilot stage with nursing staff, it is envisaged that it will be some time before competencies specific to occupational therapy are defined.

More recently, the Minister for Health and Children, Mary Harney announced the establishment of the Health and Social Care Professionals Council in March 2007, whose function it is to protect the public by promoting high standards of professional conduct, education and competence. Delivery of this objective outlined in Health Strategy “Quality and Fairness” (Department of Health & Children, 2001) will be dependent on the availability and development of a range of core competencies. The Department of Health & Children (2002) advocates that competency frameworks are an effective mechanism through which training, development and education needs can be identified and developed.
1.2 Introduction

The focus of this research study is to document occupational therapist managers’ perceptions of continuing educational activities and the impact they may have on their occupational therapy staff’s competency to practice. With the increasing expectation for accountability, value for money and better service delivery by the health service, the value of CPD must be evaluated in terms of its efficacy to promote continued competence in occupational therapy staff.

Occupational therapy staff frequently request financial support and training time to participate in continued professional development activities, but what evidence exists to reassure occupational therapist managers that they are investing in their staff members' skilled clinical competence? O’Brien et al (2001) suggested that staff may have other personal objectives to attend lectures, including entertainment, social and motivational factors.

The concepts of CPD and competency are closely related, however the concepts are not the same either in terms of substance or how they are perceived (Gosling, 1999). While CPD essentially constitutes a process, competence is a state that should form an outcome of CPD (Furnham, 1998). Competence evolves over time through repeated experiences. It occurs as new knowledge and skills are layered over past experiences, integrated with them and applied in practice (Youngstrom, 1998). Certain changes may occur during an occupational therapist’s career that require him/her to be more alert to the need for evaluating and redirecting his/her level of competence, such as changes in job roles, responsibilities and settings (Youngstrom, 1998).

A basic requirement of CPD is that it helps occupational therapists and teams to enhance their professional roles and either directly or indirectly, to enhance their contribution to patient care and service delivery. Gosling (1999) advocates that engagement in CPD activities is not a guarantee of competence: occupational therapists may demonstrate a strong commitment to their professional development
in terms of the volume of activity they undertake, but fail to address fundamental shortfalls in their competence in doing so.

Findings from Penny (2004) suggest that occupational therapist managers support occupational therapy staff in continuing educational activities, but it is unknown whether occupational therapist managers’ perceive this new learning to be transferred into new clinical practice skills.

1.3 **Aims & Objectives**

1.3.1 **Research Question**
This research study aims to explore occupational therapist managers’ perceptions of the impact of continued professional development activities on their staff’s clinical competence in Ireland.

1.3.2 **Research Objectives**
This study aims to understand whether occupational therapy managers believe that engagement in CPD activities materialises in new clinical skills which enhance competence, and if not, why not?

I am interested in the preference for and availability of formal and informal CPD opportunities for occupational therapists, and to establish how frequently staff engage in these activities. I wish to understand occupational therapy managers’ perceptions of how effective these activities are seen to influence clinical practice.

I wish to explore the supports available within organisations to promote and enable occupational therapists to undertake CPD activities, and to establish if there is a distinction between supports available to occupational therapy staff working in the HSE and staff employed by voluntary or private organisations. I wish to clarify if occupational therapy managers perceive the level of support provided by an organisation to influence occupational therapy staff’s engagement in CPD opportunities.
I wish to explore who chooses the CPD activities which staff engage in; the occupational therapist manager or the occupational therapist staff member.

I am interested in ascertaining if occupational therapy managers perceive supervision to be an effective means of assessing staff members’ clinical competence. As State registration will shortly be introduced to the occupational therapy profession, I would like to determine if occupational therapist managers would welcome a standardised national competence assessment tool, to assist in assessing clinical competence.
2 Literature Review

2.1 Introduction

A variety of research articles were sourced through numerous academic databases including: CINAHL, Cochrane, MEDLINE, Pub Med, ERIC and OTSeeker. Various national policy reports were also reviewed to gain an understanding of current developments in relation to CPD. In an attempt to obtain a comprehensive body of the existing literature, various combinations of the following key words were used; “continuing educational”, “competency”, “competence”, “Occupational Therapy”, “Continued Professional Development”, “clinical practice”, “continuing professional education”, “assessment” and “continuing learning”. (See appendix 1 for the number of search hits obtained for these terms.)

Several themes emerged in the articles including; discrepancy in the definitions of CPD and competence, contributing factors to maintaining levels of competence and the implications of CPD within practice. Other articles hypothesised the most effective means of monitoring and assessing competence, while additional articles recognised the need to evaluate the cost effectiveness of CPD activities to practice.
2.2 Defining Continued Professional Development (CPD)

Continued Professional Development (CPD) is commonly used to denote the process of the ongoing education and development of health care professionals, from initial qualifying education for the duration of professional life, in order to maintain competence to practice and increase professional proficiency and expertise (Alsop, 2001a).

The Department of Health and Children’s (2002), “Proposal for the Way Forward” distinguished between two main categories of CPD: one form of CPD aims to maintain and update professional competence and is therefore usually specific to an individual profession; and the other focuses on areas of personal development such as management skills, financial skills, personal effectiveness, leadership and facilitation skills.

Terminology other than CPD is being used by professions in healthcare such as continuing professional education, continuing education and continuing learning. Unless referring to others’ work, the term CPD will be used throughout this paper, as it reflects the wider context of CPD in the twentieth century.

2.3 Defining Competence

Alsop (2001b) advocates that qualification does not denote competence for life. Nor can it be assumed that competence naturally becomes enhanced through years of practice. The number of years of being qualified may only reflect a level of seniority within the profession and not a higher level of competence. As Brookfield (1986) remarked, length of experience does not automatically confer insight and wisdom. It is therefore, important to clarify these statements and to define competence.

Dictionary definitions of competence include such words and phrases as: “suitability, sufficiently good, sufficient for purpose, legally qualified, fitness, capacity or the ability to be capable” (Oxford English Dictionary, 2000). Most of the articles reviewed
acknowledged the varying definitions of competence, some emphasising the importance of knowledge, roles and skills; whilst others highlighted the importance of the ability to learn and to deal with change in a dynamic work environment.

Competence is a multifaceted and dynamic concept, which makes its definitive description and evaluation difficult (Youngstrom, 1998). This is evident even among therapists themselves; Fawcett & Strickland (1998) conducted focus groups with occupational therapists which examined the therapists’ perceptions of accountability and competence. Results indicated that participants had diverse views about what constitutes and contributes to competence; they reacted with surprise and curiosity to the lack of homogeneity within the groups. One participant in the focus group commented that “I know a competent practitioner when I observe one, but I cannot describe this for you” (p741).

Willis & Dublin (1990) argued that professional competence covers two broad domains of proficiencies and general characteristics. Firstly, discipline-specific proficiencies which include: knowledge base, technical skills and problem solving skills; and secondly, general personal characteristics include intellectual ability, personal traits, motivations and attitudes and values.

Davis et al (1979:1088) emphasised the importance of the work setting, and described the operational definition of competency for physical therapists as “a significant behavior or activity, performed in a specific setting, to a specific standard”. Occupational therapists, similar to physiotherapists may choose to work in varying fields of care, including paediatrics, intellectual disability, general medicine and mental health. Each of these specialist fields has very different competency requirements.

Hollis (1997) also recognised the need for therapists to be “situational competent”, i.e. have the ability to perform the roles in the specified workplace. She promotes the use of Day’s (1995:55) definition of competence which is given as the “procession of the necessary skills, knowledge, attitudes, understanding and experience required to perform in
professional and occupational roles to a satisfactory standard within the workplace.” This would suggest that as the nature of the workplace changes so will practice, and thus what constitutes competence to practice in that environment.

The development and the complexity of organisations continually demand a wider range of skills from practitioners. Alsop (2001c) advocated that an integral feature of competence is a professional’s capacity to learn, this is supported by Baskett (1993:15) who emphasised that competence was “keeping up with change, and the ability to learn from new experiences”. Similarly, Crist et al (1998:729) considered professional competence to be the “outcome of thoughtful, self-directed professional development activities that are shaped through careful evaluation of one’s current knowledge, skills abilities and individual learning needs in relation to future career and employment responsibilities”.

The literature differentiates between various terminology of the word “competence”. Fish & Twinn (1997:48) highlighted the difference between the terms “competent” and “competency”. They defined competence as “the capacity to make professional judgments according to the situation, and competency as the operation of predetermined skills developed through training.”

Alsop (2001c) further separated competent into three distinct forms; metacompetence, competence and competency. She warns that these terms are used inconsistently, but their differences are also acknowledged by other researchers. Cheetam & Chivers (1999) use metacompetence to denote overarching aspects of competence, including communication skills and creativity. Although consensus about the term is lacking, many agree that competence is more than knowledge, Alsop (2001b) states that competence also includes the understanding of knowledge, clinical skills, interpersonal skills, problem solving, clinical judgment and technical skills.

In conclusion, there is no universal agreement between authors regarding what constitutes competence, some regard it as a behavioural objective, others a process between knowledge and skill components (While, 1994). It was therefore important that
the researcher identified and included a definition of competence within the survey questionnaire, which encompassed the various interpretations of the term “competence”, in order to clarify any ambiguity surrounding interpretation of the survey questions.

2.4 Interrelationship between Competency and Practice

Youngstrom et al (1998:717) states that competency and practice are “inextricably linked”. Practice is the context in which competence is demonstrated and defines the kind of competencies that are required of the occupational therapist. The nature of competence changes as the environment changes, and this has a bearing on the activities that help to sustain competence, such as continual professional development. Ashton (1992) estimates that knowledge and skills can become out of date within five years, therefore keeping up to date with change, and foreseeing the consequences of change, enables occupational therapists to plan their CPD activities to complement new working environments.

The National Health Service Executive (2003:6) in the UK, as a major employer defines competence as “having the skills and abilities required for the lawful, safe and effective practice of the profession without supervision”, implying that there is an expectation of a minimum standard of practice. Eraut (1998: 127) also suggests that competence is the “ability to perform tasks and roles to the expected standard”, but failed to identify who set the standard; is it the professional organisation, the employer or the policy maker?

Dimond (1997: 42) attempts to clarify the legality of the term “competence”, stating that competent staff must practice “to the current accepted, approved practice of reasonable practitioners in that field”. Hinojosa (1985:540) stresses that competency based practice seems to make practice “more concrete, less variable and ultimately less vulnerable”, which is very significant in today’s litigious society.
2.5  Impact of CPD on Practice

Occupational therapist managers sanctioning staffs requests for support to undertake CPD training, expect that the investment in their staff will result in improved clinical practice and patient care. The literature supports this theory.

Davis et al (1995), in a study of over 100 randomised controlled trials agreed that engagement in CPD allows for better service provision, better healthcare outcomes and increased practitioner job satisfaction.

Andersen (2001) explored the impact of CPD on practice by undertaking a quantitative study of 1,356 Florida registered occupational therapists and explored their subjective perceptions of the impact of both formal and informal CPD activities on their clinical practice. Results from the study indicated a preference toward formal educational programmes of one or more days in length, over most informal educational activities, but formal educational programmes of less than eight hours were not deemed to be as effective as most informal educational activities such as; being mentored, observing skilled practitioners or on-the-job training.

O’Brien et al (2001) concurs with this finding, through their review of numerous articles on the effects of continuing education meetings and workshops on professional practice. They found that lectures alone are unlikely to change professional practice, but interactive workshops are more likely to result in improvements in health care. It is unknown whether Irish occupational therapists managers share this view about their staff; it is proposed that this study will provide an insight into this matter.

2.6  Motivation for Competency Maintenance

The Canadian Association of Occupational Therapists (1996) in its position statement on continuing education recognises that individual participation in life-long continuing professional education is a professional responsibility.
Alsop (2001a) suggests that not every practitioner takes responsibility for his/her professional education and that the mandatory requirement of CPD for UK registration is required as an incentive for practitioners to undertake further training.

A review of the literature for CPD activities in occupational therapy yielded many American studies, focusing for the large part on continuing or maintaining competency levels in keeping with US State Registration (Moyers, 1998). Lysaght et al (2001) noted that personal motivation appears to be an important precipitating factor for competency maintenance, with the environment either supporting the occupational therapist in competency maintenance activities or encouraging the therapist who lacks high levels of internal drive. Respondents cited that their primary motivator to pursue opportunities to enhance competency arose from a sense of awareness that they lacked the skills or knowledge in a particular area, one respondent reported that she had a sense of responsibility to herself not to “burn out”. Secondary to themselves, therapists reported that they felt that they had a responsibility to others, including their clients and colleagues.

Scissons (1982) in Lysaght et al (2001) observed that if therapists are going to pursue continuing education, they must first be motivated towards skill enhancement, recognise a need, and undertake available training as relevant to their needs. Karp (1992:173) supports this view, suggesting that “motivation is the causal factor, the mediator and the consequence of learning”, and “although learning is the ultimate goal of CPD, before this learning can take place the learner must be motivated”.

It appears that despite the mandatory requirement of CPD for US State registration, the onus is placed on individual therapists to take responsibility for their CPD.
2.7 Formal CPD Activities versus Informal CPD Activities

Much of the literature on competence has relevance for CPD. CPD encompasses a wide range of processes, including formal training and education, such as attendances at courses, studying for higher qualifications, part time “off-site” training, and informal training such as experiential learning, mentoring and conversation with colleagues.

The literature debates the limitations of formal educational programmes, which are usually the backbone of most mandatory programmes (Andersen, 2001). Garganta (1989) advocates that formal continuing educational programmes give a false sense of security, as competence is not ensured by attendance. Carpenito (1991) and Marks (1996) suggest that mandatory continuing education programmes rarely determine individual learning needs, nor do they help learners apply new skills to the work situation, despite the fact that application of skills to improve quality of care is the ultimate purpose of continuing competency.

Andersen (2001) stresses that learning and continued competency do not depend on the amount of time spent in formal continuing education programmes, as preference for and the impact of an educational activity varies among professionals, and may change with the context. This view is supported by Kozlowski (1995) in Andersen (2001) who advocated for increased recognition and integration of informal learning activities in the work setting. Philips (1987) in Andersen (2001) wrote that a health care professional’s work setting and his or her role as a member of a health care team provide an excellent environment for learning and application to the work setting. Capenito (1991); Swift (1983) and Phillips (1987) identified these informal activities as; professional conversations and visits with colleagues, on the job training, observation of skilled clinicians, effective supervision and mentoring.

Kozlowski’s (1995) quantitative study of occupational therapists found that informal CPD activities were perceived to be more effective than formal programmes of less than three hours in duration. Additional researchers attribute this effectiveness to the concept
of the “teachable moment”, in which learning takes place when the professional has a need and is ready to learn (Carpenito, 1991). The “teachable moment” was also recognised by focus group members in Fawcett & Strickland’s (1998) study, who reported that they valued informal learning most when it was in the context of the discipline, as experienced in peer groups.

Surprisingly, these respondents rated formal CPD activities higher than informal CPD activities for sustaining competence. These viewpoints cause some discrepancy in the value of continued professional educational activities and continuing competence, as occupational therapists may rate formal education higher than informal activities, but they report that they can readily demonstrate the value of new learning acquired through informal learning easier than formal learning. Therefore, should informal learning methods which may prove to enhance continued clinical competence be favored over formal training? This study aims to explore occupational therapists managers’ perceptions of the effectiveness of informal and formal CPD activities on their staff’s clinical competence, and to establish if there is any significant relationship between these types of activities.

### 2.8 Factors in the Workplace Influencing Competence

The development of CPD and competence in an organisation needs to be founded on support within the workplace. This support, (e.g. funding towards training, team building days, time to research, promotion of personal development plans) enables practitioners to identify and address their learning needs to promote professional excellence and helps them to identify and address shortfalls that threaten their professional competence (Andersen, 2000). Yungstrom (1998) notes that there are many workplace factors which influence practice and competencies needed, these include: physical location of service delivery (e.g. home, school, clinic), the social environment (e.g. absence or presence of family members, colleagues), and the service system’s culture (e.g. the expectation of intervention).
Hodkinson, (1995) suggests that individuals’ potential difficulties in demonstrating their commitment to CPD or their competence might be as much about shortcomings or inadequacies in performance on the organisation’s part. Taylor (1997) in Alsop (2001a) advocated that the failure of employer organisations to recognise the importance of CPD and to provide the resources necessary to support it is both unprofessional and unethical.

Lysaght et al’s (2001) study also recognised the importance of workplace support, with respondents emphasising the educational value of having workplace peers with whom to consult. They observed that organisations’ highest rate of support was towards in-service training and self reflection, while the lowest support was towards conducting research and preparing for specialty exams. Results from the study reflected this positive correlation between financial support for continuing education and participation in competency maintenance levels among staff, with respondents also identifying lack of funding as the most limiting factor to practice, followed by time available. The interface is therefore strong between personal, professional and organisational responsibilities.

Although several studies have expressed concern about the effect of the work setting on a practitioner’s perceived competence; further research is needed to determine the work setting characteristics that may influence perceived competence (Cottrell, 1990). This study will attempt to identify the workplace supports within various organisations (e.g. public, private, voluntary) and ascertain if occupational therapist managers’ perceived there to be relationship between these supports and their staff’s engagement in CPD activities.

2.9 Cost Effectiveness of CPD

The establishment of devolved budgeting has placed increased responsibility on occupational therapist managers to be accountable for their limited training budgets (Armstrong, 2007). Occupational therapist managers must therefore make informed decisions surrounding the allocation of this funding, while keeping in mind the overall strategic development plan for the organisation and the desirable competencies required.
of the occupational therapy staff to meet its goals. Occupational therapist managers submit annual proposals to management seeking funding for their department; in an effort to seek additional funds, they may suggest that investing in specialist staff training will demonstrate a return on investment, such as increased efficiency in assessments, treatments, and discharges, with a subsequent decrease in length of admission and overall reduction in spending for the organisation.

While individual organisations may audit the cost benefit analysis of clinical activities, none of the studies reviewed explored the opportunity cost and potential revenue that could be generated from specialty training. Kerr (1998:451) in Andersen (2001) noted that few US states have evaluated continuing education programmes to determine their effectiveness, partly because of “inherent difficulties and associated costs”, but Marks (1996), stresses that the value of these programmes should not be dismissed due to a lack of cost analysis.

It is acknowledged by Moyers (1998) that occupational therapy as a profession must become more accountable in demonstrating value for money; and needs to explore the return on investment of training undertaken by staff. Unfortunately, it is not feasible to pursue this topic within the limitations of this study.

2.10 Monitoring CPD

Occupational therapy literature reflects a twenty year debate over the need to monitor continuing education (Caldwell et al, 1992). Advocates of mandatory continuing education believe that professionals do not always accept professional responsibility to maintain their competence (Carpenito, 1991), Eraut (1994) argued that individuals change the scope of their competence throughout their professional career, moving into specialist work, into new and developing areas of practice, or taking on managerial or educational responsibilities, so the parameters of competence change. The transitional nature of occupational therapists’ careers was also acknowledged by Dunn & Cada (1998) who debated how aspects of competency should be monitored, questioning if the
therapist should be judged on old experiences from previous jobs or on his/her ability of matching new skills to a new setting? It is uncertain whether assessment of competence be evaluated across all general settings and roles or should the evaluation be specific to a therapist’s current practice?

Due to advances in knowledge and technology, health care providers have become more focused in their daily practice. The trend is for the practitioners’ scope to become narrower as he/she strives for clinical excellence in the workplace (Long & Emery, 2000). As competence may be defined as “professional encounters” (Kane 1992:711), and each encounter involves a context, a patient and the reason for intervention, Grossman (1998) argues that it is not possible to evaluate the practitioners’ ability to handle every professional encounter, including knowledge, judgement, skills, professional behaviours and ethical standards.

Issitt & Hodkinson (1995) also advise against trying to measure competency attributes separately, suggesting that it could trivialise professional practice; but they imply that competency is demonstrated by an integration of knowledge, attributes and professional judgment in pre-qualification education and therefore these traits should also be used to judge continuing competency in practice.

Grossman (1998) questions the most appropriate method of assessing competence suggesting such methods as; evaluation of patient outcomes, simulation of process of care, oral examinations, chart reviews, case study examination, reported disciplinary actions, self assessment, peer evaluation or 360° reviews. Grossman (1998) acknowledges that there are numerous limitations to each of the suggested assessment methods but also highlights that if there are multiple pathways to meet the requirements for continuing competence, there must also be some justification that differing methods measure the same aspect of competence.

Andersen (2001) noted that although practitioners believe that they maintain competence through both formal and informal activities, no research demonstrates the validity of
these claims. Cooper (1978) notes that self-directed learning is not easily measured, and is therefore frequently overlooked as a valid method to maintain competence. It may appear that objective standardised assessments are required to maintain standards, but research in the literature on such formal assessments was inconclusive.

Sternberg (1990), advocates that since competence is not an objective phenomenon, being concerned with perceived skills, it cannot be measured, unlike performance which is open to measurement. Grussing (1984) and Newble (1992) highlight that there is a difference between what an individual should be able to do at an expected level of achievement and what they can actually do in the real life setting. Newble (1992) contends that competence is not always highly correlated with performance in practice, and that greater attention should be focused on assessment of performances.

2.11 Methods of Monitoring Competence in the USA and UK

In the absence of a recognised reliable standardised assessment of competence, The American Association of Occupational Therapists (1995:20) devised a self-appraisal competency checklist, while The British College of Occupational Therapists introduced the “Management Briefing: Supervision” (COT 2006) policy document which enforces the legal and professional requirements for professional supervision. Gaitskell & Morley, (2008) observed that despite this policy imperative, there has been little research into the effectiveness of supervision within occupational therapy. Sweeney et al (2001) observe that although occupational therapy as a profession has enthusiastically adopted supervision, there is a lack of clarity about its purpose and practice. Hunter & Blair (1999) recommend that fundamental changes need to take place in order to meet the supervision goals of accountability and CPD. These include the provision of training; exposure to theories and models of supervision; and the use of agenda, contracts and feedback. This would assist practitioners to comply with the COTs Code of Ethics and Professional Conduct (2005:16), which requires a formal approach, to supervision for all practitioners. It states that:
“5.4.4 Occupational therapy personnel shall be supported in their practice and development through regular supervision within an agreed structure or model”.

While the Irish Association of Occupational Therapists also advocates the need for supervision, it places the responsibility on the individual practitioner and not on the employer to “seek support and formal supervision and to ensure that these needs are communicated to employing organisations.” (AOTI, 2002, Section 5.1.1:8). It also suggests that a practitioner undertakes self-assessment to review his/her knowledge and expertise in the interests of high quality care (AOTI, 2002, Section 5.1.1).

2.12 Challenges of Monitoring CPD in Ireland

In recognition of the British College of Occupational Therapy’s advances to formalise the supervision process and endorse accountability for clinical competence by the employer, the Association of Occupational Therapists of Ireland is promoting the use of a personal development portfolio (PDP) to demonstrate new learning and competence in practice. The use of a PDP is also supported within the recommendations of the Action Plan for People Management, which reflects the objectives of the Department of Health and Children’s “Quality & Fairness Health Strategy” (2001). It is envisaged that a recognised method of monitoring occupational therapy staff competence will become a requirement for occupational therapy state registration in Ireland as observed in Britain, where regulation of allied health professions now considers matters of competence and continuous learning as well as conduct (Great Britain Parliament, 2002).

Theme 5 of the Action Plan for People Management (2002) entitled “Investing in Training, Development and Education” presents a further challenge to occupational therapy managers to take on more responsibility and initiatives toward the training and educational needs of their staff. Managers will also be required to demonstrate their assessment of staff competencies; as yet it is uncertain what format this assessment may take. Other health professions, such as the Irish Association of Speech and Language Therapists, and the Irish Society of Chartered Physiotherapists, have adopted standardised assessment procedures (Therapy Project Office, 2008). It is currently
unknown if Irish occupational therapist managers would welcome a standardised national competency assessment tool to assist with monitoring their staff’s clinical competence. This study aims to explore occupational therapist managers’ preferences for such a tool.

Given the recent strategies and changes in healthcare service delivery, particularly with regard to occupational therapy staffing levels, as outlined in the Bacon Report (2001); enforced formalised competency assessment will impact on how occupational therapist managers organise, maintain and manage their staff, their departments and their services. Henry (1989), notes that the challenge is to be able to develop competent individuals who have the capacity to act with confidence, insight, skills and flexibility in a constantly changing world. In conclusion, Cottrell (1990) recommends that further research should be conducted to identify the factors that influence the development and maintenance of perceived competence, which can then provide insight to how it can be best monitored.

2.13 Summary

This study seeks to examine occupational therapist managers’ perceptions of continued professional educational activities on occupational therapists’ clinical competence in Ireland. There are numerous limitations in the literature reviewed, most noticeably its application to an Irish context. While, there is a substantial body of research on the value of CPD and the requirement for competence in practice; much of the research infers that CPD is undertaken to fulfill American State Registration requirements, and not for the sole aim of continuing competence. As Ireland does not currently have State registration, it is questionable that the findings of the American studies are applicable within an Irish context.

All of the studies reviewed report the subjective views of the occupational therapists themselves to gain insight into their perceived competency. Although, subjects were assured of their confidentiality, it is questionable that an occupational therapist would
admit to being incompetent or failing to integrate new knowledge acquired through CPD. The objective views of occupational therapist managers into their staff’s perceived clinical competence were not explored in any of the studies. It is envisaged that this study will endeavor to address this gap in the literature.

The literature suggests that practitioners favour formal CPD activities over informal CPD activities; despite reports that formal continuing educational programmes give a false sense of security, as competence is not ensured by attendance. This study aims to explore occupational therapists managers’ perceptions of the effectiveness of informal and formal CPD activities on their staff’s clinical competence, and to establish if there is any significant relationship between these types of activities and the frequency in which they are undertaken.

While the literature acknowledges the importance of organisational support, it fails to identify the variety of supports within various types of organisations (e.g. public, private, voluntary) or to determine if occupational therapist managers’ perceive there to be a relationship between these supports and their staff’s engagement in CPD activities.

The literature identified different theories regarding the most appropriate method to assess competence. None of articles reviewed, utilised a standardised instrument tool to assess competence. It is currently unknown if Irish occupational therapist managers would welcome a standardised national competency assessment tool to assist with monitoring their staffs clinical competence. This study aims to explore occupational therapist managers’ preferences for such a tool in anticipation of state registration.

None of the articles addressed this study’s research objectives, it is proposed that this study will address these gaps and make a methodological contribution to research through the development of a questionnaire instrument.
3 Methodology

3.1 Introduction

This chapter will outline the rational and approach adopted in this study. It will provide an overview of the research design, the population sample and ethical considerations observed.

3.2 Rationale & Approach

From the literature review, a gap was identified in the subjective views of occupational therapy managers’ perceptions of the impact of CPD on their staff’s clinical competence, and a gap within Irish literature about CPD and competence in general. This study seeks to address these deficiencies and to contribute to the literature on these subjects.

It is hoped that providing some documented evidence on the utility and effectiveness of CPD activities on clinical competence, as perceived by occupational therapy managers’ in the Irish context, that other researchers may be prompted to investigate this area further. Such research would be beneficial to healthcare managers and particularly occupational therapist managers, as it would promote the awareness of CPD activities as a means of maintaining best practice within clinical areas, and would prompt managers to reflect on the effectiveness of these activities in relation to staff competence, improved clinical practice, and ultimately improved quality of patient care.

The approach of this study is inductive, allowing generalisable inferences to be drawn out of the observations (Bryman, 2001:9). This type of research is appropriate for this research study as it allows for the emergence of themes regarding occupational therapy managers’ experiences of and views on CPD and competence. These views are not
available from the limited literature on the Irish health system and will be collated from a focus group to form the foundation of the survey instrument.

### 3.3 Research Design

This study adopted a two stage sequential mixed method approach to identify occupational therapy managers’ perceptions of CPD and competence within their staff, as my study requires the need to both explore and explain. Mixed methods design is one that involves collection and analysis of both qualitative and quantitative data in a single study (Creswell, 2003).

A sequential exploratory design is conducted in two distinct stages; the initial exploratory stage adopts a qualitative approach and analysis of the preliminary views of focus group members. The second stage employs a quantitative approach and attempts to identify if the core themes of the focus group, presented within a questionnaire instrument represent the views of a larger population.

Bowling and Ebrahim (2005:216) state that “qualitative research can address questions that are not always amenable to quantitative work, such as identifying the main topics of interest from a representative sample population”. This research method was deemed to be very appropriate for this study as no previous studies collated the views of occupational therapy managers on CPD and competence. These views would assist in developing a survey instrument.

### 3.4 Qualitative Research Design – Phase I

The capacity to reveal participants perceptions and experiences is a recognised strength of qualitative studies, and qualitative approaches are particularly suitable in exploring enquiries where there is a limited body of research. Qualitative research may take the form of individual interviews, group discussions or focus groups. This study adopted a focus group format.
Focus groups are a form of group interview that capitalise on communication between research participants to generate data. Pope & Mays (2006) noted that although group interviews are often employed simply as a quick and convenient way to collect from several people simultaneously, true focus groups are explicitly designed to capitalise on group interaction and to provide distinctive types of data. The researcher chose a focus group method having acknowledged from the literature review that the topic of competence was difficult to define and open to varying perceptions. The study also sought to gain distinctive information on this topic. This method capitalises on the group interaction between the participants to unearth their true beliefs and practices surrounding CPD and competence. It also provides scope for the focus group members to introduce topics of interest to themselves, which may not have been previously considered by the facilitator.

Pope & Mays (2006) suggest that the group process also facilitates the sharing of experiences that may be left underdeveloped in an interview and highlights the focus group members’ perspectives through the debate in the group. This argument was evident in the focus group, when a member returned to a statement made earlier in the discussion, and recalled a personal experience of being assessed as a student which probed further conversation on the topic of “assessment of competence”. Bowling & Ebrahim (2005), advocate that the synergistic effect of the group setting may generate unexpected findings which give valuable insights into a research topic, while Stewart et al, (2007) observe that differences in opinion can also help to identify how and why individuals embrace or reject particular ideas. The researcher felt that individual interviews may not have captured unexpected findings, and that respondents may have been overly positive about their practices and beliefs in an effort to impress the researcher, thereby underreporting their main concerns regarding CPD and their staff’s competence.

Stewart et al (2007) observed limitations to focus groups; suggesting that responses may not be independent of one another and therefore restrict the generalisability of the
findings. The researcher became aware that the focus group participants were familiar to each other, and sought to reduce “group think”, by seeking the individual views of each participant.

Morse (1994) claimed that focus group findings can never be completely free from the perspectives of the researcher. The researcher acknowledged this claim, and avoided engaging with the discussion, in a conscious effort to minimise verbal and non verbal cues about the types of responses and answers that were desirable.

3.5 Quantitative Research Design – Phase II

Quantitative research focuses on measuring quantities and relationships between attributes (Bowling, 2005:190). Quantitative research is most appropriate in situations when there is pre-existing knowledge about the issue of interest, which permits the development and use of standardised methods of data collection, such as a survey (Bowling, 2005). Analysis of the focus group transcripts yielded key concepts which were included in a semi-structured questionnaire, which was specifically developed for this study.

This format was considered to be the most suitable technique to use within this exploratory study. Smith (1981) advocates that a questionnaire is particularly amenable to statistical analysis as it has high amounts of data standardisation, which was required by this researcher to validate the findings from the focus group to the wider population. This research method accommodated the researcher posting the survey to 98 occupational therapist managers. Due to the geographical dispersion of the managers, the survey instrument was also considered to be the most convenient and proficient survey method, as it allowed access to all the occupational therapist managers in Ireland, while maintaining maximum confidentiality.
3.6 Integration of Qualitative & Quantitative Research Methods

In the context of health and health services research, qualitative and quantitative methods are increasingly being used together in a mixed method approach (Barbour, 1999: 39). Bryman (1992:231) advocates that, “it is the different strengths and weaknesses of both approaches which lie behind the rational for their integration”. Qualitative and quantitative approaches can complement each other; this is achieved by using qualitative research as the preliminary to quantitative research. Qualitative research facilitates quantitative research by generating hypotheses for testing or generating items for a questionnaire. Barbour (1999:1993) has suggested that mixed method studies can produce “a whole greater than the sum of the parts”.

Focus groups can be used to generate items and language for a questionnaire; the qualitative component of the study is considered to be a mark of quality, ensuring that the questionnaire is both relevant and comprehensible to the potential recipients (Pope & Mays, 2006:106). Bowling (2005: 236) suggests that it may be beneficial to see qualitative and quantitative methods as “interwoven, in that one element stimulates new ideas for data collection for the other”.

Bryman (1992: 57-78) advocated that quantitative research emphasises the researcher’s concerns, whereas qualitative emphasises the subject’s concerns. This view was confirmed within the focus group, as participants emphasised some of their concerns which were outside of the remit of the researcher’s study, but enabled the researcher to build a richer picture of the relationship between CPD and competence.

Combining research methods can also allow cross checking of results of one method of research against results from another method, thus enhancing the validity of the findings (Bowling, 2005). Webb et al (1996) argue that confidence in the findings derived from a study using quantitative research strategy can be enhanced by using more than one way of measuring a concept.
3.7 Population Sample

This study involved a census of all occupational therapist managers listed on the AOTI database of “National Occupational Therapists in Management Group” (NOTMG). There are one hundred and three members of this group.

3.8 Access Negotiation

As a member of the AOTI Continual Professional Development Committee, the researcher was aware to seek gate keeper permission from the chairperson of the National Occupational Therapists in Management Group, to access this AOTI database. (See appendix 2 for letter of request). Gatekeeper approval was received from the chairperson, to access the contact details of occupational therapy managers listed on the National Occupational Therapists in Management Group. (See appendix 3 for letter of approval from AOTI).

3.9 Inclusion & Exclusion Criteria

Participant inclusion and exclusion criteria were developed, as the researcher observed from the NOTMG database that some members on the list were senior occupational therapist, who may have been covering vacant occupational therapist manager positions.

Those included in the study held the post of acting occupational therapist manager or occupational therapist manager in a health service within the Republic of Ireland. The health service may be hospital or community based, inclusive of physical and psychosocial settings. Those excluded from the study included, any other grade of occupational therapist, including senior occupational therapists that work independently and have some management responsibility, but do not report directly to an occupational therapist manager.
3.10 Ethical Issues

De Vaus (2002) states that most professional codes of ethics stress the importance of ethical responsibilities towards research participants. These responsibilities include; ensuring voluntary participation, obtaining informed consent, to do no harm by guaranteeing confidentiality and anonymity, and respecting privacy.

3.10.1 Voluntary Participation

The principle of voluntary participation requires that people not be coerced into participating in research. It also implies that participants make a choice, and true choice requires accurate information if it is to be truly voluntary. The researcher ensured that potential participants were informed of the study, by circulating a detailed participant information leaflet. This leaflet outlined the researcher’s background, the format of the study, informing respondents of their anonymity and ensuring confidentiality, indicating secure data storage, informing of the proposed use of the data and inviting the participant to contact the researcher, should they have any further queries. The leaflet explained the voluntary nature of participation and informed of the right to withdraw from the study at any stage during the research process. (See appendix 4 for participant information leaflet).

3.10.2 Informed Consent

Closely related to the notion of voluntary participation is the requirement of informed consent. Essentially, this means that prospective research participants must be fully informed about the procedures and risks involved in research and must give their consent to participate. Each participant in phase one of this research study was required to give written informed consent. (See appendix 5 for consent form). The researcher invited questions from the participants prior to the commencement of the focus group. All participants reported that they understood the issues outlined in the participant information leaflet and readily agreed to sign the consent form.
In phase two of the research study, the local health officer (LHO) or chief executive officer (CEO) of each geographical area received a participant information leaflet and a letter informing them of future contact with the occupational therapist manager (See appendix 6 for letter to LHO & CEO). Potential respondents received the same participant information leaflet, a copy of the questionnaire and a letter inviting him/her to complete the questionnaire. According, to the guidelines circulated by the TCD Faculty of Ethics Committee (FEC), completion and return of the questionnaire implied consent to participate in the study. As all questionnaires were anonymous and could not be traced to the respondent, individual informed consent was not required for this phase of the study.

3.10.3 Do No Harm

Ethical standards also require that researchers do not put participants in a situation where they might be at risk of physical or psychological harm as a result of their participation. This research study could not cause any physical harm to the participants, but the most obvious way in which participants can be harmed in survey research is if the confidentiality of responses is not honoured (de Vaus, 2002).

In phase one of the study, data gained from the focus group transcript was recorded in a coded format and participants were reassured that this information was only available to the researcher and her researcher supervisors. Each of the focus group participants were invited to review the transcript and to remove any identifiable information, thus ensuring anonymity. This is of particular importance as Carey (1994) observed that due to the interactive dynamics of a focus group, participants may disclose more personal information than they had intended during the focus group.

3.10.4 Privacy

There are two standards that are applied in order to help protect the privacy of research participants, they include confidentiality and anonymity. Confidentiality was achieved
by reassuring focus group participants that transcript data was only available to the researcher and her researcher supervisors. The inherent quality of the anonymous questionnaire in phase two of the research study ensured that respondents could not disclose any traceable private information. The information sought in the questionnaire was not of a personal nature, and thus eliminated concerns about invasion of privacy.

3.11 Data Security & Confidentiality

To maintain confidentiality of the respondent data, coded numbers were assigned to each of the returned questionnaires. These questionnaires and focus group transcript were stored in a secure filing cabinet accessible only by the researcher. The Faculty Ethics Committee of Trinity College Dublin, stipulates that all research data is securely stored by the researcher for five years, this will be adhered to as it is implicit in the FEC approval.

Ethical approval was sought from the Faculty Ethics Committee in December 2007, as a prerequisite to undertake this research study as part of the Masters in Health Services Management. Ethical approval was granted in March 2008 to commence with the study. Ethical approval from other organisations was not required, due to gatekeeper permission from AOTI. (See appendix 7 for TCD ethical approval letter). As outlined in section 3.10.2, the researcher wrote to the LHOs & CEOs of the hospitals informing them of the study, this alerted these representatives to local ethical conditions. There were no local ethical conditions to be satisfied.
4 Research Process

4.1 Qualitative Research Process - Phase I

Phase one of the research process involved facilitating a focus group with occupational therapy managers to explore their perceptions of CPD activities on their staffs clinical competence.

4.2 Sampling Technique

Purposive sampling was chosen in this study, as it allows for particular persons to be deliberately selected for the important information they can provide, that can not be obtained from other sampling methods (Maxwell, 1997). For the initial focus group phase, eight occupational therapist managers, listed on the NOTGM database were purposively chosen for their experience, diverse organisational backgrounds (i.e. public, private and voluntary) and diverse areas of practice. These potential participants were informed of the study by phone and subsequently, with permission the participant information leaflet was posted to five interested occupational therapist managers (See appendix 4 for participant information leaflet). This practice of a researcher contacting potential study participants directly is in keeping with the existing organisational arrangements of the AOTI, due to AOTI’s limited administrative resources.

Initial feedback from the phone conversations was very positive, with several occupational therapist managers expressing their interest in the study, but regretting that they could not attend the focus group due to: prior engagements, the HSE’s recent directive that attending non clinical meetings was prohibitive, and one community occupational therapist manager cited travel as a deterrent to participating in the focus group.

Four occupational therapist managers contacted the researcher, expressing their interest in the focus group. These four occupational therapist managers were all based in Dublin...
Academic Teaching Hospitals (DATHs). These managers were thought to be very suitable focus group participants as each managed a large occupational therapy department with numerous staff and it was assumed that the areas of interest to the researcher would be evident within these hospitals. While, it was envisaged that the focus group would represent occupational therapist managers working in a variety of services, based in both urban and rural settings; this was not possible due to the absence of occupational therapist managers working in rural settings.

4.3 Facilitation of Focus Group

The initial exploratory phase was conducted using a focus group to gain an insight into the main concerns/interests of occupational therapist managers in relation to CPD activities and their impact, if any of their staff’s clinical competence.

Patton (2002) described a focus group as a form of interview technique with a small group of people on specific topic. An interview schedule based on the literature review and on the objectives of this study was developed by the researcher, to ensure that the specific topics of interest to the research study were addressed in the focus group. (See appendix 8 for a copy of the interview schedule).

Patton (1987:110) wrote that good questions in qualitative studies should be open-ended, neutral, sensitive and clear to the participant. The researcher consulted an expert colleague regarding the content of the interview schedule, to verify the clarity, understanding and sequencing of the questions.

The focus group was held in a neutral venue, not connected to either the research or to any of the focus group participants. The participants signed a consent form prior to the commencement of the study and were reassured of that they would not be identified in the study. (See appendix 5 for the consent form). Permission was sought and received to tape-record the focus group discussion. The focus group was facilitated by the primary researcher, and the group was observed by a scribe, who also was an occupational
therapist and therefore had an understanding of the terminology used within the discussion, but was in no way connected to the study or to the participants. The focus group was one hour in duration, with additional time allotted at the beginning of the group to allow for a settling in and familiarisation period. The researcher became aware that at this point that the participants were known to each other. Good interaction and communication was observed between the focus group members, as they appeared quite relaxed with each other and expressed their views openly, often interjecting the conversation to articulate their views. The researcher ensured the accuracy of the data by checking the accuracy of the emerging themes with the participants. The focus group discussion was transcribed and a copy forwarded to each participant within a week of the group.

Notes made by the independent scribe confirmed the content of the discussion. (See appendix 9 for scribe notes). A framework analysis was applied to the transcript to determine the main themes within the discussion. (See appendix 10 for conceptual analysis).

4.4 Quality & Rigour of Qualitative Data

Quality in qualitative research can be assessed with the same broad concepts of validity and relevance used for quantitative research, but these need to be used differently to take into account the distinctive goals of qualitative research (Mays & Pope, 2000). It is therefore also necessary to examine the concepts of generalisability and reflexivity of findings, acknowledging that qualitative data can not be generalised to a wider population and that the researcher is also considered to be an instrument. These concepts are discussed further below.

4.5 Validity

Validity is seen as a strength of qualitative research (Creswell, 2003). However validity in qualitative data is a highly debated topic. A number of procedures used to enhance the
validity of the qualitative data as outlined by Creswell (2003) are applied to the current research study.

- **Triangulate** different data sources of information. In this mixed methods study, qualitative data obtained from the participants in the focus group was used to inform the development of the questionnaire, which in turn was used to gauge the external validity of the themes uncovered in the qualitative phase of the research. Johnson et al (2007: 115) notes that “qualitative data can play an important role by interpreting, clarifying, describing, and validating quantitative results”. Using this analysis, a coherent and comprehensive examination of occupational therapist managers’ perceptions of the impact of CPD on their staff’s clinical competence is achieved.

- Use of **member checking** to determine the accuracy of the qualitative data. Throughout the focus group, the accuracy of the data was ensured by the researcher by checking the accuracy of the data emerging themes with the participants. These themes were also cross referenced with the scribe’s independent notes, to clarify if there were any discrepancies in the identified themes.

- Presentation of negative or discrepant information that runs counter to the themes, adds credibility as different perspectives exist and therefore are included. This data is presented in the results section.

4.6 **Reliability**

Mays & Pope (1996), state that it is essential that the research process should be made readily transparent. Reliability is achieved by carefully documenting the research process, including who collected and analysed the data and in what ways (Donovan &
The researcher attempted to document the research study in its entirety.

4.7 Generalisability

Generalisability describes the extent to which research findings can be applied to settings other than that in which they were originally tested (Altman & Bland, 1998). In qualitative research the findings are generalisable only to the small sample investigated. The researcher purposively selected focus group participants who were based in different clinical settings, in an effort to gain varied opinions from which to draw themes. It was hoped that these varying opinions would be used as a working hypotheses to develop the questionnaire instrument, and may reflect some of the opinions held by occupational therapist managers in the wider community. This research study does not seek to generalise its findings of the relationship between CPD activities and clinical competence beyond the scope of the views received by the respondents, but its findings may be of interest to other allied health professionals who work under similar competency guidelines, such as physiotherapists and speech and language therapists.

4.8 Reflexivity

The concept of reflexivity is unique and integral to qualitative research, whereby the researcher recognises that she has a social identity and background that has an impact on the research process. While it is the intention in quantitative research for the researcher to be neutral and uninvolved, reflection on the role of the qualitative researcher and the methods and analysis is considered an important component of high-quality qualitative research (Donovan & Sanders, 2005:528).

Smith (1984:383) in Desmond, (2000) observes that “different claims about reality result not from incorrect procedure, but may simply be the case of one investigator’s interpretation of reality versus another’s”. In this study the researcher, as an occupational therapist has been cautious in reflecting on her own actions, assumptions and
experience, and how they may shape the research study and affect the data collection and analysis.

4.9 Quantitative Research Process - Phase II

Phase two of the research process involved developing a survey instrument to evaluate the themes identified in the focus group to a wider population.

4.10 Development of the Survey Instrument

The evaluative phase consisted of the development of a questionnaire, to evaluate to what extent the views expressed by the occupational therapy managers within the focus group were generalisable to the broader occupational therapy manager population. Themes identified from the focus group transcript were considered in respect to the research study’s objectives and to the information extracted from the literature review. This allowed the researcher to identify common categories for inclusion in the survey instrument. These themes included:

- use of formal and informal CPD activities
- frequency of engagement
- organisational support
- perceived effectiveness of CPD activities
- the use of supervision
- monitoring competence
- impending state registration

It was evident from the literature and the focus group, that there are varying opinions regarding some of the themes identified. The researcher used this data to construct
attitudinal statements to reflect varying opinions which would then be incorporated into the questionnaire.

In designing the questionnaire, the required information was analysed into four component parts and a series of “fixed alternative” questions were designed and framed to elicit such information. Smith (1981) advocates that fixed alternative questions are more appropriate than open ended questions if the objective is simply to classify an individual’s attitude or behaviour. Thus each of the four sections of the questionnaire addressed a different aspect of the research study. (See appendix 11 for an outline of the rationale for choosing the questions in each section and appendix 12 for the list of quotes obtained from the focus group transcript to develop each of the attitudinal statements).

4.11 Pilot of the Questionnaire

A pilot study was conducted to identify potential problems in the data collection and to show that the study design is both appropriate and feasible (Drummond, 1996). A pilot study also ensures rigor and validity of the questionnaire instrument.

Polit & Hungler (1995), note that it is important that the subjects used in the pre-test possess the same characteristics as those used in the main sample. Taking this into consideration and while attempting not to deplete the population under study, three subjects were selected to pilot the questionnaire. Two of these subjects had held the post of occupational therapist managers for a number of years, but had made career changes; while the remaining subject was a member of the focus group, allowing her to highlight any significant gaps in the information discussed.

Each pilot respondent was given a cover letter explaining the proposed research project, and inviting them to fill in the questionnaire. A copy of the questionnaire and a feedback form was included with the cover letter. (See appendix 13 for copy of the pilot questionnaire, appendix 14 for the cover letter and appendix 15 for a copy of the feedback form). Robson (1993:243) advocates that “for the results to have any hope of meaningfulness, the questionnaire must be painstakingly constructed, with very clear and
unambiguous instructions and careful worded questions”. The researcher recognised through her literature review that there are numerous interpretations of certain ambiguous terms such as “competence” and “effectiveness”, and therefore included definitions of these terms in the questionnaire.

Feedback from subjects who piloted the questionnaire proved very insightful, resulting in numerous changes made to the questionnaire. (See appendix 16 for justification of the amendments made to the pilot questionnaire).

4.12 Amendments made to the Pilot Questionnaire

According to Parten (1950), the attractiveness of a questionnaire can make all the difference in the respondent’s motivation to fill it out and return it. Keeping this in mind, numerous additions were made to the questionnaire to promote its use, including:

- formatting the questionnaire to include a header with the title of the thesis in red ink to remind respondents of the core objective of the study.

- printing the questionnaire in a landscape format with two pages per sheet on double sided light green paper, to condense the questions and give the overall impression that the single sheet of paper would be not too laborious to complete. The green paper identified the questionnaire from the cover letter and the participant information leaflet enclosed within the envelope. The researcher anticipated that the green sheet of paper may stand out from other paperwork on a respondents’ desk, and was hopeful that the identifiable paper would prompt the respondent to return the questionnaire thus, increasing the response rate.

- including an offer to share the findings of the study in the cover letter, to promote the return rate.
• providing the respondents with a return date, to encourage completion of the questionnaire within a two week time frame.

• enclosing a stamped addressed envelope accompanied each questionnaire for easy of return.

(Please refer to appendix 17 for a copy of the amended questionnaire instrument)

A cover letter was drawn up, to introduce the author to the intended responses, and inviting him/her to complete the questionnaire. The purpose and proposed benefits of the study along with the assurances of confidentiality were also included. (Please refer to appendix 18 for a copy of the cover letter).

4.13 Quality & Rigour of Quantitative Data

Rigour in quantitative research is mainly assessed through the examination of validity and reliability. Reliability and validity are central to evaluating the quality, accuracy and appropriateness of the methods used in carrying a research project (Cano, 2008). Reliability refers to the extent to which a questionnaire would produce the same results if used repeatedly with the same group under the same conditions, while validity refers to whether the questionnaire measures what it is intended to measure.

4.14 Reliability

Reliability of a measurement instrument is defined in terms of consistency or stability over time (De Vaus, 2002). An instrument is said to be reliable if it produces the same results on different occasions (Lemon, 1973). The most evident way to determine stability of a measure is use of the test-retest method, which involves issuing the same questionnaire to the same people after a period of time.

However, the perceptions of occupational therapist managers are the themes under investigation in the current study and these views may legitimately change over time.
Gubrium & Holstein (1997: 188) justify this concept, stating that “one cannot simply expect answers on one occasion to replicate those on another because they emerge from different circumstances of production”, therefore it was considered that this approach was not appropriate for measuring reliability in this questionnaire.

Parahoo (1997) claims that questionnaires have adequate reliability because they are structured and predetermined, and as a rule cannot be varied, either in their wording or in the order in which they are answered. Questionnaire reliability is also reflected in the consistency with which respondents interpret and respond to the questions. It is assumed that the respondents’ understanding of the questionnaire items was enhanced by additional information provided by the researcher, such as the introductory letter, clarification of the terms “competence” and “effectiveness”, and instructions throughout the questionnaire.

4.15 Validity

Validity refers to “the extent to which an instrument measures what it is supposed to measure” (Craig & Metez, 1979:159). Three validity measures are considered for the quantitative instruments: face, construct, and concurrent.

4.15.1 Face Validity

Face validity examines whether the measure reflects the content of the concept in question (de Vaus, 2002). Face validity was established in three ways in this study. Firstly, the pilot questionnaire was developed on the themes identified from an exploratory qualitative research phase with purposive samples of the target population. Secondly, the proposed pilot questionnaire was discussed in detail with the researcher’s supervisor, who commented on the content of the questionnaire and verified that it reflected the concept under investigation. Thirdly, the questionnaires were piloted with a person who participated in the focus group, in addition to two people who had not, which resulted in further amendments to the questionnaire. The respondents to the pilot questionnaire were specifically asked to judge the questionnaires to determine whether
on the face of it, the measure seemed to reflect the concepts concerned. Alterations were made to the questionnaire, based on comments received from the pilot respondents, as outlined in section 4.11.

4.15.2 Construct Validity

Construct validity represents how well a questionnaire measures a particular concept. In this questionnaire the concepts are frequency of engagement in CPD activities, perceived effectiveness of these activities, and attitudinal statements. The researcher devised the questionnaire to reflect scale measurements which appropriately measured these concepts. Question 7 presented in a table format, used a time scale to identify the frequency of engagement in CPD activities, question 9 reflected this table format and adopted a Likert scale to evaluate perceived effectiveness. The attitudinal statements presented in section IV, also used a Likert scale format to capture respondents’ level of agreement to the statements. While constructing attitudinal statements, the researcher compromised between formulating the content of an information retrieving question and searching for a shared researcher-respondent vocabulary, as Cannell & Kahn (1968) note, the principle defect of questionnaire design is improperly worded questions.

4.15.3 Concurrent Validity

Concurrent validity is demonstrated where a survey instrument correlates well with a measure that has previously been validated. A valid criterion instrument is referred to as the ‘gold standard’. In this research study this was not possible as there is no ‘gold standard’. The questionnaire was developed specifically for this research study, and is not a standardised test which has been previously tested; therefore concurrent validity is not applicable to this study.

4.16 Response Rate

The researcher circulated the questionnaire to all eligible occupational therapist managers listed on the NOTMG database. Ninety eight questionnaires with an
introductory letter and participant information leaflet were posted to the occupational therapist managers listed on the NOTMG database. Forty four percent (n=28) of the responses were received within the two-week time. Although this response was greater than the average level of 36% response to postal questionnaires (Edwards et al, 2002), a reminder e-mail was circulated to all potential respondents, which yielded an additional 28 responses, yielding a return of 57%. The e-mail reminder correspondence proved very worthwhile, as the researcher also received e-mail correspondence from two staff members who indicated that their occupational therapist manager was no longer in post. The researcher received further undeliverable e-mail messages from six occupational therapist managers e-mail addresses indicating that they were not in post, and may have moved positions since the NOTMG database was compiled or that were out of the office on extended leave (e.g. maternity leave). This information proved very valuable, as it allowed the researcher to hypothesise that the actual number of questionnaires received by occupational therapist managers may have been 90, and the response rate when adjusted to accommodate those occupational therapist managers who did not receive the questionnaire was 62%.

4.17 Summary

This chapter has presented the research process undertaken during both the exploratory qualitative and evaluative quantitative phases and how the two interlink. It has considered rigour of these research phases, with regard to reliability, validity, generalisability and reflexivity. It outlines the response rate and factors which may be hindered additional responses. The following chapter will present the data analysis employed in this research study.
5 Data Analysis

5.1 Analysis of Qualitative Data

This study involved sequential data collection and analysis to develop the survey questionnaire. Bowling and Ebrahim (2005:525) state that “the aim in qualitative research is to understand the perspectives of those being studied and their social world”. In order to gain an understanding of the focus group participants’ perspectives of CPD and competence, the researcher analysed the focus group tape recording and transcript. This involved the researcher transcribing the focus group discussion into a MS word document within a week of the group. The researcher removed all identifying information from the transcript and sent a copy of the transcript to each participant inviting them to remove any further identifying data that may have been overlooked by the researcher. (See appendix 19 for a full focus group transcript). The transcript was then analysed by the researcher, who adopted a framework approach to identify themes which were used to inform the qualitative phase of the research study.

5.2 Thematic Analysis - Framework Approach

The focus group data was analysed using a framework approach. Donovan & Sanders (2005:529) report that this approach “begins deductively from the aims and objectives already set out in the study and provides a clearly defined procedure which aims to be transparent, with data collection usually completed before analysis commences.” This approach was relevant to this study, as the researcher required the themes from the qualitative phase of the study to inform the second quantitative phase of the study.

Using the framework approach, the coding framework was devised by the researcher based on the aims of the research study and emerging themes. These themes included; defining CPD, frequency and engagement in CPD activities, preference for formal or informal activities, organisational support, the role of supervision, defining and
assessing competence. All the data relevant to each of these categories were identified and examined using a process called constant comparison, in which each item is checked or compared with the rest of the data to establish analytical categories (Pope et al, 2000). Key words were then assigned to the categories, allowing the complete transcript to be numerically indexed and charted. These charts assisted the researcher to map the concepts identified and to describe and interpret the findings.

(See appendix 10 for the conceptual map of themes identified)

The researcher acknowledges that Starks & Brown Trinidad, (2007:1376) claim that qualitative analysis is “inherently subjective because the researcher is the instrument for analysis. The researcher makes all the judgements about coding, categorising, decontextualising and recontextualising the data.” Keeping this in mind the researcher, reflected on her own preconceptions and endeavoured to systematically analysis the data according to the framework approach protocol as outlined by Donovan & Sanders (2005).

5.3 Analysis of Quantitative Data

The data collected from the quantitative analysis was collected through the questionnaire instrument and a code book was created to allow the researcher to create codes for each of the variables on the questionnaire. Each returned questionnaire item was manually coded prior to being entered into version 14.0 of the Statistical Package for Social Sciences (SPSS), for the purpose of analysis. The entered data was scrutinised for errors and omissions. The SPSS software provided statistical analysis and graphical illustration of the findings thus facilitating comparison and interpretation of the results findings. These results are presented in the following chapter.
6 Results

6.1 Qualitative Results

This chapter firstly highlights the themes which emerged from the analysis of the focus group discussion, and then presents the quantitative findings from the questionnaire.

6.2 Relationship between CPD and Competence

Focus group respondents identified a relationship between CPD and competence, recognising that professional competency skills can be developed when undertaking CPD for clinical skill training. One occupational therapist manager stated that, “It could also be not just attending your course but actually delivering a course or having to organise a seminar or something like that, because you’re developing your professional competency perhaps in relation to time management or organisational skills rather than just looking at it from the clinical end”.

A review of the literature recognizes that there is a relationship between CPD and competence (Alsop, 2001a). The researcher wished to identify occupational therapist managers’ view of strength of the relationship between CPD and competence, and included the statement that “CPD and competence are inextricably linked” within the questionnaire to evaluate this relationship.

6.3 Benefits of undertaking CPD

There was universal agreement from focus group participants that engagement in CPD has numerous benefits; to the individual occupational therapist, to the staff within a department and to the organisation, and ultimately to the patient.

Participants reported that they recognised therapists enhanced knowledge, growing confidence, speed in decision making and awareness of their own limitations. They also commented that individual therapists viewed CPD very positively, recognising that staff see CPD as an opportunity to add “additional skills to their repertoire”. Participants
recognised the benefits of an individual’s CPD involvement to the wider staff, reporting that sharing of information among colleagues benefited the service and ultimately improved the quality of service delivery which was "reflected up through the organisation". It was not deemed necessary to include such a question in the questionnaire on the benefits of CPD, as this was not within the remit of this study’s research objectives.

6.4 Frequency of engagement in CPD

In the absence of State Registration or standard guidelines, there has been much debate within the occupational therapy profession regarding the frequency in which staff should engage in CPD activities. It is acknowledged that individual services may have their own policy or precedent with regard to CPD. One focus group respondent reported that “there’s a tradition, I think sets up in a place very quickly and in a department where the expectation is that if you work in my department, ultimately you will get your masters”.

Focus group participants identified the amount of time they released staff from clinical duties to engage in CPD activities. This dedicated time varied from an hour a week to attend the library to read journals, to a half a day a month to attend an in-service programme, to fortnightly hour long meetings to engage in departmental journal clubs, in addition to external training or attendance at courses. Occupational therapist managers advocated that in general each clinician receives on average five days CPD time per annum. One respondent reported that; “there isn’t a cap on how much people can have. It is dependent on service need and their need, but obviously there is only so much money and there are only so many study days, so as a guide about 5 study days a year would be a generally acceptable amount. But that’s at the discretion of the manager”. The researcher aimed to evaluate the frequency with which staff engaged in various formal and informal CPD activities and included question 7 in the questionnaire to capture this data.
6.5 Preference for CPD activities

Focus group participants supported attendance at the annual AOTI Conference, citing learning new practices, developing presentation skills and networking as benefits to attending. One participant stated: “There’s a lot more goes on within the conference so even if you’re presenting you’re learning, so it’s a good atmosphere to learn in”.

Another participant promoted reading of journals among her staff, and felt that staff needed to be reminded to use this valuable resource. “We get a huge amount of OT journals and mental health journals. You have to remind people to read, it’s an amazing thing that they don’t innately pick it up”. A third participant reported that she promoted membership of the AOTI, advocating that CPD is associated with professionalism.

The researcher was interested in identifying what CPD activities focus group participants do not promote. Participants referred to “flavours of the month”, such as the Bobath course, cognitive behavioural therapy and dialectic behaviour therapy. Interestingly, participants were not dismissive of this training, but were anxious to highlight that they do not support CPD activities which; were beyond the learning capacity of the therapist, (e.g. a new graduate seeking to attend a Bobath course) or those where there was a probability of limited exposure to practice the new skills (e.g. undertaking a cognitive perceptual course whilst working in an unrelated area), or those courses which qualify the occupational therapist to move into a different profession; “people you know going into different professions practically by the time they’ve finished the course”... “the hospital is not paying them to be those things, they are paying them to be an OT.”

Participants also highlighted the importance of informal CPD activities, citing that; “it might be informal which doesn’t actually seem like CPD, but in essence it is and so people are doing that all the time and so the client benefits and the service benefits.” The researcher acknowledged that focus group participants valued both formal and informal activities, but she was interested in understanding if occupational therapist managers
subjectively favored informal activities over formal activities, as it is assumed that staff may have the opportunity to engage in “free” informal activities more frequently than formal activities. This question was posed in section IV of the questionnaire, under attitudinal statements.

6.6 Ownership over choosing CPD activities

The participants’ comments about their preferences for CPD activities prompted the researcher to enquire about who chooses the CPD activities which their staff undertake. Participants reported that a collaborative approach between the staff member and the individual therapist was used to identify learning opportunities; “the managers are identifying, with the staff, what is needed”. One participant emphasised the importance of this shared approach, suggesting that occupational therapy staff would not be receptive to prescribed CPD activities; “their (OT staff) own sense of what they want to achieve…it all has to be factored in …staff certainly wouldn’t take it anyway, if I went in with a list and said these are the things that they have to do”.

It was also acknowledged that occupational therapy staff may wish to lead their own CPD activities, which may be inconsistent with the departmental goals or the organisation’s overall strategic plan. Participants felt that it is necessary to provide guidance around choice of CPD activity, as “there’s the organisation’s objectives and then obviously the health service wants OTs to be doing certain things and they (Managers) are directing that”...“Managers are trying to hold back that person, they may be stepping out of their role to do something else”.

The researcher chose to include an attitudinal statement in the questionnaire to capture the wider views of occupational therapist managers on ownership of choosing CPD activities.
6.7 The role of the organisation in supporting engagement in CPD activities

Hodkinson (1995) and Taylor (1997) advocated that the organisation has a role to play in supporting engagement in CPD activities. The focus group participants reported that the occupational therapy department also had a role to play in setting standards and promoting learning; “it is about an ethos of understanding that in order for the department and the service to be in the best interest of patients, the standard expected is very high ....it is our responsibility really, in terms of leading, to convey a positive ethos towards learning”.

Participants also acknowledge that the clinician has to be internally motivated to engage in CPD activities, “there has to be a sense of commitment to want to continue to learn on their own time as well”. The researcher included the statement: “the level of organisational support influences Occupational Therapists’ engagement in CPD activities” within the questionnaire to evaluate the views of the questionnaire respondents. This statement was developed as it recognises the influence of organisational support on CPD engagement, but also suggests that the practitioner may also have to take responsibility for his/her own learning.

6.8 The role of supervision

The topic of supervision was introduced by the focus group participants who discussed the changing role of supervision, its importance in assessing competence and the need to streamline the method of facilitating supervision.

The value of supervision as a means of identifying CPD needs and of reflecting on practice was also highlighted; “we have become much more aware of the value of professional supervision and how that is actually directly linked, not just in identifying what someone’s learning needs are, but in order to work through the process of reflection. What happens within the supervision process is in every way capturing learning and enhancing learning, through opportunities in the supervision process”.
While participants agreed that supervision is a means of assessing competence, two participants recognised that a more formalised and standardised format is required to assess clinical competence. They shared their recent efforts to develop such a tool, “the DATHs Group are in the process of developing a competency framework, in recognition of the fact that it is so difficult”, “I looked at the Office for Health Management and produced a lovely document for OT Managers competency and for managers across the therapy type profession”. In recognition of the changing role of supervision, the researcher included an attitudinal statement in the questionnaire, querying if supervision is seen as an effective means of assessing clinical competency.

6.9 Assessment of competency

In response to focus group participants’ efforts to develop competency assessment tools and in recognition that pending state registration may impose formalised assessments of competency; the researcher was interested to evaluate if a formalised assessment tool would be welcomed by all the occupational therapist managers listed on the NOTMG database and included an attitudinal statement in the questionnaire to capture this data.

As one focus group participant resigned; “things are coming in and I guess when registration eventually comes that’s another that will hit in, so the people will be regulated regarding it, there will be certain standards that people have to meet”. Analysis of the questionnaire findings will indicate the strength of occupational therapist managers’ views to this probable change and will clarify if formalised assessments will be welcomed.

6.10 Qualitative Results Summary

The analysis of the focus group transcripts have illustrated that there is a good understanding of continual professional development and competence. In keeping with the literature findings, the benefits of engaging in CPD activities were universally acknowledged among the focus group participants. Attendance at the AOTI conference,
membership of AOTI and reading of journals was promoted by the focus group participants, while engagement in CPD activities which qualified staff to pursue other career paths were not supported. On further analysis, it was found that focus group participants did not support staff undertaking CPD activities which may be beyond the therapist’s learning capacity or scope of practice. While the literature advocated that the organisation has a role to play in supporting CPD activities, focus group participants felt that the occupational therapy department also has a role to play in setting a standard for practice and promoting a learning ethos. The changing role of supervision was discussed in the focus group, with participants recognising the value of supervision in assessing their staff’s clinical competence, but also acknowledging that this process may need to be formalised. This view is supported by Gaitsell & Morley (2008) who recommended protocols and standards for supervision. Focus group participants welcomed a standardised competency assessment tool in view of pending State Registration, but literature highlights that this task should not be underestimated.

6.11 Quantitative Results

Data from the questionnaire responses were analysed using SPSS to determine the quantitative results. Section I outlines the demographics of the respondents while section II details the frequency of engagement in and perceived effectiveness of the CPD activities. Section III provides an overview of the supports available in the workplace and section IV illustrates the responses from the attitudinal statements.

6.12 Section I Demographics

Analysis of the questionnaires indicates that 71% (n=40) of respondents worked in the HSE, while the remaining 29% (n=16) of respondents worked in voluntary organisations. This response value is not representative of the number of occupational therapists managers working in the HSE or within voluntary organisations, as listed on the NOTGM database. It appears that 76% of occupational therapists working in voluntary organisations returned the questionnaire, and over half (54%) of occupational
therapists managers working in the HSE returned the questionnaire. No responses were received from occupational therapist managers working in private organisations.

Figure 6.13.1 represents the number of questionnaires received from the HSE (71%) and voluntary organisations (29%).

Figure 6.13.1

**Percentage of respondents from the HSE and Voluntary Organisations**
Question 2, asked respondents what type of service they work in. Figure 6.13.2 represents these results. Under a third of respondents (29%) reported working in primary continuing and community care (PCCC), 27% worked in acute medical services, while 20% worked in mental health. 11% or respondents worked in intellectual disabilities (I.D), and three respondents represented paediatric services. Two respondents indicated that they worked in multiple services, including: care of the elderly, intellectual disability, paediatrics, and acute medical services.

Figure 6.13.2

**Percentage of Respondents working in various services**

- Physical acute: 20.8%
- Physical rehab: 1.8%
- Mental health: 19.6%
- Paeds: 5.4%
- I.D: 10.7%
- PCCC: 28.6%
- Older persons: 3.6%
- Several services: 3.6%
Figure 6.13.3, illustrates respondents main place of work, the researcher was interested to understand how, location of work place impacted on availability and access to CPD resources and opportunities. Acute medical hospitals and the community settings were identified as the predominant places of work.

Eight respondents identified that they worked in multiple work locations, including residential settings, training centres, day hospitals and in the clients’ homes.

Figure 6.13.3

**Respondents Main Place of Work**
Questions 4 & 5 enquired about the respondents’ managerial post. Of the 56 respondents, one fifth (n=12) were acting occupational therapist managers. Figure 6.14.1 illustrates this breakdown.

On further analysis of the occupational therapist manager post occupancy, figure 6.14.2 illustrates the percentage of occupational therapist managers and acting managers.
working in each clinical area. As illustrated, acting occupational therapist managers occupied half of the posts in intellectual disability and in older person’s services. They also represented a quarter of all community posts and a fifth of positions in the mental health services.

The physical rehabilitation post and all of the paediatric posts (n=3) were occupied solely by occupational therapist managers.

Figure 6.14.2

Percentage of OT Managers and Acting OT Managers working in various locations
Respondents’ number of years in the Occupational Therapists Managers post

The respondents had a wide range of experience (see figure 6.14.3) with 30% indicating that they were less than three years in the occupational therapist managers post, 20% had 3-5 years, 27% had 6-10 years and 23% responded that they had over ten years experience within an occupational therapist manager role.

Figure 6.14.3
Further analysis of this data, illustrated in figure 6.14.4 indicates the number of years of managerial experience of those managers working in the HSE and in voluntary agencies. Of note, half the occupational therapist managers’ posts in the voluntary sector are currently filled by therapists with less than three years experience in this role. The HSE services appear to have more experienced managers.

Figure 6.14.4

**Respondents length of service in Occupational Therapist Managers Post**

- <3 years: 50.0% (Voluntary), 0.0% (HSE)
- 3-5 years: 30.0% (Voluntary), 20.0% (HSE)
- 6-10 years: 40.0% (Voluntary), 30.0% (HSE)
- >10 years: 10.0% (Voluntary), 20.0% (HSE)
Number of Staff under Occupational Therapists Managers’ Management

The respondents indicated that they managed on average three basic grade staff and seven senior grade staff, although there were wide differences in the number of staff under respondent’s management. Table 6.15.1 and table 6.15.2 illustrate the number of basic grade and senior grade staff working in the HSE and in voluntary organisations. The figures indicate that on average, twice as many senior occupational therapists work in HSE services than in voluntary services.

Table 6.15.1 Number of Basic Grade OT Staff

<table>
<thead>
<tr>
<th>Type of Organisation</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSE</td>
<td>2.7</td>
<td>39</td>
<td>2.64</td>
</tr>
<tr>
<td>Voluntary</td>
<td>2.8</td>
<td>15</td>
<td>2.46</td>
</tr>
<tr>
<td>Total</td>
<td>2.7</td>
<td>54</td>
<td>2.56</td>
</tr>
</tbody>
</table>

Table 6.15.2 Number of Senior OT Staff

<table>
<thead>
<tr>
<th>Type of Organisation</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSE</td>
<td>8.2</td>
<td>39</td>
<td>7.74</td>
</tr>
<tr>
<td>Voluntary</td>
<td>4.0</td>
<td>15</td>
<td>4.38</td>
</tr>
<tr>
<td>Total</td>
<td>7.0</td>
<td>54</td>
<td>6.93</td>
</tr>
</tbody>
</table>

Figure 6.15.3 illustrates the number of basic grade and figure 6.15.4 illustrates the number of senior grade staff working in the HSE and in voluntary organisations. The box plots illustrate the mean number of basic grade and senior grade staff (denoted by the red line) within the HSE and voluntary organisations.

The mean number of basic grade staff in both the HSE and the voluntary sector was three. There were large disparities in the number of senior staff in each organisation, as
illustrated by the box plot whiskers and the outliers denoting two services, with significantly more staff.

Figure 6.15.3

Number of Basic Grade Occupational Therapists within HSE & Voluntary Organisations

![Box plot showing number of basic grade occupational therapists in HSE and voluntary organisations](image)
Figure 6.15.4

**Number of Senior Occupational Therapists within HSE & Voluntary Organisations**

6.13 Section II  Frequency of Engagement in & Perceived Effectiveness of CPD Activities

**Attends Conferences**

86% (n=47) of respondents indicated that their staff attended conferences in the past twelve months, while 14% (n=8) did not attend a conference. Interestingly, 18% of those respondents (n=10) whose staff attended conferences, perceived them be ‘not at all effective’ or ‘not very effective’. Other respondents when rating this effectiveness scale made a distinction between attending a conference and presenting at a conference; presenting at a conference was perceived to be more effective than just attending.
**Education of Students**

The majority of respondents, 95% indicated that they actively participated in the education of students; these respondents were representative of all types of services and places of work. Facilitating students on fieldwork education placements was perceived to be a very effective means of assisting staff develop their own CPD, with 95% of all respondents rating education of students to be effective (25%), very effective (47%) and extremely effective (22%) respectively.

Figure 6.16.1

**Perceived Effectiveness of Educating Students**

![Bar chart showing the percentage of respondents rating the education of students as not very effective, effective, very effective, and extremely effective.](chart.png)
**Attendance at Special Interest Group Meeting**

91% of the respondents reported that their staff attended special interest groups bi-annually. These special interest groups, generally formed to explore specific clinical areas within practice were seen to be effective by 82% of respondents.

**Shadowing a Peer**

71% of respondents reported that their staff engaged in shadowing a peer as a method of professional development, Figure 6.16.2 illustrates that staff who did not engage in this activity tended to work in a mental health setting, while staff working in community settings had the greatest exposure to shadow a peer. Similarly, shadowing a peer was also seen to be effective by 87% of respondents.

Figure 6.16.2

**Percentage of Services which Facilitate Shadowing a Peer**

![Bar chart showing percentage of services that facilitate shadowing a peer.](chart.png)
Journal Club
Just over half the of the respondents (54%), indicated that their staff participated in monthly journal clubs, but 72% of respondents rated journal clubs as effective (52%), very effective (17%) or extremely effective (4%), suggesting that there may be scope for occupational therapists to further engage in journal clubs.

Post Graduate Study Leading to a Qualification
41% of the respondents reported that their staff participated in post graduate study leading to a qualification within the previous twelve months, while 95% of respondents rated this additional study as effective (34%), very effective (37%) or extremely effective (23%).

Figure 6.16.3

Effectiveness of Post Graduate Study leading to a Qualification
Peer Supervision

Figure 6.16.4, illustrates that peer supervision was generally undertaken quite frequently, with 8% of staff engaging with supervision on a daily basis, 18% on a weekly basis and 52% reported engaged in monthly peer supervision. 14% (n=7) did not engage in peer supervision. This CPD activity was rated highly by respondents, with 31% rating it as effective, 47% as very effective and 4% as extremely effective.

Figure 6.16.4

Percentage of Respondents who Reported Staff Engagement in Peer Supervision with Colleagues
Attendence at Case Conference & Lecturers

Attendance at case conferences (91%) and lecturers (82%) proved popular with staff. On average, case conferences were attended on a weekly (43%) or a monthly (32%) basis. Figure 6.16.5, illustrates the type of services which facilitate staff attending case conferences. Half of all staff working in mental health services attend case conferences. Staff based in physical acute hospitals and in community settings attend significantly more case conferences than those who do not. Figure 6.16.5

Percentage of OT Staff working in a variety of settings who attend Case Conferences

![Chart showing the percentage of OT staff working in various settings who attend case conferences.](chart.png)
While respondents reported a very favourable attendance at case conferences and lecturers, they were also anxious to highlight that the effectiveness of these CPD activities was dependent on the relevance of the topic to the occupational therapist’s clinical work. Six respondents rated case conferences as “not at all effective” or “not very effective”. Figure 6.16.6 indicates that 14% (n=7) of respondents did not feel that lecturers were an effective means of improving clinical practice.

Figure 6.16.6

Perceived Effectiveness of Attending Lecturers
Intradepartmental Information Sharing & Professional Conversations with Colleagues

Communication rated highly on the questionnaire, with 98% of respondents claiming that they engaged in daily intradepartmental sharing, and daily or weekly professional conversations with colleagues. Respondents working in acute physical hospitals reported having the most frequent communication with occupational therapy colleagues, with respondents working in the community reporting having weekly or monthly contact. This finding indicates that the environment is a supporting factor with respect to the level of intradepartmental information sharing.

Under half of the respondents (46%) indicated that they had monthly intradepartmental information sharing meetings.

On-the-spot Training / Demonstrations

Most respondents indicated that staff engaged in on-the-spot demonstration (93%), within the past twelve months. This CPD activity was perceived to be extremely effective by 22% or respondents, very effective by 46% and effective by 27% of respondents.

Figure 6.16.7 illustrates the percentage of staff who engage in on-the-spot demonstration, and the frequency with which it was undertaken.
86% of respondents reported that their staff attended workshops; 31% monthly, 35% bi-annually and 19% annually. This CPD activity was also perceived to be quite effective, with 39% of respondents rating it as effective, 32% as very effective and 22% as extremely effective.

**Other CPD Activities**

Nineteen respondents identified additional CPD activities which were not listed such as; in-service training, manual handling, cognitive behavioural training, visits to other organisations, attendance at regional group meetings and weekly CPD portfolio submissions.
**Summary of All CPD Activities**

Figure 16.6.8 illustrates the perceived effectiveness of all the listed CDP activities. The most highly rated activities included: education of students, information sharing, on-the-spot demonstrations and professional conversations with colleagues.

Journal clubs and attending lecturers and conferences were perceived to be the least effective CPD activities.

---

1 Perceived Effectiveness Key Code

1 = not at all effective, 2 = not very effective, 3 = effective, 4 = very effective, 5 = extremely effective
6.14 Section III  Supports available in the Workplace

22% of services (n=12) indicated that they have most of the CPD supports listed in question 8 of the questionnaire within their organisation, including: training budget, protected CPD time, in-service training, access to professional journals, supervision, student education, and access to in-service training co-ordinators.

40 respondents, 74% of the respondents had between 5 and 7 of the listed supports within their organisation. Two respondents, (one from the HSE and one from a voluntary organisation), indicated that they had few organisational supports, with less than five of the listed supports available in their organisation.

Figure 6.17.1 illustrates the perceived level of organisational supports among respondents from the HSE and voluntary organisations. When adjusted according to the response rate, there appears to be minimal variance between the organisations.
Figure 6.17.1

Perceived Level of Organisational Support within the HSE and Voluntary Organisations

- Level of Organisational Support:
  - Many Organisational Supports
  - Some Organisational Supports
  - Few Organisational Supports

Number of Respondents

Type of Organisation

- HSE
- Voluntary

Perceived Level of Organisational Support within the HSE and Voluntary Organisations
Relationship between the Perceived Levels of Organisational Support & Size of Staff

Figure 6.17.2 illustrates that the majority of respondents indicate that their organisation provided some (i.e. between 5 and 7) of the listed organisational supports in question 8. Thirteen respondents reported that they had most of the organisational supports listed (i.e. between 8 and 10); with ten of these respondents citing that they have a large number of occupational therapy staff. This suggests that organisations with a large number of staff have good organisational support.

Figure 6.17.2

Relationship between the Number of OT Staff in a Service and the Perceived Level of Organisational Support Available
**Training budget**

46% of all services have access to a dedicated annual training budget, while 73% of services have access to a training budget on request. Figure 6.17.3 illustrates that 44% of HSE services and 53% of voluntary services have access to a dedicated annual training budget. 74% of respondents working the HSE and 66% of voluntary service indicated that they have access to a training budget on request.

Figure 6.17.3

**Percentage of Organisations with Access to a Dedicated Annual Training Budget**
Figure 6.17.4 illustrates that 74% of respondents working the HSE and 66% of voluntary service indicated that they have access to a training budget on request.

Therefore voluntary services have access to a dedicated annual training budget, while HSE services have greater access to a training budget on request.

**Protected CPD/ Training time for OT activities**

Just over half the respondents (54%) reported that they had protected CPD time. Some respondents indicated that they allocated a half a day a month towards CPD activities, while another respondent reported that staff were responsible for allocating weekly CPD
time into their schedule. Focus group participants commented that they allocated on average five days per annum, while another focus group participant reported that allocated CPD time depended on the individual CPD activity.

**Regular in-service training for staff**

In-service training was undertaken by all organisations, with respondents listing CPR, moving and handling, Mental Health Act (2001) training and break-away techniques being taught.

**Access to professional journals**

93% of organisations provide access to professional journals.

**One-to-one supervision with the occupational therapist manager**

The majority of occupational therapist managers (96%) provide individual supervision with their staff. Peer supervision was undertaken monthly by 52% of respondents.

**Regular peer supervision with colleagues**

75% of services support peer supervision with colleagues, with 2/3 of voluntary organisations and 77% of HSE services offering this support.

**External supervision**

18% (n=7) of HSE services have access to external supervision, while none of the voluntary services have this resource.

**Opportunity to participate in student education**

The majority of organisations (94%) had the opportunity to participate in student education. All work locations facilitated education of students.

**In-service training co-ordinator**

On average, a third of services have an in-service training co-ordinator, with 40% of voluntary organisations having this support and 29% of HSE organisations. These findings are illustrated in figure 6.17.5.
Figure 6.17.5

Percentage of Organisations with Access to an In-service Training Co-ordinator
6.15 Section IV Attitudinal Statements

Figure 6.18.1 illustrates that 98% of respondents agreed with the first attitudinal statement that “CPD is implicit in an Occupational Therapist’s job description”.

Figure 6.18.1

Attitudinal Statement: "CPD is implicit in an Occupational Therapist's Job Description"
Figure 6.18.2 illustrates that 92% of respondents either agreed or strongly agreed with the second attitudinal statement that “CPD and competence are inextricably linked.”
The third attitudinal statement, suggested that informal CPD activities are more valuable than informal CPD activities. Figure 6.18.3 illustrates that there was a mixed response to this statement, with over half the respondents neither agreeing nor disagreeing with the statement.

Figure 6.18.3

**Attitudinal Statement: "Informal CPD Activities are more valuable than Formal CPD Activities"**
The fourth attitudinal statement enquired about the level of organisational support, and whether the respondents perceived this support to influence their staff's engagement in CPD activities.

The majority of respondents either strongly agreed (39%) or agreed (49%) with the statement. Four respondents disagreed with this statement.

Figure 6.18.4

Attitudinal Statement: "The level of Organisational Support influences Occupational Therapists' engagement in CPD Activities"
The fifth attitudinal statement explored occupational therapist managers’ perception regarding ownership of choosing the CPD activity. Figure 6.18.5 illustrates that 82% of respondents either disagreed (67%) or strongly disagreed (16%) with the statement that occupational therapist managers are reluctant to allow occupational therapists’ lead their own CPD activities. 16% of respondents were neutral / undecided about the statement, while one respondent agreed with the statement. The focus group discussion revealed that occupational therapists managers have some reservations about allowing staff to lead their CPD choices / activities.

Figure 6.18.5

**Attitudinal Statement:** "Occupational Therapist Managers are reluctant to allow Occupational Therapists' lead their own CPD activities"
90% of respondents agreed or strongly agreed with the sixth attitudinal statement, that supervision was an effective means of monitoring staffs clinical competence. Two respondents from HSE services felt that supervision was not an effective means of monitoring competence, with one respondent commenting that it needs to be a performance assessment tool and not a competency assessment tool. Figure 6.18.6 illustrates these findings.

Figure 6.18.6

**Attitudinal Statement: "Supervision is an effective means of Monitoring an Occupational Therapist's Clinical Competency"**
The final attitudinal statement sought to ascertain if occupational therapy managers felt that there is a need for a national competency assessment tool, due to pending state registration for occupational therapists. The data revealed that 72% of respondents feel that there is a need for a national competency assessment tool to assist with pending state registration, while 20% are undecided and 11% of occupational therapist manager respondents disagreed with this statement. These findings are illustrated in figure 6.18.7.

Figure 6.18.7

**Attitudinal Statement: "There is a need for a National Competency Assessment Tool, due to pending State Registration for Occupational Therapists"**
6.16 Quantitative Results Summary

The quantitative results provided insight into the respondents’ geographic details, thereby allowing the researcher to identify relationships between services. These results revealed that one fifth of occupational therapist manager posts are occupied by acting managers, who represent half the therapists in intellectual disability and older persons services. On average the respondents managed three basic grade and seven senior grade occupational therapy staff.

The analysis of the qualitative results has verified much that the qualitative results have shown. They identify that there is a strong relationship between CPD and competence. Respondents agreed with the focus group participants who suggest that the organisation has a role in supporting occupational therapists to engage in CPD activities. Most respondents indicated that their organisation provided “some” organisational supports.

There was a discrepancy between the supports available to services within the HSE and voluntary organisations. HSE services had greater access to a training budget on request and access to external supervision, while voluntary organisations had greater access to a dedicated annual training budget and an in-service co-ordinator.

The quantitative findings indicate that the majority of respondents value and facilitate regular supervision as a CPD activity and as a means of assessing competency. The majority of respondents would welcome a national competency assessment tool, to assist in evaluating staffs clinical practice.

The following chapter discusses the research findings in the content of the literature already discussed. It draws conclusions from the study, addresses the limitations of the study and makes recommendations for further research.
7 Discussion

This discussion aims to firstly give an impression of the respondents and their backgrounds and then to address the research objectives of this study.

7.1 Demographics of Respondents

71% of occupational therapist managers worked in the HSE and 29% within voluntary organisations, with a proportionally higher response from voluntary organisations than HSE services. No responses were received from the minority private services; therefore this study can not make any inferences regarding private services.

Acting occupational therapist managers accounted for a fifth of the questionnaire respondents. It is assumed that the majority of these managers account for those respondents who indicated that they were three years or less in the occupational therapist manager role. 2

Of note, half the occupational therapist managers’ posts in the voluntary sector are currently occupied by acting occupational therapist managers; this finding is disproportional to the number of acting occupational therapist managers working in other services.3

2 Ongoing pay enhancements through the implementation of the recommendations of the Public Benchmarking Body may have attracted senior occupational therapy staff to apply for and temporarily secure occupational therapy managers positions.

3 This may be as an outcome of the Disability Act (2005) and the Education for Persons with Special Needs (ESPEN) Act (2004), which opened up 446 new therapy posts in the intellectual disability services, to provide assessments and ongoing services interventions in response to the 2005 Disability Act (Inclusion Ireland, 2008). There is a similar number of acting occupational therapist managers working in primary continuing and community care (PCCC) services, this may be in response to the recent Primary Care Strategy – A New Direction Health System for You (Dept. of Health and Children, 2001).
Results indicate that occupational therapist managers manage an average of three basic grade and seven senior staff. There was a wide standard deviation, indicating that one service had up to 40 staff, while others managed two therapists. It was noted that several community services (i.e. PCCC) were responsible for a large number of senior staff, reflecting the autonomous type of work undertaken by experienced therapists in the community. Acute teaching hospitals were observed to have a large basic grade staff, which may reflect a higher intake and turnover of new graduates seeking to gain experience in a supportive environment.

7.2 Engagement in CPD Activities

This study sought to identify if occupational therapist managers perceived engagement in CPD activities to materialise in new clinical skills. There was unanimous agreement that staff benefited from CPD activities, with focus group participants agreeing that “they will be more informed, they’ll be more knowledgeable and hopefully more confident”. Analysis of the qualitative data has indicated that there is a consensus that engagement in CPD activities enhances staff’s clinical competence. This is supported by Davis et al. (1995) who advocated that engagement in CPD allows for better service provision, better health outcomes and increased practitioner satisfaction.

Further discussion in the focus group revealed that participants sensed that engagement in CPD activities did not always materialise in new clinical skills; if the new learning was lost due to lack of exposure to practice the new skills, or if the training was beyond the learning capacity of the staff member. Participants also felt that staff may pursue CPD activities which do not directly enhance their occupational therapy skills.

7.3 Occupational Therapists Managers Preference for CPD activities

Focus group participants acknowledged the benefits of both formal and informal CPD activities; while they did not identify a preference for either method, analysis of the third attitudinal statement suggests that occupational therapist managers rate formal CPD activities more highly than informal CPD activities. This finding is in keeping with
previous studies, which suggest that therapists consider formal CPD activities which are often costly and involve time away from clinical duties to be more prestigious than informal CPD activities (Fawcett & Strickland 1989, Andersen 2001). This may be due to an appreciation that certified formal CPD activities are favourably recognised on curriculum vitae.

Focus group participants identified that they valued several CPD activities including: reading journals, educating students, attendance at the AOTI conference, supervision and being a member of AOTI.

The majority of organisations (94%) had the opportunity to participate in student education, and 95% of respondents reported that engagement in education of students was effective. Focus group participants highlighted the benefits of facilitating fieldwork education placements as a CPD activity for their staff, suggesting that it encouraged staff “to keep up with the students”. Students were seen to “bring things with them from college and it encourages the clinician to try out things”, while education of students “raises the clinician’s learning...and enlightens you”.

84% of questionnaire respondents indicated that their staff attended a conference within the previous twelve months, with 78% perceiving this CPD activity to be effective. The most widely recognised and attended conference within the occupational therapy profession is the annual AOTI Conference. The literature suggests that occupational therapists value attending a conference; Fawcett & Strickland (1998:740) study participants uniformly viewed attendance at a conference sponsored by a professional association as important to their continued professional development.

7.4 Frequency of Engagement

This study sought to identify the frequency with which staff engaged in CPD activities. Analysis of the findings suggest that there is a variance in the frequency in which staff engage in CPD activities, with some focus group participants allocating a half a day a
week and others suggesting that five days a year is the norm. The frequency of engagement is dependent on the particular CPD activity. It appears that staff working in acute physical hospitals and in the community have greater access to case conferences and lecturers than staff working in residential units, training units or day hospitals.

Respondents working in acute physical hospitals reported having the most frequent communication with occupational therapy colleagues, reflecting the practice of working in close proximity within occupational therapy departments. Respondents reported that staff working in the community have weekly or monthly contact with colleagues; this finding reflects the standardised practice of weekly multidisciplinary team meetings.

7.5 Perceived Effectiveness of CPD Activities

It appears from the questionnaire findings, that 95% of staff engage in informal activities more frequently than formal activities. Occupational therapist managers also report these informal activities to be more effective than formal activities; despite rating formal CPD activities over informal CPD activities, (as reported in attitudinal statement 3). This contradiction illustrates a difference in the perceived value of and effectiveness of various CPD activities. This may be due to practitioners’ tendency to value the qualification which accompanies a certified formal CPD activity, (such as the Bobath seating course) over the ease of implementing skills attained through informal methods, such as shadowing a peer.

The perceived effectiveness of informal CPD activities, may be attributed to Carpenito’s (1991) concept of the “teachable moment”, as analysis of this study’s findings reveal that spontaneous CPD activities such as on-the-spot demonstration, conversations with colleagues and education of students were perceived as the most effective of all the CPD activities. Peers in the workplace were perceived to be the most important source of support, with the majority of respondents rating peer supervision, attendance at special interest groups and professional conversations favourably. Several respondents identified CPD activities as effective, despite them not being undertaken in
their own organisation, such as journal clubs and post graduate study. Respondents were also mindful to highlight that the effectiveness of some CPD activities, such as lectures and case conferences are determined by its relevance to the staff’s clinical work.

While, DeSilets (1995) highlighted the importance of a national conference for continuing education. 18% of respondents rated attending conference as “not at all effective” or “not very effective”. Further analysis of these questionnaire responses indicated that their staff did attend conferences. Future research is required to explore these views and to elicit why conferences are not seen as an effective means of enhancing clinical competence, perhaps these respondents may agree with O’Brien et al (2001) who suggested that staff may have alternative motivation interests to attend conference, including socialising.

7.6 Availability of Organisational Supports

The majority of respondents either strongly agreed (40%) or agreed (48%) with the attitudinal statement, that the level of organisational support influenced occupational therapists participation in CPD activities. The importance of organisational support is referenced by numerous authors, including Andersen (2000) who reported that organisational support enables practitioners to identify and address their learning needs; Youngstrom (1998) recognised that the service system’s location, culture and expectation of intervention influenced practice and competencies needed, and Rouiller & Goldstein (1993) emphasised the influence of continuing learning in organisations, which not only encourages new learning, but also promotes transfer to learning to the work performed.

Four respondents disagreed with the statement suggesting that the clinician must also take some personal responsibility for maintaining his/her competence. This view was also explored in the focus group discussion, with a participant advocating that “there has to be some commitment to want to learn”. The literature also supports the need for

Survey findings suggest that the majority (68%) of respondents reported having “some” organisational supports, with a further 23% indicating that they had most of the organisational supports listed within question 8. These respondents tended to manage larger numbers of occupational therapy staff, suggesting a positive correlation between the availability of organisational supports and the number of staff.

The results also reveal that there is a discrepancy between the supports available to services within the HSE and voluntary organisations, with regard to access to training budgets, external supervision and the availability of an in-service co-ordinator. The findings reveal that 46% of all services have access to a dedicated annual training budget, while 72% of services have access to a training budget on request. It appears that voluntary organisations with the assistance of their in-service training co-ordinator have a stronger commitment to a dedicated annual training budget, than HSE services that are more reliant on seeking funding on request for CPD activities. Three HSE questionnaire respondents commented about their lack of dedicated training budget, citing that the budget was “miniscule”, “current cut backs are severe”, “reliant on student money”.

This suggests that voluntary organisations are in a better position to plan and co-ordinate their staff’s annual professional development activities than HSE services. This may be due to awareness within the HSE that training is not considered a necessity, and in times of health service cutbacks, this funding is the first to be withdrawn. Therapy professions also have less access to sponsored training than medical professions, who can access generous sponsorship from large pharmaceutical companies.

7.7 Ownership over Choosing CPD activities

This study sought to identify who chooses the CPD activity which the staff undertake. Findings from the focus group initially suggested that it was a collaborative decision
between the occupational therapist manager and the staff member. Further discussion revealed that focus group participants have some reservations about allowing the staff member to independently choose CPD activities. The majority of questionnaire respondents disagreed with the statement that occupational therapist managers are reluctant to allow staff to lead their own CPD, yet these managers are accountable for ensuring that the needs of the service are met and will oversee the choice of CPD activities undertaken by their staff. The choice of and access to particular CPD activities is influenced by clinical trends, which favour training for topical clinical conditions or treatments, such as autism, attention deficit hyperactivity disorder and cancer care. As CPD funding becomes more restricted, occupational therapy managers will need to look to in-service training to fulfill their staff’s CPD requirements and maintain their competence.

7.8 Supervision as a means of Assessing Staffs Clinical Competence

The findings suggest that supervision is a highly valued CPD activity. While, 90% of respondents agreed or strongly agreed that supervision was an effective means of monitoring staff’s clinical competence, focus group participants suggested that there needs to be a formalised method of recording this assessment process. The literature acknowledges that formalised assessment of competence is a difficult task (Grossman (1998), Alsop (2001a), Dunn & Cada (1998).

Although occupational therapy has a track record in clinical supervision, Gaitskell & Morley, (2008) reported that there appears to be scope for improving its effectiveness by clarifying the intended outcomes and building knowledge and skills. They recognised that while an appraisal of current supervisory practices may be interpreted as an impingement on professional autonomy, these measures do have the potential to allow occupational therapists demonstrate the effectiveness of supervision, both in improving care and in supporting staff development (Gaitskell & Morley, 2008).

While this study’s findings reveal that the minority of services (n=7) have access to external supervision, one focus group participant highlighted the benefits of this CPD activity. She suggested that this structured time assisted practitioners to clarify their
clinical competencies and assisted in developing skill. She also acknowledged the cost of this service to the organisation.

Two respondents from HSE services disagreed with the majority of the respondents, and reported that they felt that supervision was not an effective means of monitoring competence, with one respondent commenting that it needs to be a performance assessment tool and not a competence assessment tool. This suggestion is also reflected in Newble (1992) and Grussing (1984) who advocated for the use of performance assessment over competence assessment.

7.9 Perceived need for a National Assessment Tool

The majority of questionnaire respondents (71%) reported that they would welcome a standardised assessment tool in view of pending state registration. Future regulation of occupational therapists will be expected to include measurement of the qualifications of practitioner not only at the time of their entry into the profession, but also throughout the lifetime of their practice. Thus, it would be desirable for occupational therapists’ to develop a common language for describing and ultimately measuring competence rather than wait for a system of competency measurement to be imposed by external groups who may not seek the input of the therapists or have an appreciation of the complexity of the practice. This researcher recommends that occupational therapists pilot assessment approaches, such as practice audits, peer review to find cost-effective ways of measuring and improving continuing competence. While (1994) also advocates that occupational therapy staff competence needs to be assessed and suggests that a formalised assessment of performance is preferable to a subjective assessment of competence.

7.10 Summary

The study aimed to explore occupational therapist managers’ perceptions of the impact of CPD activities on their occupational therapy staffs clinical competence. Adopting a mixed method research approach enabled the researcher to identify the qualitative themes of importance to the focus group members and to incorporate these themes into the quantitative
survey instrument. The benefits of this mixed method approach is evident in richness of the findings with in this discussion. As, Bowling & Ebrahim (1992:237) advocate “the overlapping the topics covered in both the qualitative and quantitative components forges a path to integration at the interpretation phase”.

7.11 Limitations of the Research

The researcher reflected upon the research process and acknowledges some limitations with the research study. The researcher used the AOTI’s NOTMG database to access contact details for occupational therapist managers. It appears that this database was compiled in 2006 and some of its contact details are incorrect, thus it is hypothesised that at least eight occupational therapist managers listed on this database did not receive the survey questionnaire. This limitation may have impacted on the response rate.

While, the researcher invited a representative sample of occupational therapist managers from diverse background to participate in the focus group, she acknowledges that the four focus group participants were all members of the DATHs hospital group. The researcher recognises this study limitation as themes emanating from this group may not represent the views of occupational therapist managers working in community or rural settings.

The researcher recognises that the survey instrument is in itself a potential limitation to the study, as the researcher was constrained in the number of questions that could be asked in a two page instrument.

The survey instrument measured the respondents’ perceptions of CPD, perceived frequency of engagement in these activities; perceived organisational supports and subjective views of the effectiveness of these activities on their staff’s clinical competence. These perceptions are not as accurate as measuring the phenomena themselves.
Despite these limitations, the researcher feels this study was an effective method of exploring occupational therapist managers’ perceptions of the impact of CPD on their staff’s clinical competence.

7.12 Recommendations for Further Research

The findings from this study have yielded a broad range of issues concerning engagement in CPD activities and clinical competence. Throughout the discussion, the researcher acknowledges the emergence of additional focus group themes, which were outside the remit of this study, but which merit further investigation. It is also evident from the literature review that there is an absence of research pertaining to CPD and competence in an Irish context. The researcher suggests the following areas for further research:

- Address occupational therapists own perceptions of the types of CPD activities which they feel enhance their clinical competence, and identify factors influencing participation in CPD activities.
- Explore who chooses the CPD activities, (i.e. the staff member or the occupational therapist manager) and how this choice is perceived to impact upon engagement in the activity.
- Assess occupational therapists perceptions of motivation to engage in self directed CPD activities.
- Systematically explore how CPD needs are identified.
- Identify why formal CPD activities are perceived to be superior to informal CPD activities.
- Undertake a cost benefit analysis of CPD activities and benefits to patient care.
- Explore the role and effectiveness of clinical supervision, as perceived by occupational therapists. Assess and analyse occupational therapist managers’ supervision styles.
• Explore occupational therapist managers’ perceptions of incompetence and examine how this is addressed.
• Explore occupational therapist managers’ views on various competency assessment tools.
• Examine the rationale for establishing a standardised competency assessment tool with a view to State Registration.
8 Conclusion

The findings from this sequential exploratory study have elicited valuable information regarding occupational therapist managers’ views of the impact of CPD activities on their staff’s clinical competence. These findings are relevant in view of the limited research on CPD and competence within the Irish health system.

The study highlighted how often occupational therapy staff undertake various CPD activities, and how effective these CPD activities are perceived by occupational therapist managers to influence their staff’s clinical competence. The study revealed that occupational therapist managers rate formal CPD activities as being superior to informal CPD activities, but value informal activities as being more effective than formal activities.

The study identified the varying levels of organisational support available to staff within the HSE and voluntary organisations to engage in CPD activities, noting that voluntary organisations had greater access to an annual training budget and an in-service training co-coordinator than HSE services. HSE services had greater support towards a training budget on request and external supervision for their staff. Irrespective of the amount of organisational support, occupational therapist managers reported that organisational support is necessary to enable staff to engage in CPD activities.

Findings revealed that occupational therapist managers have reservations regarding staff choosing their own CPD activities, suggesting that these activities may not complement the organisation’s goals.

The study explored the changing role of supervision, and identified that while it is highly valued as a means of enabling staff to reflect on their practice and is a useful opportunity to assess staff competence, occupational therapist managers would welcome a national
competency assessment tool to assess their staff’s competence. This revelation supports the need to explore standardised assessment tools and in view of imminent state registration will require the occupational therapy profession to voice its preferred method of assessing competence. While presenting real challenges, it should be possible to develop a framework that through its focus on learning achievements enables individuals to pursue their lifelong learning, whilst meeting external expectations to demonstrate their competence.
# 9 Appendices

## Appendix 1

**Literature Review by Key Word Hits**

**Literature Review Search of key words and findings from electronic search engines**

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Appendix 2

Letter to AOTI seeking access to NOTMG database

19 Gardiner Place,
Dublin 1.

1st September 2007

Re: Access to National Occupational Therapists Managers Committee Database

Dear Sir/ Madam,

I am a post-graduate student on the Masters in Health Services Management programme in Trinity College Dublin. As part of the fulfilment of the Masters Programme, I intend to conduct a research study among Occupational Therapy Managers in hospital and community settings.

I wish to seek access to your Committee database of listed members, to assist with my recruitment and selection of potential study participants. Any information shared by the Committee will be confidential and stored in a secure unit. It shall not be disclosed to third parties nor used for any other purpose other than this proposed study.

The purpose of the study is to explore Occupational Therapist Managers perceptions of the impact of continuing professional development on their staffs continued competence to practice. I intend facilitating a focus group with approximately eight Occupational Therapist Managers to identify themes to develop a questionnaire instrument, which will be then posted to all Occupational Therapy Managers in the Republic of Ireland. The study will be submitted for ethical approval to Trinity College Dublin in December 2008.

I would appreciate if the Committee could give my request some consideration. If you have any queries with respect to the study, please contact me on 086 9347979 or shortalf@tcd.ie.

Yours sincerely,

___________________________________
Fidelma Shortall
Senior Occupational Therapist
Appendix 3

Letter of approval from Chairperson of NOTMG granting access to the NOTMG database

ASSOCIATION OF OCCUPATIONAL THERAPISTS OF IRELAND

Ground Floor Office, Bow Bridge House, Bow Lane, Kilmainham, Dublin 8
Tel: 01 6337222

11th January 2008

Re: Access to the National Occupational Therapists Managers Committee Database

Dear Sir/Madam,

This letter is to verify that Ms. Fidelma Shortall, has received permission from the Association of Occupational Therapists of Ireland to access Occupational Therapist Managers contact details, from our database of Occupational Therapist Managers who are members of the National Occupational Therapist Managers Committee, for research purposes, pending ethical approval from Trinity College Dublin.

Due to resource constraints, it is the practice of the AOTI to allow researchers to contact potential participants directly.

If you require further clarification, please do not hesitate to contact us at the above address.

Yours sincerely,

Mary Barrett Chairperson
Occupational Therapist Manager Group
Appendix 4

Participant Information Leaflet

“Occupational Therapist Managers perceptions’ of the impact of continued professional development (CPD) activities on their staffs continued competence”

RESEARCHER
My name is Fidelma Shortall and I am a final year student of the post-graduate Masters in Health Services Management programme in Trinity College Dublin. This study is conducted in part-fulfilment of a masters degree programme.

OUTLINE OF STUDY
The purpose of this study is to identify Occupational Therapist Managers’ views of CPD activities and their perceived impact, if any on staffs’ clinical competence.

I plan to conduct a focus group with a selection of participants to identify themes, from which a questionnaire will be developed. This anonymous questionnaire will be distributed to all Occupational Therapist Managers listed on the Association of Occupational Therapists of Ireland’s National Occupational Therapists in Management database.

VOLUNTARY PARTICIPATION
Participation in this study is completely voluntary. Participants will be required to give written consent to participate in the study. Each participant may withdraw from the study at any time and for any reason.

METHOD OF DATA COLLECTION
Data will be collected in two phases in the study. Phase one data will be sourced from participants in a focus group. This study phase involves audio taping the focus group, participants will have access to the transcript, if they so wish. The data collected will
identify themes which will be used to develop a questionnaire. Phase two will involve the distribution of the questionnaire to all Occupational Therapist Managers in Ireland.

PARTICIPANT INVOLVEMENT
I am currently seeking your consent to participate in a focus group, which is phase one of the study. You will have access to the transcript of the focus group within ten days of the focus group. An anonymous questionnaire will be forwarded at a later date.

BENEFITS / RISKS OF PARTICIPATION
Participation in the study will assist the researcher in producing a consolidated analysis of Occupational Therapists Managers views of CPD activities and the perceived impact, if any on staffs’ clinical competence. Findings from this study may assist Occupational Therapist Managers in planning future CPD activities for their staff, and may be used towards the development of future policies pertaining to the practice of continued professional development. There is no risk of adverse outcome for research participants.

CONFIDENTIALITY AND DATA STORAGE
The data gathered from the focus group will be recorded in an anonymised form. Each participant will have access to the transcript within ten days of the focus group. Data will be coded and stored electronically in an aggregated form. The questionnaire to be sent at a later date will be completely anonymous; respondents could not be identified from the returned questionnaire as no identification details will be included on the form. Each questionnaire will be numbered only for administration purposes.

Only the researcher and her thesis supervisors will have access to the raw data. No published data will be attributed to named individuals, citation of focus group statements will instead be attributed by an anonymous system of field note codes. Self-identifying information from the focus group scripts will be removed as deemed appropriate by the participant concerned, who will have the opportunity to review transcripts for this purpose. Audio-tapes of interviews will be destroyed upon completion of the study.
FUTURE USE OF THE DATA
Anonymised data will be held under secure storage for five years as specified by Trinity College Dublin. It will be held by the principle researcher only. Results of this study may be published, although no published data will be attributed to named individuals.

Ethical approval has been obtained from Trinity College Dublin for this study.

If you have any queries or require further information, please contact me on 086 9347979 or at shortalf@tcd.ie
Appendix 5
Informed Consent Form

Informed Consent Form

Researcher: Fidelma Shortall

Title: Occupational Therapist Managers’ perceptions of Continued Professional Development Activities and their impact on staffs’ Clinical Competence.

Declaration
I have read this consent form and information leaflet. I have had the opportunity to contact the researcher to ask any questions. I freely and voluntarily agree to be part of this research study, without prejudice to my legal and ethical rights. I understand that material from this study will not be used in future unrelated studies without further specific permission being obtained.

I understand that I may withdraw from the study at any time and without reason.

Participant’s Name: ________________________________

Contact Details: __________________________________

Participant’s Signature: _____________________________

Researcher Responsibility
I have explained the nature and purpose of this study, the procedure to be undertaken and any risks involved. I have offered to answer any questions and fully answered any questions. I believe that the participant understands my explanation and has freely given informed consent.

Researcher’s Signature: _____________________________

Date: __________________________
Appendix 6

Letters to the CEO & LHO Managers

Fidelma Shortall,
Senior Occupational Therapist,
Cluain Mhuire Family Services,
Newtownpark Avenue,
Blackrock,
Co. Dublin.

January 2008

Research Project

Dear Sir/Madam,

I am a post-graduate on the Masters in Health Services Management programme in Trinity College Dublin. As part fulfilment of the Masters programme, I am conducting a research study among Occupational Therapist Managers.

The purpose of the study is to explore Occupational Therapist Managers’ views of continued professional development activities and the impact, if any, these have on staffs’ clinical competence. This study has received ethical approval from Trinity College Dublin.

I have conducted a focus group with Occupational Therapy Managers to identify themes to develop a questionnaire instrument. The questionnaire will now be posted to all Occupational Therapist Managers listed on the AOTI’s National Occupational Therapists in Management database.

I have enclosed a participant information leaflet for your information.

The questionnaire will be posted to all Occupational Therapist Managers within the service within the next two weeks.

If you have any queries with respect to the study, please contact me on 086 9347979 or shortalf@tcd.ie.

Yours sincerely,

Fidelma Shortall
Senior Occupational Therapist
Appendix 7

Letter of FEC Ethical Approval

Ms Fidelma Shorthall
19 Gardiner Place, Dublin 1

Monday, 10 March 2008

Study Title
Occupational Therapist Managers Perceptions of the impact of Continued Professional Development Activities in their Staff’s Clinical Competence

Dear Applicant

Further to a meeting of the Faculty of Health Sciences Research Ethics Committee 2007 - 2008, I am pleased to inform you that the above project has been approved without further audit.

Yours sincerely

Naílle Baskeloe

Dr. Orla Sheils
Chairperson
Faculty of Health Sciences Ethics Committee

cc.
Ms Fiona Armstrong (Supervisor)
Occupational Therapist, Cappagh Hospital, Finglas, D 11
Appendix 8

Focus Group Interview Schedule
1. Understanding of the term “Continued Professional Development”

2. Types of CPD undertaken by staff
   - Formal
   - Informal
   - Frequency of engagement

3. Opportunities available to staff
   - Who sources CPD opportunities? Staff member, Manager, Organisation
   - Does this affect engagement?

4. What CPD activities do you promote in your department?
   - Why?
   - Why not promote other CPD activities?

5. Factors which hinder involvement

6. Implications of CPD on clinical practice
   - How is this determined?
   - Developments in the OT Dept?
   - Staffs level of confidence in performing an activity?

7. Defining Competence
   - Your understanding of the term “Clinical Competence” (performance skills v knowledge v interpersonal v decision making etc)

8. Factors which determine competence and incompetent
   - Your views
   - Contributory factors to maintain competence
   - Role of self motivation?
   - Role of organisational support?

9. Role of the workplace
   - What supports available in each organisation
   - Perceived learning attitude within your organisation

10. Does engagement in CPD activities impact on staffs’ clinical competence?
    - How is this known / assessed?

11. Assessment of competence
    - Is this undertaken?
    - How is this undertaken? (Informal observation, performance appraisal etc.)
Appendix 9  Focus Group Scribe Notes

- Introduction of focus group topic & participants

Integration / Best practice

Courses / Events

Understanding of CPD

- organising / delivering courses / seminars

Formal

Informal

AOTI as a guide

Staff use their needs

knowledge

Skills

Staff frequency of engagement in CPD

- influence external & in-house programme

Is there a set number?

Needs analysis from all staff

Dependent on individual need

Agreed that peer support own CPD Basic Grade

Balance of own input & service

Performance Review

Senior staff compulsory

Supervision
External Supervision identifies needs for CPD

Senior Staff

Junior Staff supervision

External v’s Internal

Valuable reflection enhanced must be a 2 way process

Ownership of

Expectation of learning cultures in Dept.

Managers identifying “group needs”

Need for sense of commitment

Sources of CPD Activities

Ethos in the dept. high std expected not just 9-5 job
develop quality for service & patient

regulated by external bodies i.e. accreditation identified through supervision

expectation of new Basis Grades upgrade knowledge v’s CPD

support of new staff collective approach
types of learning team dynamic

related to OT post – overriding the organisations objectives

manager regulates
CPD activities not supported

"Flavour of the month", timing related to stage of learning

Manager must be clear

CPD activities supported

Formal & Informal

Budgetary constraints / resources

Networking

OT Conference

Professionalism & CPD

Learning

Presenting & learning

AOTI member

Mixture

Own volition, impact on practice

Ethos of continuous learning

Not tangible in Mental Health

Related to most patients, e.g. bereavement studies

Needs exposure or is lost

Planning & timing

Physical setting

E.g. seating, props

Must have opportunities to practice

Benefits / Impact on daily practice

Inform decisions

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individual needs
→ students bring enthusiasm

skills v’s awareness

use of “gut feeling” / team members

Proficiency

Proficiency determination assist in the development of a framework process

Desired / preferred skills

Too much in the framework

Not enough use of standardised assessment

Competency

Insight / awareness

Self rating

Knowledge/ Skills/ Attitudes

Supervisor and self

Required to fit expectations of job

Assessing Competency

Qualitative feedback

Feedback from the MDT based on the teams perceptions of OT!

Shift to generic working e.g. OT as the case manager

Creates new expectations of competency

Incompetence

When standard within the OT dept is high

It becomes clear

Often through mistakes
Requires all 3: knowledge, skills & attitudes

Appendix 10

Conceptual Map

Defining CPD

“participating in courses”

“best practices”

“formal but can be very kind of informal”

“anything at all that enables us to develop our skills”.

“educational events”

“Keeping up to date”

“reflecting on a treatment session”

Frequency and Engagement in CPD activities

“in service programme running on a monthly basis for a half day”

“at the discretion of the manager”

“guide about 5 study days a year”

“learn on their own time as well”

“meet for a half day”
“an hour of CPD time per week to go to the library, source the internet, read the journals.”

“about five days per person but based on clinical need and service need”

“I think OT needs different types of learning you know….. some people are great at going on a course”

“I would emphasise for most of them to go to the OT Conference”

Preference for Formal or Informal activities

“using reflective practice, they will be more informed”

“I would also emphasise that they read the journals”

“it might be informal which doesn’t actually seem like CPD, but in essence it is”

“it is about an ethos of understanding that in order for the department and the service to be in the best interest of patients, the standard expected is very high

“it is our responsibility really in terms of leading, to convey a positive ethos towards learning”

Importance of Organisational Support

“gets reflected up the organisation”
“the supervision process is in every way capturing learning and enhancing learning, through opportunities in the supervision process”

“Peoples’ needs are often identified during supervision”

“The senior staff are supervised externally and the hospital is prepared to pay for it”

“A huge emphasis on supervision”

“The focus on supervision has definitely increased in the last number of years and the importance of it”

“We have become much more aware of the value of professional supervision”

“We are going to be more viewed in the future on our proficiency and competency”

“Certain standards that people have to meet”

Need to Monitor Competence

“Things are coming in and I guess when”
registration eventually comes
that’s another that will hit in”

“They are all now being regulated and accredited”

“I’ve often tried to find how you do judge competency”

Difficulty Assessing Competency

“I know the outcome of somebody.......... I’m finding it difficult…”

“So I would have a sense of it and I think you have to have a sense of competence as well as to what that is”
Appendix No. 11

Rationale for choosing the questions in each section

Section I: Demographics
As all potential respondents were assured of confidentiality within the participant information letter, no identifying demographic information was sought in the questionnaire, but broad categorical demographic information was required to address the research objectives. These included ascertaining if there was a pattern in the availability or lack of CPD activities, and a variance in the type of organisational support available within the three health care organisations. The questionnaire recipient was requested to identify their type of organisation.

The researcher was also interested in the area of the respondents’ place of work, as she was interested in establishing if there was a relationship in the location of the work (e.g. acute hospital versus community) and the availability of CPD opportunities and frequency of engagement.

The researcher was aware that the number of staff under the management of the occupational therapist manager may vary between organisations, therefore she wished to ascertain the number of basic grade and number of senior grade staff with the organisation and the establish if there is a relationship between the number of staff and the available supports within an organisation.

Section II: Engagement in CPD Activities
The researcher was interested in the frequency that staff engaged in CPD activities. This question was presented in a Likert scale table; where respondents were asked to choose a time scale which best represented how often a CPD activity was undertaken. Respondents were given the opportunity to add additional CPD activities that the researcher may have omitted, or those that may have been unique to the particular service. The researcher aimed to identify if there was a correlation between the

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frequency of engagement in CPD activities and the occupational therapist managers’ perception of these activities’ effectiveness.

Some of the CPD activities listed in question 7 require the support of the organisation in either a financial or time resource means. The researcher was interested in ascertaining if organisational support promoted occupational therapists engagement in CPD activities, hypothesising that organisations with strong organisational support would engage in more CPD activities, more frequently than organisations with weak organisational support. This question also pre-empted the respondent to reflect on the types of support that their organisation provides, in preparation to respond to the fourth attitudinal statement which asked respondents to rate if they perceived the level of organisational support to influence occupational therapists engagement in CPD activities.

Section III: Perceived Effectiveness of CPD Activities
In relation to CPD activities, it was imperative not only to examine the extent to which CPD activities were engaged, but also to the degree to which they were perceived effective by occupational therapist managers. This question mirrored the table presented in question 7 and asked respondents to rate the effectiveness of all the CPD activities on a five point Likert scale, ranging from “not very effective” to “extremely effective”.

Section IV: Attitudinal Statements
This section included seven attitudinal statements which were developed from the data gathered from the qualitative phase of the research and reflected the research objectives of the study. The statements asked respondents to choose from a five point Likert scale, between strongly agree to strongly disagree in relation to each statement.

- Statement 1, aims to gain a view of the respondent’s general sense of CPD, and infers that it may be part of the role of the occupational therapist to engage in same.
• Statement 2, aims to identify the respondent’s view of strength of the relationship between CPD and competence.

• Statement 3, identifies the respondent’s overall perception of the value of formal or informal CPD activities.

• Statement 4, identifies the respondent’s views of the influence of organisational support on CPD engagement.

• Statement 5, aims to identify who chooses the CPD activity which the occupational therapist undertakes: the occupational therapist manager or the staff member. This discrepancy was acknowledged in the focus group, some focus group participants suggesting that occupational therapy staff may wish to lead their own CPD, which may be inconsistent with the departmental goals or overall organisational strategic plan.

• Statement 6, explores respondents thoughts on supervision as a means of monitoring clinical competence, based on a discussion by the focus group members on the role and value of supervision.

• Statement 7, informs respondents of pending state registration, and enquires if they feel there is a need for a national competency assessment tool to reflect the future legal status of registration.
Appendix No. 12

Generation of Questionnaire Attitudinal Statements from the focus group transcript

Statement 1
CPD is implicit in an Occupational Therapist’s job description

This statement was used to assess the respondent’s general view of CPD, and infers that an occupational therapist must engage in CPD as part of his/her role. This introductory statement is seen to be non-threatening.

Statement 2
CPD and competence are inextricable linked

This statement aimed to identify the respondent’s view of strength of the relationship between CPD and competence. This statement was identified from the literature; Youngstrom et al (1998:717) stated that competency and practice are “inextricably linked”.

This link was also identified from focus group quotations:

1. “It could also be not just attending your course but actually delivering a course or having to organise a seminar or something like that because your developing your professional competency perhaps in relation to time management or organisational skills rather than just looking at it from the clinical end”
Statement 3
Informal CPD activities are more valuable than formal CPD activities

This statement identifies the respondent’s overall perception of the value of formal or informal CPD activities.

Indentified from focus group quotations:

1. “I think OT needs different types of learning you know….. some people are great at going on a course and learning splinting, and they love it, you know, and that’s what they like to get facts. Other people like a sort of vague, you know, conceptual philosophical course”

2. “I would also emphasise that they read the journals, not that I can force them to read it, but we do get like you a huge amount (of journals)”

3. “I would emphasise for most of them to go to the OT Conference”

4. “using reflective practice, they will be more informed, they’ll be more knowledgeable and hopefully more confident to then go onto the next patient”

5. “it might be informal which doesn’t actually seem like CPD, but in essence it is and so people are doing that all the time and so the client benefits, the service benefits because they are able to make a more speedy decision the next time, they have learnt, they have become more confident and they can then pass that onto their colleagues”

6. “encourage students within your service that has the effect of continued professional development as well, because they (students) come with new learning and that raises the clinicians learning and there is a sharing then of information and learning”
Statement 4
The level of organisational support influences Occupational Therapists’ engagement in CPD activities

This statement identifies the respondent’s views of the influence of organisational support on CPD engagement, but also suggests that the occupational therapist may have to take responsibility for his/her own learning, as defined in AOTI’s Code of Ethics.

Indentified from focus group quotations:

1. “it is about an ethos of understanding that in order for the department and the service to be in the best interest of patients, the standard expected is very high ....it is our responsibility really in terms of leading, to convey a positive ethos towards learning”

2. “... and that then gets reflected up the organisation regardless of whether your in a private hospital or in publicly funded or voluntary”

3. “there has to be a sense of commitment to want to continue to learn on their own time as well and so that is something that I would be cautious about”
Statement 5
Occupational Therapist Managers are reluctant to allow Occupational Therapists’ lead their own CPD activities

This statement aims to identify who chooses the CPD activity which the occupational therapy staff member undertakes; the occupational therapist manager or the staff member. It was acknowledged in the focus group that occupational therapy staff may wish to lead their own CPD, which may be inconsistent with the departmental goals or overall organisational strategic plan.

Identified from focus group quotations:

1. “The managers are identifying with the staff what is needed”
2. “You also have to be mindful, but people go off on very specific tangents in terms of CPD”
3. “Managers are trying to hold back that person, they may be stepping out of their role to do something else”
4. “They become very skilled and they become maybe a psychotherapist or a Cognitive Behavioural Therapist and that wasn’t what they were employed to be, they were employed as an Occupational Therapist”
5. “(Managers) have to be very careful to balance what is professional development and what is really just upgrading your own knowledge”
6. “There’s the organisation’s objectives and then obviously the health service wants OTs to be doing certain things and they (Managers) are directing that”
7. “their (OT staff) own sense of what they want to achieve…it all has to be factored in …staff certainly wouldn’t take it anyway, if I went in with a list and said these are the things that they have to do”
8. “people you know going into different professions practically by the time they’ve finished the course, that’s one of the things I would discourage that kind of professional development… the hospital are not paying them to be those things, they’re paying them to be an OT”
Statement 6
Supervision is an effective means of monitoring an Occupational Therapist’s clinical practice

This statement explores respondents’ thoughts on supervision as a means of monitoring clinical competency. The role and value of supervision was discussed in the focus group in great detail.

Indentified from focus group quotations:

1. “Peoples’ needs are often identified during supervision”

2. “a huge emphasis on supervision so the staff may be, basic grade OT’s are supervised by the senior staff but the senior staff are supervised externally and the hospital is prepared to pay for it”

3. “the focus on supervision has definitely increased in the last number of years and the importance of it”

4. “we have become much more aware of the value of professional supervision and how that is actually directly linked, not just in identifying what someone’s learning needs are, but in order to work through the process of reflection, we’ll say, what happens within the supervision process is in every way capturing learning and enhancing learning, through opportunities in the supervision process”
Statement 7
There is a need for a national competency assessment tool, due to pending State Registration for occupational therapists

This statement informs respondents of pending state registration, and enquires if they feel there is a need for a national competency assessment tool to reflect the future legal status of registration, in recognition that assessing competence can be a difficult task.

Identified from focus group quotations:

1. “we are going to be more viewed in the future on our proficiency and competency rather than just the fact that we have a piece of paper saying that you passed a qualifying exam”

2. “things are coming in and I guess when registration eventually comes that’s another that will hit in, so people will be regulated regarding it, there will be certain standards that people have to meet, accreditation does that as well”

3. “they are all now being regulated and accredited, so the OT within the team or within a service has to say “well this is what I’m competent to do” and “this is what I’m taking on”.”
Appendix 13 Pilot Questionnaire Survey

Occupational Therapist Managers’ perceptions of the impact of Continued Professional Development activities on Occupational Therapy staffs’ clinical competence.

This questionnaire is part of a research study in part fulfilment of a MSc programme, it should take no more than minutes (TBC) to complete, all responses will be confidential.

*Continued Professional Development (CPD) is the process of ongoing education and development of healthcare professionals.*

Section I Demographics

Please tick √ the appropriate boxes.

1. What type of organisation do you work for?
   - HSE □
   - Private □
   - Voluntary □

2. What type of service do you work in? Location of Work?
   - Physical □ Hospital □
   - Psychosocial □ Community □
   - Care of the Elderly □ Day Centre □
   - Paediatric □ Day Hospital □
   - Intellectual Disability □ Training Centre □
   - Primary Care □ School □
   - Research □ Other (specify) □
   - Management □
   - Other (specify) □

3. Are you in an Acting OT Manager post or an OT Manager post?
   - Acting OT Manager Post □
   - OT Manager Post □

4. How many years are you in this post?
   - < 3 years □
   - < 5 years □
   - < 10 years □
   - > 10 years □
Section II  Engagement in CPD activities

5. Please indicate by ticking YES or NO. Which of the following CPD activities have your OT staff undertaken in the previous 12 months?

If you answered YES, please indicate how often your staff engaged in this activity. (If you answered No, please ignore the time scale)

<table>
<thead>
<tr>
<th>CPD Activity</th>
<th>Frequency of Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conference (e.g. AOTI)</td>
<td>YES  NO Daily Weekly Monthly BiAnnually Annually</td>
</tr>
<tr>
<td>Student Teaching</td>
<td></td>
</tr>
<tr>
<td>Lectures</td>
<td></td>
</tr>
<tr>
<td>Attendance at a Special Interest Group Meeting</td>
<td></td>
</tr>
<tr>
<td>Shadowing a peer</td>
<td></td>
</tr>
<tr>
<td>Journal Club</td>
<td></td>
</tr>
<tr>
<td>Post graduate study leading to a qualification</td>
<td></td>
</tr>
<tr>
<td>Peer Supervision</td>
<td></td>
</tr>
<tr>
<td>Case Conference</td>
<td></td>
</tr>
<tr>
<td>Intradepartmental information sharing</td>
<td></td>
</tr>
<tr>
<td>On the spot training/demonstration</td>
<td></td>
</tr>
<tr>
<td>Professional Conversations</td>
<td></td>
</tr>
<tr>
<td>Workshop</td>
<td></td>
</tr>
<tr>
<td>Other, please specify</td>
<td></td>
</tr>
</tbody>
</table>

6. What supports are available in your organisation to promote engagement in CPD activities?

Please tick √ all which apply.

- Training budget
- Protected CPD / Training Time for OT activities
- Regular in-service training for staff
- Access to professional journals
- Regular peer supervision / mentoring
- Opportunity to take a student
- In-service training coordinator

Other (specify) _________________________________
Section III Impact of CPD activities on clinical competence

Competence is the procession of the necessary skills, knowledge, attitudes, understanding and experience required to perform in professional and occupational roles to a satisfactory standard within the workplace.

Effectiveness is the ability to produce a specific result or to exert a specific measurable influence

7. Please rate the following CPD activities according to their effectiveness in enhancing staffs’ clinical competence. (please place a tick √ in the corresponding box)

<table>
<thead>
<tr>
<th>CPD Activity</th>
<th>Perceived Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Conference (e.g. AOTI)</td>
<td></td>
</tr>
<tr>
<td>Student Teaching</td>
<td></td>
</tr>
<tr>
<td>Lectures</td>
<td></td>
</tr>
<tr>
<td>Attendance at a Special Interest Group Meeting</td>
<td></td>
</tr>
<tr>
<td>Shadowing a peer</td>
<td></td>
</tr>
<tr>
<td>Journal Club</td>
<td></td>
</tr>
<tr>
<td>Post graduate study leading to a qualification</td>
<td></td>
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<tr>
<td>Peer Supervision</td>
<td></td>
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<tr>
<td>Case Conference</td>
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<td>Intradepartmental information sharing</td>
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<tr>
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<tr>
<td>Professional Conversations</td>
<td></td>
</tr>
<tr>
<td>Workshop</td>
<td></td>
</tr>
<tr>
<td>Other, please specify</td>
<td></td>
</tr>
</tbody>
</table>
Section IV Statements
Please indicate one of the following by circling the relevant figure

CPD is implicit in an Occupational Therapist’s job description

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

CPD and competence are inextricably linked

<table>
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<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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Informal CPD activities are more valuable than formal CPD activities

<table>
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<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<td>5</td>
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The level of organisational support influences Occupational Therapists’ engagement in CPD activities.

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<thead>
<tr>
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<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<tr>
<td>5</td>
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Service managers are reluctant to allow Occupational Therapists’ lead their own CPD activities

<table>
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<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
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Supervision is an effective means of monitoring an Occupational Therapist’s clinical competency

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<tr>
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<th>Neutral</th>
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There is a need for a national competency assessment tool, due to pending State Registration for Occupational Therapists

<table>
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<tr>
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<th>Neutral</th>
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<tr>
<td>5</td>
<td>4</td>
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<td>1</td>
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</tbody>
</table>

Thank you for taking the time to complete this questionnaire
Please return the completed questionnaire in the enclosed SAE provided by DATE.
Appendix 14

Letter seeking feedback on pilot questionnaire – Phase 1

Fidelma Shortall,
Senior Occupational Therapist,
Kilrock House,
Kilrock Road,
Howth,
Co. Dublin.

26th March 2008

Research Project – Pilot of Questionnaire

Dear Colleague,

I am a post-graduate on the Masters in Health Services Management programme in Trinity College Dublin. As part fulfilment of the Masters programme, I am conducting a research study among Occupational Therapist Managers.

The purposed of the study is to explore Occupational Therapist Managers’ views of Continued Professional Development (CPD) activities and the impact, if any these have on staffs’ clinical competence. CPD is a term commonly used to denote the process of ongoing education and development. At present, research on CPD and competence among occupational therapists is limited.

I have conducted a focus group to identify themes of importance to Occupational Therapy Managers around this topic. A questionnaire instrument was developed incorporating these themes. I have reviewed the transcripts of the focus group and identified themes on which a questionnaire instrument was developed. I enclosed a copy of the questionnaire which I wish to pilot.
I would be very grateful if you would take the time to complete the pilot questionnaire. I enclosed a worksheet for your convenience, and I would be very grateful if you would return it to me as soon as possible, in the stamped addressed envelope provided.

The revised questionnaire will then be posted to all Occupational Therapist Managers listed on the AOTI’s National Occupational Therapists in Management database.

If you have any queries with respect to the study, please contact me on 086 9347979 or shortalf@tcd.ie.

Thanking you in anticipation of your time and co-operation,

Yours sincerely,

__________________________________

Fidelma Shortall
Senior Occupational Therapist
Appendix 15

Pilot Questionnaire – Feedback Worksheet  Phase 1

When completing the questionnaire, please consider the following questions and make any comments as you deem appropriate.

1. Do you understand the questions?
   ______________________________________________________________

2. Do the questions follow a logical sequence?
   ______________________________________________________________

3. Is the questionnaire attractive in its layout and design?
   ______________________________________________________________

4. Are any of the questions unclear?
   ______________________________________________________________

5. In your opinion, has any major topic been omitted?
   ______________________________________________________________

6. Should any questions be omitted?
   ______________________________________________________________

7. In your opinion, did the questionnaire measure what it is supposed to measure?
   ______________________________________________________________

8. How long did it take you to complete the questionnaire?
   ______________________________________________________________

9. Any other comments?
   ______________________________________________________________

Thank you for taking the time to complete this work sheet.
Appendix No. 16

Amendments made to the pilot questionnaire

- The response style of Question 2 was changed from a pre-coded response choice to an open question. This modification was suggested on the basis that respondents may work in several of the specified areas and may tick numerous boxes which fulfill their area. For example, a respondent may have selected: physical rehab and care of the elderly and education. An open question format allowed respondents to personally specify which type of service they predominantly worked in, without the restrictions of pre-coded categories.

- Question 3 was also changed from a tick box format and reworded from “Location of work” to “What type of environment is your main place of work?” This change allows the respondent to be more flexible in identifying their primary location of work, and facilitates the researcher in coding the respondents’ place of work more accurately.

- Question number 6 was introduced to ascertain the number of qualified occupational therapists under the management of the occupational therapist manager. This question would allow the researcher to make inferences about the size of the service and the prevalence of CPD activities within the service.

- In question 7, the wording of “student teaching” was changed to “education of students”, which involves teaching but also implies greater endorsement of skills such as planning, organisation, supervision and management of the fieldwork practice placement.

- Similarly in question 9, the wording was also changed from “student teaching” to “education of students”.

• Question 8 was modified to include further specification of the training budget from an implied “generalised training budget” to a dedicated training budget and a budget on request, as it is common practice that some services may not have an allotted annual training budget, but rather Management will consider each training request submission on its own merits.

• “Regular peer supervision / mentoring” were also further specified in Question 8, into regular peer supervision with colleagues, external supervision and one-to-one supervision with occupational therapist manager. The term “mentoring” was removed as it implied a different form of guidance which is not prevalent within the roles of basic grade or senior occupational therapists, but more evident within the role of occupational therapist manager.
Appendix 17 Questionnaire Instrument

“Occupational Therapist Managers’ perceptions of the impact of Continued Professional Development activities on Occupational Therapy staffs’ clinical competence.”

This questionnaire is part of a research study in part fulfilment of an MSc programme, it should take no more than 7 minutes to complete, and all responses will be confidential.

Continued Professional Development (CPD) is the process of ongoing education and development of healthcare professionals.

Section 1 Demographics

Please tick √ the appropriate boxes or write the corresponding answer.

1. What type of organisation do you work for?
   - HSE □
   - Private □
   - Voluntary □

2. What type of service do you work in? (e.g. acute physical, mental health, paediatric, I.D, Primary Care, research)
   ____________________________________________________________________

3. What type of environment is your main place of work? (e.g. Acute Hospital, Day Hospital, training centre, Community, Day Centre, school)
   ____________________________________________________________________

4. Are you in an Acting OT Manager post or an OT Manager post?
   Acting OT Manager Post □ OT Manager Post □

5. How many years are you in this post?
   <3 years □ 3-5 years □ 6-10 years □ > 10 years □

6. How many qualified Occupational Therapists are under your management?
   Basic Grade OTs ___________ Senior OTs ___________
## Section II  Engagement in CPD activities

7. Please indicate, by ticking YES or NO, which of the following CPD activities any of your OT staff have undertaken in the previous 12 months.

Where relevant, please indicate how often your staff engaged in each of the activities.

<table>
<thead>
<tr>
<th>CPD Activity</th>
<th>Frequency of Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conference (e.g. AOTI)</td>
<td>Daily       Weekly  Monthly Biannually Annually</td>
</tr>
<tr>
<td>Education of Students</td>
<td>YES NO       Daily       Weekly  Monthly Biannually Annually</td>
</tr>
<tr>
<td>Lectures</td>
<td>YES NO       Daily       Weekly  Monthly Biannually Annually</td>
</tr>
<tr>
<td>Attendance at a Special Interest Group Meeting</td>
<td>YES NO       Daily       Weekly  Monthly Biannually Annually</td>
</tr>
<tr>
<td>Shadowing a peer</td>
<td>YES NO       Daily       Weekly  Monthly Biannually Annually</td>
</tr>
<tr>
<td>Journal Club</td>
<td>YES NO       Daily       Weekly  Monthly Biannually Annually</td>
</tr>
<tr>
<td>Post graduate study leading to a qualification</td>
<td>YES NO       Daily       Weekly  Monthly Biannually Annually</td>
</tr>
<tr>
<td>Peer Supervision</td>
<td>YES NO       Daily       Weekly  Monthly Biannually Annually</td>
</tr>
<tr>
<td>Case Conference</td>
<td>YES NO       Daily       Weekly  Monthly Biannually Annually</td>
</tr>
<tr>
<td>Intradepartmental information sharing</td>
<td>YES NO       Daily       Weekly  Monthly Biannually Annually</td>
</tr>
<tr>
<td>On the spot training/demonstration</td>
<td>YES NO       Daily       Weekly  Monthly Biannually Annually</td>
</tr>
<tr>
<td>Professional Conversations</td>
<td>YES NO       Daily       Weekly  Monthly Biannually Annually</td>
</tr>
<tr>
<td>Workshop</td>
<td>YES NO       Daily       Weekly  Monthly Biannually Annually</td>
</tr>
<tr>
<td>Other, please specify</td>
<td>YES NO       Daily       Weekly  Monthly Biannually Annually</td>
</tr>
</tbody>
</table>

8. What supports are available in your organisation to promote engagement in CPD activities for your OT Staff?

Please tick √ those applicable.

- Dedicated annual training budget
- Training budget on request
- Protected CPD / training time for OT activities
- Regular in-service training for staff
- Access to professional journals
- One-to-one supervision with OT Manager
- Regular peer supervision with colleagues’
- External supervision
- Opportunity to participate in student education
- In-service training coordinator
- Other (please specify) _________________________
**Section III Impact of CPD activities on clinical competence**

*Competence is the possession of the necessary skills, knowledge, attitudes, understanding and experience required to perform in professional and occupational roles to a satisfactory standard within the workplace.*

*Effectiveness is the ability to produce a specific result or to exert a specific measurable influence*

9. Please rate the following CPD activities according to their effectiveness in enhancing OT staffs’ clinical competence.
   (please place a tick √ in the corresponding box)

<table>
<thead>
<tr>
<th>CPD Activity</th>
<th>Perceived Effectiveness</th>
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<tbody>
<tr>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Not at all effective</td>
</tr>
<tr>
<td></td>
<td>Not very effective</td>
</tr>
<tr>
<td></td>
<td>Effective</td>
</tr>
<tr>
<td></td>
<td>Very effective</td>
</tr>
<tr>
<td></td>
<td>Extremely effective</td>
</tr>
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<td>Other, please specify</td>
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**Section IV  Statements**

Please indicate one of the following by circling the relevant figure

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<th>CPD is implicit in an Occupational Therapist’s job description</th>
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<tbody>
<tr>
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<td>5</td>
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</table>

Thank you for taking the time to complete this questionnaire

Please return the completed questionnaire in the enclosed SAE provided by Friday 11th April 2008.
Appendix 18
Letter to Occupational Therapist Manager to participate in research – Phase 2

Fidelma Shortall,
Senior Occupational Therapist,
Cluain Mhuire Family Services,
Newtownpark Avenue,
Blackrock,
Co. Dublin.

4th April 2008

Research Project Questionnaire

Dear Colleague,

I am a post-graduate on the Masters in Health Services Management programme in Trinity College Dublin. As part fulfilment of the Masters programme, I am conducting a research study among Occupational Therapist Managers.

The purposed of the study is to explore Occupational Therapist Managers’ views of Continued Professional Development (CPD) activities and the impact, if any these have on staffs’ clinical competence. CPD is a term commonly used to denote the process of ongoing education and development. At present, research on CPD and competence among occupational therapists is limited.

I have conducted a focus group to identify themes of importance to Occupational Therapy Managers around this topic. A questionnaire instrument was developed incorporating these themes. The anonymous questionnaire, enclosed has been posted to all Occupational Therapist Managers listed on the AOTI’s National Occupational Therapists in Management database.
Your views regarding CPD and competence would be most helpful. I would be grateful if you could take the time to complete the enclosed questionnaire and return it to me in the stamped addressed envelope provided. I have enclosed a participant information leaflet for your information.

This study has received ethical approval from Trinity College Dublin.

If you are interested in receiving a copy of my report, I would be happy to forward it to you on completion.

If you have any queries with respect to the study, or would like to seek a copy of my report, please contact me on 086 9347979 or shortalf@tcd.ie.

Yours sincerely,

__________________________________
Fidelma Shortall
Senior Occupational Therapist
Appendix 19

Focus Group Transcript

Key Code

F  = focus group facilitator
A  = All focus group participants
1  = focus group participant number 1
2  = focus group participant number 2
3  = focus group participant number 3
4  = focus group participant number 4

(F) I have a number of topics to be covered, I will refer to my list here so from time to time I may intervene just to redirect you back to the areas I need to focus on for my study so please don’t be offended if I say “can we get on to something else.”

The four focus group members identify themselves and the type of organisation they work in.

(F) As you are aware, I mentioned the focus for today’s topic is on “Occupational Therapy Managers and their perceptions of the impact of continued professional development activities on your staff’s clinical competence.” So just to get a base line, what is your general understanding of the term Continued Professional Development?

(1) Well it would be kind of participating in courses and educational events that keeps them very formal but can be very kind of informal.

(2) Keeping up to date with current best practices and integrating that into current clinical practice
(3) And it is probably anything, anything at all that enables us to develop our skills, isn’t it? So formal and informal, even reflecting on a treatment session, anything at all that enables us once were supporting the process.

(4) It could also be not just attending your course but actually delivering a course or having to organise a seminar or something like that because you’re developing your professional competency perhaps in relation to time management or organisational skills rather than just looking at it from the clinical end.

(F) So you recognise both formal avenues of obtaining CPD, for example conferences and delivering seminars, to the informal like peers supervision and reflecting on practice on interventions with people. I assume that all your staff has some involvement in CPD?

(A) Yes they do. / Yes / Yea

(F) How often do they engage in different CPD activities?

(1) We use the AOTI manual / portfolio, big green folder, (laughter)…. So like since that has been issued we use it very much as a kind of the guideline for what’s going to be the turnout for the year so I mean it’s as regular as…. They identify their goal professional developmental needs and then we work through that.

(2) Well we use to have are own kind of set people for professional development but that was prior to AOTI portfolio being released, but again it was used in a very similar way just a kind of bench marker or guide and for people to look at whether it was knowledge or skills or what exactly they were looking for from CPD and how that might be linked in with their job description and the expectations of the post at different grades and within different clinical areas as well.
(F) And just to reflect back, you’re saying that the CPD portfolio or similar documentations is helpful in planning a staff’s professional development? But do you find that you might have a set number of workshops that you allow a staff member to attend each year or do you have a set number of journal clubs that you aim to facilitate. How often do you feel you do CPD?

(3) We have; first of all, we have a PDP structure as well so that’s the framework that would determine what people would be supported to do through the year so through prioritising with them as to what their learning needs would be. But than separate from that, so that relates to a number of different training areas but internally we have a framework where there is an in service programme running on a monthly basis for a half day so it is made up of clinical speciality areas which are similar so there are a number of programmes running at the same time, so people attend the group that is related to what their doing and so we have changed it so that it is not a generic programme it is very much clinical area based. In addition to that than the basic grades work with the basic grades in Hospital Name and Hospital Name where they have, every two (we have changed it to every two months now) they meet for a half day so they have a programme running their as well, and then in addition the hospital obviously supports external training and there isn’t a cap on how much people can have it is dependent on service need and their need but obviously there is only so much money and there are only so many study days, so as a guide about 5 study days a year would be a generally acceptable amount but that’s at the discretion of the manager depending on the service need and their own need. It is not as black and white as a cut off.

(F) And that’s quite structured as well?

(3) Yes it’s very structured, yea.

(4) For us we have something quite similar. We start off in January each year with a needs analysis to determine what people feel they need to focus on for the year and we have an in-service co-ordinator so all the responses go to that person, they are collated
and then we plan our schedule of in-services based on that feedback. We consistently put all the feedback, as it has always been, to continue our current system of feedback as it is, which is a weekly meeting for one hour and we alternate the 1st and 3rd Thursday of the month is a business meeting and the alternate ones are in services and that’s either internal or external lectures. We would have as well journal clubs rotating through these and then on some services there are additional ones just for example ‘Care of the elderly’ they would have a journal club and the different members of the team would present on that.

Each staff member has an hour of CPD time per week to go to the library, source the internet, read the journals. We get most of the overseas larger journals so they can access that information and so for example each month we would get an electronic printout to say what’s on the contents of the BJOT, AJOT, Canadian Journal, Rehab etc., so people could see that. It’s compulsory for seniors to give a formal in service once a year and its optional for the staff grades and then we have performance reviews on an annual basis so within somebody’s performance review they will need to document what their short-term goals are and their long-term goals for the next year, and then similar to what has been said before, people can attend lectures or in-service seminars throughout the year and it probably would be similar to what Focus Group Member’s Name has said, about five days per person but based on clinical need and service need.

(F) Ok

(2) I guess outside of the main department its certainly within the mental health area there has been a bit of energy put into basic grades meeting and sharing within a peer level, inter-hospitably and inter community, so they have that opportunity and its their protected time to maybe reflect and become I guess initiators of their own CPD rather than it always being directed from at Manager level or, you know, its an expectation, there needs to be a balance in term, you know, of people developing themselves and than what the job expects their development to be.
Isn’t there something in Galway, a fantastic programme in Galway were the basic grades meet community and hospital, there was something written about recently, it’s not familiar to anybody no?

The whole area of supervision, it started off being, you know, in the profession a very different thing and for different people, we have, well all of us have, a huge emphasis on supervision so the staff may be, basic grade OT’s are supervised by the senior staff but the senior staff are supervised externally and the hospital is prepared to pay for it. Quite a considerable amount of money, I don’t have a huge staff, but you know its considerable amount, it would be the going rate of some psychotherapy nearly every month and it has proved very, very beneficial cause I can step away from that sort of level of supervision, you know it’s a kind of, and I can just deal with the running of the department, so peoples needs are often identified during that supervision that they can come back to me with them sort of decided. It’s just another angle

Very good

We are putting that on our agenda for our next regional OT Managers Meeting which is Dublin North up to Cavan Monaghan. We meet quarterly, about the whole area of managers having supervision because we don’t get supervision and for example my line manager is the CEO of the hospital whose is not going to dedicated whatever time is required to supervise somebody so likewise we would have our OT basic staff grade supervisory systems, they formally supervise themselves once a week by the seniors, I supervise the seniors then there is nobody supervising me and we have just recently set up a DATHS group a senior from each hospital is going to represent the different acute large hospitals in terms of their training needs and so for example the first meeting is being held either today or tomorrow?

Today
… and they are going to looking at the areas of seating and what sort of training needs they feel that each hospital has in relation to that and then we will put forward a business case for all of us to get training on that particular item.

(F) Fantastic so that’s strength in numbers and everybody benefiting from it.

(3) Also it will enable us to use the resources we have very efficiently so really we are identifying that the hospitals have the same source of learning needs in terms of external training needs and so we can post a course that can meet the needs of that group.

(2) There is an expectation that you have to go out side where that expertise my well be in Hospital Name or Hospital Name, well you know that that can be developed and shared and we don’t have to go to somebody outside.

(1) The likes of Hospital Name which is a teaching hospital for Trinity so they have a huge amount of things going on on that that couldn’t necessarily be identified as an OT specific obviously, but, you know, it would be foolish not to let staff see and go to all, I think fascinating psycho-therapeutic things, and that’s a huge resource to have a University behind you.

(3) But I think Focus Group Members Name your point about supervision is so right in the sense that we have become much more aware of the value of professional supervision and how that is actually directly linked, not just in identifying what someone’s learning needs are but in order to work through the process of reflection we’ll say, that happens within supervision process so in every way capturing learning and enhancing learning through opportunities in the supervision process, so when we have in, we have had a professional supervision training course, a four day course, this year, with the whole team engaged and Hospital Name have done the same and Hospital Name, so that we are all working from one model and we have had a lot of training on how best to develop the supervisee and the supervisor and so on and the model means
that we are all buying into the same thing so the focus on supervision has definitely increased in the last number of years and the importance of it.

(F) I just want to pick up one point that when you mentioned that its great that the basic grades were creating an opportunity for themselves to, I suppose focus on the areas that they identified as being important. One of the points I just wanted to note here was who generally sources the CPD opportunities for your staff? Now you have mentioned that the seniors have all come together and they have identified that they want to look at seating at the moment.

(3) We actually identified that, it was the managers

(F) Oh, OK

(4) We thought that from a strategic point of view it would be much more sensible and it actually came on the back of that recent proposal for funding from the LIT, the Local Implementation Team about getting funding for CPD and we thought it would be much more strategic to put in a joint submission rather than each of the hospitals putting in their own individual ones, in it is case there is no money forthcoming, but we thought that it would be strategic instead of me thinking oh perhaps I need to run a splinting workshop and then see what’s going on in another hospital that we would think that you have a person that has run it as in house or to source it from another hospital who can run it in-service and we can do it free of charge. So the current one is going to look at seating and then for example it has come up in one of the hospitals that there is a particular need for lymphodema training or dealing with abusive family members or whatever and than that we would look at that.

(F) So can I just clarify the current need to address seating at this particular training day, who identified the seating and the topic?

(4) The Managers
The Managers on the basis that they are working with the staff so it’s not simply, it is a combination, obviously the managers are identifying with the staff and what’s needed.

And that’s a group level, and then obviously at individual level you know like Focus Group Member’s Name was saying people have different needs, there are different stages of their development it depends on how, many there are, the clinical areas their working, the clinical team, there own sense of what they want to achieve within that, it all has to be factored in its not you know, well staff certainly wouldn’t take it anyway if I went in with a list and said these are the things that they have to. You know..

And there’s a tradition I think sets up in a place very quickly and in a department were the expectation is that if you work in my department ultimately you will get your masters, .......laughter..... but Hospital Name have done it, you know, and I mean if you come with it than obviously you come with it, but its that kind of expectation and it is not necessarily going to continue, this expectation. And there is an expectation that they will, so when people tell people and at all the interviews now it is becoming more and more evident that people are very clear about the identification of what their professional development will be.

Having said all that and listened to everyone’s contribution I think one thing to be careful about is that the concept of spoon feeding, say I for example would say to my staff this is the expectation you will attend these in-services, you will do this so and so. At the same time I know when I’m thinking back to when I was a staff grade therapist, I read whatever journals were pertinent to my area that I was working in of course some of that would have been on my own time in the evenings and I suppose back then to some extent it was I suppose it was a life long learning, whereas I sometimes feel with the junior staff in particular that they feel that you know they have done their 9-5 their going home and that any learning should be done during work time and that to me doesn’t strike me as very professional. That there has to be a sense of commitment to
want to continue to learn on their own time as well and so that is something that I would be cautious about.

(3) I would agree because it comes back to the ethos in the department and it comes back to things that we talked about like the supervision, they way in which that is address in the department. It is about an ethos of understanding that in order for the department and the service to be in the best interest of patients, the standard expected is very high. So very high means you put more in than just your 8-4 on the ward and that is our responsibility really in terms of leading, to convey that in a very constructive way but it’s about a positive ethos towards learning

(2) And that then gets reflected up the organisation regardless of whether your in a private hospital or in publicly funded or voluntary because they are all now being regulated and accredited and you know, so the OT within the Team or within a service has to say well “this is what I’m competent to do” and “this is what I’m taking on”, so your feeding up into the service and then that is developing from a quality point of view for the person that were ultimately delivering the service to. You know, that the patient is getting a better service. So you know, things are coming in and I guess when registration eventually comes that’s another that will hit in, so the people will be regulated regarding it, there will be certain standards that people have to meet, accreditation does that as well.

(1) And as a follow up to that, a red flag area I think as well, is the expectation that when your finished your degree that you would have a lot more time to study on the job. You know I think when you’re finished your undergraduate degree there is a need for clinical participation and I haven’t had it much but once or twice, you know, an OT forgot that she was qualified, that student life was being pulled into first and second year of working. Now it doesn’t happen a lot but it does happen. So you have to be very careful to balance what is professional development and what is just upgrading your own knowledge really.
(2) You also have to be mindful, I’ve seen it with certain staff, you know, just observing staff around different areas, but people go off on very specific tangents in terms of CPD. They become very skilled and they become maybe psychotherapist or Cognitive Behavioural Therapist and that wasn’t what they were employed to be. They were employed as an Occupational Therapist and it is very hard then, you can see you know managers trying to hold that person back, you know, that they may be made to step out of their OT role and do that in a different way, you know, all your energy is focused in, and I particularly want to become a psychotherapist, you know, it’s a lot of drawing from the department then to fund me to do that and then its not really related to what I’m employed to do.

(3) And I suppose that’s the bit that the manager has to oversee and be sure it doesn’t go beyond a point. Because it gets confusing for the staff member if there is to much support in one direction and then there is a difficulty, the planning bit the PDP bit is important in that situation. And a couple of other thoughts I had were mentioned briefly the understanding the stage that the person is at within the team and what stage the team is at so it is very much also considering the team dynamic and the Manager and the Seniors and the Basic Grades all because it is lead from the managers understanding and filtered down, and it should be, so that it becomes a collective approach. But a really good emphasis on team development and the team dynamic helps to ensure that the CPD is relevant for the person, so if somebody is new they need much more concrete clinical kind of learning or if they are even more senior and they take on a new clinical area they go right back to stage one where they are concrete black and white and don’t know what their doing and that’s acceptable, that’s absolutely fine that’s what happens. So in responding to that and recognising and ensuring that the support is tailored all the time in the right direction then there needs to be an understanding of the team dynamic, team stages. So that is very much an area that the manager has got to have skill in if they are not clear on that, you know. The other, the only other thought I wanted to mention at this stage before we move on from it was the supervision bit again, the part of our model is that it is a shared agenda so when we talked about there being ownership on the part of the staff member who is the supervisee, we will say in that case, the
supervisee is equally responsible to bring agenda items as the supervisor so it is not set, its not directed its actually very much, and it sends a message of it being their responsibility as well so that’s all capturing that complex component.

(4) That’s a very good point Focus Group Member’s Name, when I first started in supervision in our department, you know, we would explain to the staff all the nuances of it about being confidential and all the rest and then I had a page which I used to write down what was discussed and then the actions and then one day one of the seniors said to me, and I use to raise the agenda really, and then one of the seniors said to me you know its my supervision I wonder if I should be saying first what I want to say ‘cause actually most of the things I might have on my list are exactly the same that you might have on your list but it is my supervision, and I thought it was a really good idea. So now it’s the person who is being supervised that they bring forth their agenda items, there discussed and then if there is anything else it’s raised. But recently as well, I have got the supervisee to complete the documentation rather than me writing it and then reading it and signing it. So their now reading it, so it’s giving them more control. It’s only a tiny little thing but I feel the dynamic is much better with that.

(F) It enhances the sense of ownership over the supervision.

(2) It’s hard for people as well, ‘cause I’ve had staff that come who haven’t had that experience to be able to compare and comment. And they look at you and kind of go “but no but you do it” and you’re “no, you do it” and its really hard for them to think what am I good at, what do I need to work on, you know and it takes, that’s a whole learning as well in term of taking on strengths also….

(4) I think as well one huge difference that comes to my mind is that in the last couple of years the amount non-Irish trained O.T’s that I would be employing and my department is much the better for the foreign staff, that we have there, who are absolutely fantastic but depending on where the person is trained their background can be quite different and therapists from certain countries, for example, India and the Philippines they would have
very different emphasis on the training, for example, it would be very much say ‘paeds’ based where as if they were working in acute care with adults it does take longer for them to settle in, the whole orientation, their CPD needs would be greater. The other staff in the department recognise that, including staff who are from India who are all fully up skilled now and they recognise, well you know your background is going to be a bit different were going to have to polish you with this this this and this.. That’s how I was like when I came. And I’m finding that very interesting but it’s certainly well worth the effort once you have somebody up to speed.

(F) Can I just ask what CPD activities do you promote in your department and would you favour in your department?

(1) As in what?

(F) As in do you promote Conference, do you prefer workshops, do you prefer journal clubs?

(1) Kind of a mixture…

(1) I think that probably the conferences in that a lot of it is budgetary certainly list that you gave out are cheap you know they don’t cost anything financially whereas others obviously cost a huge amount. One I would emphasise for most of them is to go to the OT Conference. You know I think that’s an important thing; I mean, I know, it’s very….., they should be going I think. That would be one thing I kind of would be more proactive with the thing…..

(2) It actually… you can actually get to present at the AOTI conference, its an opportunity… it’s an opportunity to present as well so you can have CPD.

(1) There’s a lot more goes on in it, within the conference so even if you’re presenting you’re learning so it’s a good atmosphere to learn
(2) You can identify with it because its oh that’s what there doing in Hospital Name I can follow up on that very easily or maybe I can go and visit and use that, you know and you’ve got the networking then to say, Focus Group Members Name can I come and see that or ..... 

(1) One thing I would also emphasise its just my own interest is that they read the journals, my staff, not that I can force them to read it but that we get a huge amount of OT Journals and Mental Health Journals. You have to remind people to read, its an amazing thing that they don’t innately pick it up, so now I kind of, not pretend, but sort of, what ever the word is, that the journals will stop and I think they will if there not seen to be read by OT’s because there expensive and the Librarian said to me, like you know, if there not used they’ll get some other journals. So that’s been my tack... Well I feel that it would be awful to start dropping the journals.

(4) In relation to the conference I say to people that, you know, I get funding every year for five to go so you can only go if you’re a member of AOTI, and I think being a member of the professional body that there are some CPD advantages but certainly it’s the whole aspect of professionalism and I think its all very interwoven you will rarely find somebody who is hugely professionally and very focused and has no interest in their CPD its usually very closely interwoven.

(F) Are there any particular CPD activities which you wouldn’t highly recommend or you find don’t make a big impact; they don’t affect practice?

(3) Something that comes to mind is people, recently in where I am, seeking to go on the Bobath course when they are new Basic Grades. That’s not useful to them, its beyond what there able to take in so the timing of certain training is very important to consider in light of what they would be able to take on.

(2) Because some things become flavour of the month.
Absolutely!

Everybody starts taking to you like, can I take Bobath, can I take… and your kind of going, hang on here a minute..

CBT is another…. And DBT..

What’s DBT?

Dialectic Behaviour Therapy…. This is the new in thing?

That’s right, they are flavour of the month.

And part of that is some of the bigger courses are not very accessible so when they come everybody rushes, they have to got to get them because they wont get a chance for another year, another 18 months so, but that’s not a reason to do it at that time so there needs to be some help in helping people to see that.

And when you said that, about people you know going into different professions practically by the time they’ve finished the course, that’s one of the things I would discourage that kind of professional development. Where basically the person is not going for a day to just hear about CBT or whatever it is there going to basically become something else. Even a drama therapist, who was talking with me, was talking about drama therapy and psycho-drama in London but if you do that and qualify you are a completely different thing. I am not employing, you know, whatever about doing a course in drama therapy I feel it’s a part of your..

…So you have a couple of extra skills
(1) But for somebody to go off and do a two year or a years course in art therapy its a very different… and the hospital are not paying them to be those things, they are paying them to be an OT.

(2) And also, like I mean, there is that overt thing, you know, you have your OT level but there’s the organisations objectives and then obviously the health service wants OT’s to be doing certain things and there directing that.

(4) Just in relation to CPD following on say to the OT assistance. You know there is a recent training there and it was quite different how, sometimes the therapists themselves were keen enough on doing this course that I am putting a lot of effort into it and yes I will do some study on my own time, whereas, sometimes I had it recently that one of my assistance felt that she was doing something additional and she should have extra time off to study for that, whereas I would never have come across an OT qualified staff member feeling they were doing a course, it was helpful to them and they should be getting extra time off to study so I think that is very positive and that they see it as additional skills in their repertoire.

(F) Do you feel that CPD has a positive impact on practice, on day to day clinical practice; can you see the impact on somebody having undertaken a course?

(4) Absolutely…

(F) Can you describe them? What do you notice or observe?

(4) Well even for a very minor aspect of, say for example the therapist not being fully sure about a particular seating system that a patient requires and you might get a rep in for them, or they might organise for the rep to come in and go through the pros and cons of say two or three different seating systems. By the end of that maybe even only 30 minutes, they will be more informed, they’ll be more knowledgeable and hopefully more confident to then go onto the next patient and think, you know, using my reflective
practice, bringing all that to mind, I think that Mrs X would actually do very well on a reassist, based on what, that rep said yesterday. So it might be as informal as that, which doesn’t actually seem like CPD, but in essence it is, and so people are doing that all the time. So the client benefits, the service benefits because they are able to make a more speedy decision the next time, they have learnt, they have become more confident and they can then pass that onto the colleagues.

(F) Is that a shared view in mental health ‘cause I suppose it's not as tangible?

(1) Oh yes, I mean, I think, I can even see it in myself, its not even just about your staff. I have done courses over the years and I know that my clinical input and practice has improved. I finished about two years ago a diploma in bereavement studies which is really like, well you would wonder,! but anyway, and that has not had an obvious impact in it, but the more I’ve…familiar with the suicides, that are happening, I didn’t even think about it in relation to Hospital Name I did it because I was interested in it. But I can see myself being better at it and I remember doing a course years ago in ergonomics, when I was working Hospital Name I think, and it stood to me all my career, you know. You know the way some people the energy, when you think back, and I mean I know that staff would say the same, you would do anything to educate yourself.

(2) Once you do something that you’re interested in and it then translates back to…

(1) But your motivation is increased … to implement and then go back and think that this would make it better…

(3) I’m going to throw a slight spanner in the works, ‘cause I think yes, … except there are times when if the timing is wrong for somebody and if they don’t have exposure quite regularly afterwards, it can be lost, the opportunity, and I have seen that, say a Cognitive Perceptual Course and the person isn’t in the area where they are going to use that regularly and its gone, so its fine provided there is follow up through the supervision process and that means enabling opportunities to be put in front of the person to continue
to develop those skills, so yes but with a slight word of caution that it doesn’t always work, there needs to be planning around it, the timing needs to be right for their stage and they need, sometimes, continued exposure to build on the confidence in developing these new skills, because if there is a gap it can be lost.

(1) Sometimes I think in Mental Health, I know its very different really, because of .. I think that, the type of courses that people can do are often not tangible but their increased understanding of human behaviour is so important that it inevitably effects their participation. Like a course on communications, a course on listening, a course on humanism, OT, you know, the kind of structure, but certainly any of the courses that I’ve seen have going on with that kind of flavour, their awareness of their own limitations, if that’s the best way of putting it, or their skills is extremely good. So seating all these things would be lovely because they do have an outcome, but sometimes mental health is more about….human behaviour.

(2) Or if you are doing something very specific or around cognitive for the elderly you do have to have, and I agree with Focus Group Members Name, opportunities to practice that, and if you have gone there of your own volition its fine but if I as a manager suggested it then you find the practice doesn’t change, you know.. like we’ll do it this way because that’s the way we have always done it. You know, there is always that because otherwise you would have beautiful services, you know we have services that are doing, certainly in mental health, that are doing things they were doing 30 years, 50 years ago! There hasn’t been a change!

(3) And that comes back to the ethos and the manager assisting in developing an ethos of continuing learning. Continuing learning means continuing change so when that is excepted as great, constantly, constantly questioning and changing were change is needed then there is more value.. you know.

(1) I think OT needs different types of learning you know….. some people are great at going on a course and learning splinting, and they love it, you know, and that’s what
they like to get facts. Other people like a sort of vague, you know, conceptual, philosophical course. I know in my staff there is a mix of both including myself, some people do benefit if they’ve learnt, want to do the course they want which is very boundaried and tangible and they come back with a new skill as opposed to just a new awareness, so it depends on the learning capacity of the student.

(4) I think tying a lot of what people have said and listening to people, is the opportunity, the timing is very important and I have given quite a few seminars down through the years on NDT ‘Neuro Developmental Training’, and I remember I went to a course on that as a student when I was doing a placement in London I just happened to be in the right place at the right time with a little bit of a neck asking if I could get on it and even though the person who ran the course will only take seniors and not, because she felt you didn’t have the skills and here I was a final year student. But anyway I impressed her, got on the course and I have thought of that woman so many times down through the years, she was brilliant persons name was her name, magnificent teacher, she went through everything, she practiced with you and then she got the patient in and then you actually physically saw what was going on and each time I do that I do the same format. I go through the process, the neurology behind it, I get them to practice and then I get a patient in for the next part of the session and then they practice on the patient. And it was just, you know, because I was very enthusiastic that I wanted to do that. But I have given that course almost free of charge, I got to go on that free of charge and it doesn’t have to be something that is really expensive and based in the U.K. or in the States or wherever that you know its just being enthusiastic for it.

(2) The other thing is when you have encouraged students within your service, that has the effect of…. it’s a continued professional development as well, because I think that’s very important in people but they come with new learning and that raises the clinicians learning and there is a sharing then of information and learning and that, and having students about the services really just enlightens and you know, it just brings a great enthusiasm, you know, if they are a perfect student I suppose! Or even if there not if
there learning enough but you just get, they bring you things from college and that it encourages the clinician then to kind of try out things.

(1) That’s so true, because only yesterday I found or saw a book of a student, and she had a book a text book, it might be a re-edition of something but it was familiar to me this is a text book. I thought “Oh my God!”, so I rang Trinity and asked them to send me out the list of books, I do that periodically, but I thought that’s very good, but the O.T’s that are with me were unfamiliar with it.

(2) You have got to keep up with what the students …..what they're at.

(A) Yea

(4) I have one little thing that I wanted to add in that very often people focus on the proficiency or the competency when you’re at college as a student, and how are you doing on your learning plan and your learning contract and its all very focused on the student and I think in my day there was a perception that when you qualified that was it. Off you went and you were very much left to your own devices. I certainly had no supervision until I went and worked in the States so none in Ireland and none in, well I hadn’t worked in Ireland, but none in the UK and it was very much your qualified now sort of “go and do it” and if you do a bit of reading well and good and I think the whole attitude now is so different that it is just brilliant. There is the focus on life long learning the concept that you should be reflecting on your practice and I have only heard these things since I qualified rather than as a student. So I think it is very good that the profession has developed in that way and I think the AOTI is developing that way as well in the fact that we do have our AOTI portfolio, we do have a project officer at the moment looking at this whole area and how we are going to be more viewed in the future on our proficiency and competency rather than just the fact that we have a piece of paper saying that you passed a qualifying exam.
(F) You have brought us on nicely I suppose onto the next topic of competency, can I just clarify what is your general understanding of the term competency?

(4) Being proficient in a skill or a task

(3) To the standard expected for that particular post

(F) I suppose, how would you determine whether a staff member is competent or incompetent?

(1) Well it is a very difficult thing because I know when I worked in the States the competency was assessed by your peers, basically in relation to kind of supervision, assessment done every month by a speech therapist, on a speech therapist, an OT on an OT.

(3) My goodness!

(1) It was quite, you know, and the competency was you would be set a task at random and you would just do it. You would be doing it every day but the assessment was based on this particular task of for example, dressing practice and ….it didn’t settle well with me and it didn’t settle with a lot of the European trained OT’s it just felt really…intimidating. It’s a very cultured thing, you know the Americans loved it, you know up to their tonsils in it. But, I do think, since I’ve come back I’ve often tried to find how you do judge competency. I know the outcome of somebody…..I’m finding it difficult...

(3) We have started the DATHs Group are in the process of developing a competency framework, in recognition of the fact that it is so difficult, how to pin it down, how exactly so we have broken down each clinical area now into or are in the process of breaking down each clinical area into exactly what’s required. So its broken through the OT process absolutely, following the OT process and every “component”, is the word I
suppose that would be required to be deemed to be competent to work in that area. So it’s a help but its not a ….

So for like for the assessment part of the process? Can they carry out the assessments that are?

(4) So say you were working for example Orthopaedics, and have to do three pages and its designed under essential and desirable and the knowledge and theory is one bit and then communication and all the rest so its like… is competent in doing an initial evaluation and then it would be standardised and the non standardised and then there all listed out and that would be for Orthopaedics, Neurology, Stroke, Care of the Elderly etc.,.

(2) I did my research on Competency.

(3) Oh Good.. well you had better butt in then !

(Laughter)

(3) Oh yes, when you were doing your Masters.

(2) I looked at the Office for Health Management…..Produced a lovely document for OT Managers competency and for managers across the therapy type profession.

(2) And the theory would say, that people spent so much time designing the competency and looking for all the little subsections that are under each of us, that nobody puts any energy into actually managing the competency or reviewing the work testing that all the energy is put into designing and then it falls down. And if you look at that competency frame work, a huge amount of money went into it, it was fantastically design and everything and I would say no manager within the country is using it and I think it was just that, nobody took it on and said ok now were going to work with the managers around this and look at it. So it falls at the first stage, the design and the concept of it is
all well written about, its beautiful….. but when you come to the next part it just falls down because nobody actually time frames that or puts the energy into that so be mindful of that when your designing cause all the energy goes into that and the time somebody is ……

(3) Yea

(1) Whereas, in the States they did do that next stage which was …

(2) And so then I think you have to be careful of the culture thing and how you benchmark whether is somebody is competent if its very tangible, its very easy and the other thing, the feeling they are then…. the sense of “oh yeah Focus Group Members Name is an OK therapist”, you know that would be, and I would certainly sometimes work a lot on my gut when I think “oh yeah I’m happy with that”, I have a sense of the staff member and I’ve observed or you know I’ve walked around that kind of thing and the feedback I would get from the patients or the other clinicians on the team would be oh yeah Focus Group Members Name working very well on the Team or other Team members have kind of said that to you, so I would have a sense of it and I think you have to have a sense of competence as well as to what that is.

(3) Yea

(2) We designed a documentation competency some years ago, a standard, we were trying to influence that into the system and whenever you put something into a system the system reacts and changes it and modifies it to the culture, and I’m just thinking here of you Focus Group Members Name, what we did was because people, they thought we were looking at something and we were going to be very critical and you know and we were going to get a score and you know you were suddenly going to be nought! There was lots of people in the service who at various levels had recorded their interventions so we didn’t have a uniform, so this was a broad standard across mental health in the Dublin area, so lots and lots of people, so what we did was we got people to break down
their anxiety, was pick somebody and get them to come and randomly pick three or four files and see if you are doing very basic documentation stuff that would meet the standard. So that kind of made it less threatening so they had there cup of tea and there scone and they sat down and they well we’ll show them… and then you do, you know, five for me and somehow that they, that there was a little bit of learning in it, you know, at least the basic standard was been met but it does, there is a huge resistance to those kind of…

(3) I’m interested in listening to you Focus Group Members Name and I need to talk to you more because you are saying good points. We have factored in a self and a supervisor rating scale not necessarily managers, rating scale

(2) An initial and half way

(3) That’s right, through the rotation and the initial is the self rating of your competence to complete whatever, because the supervisor doesn’t know you then so that’s the starting point what you think you are and it’s about insight as well. It gives you room for discussion around awareness and insight and then mid point it is the supervisor and the self and it is discussion, you know, so it is less threatening in that way I suppose. What does that sound like? Has there been similar?

(2) Oh yeah ‘cause I remember as an OT student, do you remember those forms where there was 1-5 and you got all these ticks…and suddenly you were back to college discussing it, how many you scored!

(Laughter)

(2) There are different ways of … yeah of assessing things

(2) As a manager you know I think certainly you have to kind of be aware and get external peer feedback as well cause, if you can from others… you know, generally in
psychiatry it would be the consultant who is the lead on the team so usually your kind of getting a sense from them as to…Or they will generally come back to you and say so and so isn’t performing or we don’t seem to be getting you know.. I would have a different expectation of what an OT should be doing on the Team maybe or the referrals aren’t been seen quickly enough or we don’t, you know.. So people I think do come back now a days and say well such and such is ….  

(1) But I think you have to be mindful of the fact that some people complain about say a therapist but in fact the therapist has been perfectly boundaried.. you know I mean I know one Consultant comes to mind who would love the OT to do just’ everything, you know they are just left with everything and then the OT left and a new OT came in from a different culture altogether anyway, as it happened and wasn’t going to look at any of this….you know. They weren’t going to be taken “funny bunny” kind of referrals, and he came down to me and he said she’s not pulling her weight and I thought,….. you know, that she in fact, was perfectly professional  

(2) But then you had the evidence, you new, so you were able to ….  

(1) Yea, yea  

(1) The feedback would be that peoples’ perceptions, particularly in Mental Health are not doing what they think OT is and that’s the biggest problem. I think it’s probably gone by the board in general medicine. But there is still the old school of thinking that we employ an OT, not with the young, not with most people, but there is the odd Consultant who still sees if they don’t do what they perceive OT to be they are not good.  

(4) I am just thinking back to what you said earlier about your time in the States. I know when I first went there when I had supervision I thought what a waste of time; I’ve worked for two years. I’ve been a senior one in the U.K. and here I am coming for supervision. And I just thought it was ludicrous but it was also putting extra pressure time wise on me. But the more I got going through it and feeding back what I was doing
to patients I realised that it was a totally different system and it was a good springboard for me to find out that what I was doing was correct and to find out how I should be doing things and then they did have in services, a little like what you were saying were you had to go along and you had lectures on cognition and maybe another one on perception. But the thing that was terrifying for me was that we were to do a stress test for patients and have them hooked up to the EKG monitor and then we had to learn how to use it. So I was actually thinking more from the other end…. “Bloody Hell this is very different I’m going to have to know if someone is going into V Tack to stop them because otherwise I had to keep pushing them” and so it was a very different, I was way out of my comfort zone and so it was, you have to learn things because you have to fit in what they consider now to be competent to do that here. I was having to learn, learning how to do manual muscle testing I think I had learnt that as a student and you know just got through it because I had memorised all the stuff rather than because I knew it. So in terms of what they expected then as being competent and what they expected you to do in your CPD was very different than what a basic grade over here was doing and so from that point of view I soon started to think “Wow this is to my advantage to row in with this so that I know exactly what I’m doing that I am competent according to their standards and that I don’t kill someone in the first instance or get fired in the second.” So I did swing around to their way of thinking.

(2) There is also a point at the moment within various establishments within the Mental Health Services to have a generic worker within a Team and everybody does the same and everybody can do the, everything, from administering the medication to making a risk assessment of somebody in the likelihood,… and for when junior and new members of staff who aren’t competent to do that there needs to be a boundary to say no basically a senior even isn’t competent to do those things, and they haven’t been trained in that so there has to be a guard of ethic because there is a very strong push, you know, we can’t get nurses now, so OT’s can start doing medications and you know or case workers and case managers and that’s a whole other set of competence that you need to have x number of years of experience to do so knowing whether somebody is competent to do that or not it’s difficult. Also I don’t, I have never had staff in a department in Mental
Health Services so people could be across lots of different sites, I mightn’t see them for a couple of weeks so you have to have other ways, you know, I can’t sit in a department and have lunch or tea on a regular basis and know, so you have to work out other ways and your reliant on the person then coming back to you and being open and honest and saying “I’m having difficulty” or “this is going well” and maybe doing some site visits or if a lot of the work is done in the home you know, so there are kind of different levels of kind of assessing their competency.

(1) But having said, that if you have an incompetent OT or whatever, its very hard to realise until something has happened, which is the reverse of what we are talking about. Its only happened to me once or twice in my career were the person really wasn’t doing, but it was so well shrouded in, you know, even if you have things set up and your gut tells you things, you know its awful when you realise that the horse has bolted and you realise the level of incompetence!

(2) Until you go searching, then you’re digging down and...

(1) You realise that it was maybe more obvious then you thought

(4) And if you think back to what the minimum standards are in education for OT’s about knowledge skills and that to… somebody may have the knowledge that they got through the exams, they may have the skills so they can get through the job but they may have the wrong attitude and I am thinking in one department I work in, in the States were there were 85 OT’s and there was one person who had the knowledge and the skills but didn’t have the attitude and overall I would have felt that she was incompetent, so she could manage to float by with things, you just couldn’t necessarily quite pick it out, but overall she I felt wouldn’t have met the standard and likewise I would have felt one person working for me here and when I went back in a discussion with the individual and asked them how they got on in their placements, there were certain things that were done quite badly, on several instances and had asked could I contact a former supervisor
and the former supervisor was; “this individuals absolutely lovely, a real pet but totally useless”, and yet they had got through!

(2) You find that all the time, they pass people and they say, “well there going to mental health now so they will sort them out.”

(Laughter)

(2) And your actually, why? why? why?

(4) And now your looking at this individual, who doesn’t have any insight and maybe doesn’t have the right attitude or has a lovely attitude but doesn’t have the skills or the knowledge, but whatever anyway, their not firing on all cylinders and here they are helping you determine quality for the patient, but I know this particular individual when I sat down with them and said look, were going to actually take you on for the next three months we will pay you as a staff grade but we are going to take you on board really as if you are a student and we will set up a learning contract and we will get you through in the three months so that you can leave here and go for a basic, basic, basic, basic grade job and that you will be, you know, a qualified OT and we sat down with the paper work, this person would have failed their second year competencies, and it was then, you know, that I got that individuals permission and spoke with their, all if not several previous supervisors and then you think, that person, you know, its just, that there are people in this system that would be a bit like that, and they really do, and this individual then when their time was left with me and I said, “I will give you a reference for some facilities only. I will under no circumstances give you a reference for an acute care general hospital anywhere in Ireland” and then the next I get a phone call from the head of OT in Hospital Name …. “Would I give a reference?” and I said “No” and so for this individual, all the input he had, the whole department nursed the individual, he didn’t take it on board and is still left, had the knowledge by the end, had much more skills, the attitude was way off and I am sure that that person is still going to floating like that to some extent. So I think it is really important that competencies get tied up.
(2) Then we go into the area of industrial relations and due process for the person and all of that and that all brings another whole set of skills together that the manager has to have and there is very rigid standards and you know the union lays down things that you have to follow through so you know that’s a nasty side of, you know, that can be very hard on everybody because mainly, some of them might be abstract in terms of the attitude as well but how do you document that, where does that come in on your standard, you know, what is the expectation in this department. So that’s kind of boundary less, you know, it can be hard, and if the person hasn’t been explained that, “this is what’s expected of you and this would be what we need”. Then if you don’t do that on day one…

(1) I’m a great believer, I always have been on the fact that, you know water finds its level, you know that kind of concept. That in a department if you have a lot of very good therapists, you know, I shouldn’t say this, I don’t know if it does happen really but that it brings up the standard and peoples incompetence its either that they, it does show up more than you would think or that people leave, you know. I think it is true in any job. You know, in psychiatry you see it an awful lot with some of the facilities in this country where nobody gives a damn about anything, so even if you are competent it doesn’t matter, ‘cause its all gone down to depths where as if the standards are high in the department or in the hospital or in a unit, you know people come with that if they can’t it becomes clear …

(3) And they leave.

(2) Yeah definitely

(1) You know, it is its own correction, and I know you can’t depend on that but it does in reality happen.
(4) And unfortunately sometimes people give a reference just to get rid of them, which is a whole other ball game altogether, and then you know,

(2) But references are so basic these days your really only giving dates of employment …And they arrive with a list of places

(2) And nobody would dare write down a character reference, you know, your wide open for litigation

(F) Thank you so much for all your comments, I’m just mindful of the time and I did say that we would finish up about eleven. So if there are any final thoughts or any burning reflections or new insights that have come to light?

(3) Have you covered all you need from us?

(F) I’ve plenty thank you

(4) It was interesting in itself

(3) Yea

(F) And it was a very enjoyable discussion to be listening in on and I am looking forward to playing it back and analysing it. Thank you very much.
Appendix 20

Research Study Time Line

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<tr>
<th>Event</th>
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<tbody>
<tr>
<td>Submission of Research Study Proposal</td>
<td>May 2007</td>
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<tr>
<td>Submission of Literature Review</td>
<td>September 2007</td>
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<tr>
<td>Submission of Ethical Approval Application to Faculty Ethics Committee</td>
<td>December 2007</td>
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<tr>
<td>Ethical Approval Received from Trinity College Dublin</td>
<td>February 2008</td>
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<tr>
<td>Focus Group Facilitated &amp; Thematic Analysis Conducted</td>
<td>March 2008</td>
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<tr>
<td>Pilot Questionnaire Circulated &amp; Amendments made</td>
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<tr>
<td>Survey questionnaire circulated nationwide</td>
<td>April 2008</td>
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<tr>
<td>SPSS Data Analysis conducted on questionnaires</td>
<td>May 2008</td>
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<tr>
<td>Write up of chapters</td>
<td>June 2008</td>
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<tr>
<td>Submission of first draft to supervisors</td>
<td>June 2008</td>
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<tr>
<td>Undertake revisions</td>
<td>August 2008</td>
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<tr>
<td>Submission of completed research study</td>
<td>September 2008</td>
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