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USING THE CANADIAN MODEL OF OCCUPATIONAL PERFORMANCE IN OCCUPATIONAL THERAPY PRACTICE: A CASE STUDY ENQUIRY

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A thesis submitted in partial fulfilment of the requirements of the University of the West of England, Bristol for the degree of Professional Doctorate in Health and Social Care.

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Abstract

In 2004 Occupational therapists working in one county, across a range of health and social care settings, adopted the Canadian Model of Occupational Performance (CMOP) (Townsend *et al.* 1997, 2002). Implementation of this theoretical model was through action research (Boniface *et al.*2008).

Introduction: The focus of this thesis was to build upon this earlier research and explore the clinical practice of occupational therapists in more depth. The study sought to understand potential issues of using a single model and explore how momentum and use of the CMOP was sustained in a constantly changing and evolving health and social care system. The overarching research question was: *"How does the Canadian Model of Occupational Performance (CMOP) influence occupational therapy practice?"*

Method: Case study methodology based on Yin (2009) was used. Three sources of data were examined; namely minutes from steering group meetings that oversaw the implementation of the model, artefacts created by the steering group, for example, training packages and manuals and interview participants. Each unit was examined separately using thematic analysis and then themes and patterns across the dataset were identified to understand inter-relationships and contextual factors which influence use of the model in practice.

Results: Four converged themes were identified which directly related to the research questions and propositions, '*This is what we do it here*', '*Can we talk*?', '*Setting out my stall*' and '*Documentation is a battleground*'. Examination of the data revealed that use of the CMOP was a complex multifaceted social process where ongoing socialisation was required to create and maintain a shared identity. The inter-relationship between the steering group, artefacts and individual practitioners was evident and testimony that use of a model was a dynamic process which required commitment and leadership. Professional growth, in particular within generic teams, required occupational therapists to articulate their worth and adapt. The CMOP was an integral part of the creation of a professional identity for occupational therapists in this study. Understanding relationships with external stakeholders were equally relevant when exploring the social world of occupational therapy practice.

This study identified that use of a single model; the CMOP actively encouraged practice development in this county and was a dynamic and multifaceted social process. The findings contribute theory building in occupational therapy practice.

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1. Introduction

1.1. Overview

In 2004, occupational therapists working in one county, across a range of health and social care settings, integrated into one service. At this time, the decision was made to adopt the Canadian Model of Occupational Performance (CMOP) (Townsend *et al.* 1997, 2002) as a theory base to underpin practice. Implementation of this theoretical model was through action research (Boniface *et al.*2008). The focus of this thesis is to build upon that work, and presents case study research which seeks to understand the relationship between the CMOP and clinical practice, from a number of interrelated perspectives. In this chapter, I will set out my area of research interest and include a brief account of the setting, my role as researcher, and relevant developments that occurred post adoption of the CMOP. There will be a brief background to explain why theory is important for occupational therapists, with a short description of conceptual models of practice and the CMOP. The chapter will conclude with the aims of the thesis and an overview of contents.

1.2. Development of occupational therapy theory

Occupational therapy theory has traditionally been difficult to describe, and practitioners have not always overtly used or articulated theoretical principles in relation to their own practice (Feaver and Creek 1993b; Creek, 2003). Despite recognition that occupational therapy as a profession has value, there has been a struggle to identify one discrete body of knowledge underpinning practice. This has contributed towards inarticulacy within the profession, which still exists today, with a lack of agreement for definitions of theoretical concepts (Duncan, 2006; Cole and Tufano 2008). Numerous explanations of what occupational therapy is, and what occupational therapy does, are in existence. Whilst arguably this can be seen as useful for practitioners who work in a variety of settings, it can be viewed as an issue for a practitioner who is trying to succinctly explain the philosophy underpinning their profession in a way that is understood by others (Kramer, Hinojosa and Royeen 2003; Duncan, 2006; Boniface, 2012).

Theory does not have one simple meaning but is a set of statements to explain a group of facts which have been tested and widely accepted (Duncan 2006, Fish and Boniface, 2012). When theory is used, it influences the way we view the world (Kielhofner, 1985; Turpin and Iwama, 2011). Theories can be scrutinised and tested to help therapists articulate

interventions, explain why actions are taken, and improve services provided (Kielhofner, 2005; Turpin and Iwama 2011). Yet occupational therapy literature reveals many practitioners do not use theory to guide practice citing reasons such as, it does not reflect the ever changing world of practice, which has led to an acknowledged theory-practice gap (Kielhofner, 2008; Sherratt, 2005; Turpin and Iwama 2011; Ikiugu, Smallfield and Condit 2009 and LeClair *et al*. 2013). Whilst these gaps are not unique to occupational therapy and are found in other professional groups, such as nurses and social workers (Rolfe, 1996; Thompson, 2000; Turpin and Iwama 2011), this is a worrying trend. Duncan (2006) astutely commented that a client has a right to expect the same quality of service irrespective of where it is being provided from, and by whom, and observes that achieving a level of consistency is difficult if practice is influenced predominantly by personal bias, values or beliefs. In the literature, there is agreement that the use of theory supports practitioners to be confident about both professional knowledge and responsibilities (Fish and Boniface 2012; Turpin and Iwama 2011; Duncan, 2008). However, practitioners face an external environment, which is dynamic and constantly evolving, and any actions taken are influenced by contextual surroundings in which the practice is enacted. Greber (2011) identifies that many therapists continue to view their practice from what they see on a day-to-day basis. Therefore, it can be suggested, environment influences how professional theory is applied.

Historically, external influences have strongly shaped the development of occupational therapy practice, which has undergone a number of paradigm shifts during the last century. A paradigm shift has been described as, when an existing shared vision and understanding alters, and is replaced with a new consensus of fundamental beliefs for the profession and practice (Duncan, 2006; Kielhofner, 2002). In particular, during the 1940s and 1950s, there was a distinct lack of clarity and purpose for the occupational therapy role, and reductionist interventions were conducted under medical direction. Practice had moved away from the therapeutic and occupational focus that was evident earlier in the century. In the 1960s, a seminal lecture was delivered by Mary Reilly, who called upon occupational therapists to refocus practice upon occupation (Reilly 1961). Since the 1980s, the development of occupational therapy theory has been rapid (Christiansen, 1999; Reed and Sanderson 1999; Kielhofner, 1985, 1995, 2002, 2008; Townsend *et al.* 1997, 2002 and Polatajko *et al.* 2007, 2013), and produced theoretical models specifically to be used to create a tangible link between theory and practice.

Multiple definitions and meanings for models, frames and approaches exist with the terms often being used interchangeably. Key authors have sought to clarify terminology (Cole and Tufano 2008; Kielhofner, 2008; Duncan, 2006; Boniface 2012). There is general agreement

that theory exists on three levels; paradigm, occupation based models and frames of reference. Broadly speaking, a paradigm is the part which embodies the philosophical beliefs and values of the profession as a whole. Models are occupationally- focused theoretical constructs, developed specifically to explain the process and practice of occupational therapy; whilst frames of reference are theoretical ideas developed outside the profession that are applicable to practice. Both models and frames of reference provide a theoretical framework for planning assessment and intervention processes, and can be used as a way of explaining and describing the occupational therapy process (Turpin and Iwama 2011; Duncan, 2006; Creek and Feaver, 1993a, Hagedorn, 1996; Kielhofner, 1985, 1995, 2002, 2008). An important function of models is to encourage practitioners to think about the needs of their client, not simply what can be achieved in the setting in which the intervention is being conducted (Turpin and Iwama 2011; Boniface 2012).

1.2.1. **Conceptual models of occupational therapy practice**

Conceptual models usually have schematic, graphic and visual representations of concepts and assumptions, which act as a guide for theory development (Stamm *et al*. 2005). Kielhofner (2005a, 2008) suggests that models can be used as a way of developing tools and outcomes, which ensure theory and practice, are integrated.

In the last thirty years there has been an increasing focus upon *occupation* based conceptual models and, in particular, there has been an emphasis upon occupational performance. This is defined as:

> *'…the dynamic relationship between the person, the environment and the occupation. It refers to the ability to choose and satisfactorily perform meaningful occupations that are culturally defined and appropriate for looking after one's self, enjoying life and contributing to the social and economic fabric in the community. Occupations are groups of activities and tasks of everyday life.' (Townsend et al., 2002 p. 45)*

Whilst many different conceptual frameworks exist to guide practice, as yet, no one model has emerged as the definitive model for the profession of occupational therapy. In occupational therapy there are currently a number of occupationally focused models. Table 1.1 presents some which are available for occupational therapists to use.

Table 1.1: Conceptual models of practice which may be used by occupational therapists

Adapted from Turpin and Iwama (2011), Boniface and Seymour (2012); Duncan (2006), Kramer, Hinojosa and Royeen (2003)	
Conceptual Models of Practice for occupational therapists	**Year created and by whom**
Model of Adaptation through Occupation	Reed and Sanderson (originally 1983)
Model of Human Occupation (MOHO)	Kielhofner (originally 1985) Later versions of the model (1995, 2002, 2008)
Occupational Adaptation	Schkade and Schultz (1992)
Ecology of Human Performance	Dunn, Brown, and McGuigan, (1994)
Person- Environment- Occupation Model of Occupational Performance	Law *et al* .(1996)
Occupational Performance Model (Australia) (OPMA)	Chapparo and Ranka (1997)
The Canadian Model of Occupational Performance (CMOP) and later the Canadian Model of Occupational Performance and Engagement (CMOP-E)	Townsend *et al.* (1997; 2002) Polatajko *et al.* (2007; 2013)
Occupational Performance Model (OPM)	Pedretti and Early (2001)
Person-Environment-Occupation-Performance (PEOP)	Baum and Christiansen (2005)
Kawa Model	Iwama (2006)

The role of models in practice is contentious. It has been suggested that the adoption of only one model, can:

'Lead to routine practice rather than reasoned and reflective practice'
(Creek 2003 p. 35).

Two opinions are evident in the literature; firstly, that practitioners should choose the appropriate model for each particular intervention (Mosey,1985; Maclean *et al.* 2012; Ikiugu, Smallfield and Condit 2009) and secondly, that use of a single model creates a link between theory and practice, enables communication of complex ideas in a succinct way, which is

then contextualised by the context in which it is being interpreted (Duncan, 2006; Boniface *et al*. 2008; Wimpenny *et al.* 2010; Melton, Forsyth and Freeth 2012). These opinions are further complicated by revelations that many practitioners view theory to be distinct and separate from practice and, as such, may not necessarily choose to use them (LeClair *et al*. 2013; Kielhofner, 2005a; Turpin and Iwama 2011; Ikiugu, Smallfield and Condit 2009). Yet within the literature there is evidence of positive partnerships between academics and clinicians, who have worked together to discuss using theory in practice, and, specifically, conceptual models in practice, through communities of practice (Kielhofner, 2005a; Wimpenny *et al* .2010; Melton, Forsyth and Freeth 2012).

There is increasing urgency in the current climate of accountability for occupational therapists to be able to explain to colleagues, managers, commissioners and clients what they do and what can be offered (DH 2007; DH 2010; DH 2014; HCPC 2004, 2007, 2013). Ongoing professional inarticulacy does not negate a responsibility for occupational therapists to use a theory base to underpin practice. Duncan, Paley and Eva (2007) perceptively commented:

"Why should they take pride in the fact that they have no idea what the effects of their work will be?" (p. 204).

Evidence in the literature indicates that a connection made between theoretical principles of occupational therapy and practice through use of conceptual models can support practitioners to be confident about the scope of professional knowledge; enhance accountability, provide practical guidance and prevent practice being conducted in a haphazard way (Turpin and Iwama 2011; Duncan, 2006). Without theory for guidance, occupational therapists risk their practice being seen as simplistic. Other stakeholders may not value, nor attribute their skills to those required of a registered professional, which may in turn promote a lack of respect and misunderstanding (Forsyth, Summerfield Mann and Kielhofner 2005; Feaver and Creek 1993b; Fish and Boniface, 2012).

Whilst numerous models exist and there is argument for and against the adoption of one model of practice, the focus of this study was the CMOP. This model was selected for adoption as a single model of practice by occupational therapists working in health and social care services within one county that is central to this case study and will now be described.

1.3. The Canadian Model of Occupational Performance (CMOP)

In the 1980s and early 1990s, a national group of Canadian occupational therapists and medical representatives joined together and developed guidelines to facilitate an occupationally focused, client-centred practice of occupational therapy (Townsend *et al.* 1997, 2002). A key driver for the work was to demonstrate the effectiveness of interventions, justify actions and promote the profession of occupational therapy. Emphasis was placed upon ensuring that occupation was recognised as a core concept of occupational therapy practice. The original model was based upon the work of Reed and Sanderson (1999) and called the Occupational Performance Model (OPM) (1982, 1983, and 1991) with occupation divided into self-care, productivity and leisure. The OPM was updated in 1997 in a book called *Enabling Occupation* (Townsend *et al.* 1997, 2002) and the updated model was called the Canadian Model of Occupational Performance (CMOP).

There were two key changes; firstly, the introduction of a central concept, spirituality, the 'true essence of a person' and what motivate or engages an individual (Urbanowski and Vargo, 1994) and, secondly, the new model placed the person in a socio environmental context (Sumsion, 2006) whereas, in the OPM, environment was located outside of the person. This was in response to criticism that the OPM was two-dimensional and did not reflect the dynamic nature of occupation. Schematically, the CMOP was depicted to present a dynamic relationship between a person, their occupations and the environment. In the CMOP, components of occupation are called self-care, productivity and leisure, and these are influenced by the individual's own physical, affective and cognitive abilities. These occupations are enacted within the context of a dynamic, multi-faceted environment (Townsend *et al* 1997, 2002). The model had clear client-centred practice principles, which provided a conceptual framework for practitioners to work effectively with a client throughout the occupational therapy process (Sumsion and Blank 2006). The model can be used to create collaborative partnerships between the occupational therapist and client, to enable the client to achieve satisfactory performance in those occupations they choose to participate in (Townsend *et al*. 2002 p. 30). Central to the process is for the practitioner to help a client to identify their occupational performance issues (OPIs), rather than telling the client what they think they should be working on. These are then worked upon together. The client is acknowledged to be an occupational being, with intrinsic dignity and worth, able to make choices about life and actively participate in their chosen occupations (Townsend *et al.* 1997, 2002).

The schematic depiction of the CMOP model is shown in figure 1.1 where occupations (self-care, productivity and leisure) are described as a circle with a triangle representing the doing (physical), feeling (affective) and thinking (cognitive). Points of the triangle extend beyond the occupation circle to the environmental components, namely physical, social, cultural and institutional, demonstrating the interactions (and therefore dynamic nature) between the person, their occupations and the environment. The central element is spirituality, described as the motivator or driver of the individual (Townsend *et al.* 1997, 2002; Sumsion and Blank 2004).

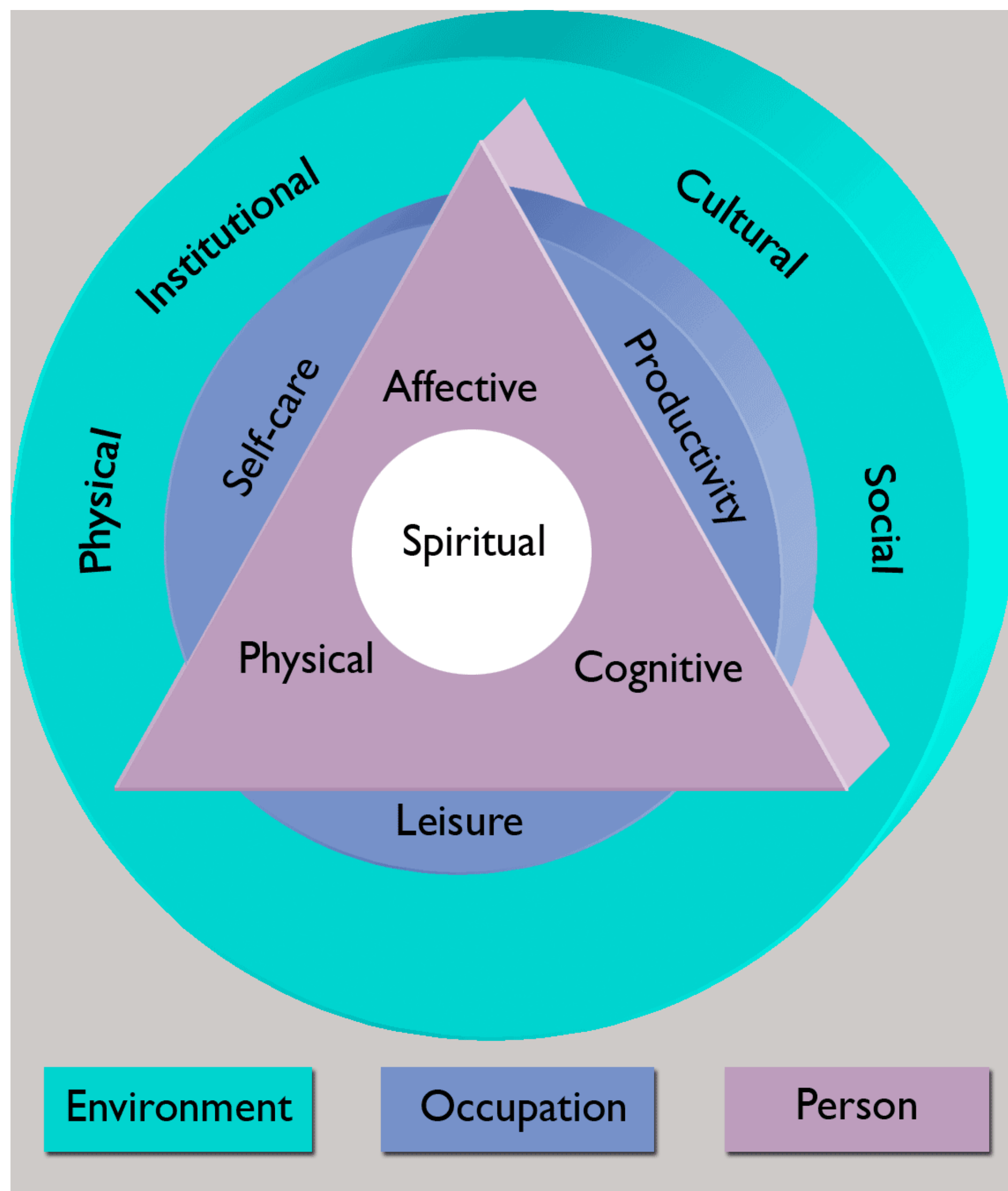

Figure 1.1: Diagrammatic Representation of the CMOP Reproduced from Townsend et al (2002) (Ed) Enabling Occupation. An Occupational Therapy perspective. Revised Edition. Ottawa: CAOT Publications. Reproduced with permission by CAOT (appendix 1).

Included in the *Enabling Occupation* guidance (Townsend *et al.* 1997, 2002) was an Occupational Performance Process Model (OPPM), adapted from Fearing (1993) and Fearing, Law and Clarke (1997).The OPPM process was the recommended approach to apply the concepts of the CMOP to practice. Also produced at a similar time was the Canadian Occupational Performance Measure (COPM), an outcome measure designed for use with the CMOP (Law *et al.* 1991, 1994, 1998, 2005). The COPM was developed as a client-centred outcome measure which could be used to enable individuals to identify and

prioritise issues that restrict or impact how they perform occupations in their own day-to day-life. The COPM asks the client to identify perceived difficulties in the areas of self-care, productivity and leisure, and these are the identified OPIs to be worked upon with the occupational therapist. These OPIs are then subjectively rated. The client is asked to rate the importance of being able to perform each OPI and their satisfaction with their current performance of it. Following intervention, the client is asked to again rate their performance and satisfaction of each OPI. What is unique about the measure is that it captures a client's self-perception of how they perform occupations that are important to them (Law *et al.* 2005; Sumsion and Blank 2006). Use of the Canadian Occupational Performance Measure (COPM) (Law *et al.* 1991, 1994, 1998, 2005) had previously been examined locally in the workplace setting (Fedden, Green and Hill, 1999). In the current work, the focus is on adoption of the CMOP in a UK practice setting.

1.4. Adoption of the CMOP in a practice setting

The CMOP was adopted and introduced in 2004 into an organisation where practitioners who worked in health and social care settings were being integrated into one occupational therapy service, under the Health Act Flexibilities, Section 31, latterly Section 75 (DH 2006). The aim of integration was to promote more joined up working across health and social care sectors, improve care pathways and provide a more responsive service (Waygood *et al*. 2012). At the time, there were changes in national policy direction towards collaboration and partnership working, and occupational therapy managers wanted to make overt the link between theory and practice, believing this would prepare staff to engage with the current policy direction (DH 1997, 1998, 2007; HCPC 2004, 2007, 2013; COT 2006, 2015). Subsequently, there has been an increased expectation for services to be less fragmented, provide a better client experience and, importantly, offer value for money from finite resources (DH 2007, 2010, 2014). Changes have also been made to professional registration, with the development of a new Health Professions Council (HPC), now known as the Health and Care Professions Council (HCPC). Registration requirements expect practitioners to sign a formal declaration stating that they meet specific standards of proficiency (HCPC 2004, 2007, 2013). A clear expectation within the HCPC standards is for occupational therapists to be evidence and theory based practitioners (HCPC 2013 9, 13).

I have worked as an occupational therapist for over twenty five years and have been working in the county since 1997 in a variety of health and social care settings and roles. At the time the CMOP was introduced in the county, I had two roles, that of clinician and manager. Clinically, I worked in out-patients, primarily with rheumatology clients, and also managed

a team who provided occupational therapy in two community hospitals. Prior to integration in 2002, I had conducted research that examined training and development needs for occupational therapists, which culminated in a Continuing Professional Development strategy document '*Fit for the Future'* (unpublished, Hurst 2003). A central recommendation was to adopt a single conceptual model, promote overt use of theory in practice and make a clear connection with occupation. Following integration, the Head of Service wanted a workforce with competent practitioners who had a clear professional identity, were able to handle competing demands from clients and employing organisations, and met regulatory body expectations. She felt that using a single model to underpin practice could be beneficial (Boniface *et al.* 2008; Waygood *et al.* 2012). A period of negotiation took place in 2003 with an academic from a local university who was employed to run a series of workshops. All 350 occupational therapy practitioners, both registered and non-registered, were invited to explore the use of theory and models in practice. Agreement was made in principle to adopt one model that focused upon occupation, did not necessitate learning a whole new language, and had an associated outcome measure. A recommendation was made, and accepted, to adopt the CMOP (Boniface *et al.* 2008; Waygood *et al.* 2012). One service area, specialist wheelchairs, decided not to adopt the CMOP. The practitioners identified some challenges with adopting the model when the workforce consisted of occupational therapists, physiotherapists and rehabilitation engineers. They felt that adoption of the model would extend their role beyond core mobility and seating, which would negatively impact upon timely access to services (Boniface *et al.* 2012).

The decision to adopt one model had two main pragmatic drivers; firstly, that deeper understanding of a single model would be a more successful way to achieve the desired objectives, that may not be achieved through superficial understanding of several models and, secondly, the cost of resources, such as books and workbooks to support shared learning and understanding, within a large staff group, was substantial (Boniface *et al.* 2008). It was recognised that implementing the CMOP involved change and challenge to current practice and that practitioners needed to be engaged to create a shared understanding and use of the CMOP (Walker and Thistlewood, 2012). There was a need to steer and guide the process and develop effective communication systems and networks, and a steering group was established in 2004 who led the process. Initially, the group consisted of self-selecting practitioners and I was a member of the steering group. I had a period of absence (2004 – 2005) and became a regular member from 2006 and the chair at the end of that year. Early decisions taken by the steering group as to how the model should be introduced were influenced by earlier experiences in the county. Fedden, Green and Hill (1999) unsuccessfully tried to introduce an associated outcome measure, the Canadian Occupational

Performance Measure (COPM), and a lack of success was attributed to there not being clear understanding of the theoretical principles of the CMOP. Therefore, the group were very clear that the theory of the CMOP needed to be understood before any other changes could be made.

The steering group was an active and evolving group that grew to include representatives from all parts of the county, all clinical areas, and all grades (Boniface *et al.* 2008). In any staff group, there is a range of experience, length of service and personal attributes that influence individual actions taken by practitioners and how they used the CMOP. Each practitioner had their own individual values, beliefs and assumptions about occupational therapy identity, some had studied models at college and others had not (Waygood *et al.* 2012). The range of experience meant that, prior to the introduction of the CMOP, each individual practitioner conducted their practice in their own way, and there was no consistent interpretation of the occupational therapy role. To create shared understanding, the steering group created a number of tools to support practitioners. These included study days, a supervision DVD, user manual, documentation, and a delegation and assignment framework.

An important aim of the steering group was to collaborate with colleagues, to ensure that the model became part of the culture of the integrating service and the group led an action research project (Boniface *et al*. 2008, p. 534). Three publications have resulted from this work and I am co-author on the Boniface *et al*. 2008 and Waygood *et al*. 2010 publications. In Boniface *et al*. (2008), a description is given as to how the CMOP was adopted and concluded that embedding a model takes time, however, the benefits were worthwhile to provide a strong, occupationally focused, and client-centred identity. The paper identified that this process needed leadership and also hinted at some potential issues. In particular, how some practitioners might simply want to adapt the assessment documentation to reflect the headings of the model, rather than gaining an understanding of theoretical principles of the model.

Walker and Thistlewood (2012) discussed some of the challenges with adopting the CMOP and how these could be met. They identified that having a framework in place supported practitioners to use the model and promoted a client-centred, occupationally focused ethos. Similarly, Waygood *et al*. (2012) described how the steering group led the creation of a number of tools to support use of the CMOP in the county, keeping up momentum to use the model in practice. The book chapter described how the CMOP was being continually adapted to suit local requirements. One strength of the published works were the descriptions for how the CMOP had been implemented and how potential challenges were addressed. However, the work also raised questions about the difficulties with adopting the CMOP, and there was

limited explanation of what was actually happening in practice. These questions provided the genesis for the work presented in this thesis.

1.5. Developments post adoption of the CMOP

1.5.1. Evolution of the CMOP

In 2007, the CAOT published new guidelines edited by Townsend and Polatajko and entitled, *Enabling Occupation* II (Townsend and Polatajko 2007; 2013), which presented an updated version of the CMOP, now called the CMOP-E. Whilst the authors retained the original definition of occupation, they made a distinction between occupational *performance* and occupational *engagement*. Whilst the concept of occupational performance remains implicit within the model they did not restrict occupation to performance and encompassed the idea of occupational engagement, the rationale being, that one can be engaged with an occupation without actually performing it (Polatajko *et al.* 2007 pp. 23-27). In this edition, client had a broader definition than the individual and now included families, groups, communities, organisations and populations.

Enablement and client-centred practice are processes with which the occupational therapist facilitates occupational performance and engagement and, to help practitioners, the OPPM was also updated in this edition. Primarily, this was made in response to criticism that the OPPM process was too linear and required a more dynamic presentation to represent the complexity of practice (Townsend, 2003). These guidelines were called the Canadian Model of Client Centred Enablement (CMCE) (Townsend *et al.* 2007 pp. 83-133) and Canadian Practice Process Framework (CPPF) (Craik, Davis and Polatajko 2007 pp. 229-246).

1.5.2. Local evolution of the CMOP

Publication of the CMOP-E created a dilemma for the steering group, and there were discussions between members and managers on how to respond to this new publication. Practitioners in the county appeared to be engaged with the adapted CMOP and steering group members were actively engaged with the interpretation and creation of tools to support practitioners. Indeed, the creators of the CMOP themselves identified:

> *"Occupational therapists are encouraged to apply theory in everyday practice, and use their experience of everyday practice to advance theory."*
> *(Townsend et al. 2002 p. 3)*

Similarly, Egan (2003) described that theory advancement came from practice. Mackey (2007) equally described that professional identity should be developed in a local context and changes made should be in response to local need demands. These experiences appear to provide a caveat that, rather than creating variations of existing models, we should examine and adapt those models which are currently in use. LeClair *et al*. (2013) makes an important point, that understanding how theory is successfully integrated into practice requires identification of the crucial elements required to persuade practitioners to use it.

The CAOT developed the CMOP which became the CMOP-E in response to shifts and changes in Canadian health and social care policy, which had an increased emphasis upon new models of healthcare. They adapted the CMOP in response to both development in the thinking of the authors and changes in requirements of the people, places, systems and culture within Canada. Whilst some of these are equally important in a British setting, such as, evidence-based practice and accountability, it needs to be remembered that changes made to the CMOP were made in response to needs within the Canadian sociocultural society. Similarly, the CMOP had been adapted in this county in response to local needs. To simply cast the CMOP aside and use the CMOP-E, which has been developed in another culture and setting, did not seem logical and risked damaging local understanding. Research conducted by Pridmore, Murphy and Williams (2010) identified that nursing models had become increasingly unpopular within the profession. The authors, attributed this to two main factors firstly, that the models were developed in America and as such, practitioners did not feel they were culturally relevant in a British setting. Secondly, they were introduced with a 'top down' approach which did not create ownership by practitioners. If we consider these experiences in relation to occupational therapy, it is evident that, to be used effectively, models need to be both valued and adapted to suit the context in which they are being used. Practitioners, it could be argued, should not simply look to a few key authors from different cultures to overly influence how their own unique professional practice should be conducted in their own particular setting. Ownership of the model is important and this may be lost if practitioners simply say they are using a new model when later editions are published. Therefore, the decision was made by the steering group that they would continue to use the locally adapted CMOP.

1.6. Purpose of the investigation

The focus of previous research about adoption of the CMOP in the county has been upon how one model was used in a health and social care setting (Boniface *et al*. 2008). The study hinted at some potential issues and, given that the process of implementation was ongoing,

it raised questions about how momentum and use of the CMOP could be sustained in a constantly changing and evolving health and social care system. Other work published from local implementation discussed how some of these challenges could be met, through having a framework in place to support practitioners, and the use of tools which were specifically created by the steering group to support practitioners (Walker and Thistlewood 2012; Waygood *et al*. 2012). These published works are a valuable source of insight and recognise that the steering group, and the tools they created, were important factors for the enduring, ongoing use of the CMOP in the county. However, no research has been conducted that considers how practitioners viewed and used the model in practice. My research sought to specifically understand how the CMOP was being used in this context and setting, through understanding the relationship between the model and clinical practice from a number of interconnected perspectives. This required more in-depth understanding of specific factors and their inter-relationship, in order to answer the research questions. In this study these were identified to be; the steering group minutes that presented accounts of discussions and actions taken to embed the model, examination of tools created by this group, and practitioner descriptions of how they used the model within their own unique practice settings. Examination of these three elements would be used to describe, understand and explain the influence of the CMOP upon occupational therapy practice in this setting. Insights will enhance knowledge in this area and contribute to the ongoing scholarly discussions about the role of conceptual models and practice.

1.7. Aims of the study

The aim of the work was to explore the clinical practice of occupational therapists who implemented the Canadian Model of Occupational Performance (CMOP) (Townsend *et al.* 1997, 2002) in a health and social care setting. The research question was:

"How does using the Canadian Model of Occupational Performance (CMOP) influence occupational therapy practice?"

Sub research questions:

(1) How does the CMOP help occupational therapists to address the Occupational Performance needs of clients?

(2) How does the organisation influence the occupational therapists use of the CMOP?

(3) How does the CMOP contribute to the understanding of occupational therapy practice?

1.7.1. Research design/approach

Adoption of CMOP by the health and social care service in one county in the United Kingdom provided a unique opportunity to understand the ways in which a conceptual model was being used in a practice setting. Case study methodology was considered best suited to study the subject area in a natural setting, and how use of the CMOP influenced occupational therapy practice. Yin (2009) described structure and methods for use in case study research and his approach is followed in the presented work. Data is examined from the steering group minutes, created artefacts[1], described as a '*physical or cultural artifact- a technological device, a tool or instrument, a work of art of some other physical evidence'* (Yin, 2009 p. 113), and interviews of occupational therapists. Each is analysed separately and then patterns are examined across the dataset to explain the case, namely occupational therapy practice. The research focused upon understanding the relationship between the CMOP and clinical practice from these three interrelated perspectives. This required in-depth understanding of the complex interactions between these individual factors and the case being examined, in order to answer the research questions.

1.7.2. Changes

This study started in 2011 and I suspended my studies from August 2011 – February 2013 for personal reasons. During this time, there were substantial organisational changes, which is a challenge when research is undertaken in a real life setting. The most noticeable change was that the integrated occupational therapy service, to which the CMOP was introduced in 2004, no longer existed. Occupational therapists now worked within a variety of team structures, with some retaining uni-professional leadership, whereas others became part of integrated community teams (ICTs), with a variety of management structures. Yet, despite these changes, the CMOP continued to be used as a theoretical model to underpin the practice of occupational therapists in the county. Membership of the steering group continued, with representatives from all parts of the county and clinical settings, and artefacts continued to be used to support practitioners.

[1] Yin's terminology is being used in this thesis therefore the tools created by the steering group will be referred to as artefacts in the subsequent chapters of this thesis.

Ongoing permission to conduct the study was agreed in February 2013, when the study recommenced.

1.7.3. Layout of the thesis

In chapter 2, a literature review is presented to examine works in the subject area, namely use of the CMOP in practice. Relevant background information about professional, social and organisational issues are included, with an exploration of literature that examined academic and clinical partnerships that used a single model of practice and change management theory and processes.

In chapter 3, the research methodology is introduced which underpins this study and describes why the study design was chosen. An overview of data collection approaches used and methods of analysis employed are presented, and data collection methods are discussed

In chapter 4, Unit 1, the steering group is presented. Minutes of the steering group meetings from between 2004-2013 and identified key points of interest within the text are presented in this chapter.

In chapter 5, Unit 2, the artefacts are presented. Key tools developed by members of the steering group to assist occupational therapy practitioners to use the CMOP are examined and key points presented in this chapter.

In chapter 6, Unit 3, data and themes extracted from interviews conducted with eleven self-selecting participants, who worked in a variety of clinical settings, and with a range of experiences and grades, are presented.

In chapter 7, converged themes are outlined from the triangulation of data across the three units. Four converged themes were identified, which directly relate to the research questions and propositions.

Chapter 8, discussion chapter focuses upon establishing how the research aims have been addressed and answered. It includes pattern matching and theory building.

Chapter 9, conclusion discusses the implications of the findings in relation to answering the research question. New contribution to knowledge is presented. Limitations of the study and suggested areas of new research are included.

2. Literature review

2.1. Introduction

The literature review is presented in two parts. The first part considers professional, social and organisational issues that may provide an understanding for the initial implementation of the Canadian Model of Occupational Performance (CMOP) in the county. Part two, focuses on reviewing literature related to the use of the CMOP as a model in practice and theoretical application of the CMOP to literature based papers. Whilst I refer to the model as the CMOP, I acknowledge that papers reviewed post 2007 will most likely pertain to the CMOP-E (Polatajko *et al.* 2007; 2013), and literature before that date will be the CMOP (Townsend *et al.* 1997; 2002). In the introduction chapter, local action research, conducted within the county related to the implementation of the CMOP (Boniface *et al.* 2008) and associated publications (Waygood *et al*. 2012; Walker and Thistlewood 2012) were presented. Consideration of this work has been included, where relevant, within part one of this chapter and as part of the reflections at the end of this chapter. The review will analyse and reflect upon the current available literature that informed this study.

2.2. Search strategy

Extensive and structured literature searches were conducted on several occasions throughout the course of the research, to identify published literature pertaining to the CMOP and other articles related to the research questions. Literature was initially examined in 2011, as my research question was being refined. I conducted more specific searches in January 2015, August 2015, November 2015 and November 2016. National Health Service (NHS), College of Occupational Therapists (COT) and the University of the West of England (UWE) library resources were used. The databases searched included, EBSCO and CINAHL PLUS, British Nursing Index, Medline and the Cochrane Library. Grey literature was reviewed using Google Scholar and unpublished theses reviewed via British Library. In addition, reference lists and citations in published research papers and books were scrutinised. The literature search strategy commenced with 'occupational thera*' and was combined with a number of the key words reported in appendix 2, to identify the available literature in the research area. Terms such as AND, OR and NOT were used to refine the searches. Where particular themes were identified that could inform the development of my research questions, this literature was reviewed.

Although initially, there was a hope to focus the review upon research articles, initial searches revealed a paucity of literature pertaining to the use of the CMOP as a model in practice. The Canadian Occupational Performance Measure (COPM) and client-centred practice are often associated with the CMOP (Duncan 2006, p. 115) and a review of the literature revealed that extensive literature was available about its associated outcome measure, the Canadian Occupational Performance Measure (COPM), for example; Carswell *et al*. (2004); Cup *et al.* (2003); Dedding *et al.* (2004); Fedden, Green and Hill (1999) Law *et al*. (1991; 1994; 1996; 1998; 2005); McColl *et al.* (2005) to name a few. Equally, there was a range of studies concerning client-centred practice, including; Lane (2000); Wilkins *et al* (2001); Sumsion (2005) Sumsion and Law (2006); Sumsion and Lencucha (2007; 2009). However, these were not the focus of this study and were not included.

The literature review was expanded to consider the context of the wider professional, social and organisational issues, this included academic and clinical partnerships, and change management, to deepen understanding of factors that influenced the implementation of the CMOP in the county. Additional key words were then used to focus the search upon relevant literature. Terms reviewed included; 'academic AND 'practitioners'; or 'academic' OR 'practitioners' AND 'partnerships'; 'change' AND 'management'; 'organisations' AND 'change'. Review, critique and reflections of research articles and book chapters contained in both parts of this chapter assisted me to develop my research questions.

2.2.1. **Selection of literature**

Screening the literature: Initially, literature was screened by reading the title and abstract to establish relevance to the research topic. The limited availability of suitable literature in the research area proved challenging. The review includes papers from a wide range of sources, relevant to the research topic and, where relevant, in part one, book chapters are included. Appraisal of the literature considered relevance of the findings to my study, rigour and validity of the study (trustworthiness), size and location of study sample and the year that the study was conducted.

Research papers, opinion pieces and literature reviews were subject to rigorous appraisal, and not excluded if methodological quality or detail was lacking, if they informed the research. Limitations of papers, where applicable, are acknowledged in the review. Each article was appraised using the McMaster qualitative critical appraisal tool (Letts *et al*. 2007), to assess the quality of the published literature and reported findings (appendix 3). A critical appraisal tool supports the systematic review of research papers to appraise the content of research

papers and evaluate the findings. The McMaster tool includes extensive notes for the user, and this was useful guidance to evaluate the papers included in this review.

The quality of the reviewed literature was variable. The research based literature presented was from small scale studies with a small number of participants, and from within one service area. Other studies reviewed included literature based reviews or opinion pieces. Whilst these provided relevant information, it needs to be acknowledged that they varied both in quality and provision of methodological detail. It is noted that whilst the appraisal tool was effectively used to appraise both the quality and content in a systematic way, it was more challenging when applied to review opinion pieces and literature reviews. However, it provided a structure so the same questions were asked of each paper and this increased the rigour of my review. Presentation of the findings from the review has been grouped into themes, with detail in the review to identify the empirical research, opinion pieces and literature based reviews.

2.3. Part one: Consideration of professional, social and organisational factors

Introduction of the CMOP into the county was at a time of integration of practitioners who worked in health and social care settings into one integrated occupational therapy service. This was a time of great change and part of the desire of the newly integrating service was to make overt the link between theory and practice (Boniface *et al.* 2008; Waygood *et al.* 2012). This published literature described how an academic provided support and partnership in two ways, firstly, through leading a series of workshops where models were explored and making a recommendation, which was accepted, to adopt the CMOP. Secondly, through ongoing support by becoming a member of the steering group that, led the implementation of the model in practice. This process has been described in both chapter one and published literature (Boniface *et al*. 2008; Waygood *et al*. 2012 and Walker and Thistlewood 2012). This section will explore other published literature that examines academic and clinical partnerships who used a single model of practice and change management theory and processes, to provide relevant background information about these professional, social and organisational issues.

2.3.1. Practitioner and academic partnerships

Alliances and collaborations between academics and practitioners are useful partnerships to increase uptake of theoretical concepts into practice (Kielhofner 2005a). This is where; theory is developed, created and reviewed by academics and practitioners together, rather than just by academics. This has been described as communities of practice (Wilding, Curtin and

Whiteford 2012; Piskur *et al*. 2015), knowledge translation activities (LeClair *et al*. 2013) or scholarship of practice (Kielhofner, 2005a; Forsyth, Summerfield Mann and Kielhofner 2005; Taylor, Fisher and Kielhofner 2005). This type of research marks a change from traditional academic research, where an academic who is distinct and separate from practitioners undertakes research which, it is then assumed, will be used in practice by practitioners. Instead academics and practitioners are collaborators in joint participatory research, working as partners to conduct research and so are making an overt link between theory, or research and practice.

2.3.2. Communities of practice who used the CMOP

Two international studies conducted by Wilding, Curtin and Whiteford (2012) and Piskur *et al*. (2015) described how the principles in *Enabling Occupation II* (Townsend and Polatajko 2007, 2013) were discussed by academics and practitioners in communities of practice.

The action research study conducted by Wilding, Curtin and Whiteford (2012) recruited twenty practitioners working in Australia to participate in teleconference discussions with researchers, as part of a community of practice. Monthly teleconferences took place, where they reviewed chapters from *Enabling Occupation II* (Townsend and Polatajko 2007; 2013). Practitioners were invited to reflect upon their own practice in relation to principles found in the book. The findings suggested that, through reviewing the book as a group, with an academic, practitioners were more confident in being able to reflect upon and articulate their own practice and to think about ways to improve it. Dialogue between academics and practitioners was described as a positive way forward for professional development. A strength of the study was the methodological detail provided, as to how the study was conducted.

Piskur *et al*. (2015) conducted a qualitative study, where the authors described the introduction of the *Enabling Occupation* II guidelines in a Dutch setting. For eighteen months, nine occupational therapists participated in a community of practice with three researchers, where focus groups were used to explore experiences of applying the guidelines in practice. Whilst the paper is of interest, it is not clear which guidelines were applied, whether it is the CMOP-E, the associated leadership tool, the Canadian Model of Client Engagement (CMCE) (Townsend *et al.* 2007) or process framework, the Canadian Practice Process framework (CPPF) (Craik, Davis and Polatajko 2007). A weakness of this study was that no methodology was described. The authors identified that effort was required with reading English, and understanding concepts and theories from a different culture; nevertheless, reflections on the concepts found within the book, which they considered as a group, made them re-evaluate

their own professional identity. The authors acknowledged an important caveat, that organisational constraints were a challenge when applying client centred principles.

Both studies identified that relationships between academics and practitioners were positive for facilitating discussions about professional issues and for translating theoretical concepts to practice. Overt discussion of professional theory using the CMOP-E with an academic partner, gave practitioners a focus to be able to consider how professional theory could be used in practice. The studies included participants from a variety of settings and so, collectively, they considered the model in two ways, firstly, in relation to their own areas of practice and then as part of a wider discussion about practice beyond individual settings. These discussions identified some challenges and, in particular, the study conducted by Piskur *et al*. (2015) identified cultural challenges when a model developed in another country in a different language was used in a Dutch setting. Both studies indicated that the discussions made them reconsider professional identity and development, within individual practice settings.

2.3.3. Community of practice who used MOHO

Wimpenny *et al*. (2006) and Wimpenny *et al*. (2010) published two articles that presented a study where participatory action research (PARS) was undertaken between a university researcher and practitioners in a mental health trust, over a two year period. Together, they developed a community of practice to introduce the Model of Human Occupation (MOHO) as a theoretical model to be used to inform practice. The articles describe the research at two different stages, one a year into the study and the second after the research finished. These papers were included as they described how a single conceptual model used by occupational therapists, the MOHO, was implemented in practice.

Wimpenny *et al*. (2006) presented a practice evaluation paper of the group supervision action and reflection process taken from the first year of research. The concept of the group was based upon a belief in a ‘scholarship of practice’. For one year, two hour meetings took place every four weeks between an academic and practitioners who worked in one of three mental health teams; acute adult, community adult and older adult teams. Findings in this paper identified key points for practitioners to consider when implementing a model, these included; creation of a culture for effective and open communication and the need to prioritise and commit time to reflect upon theoretical concepts of one model. It supported the view that, change in practice requires alteration of thinking so there is a change to the ‘doing’.

Wimpenny *et al*. (2010) presented findings after completion of this study. Data in this paper included final analysis of both monthly and individual meetings between an academic

facilitator and participants taken from the two year study. The exact number involved in the process was not clear, however, the authors identified that a minimum of fifteen attended each of the thirty six group sessions. The article described a cycle of action and reflection, and shared key findings of the participatory change process, where practitioners were asked to rethink and renegotiate their professional identity and to explain how they thought use of the MOHO enhanced practice. The authors asserted that the MOHO became viewed as an 'indispensable resource' (Wimpenny *et al* 2010 p. 512) and that it was adapted and modified to meet personal and professional needs. However, it was not clear whether this was a valid point for some or all participants. The findings from this research identified some important points that enhance knowledge and understanding about how single conceptual models are used in practice. Key points were that; partnerships between academia and practice can effectively lead therapists to adopt theory and advance their practice, barriers to using theory in practice can be overcome by collective effort and shared communication, successful implementation of a single model requires commitment, care and persistence through developing a shared language base, assessment tools and intervention resources and that learning is a social process. This work provides a valuable contribution to ongoing scholarly discussions about the role of conceptual models and practice. However, it must be noted that the study was conducted within a mental health setting and findings may not necessarily be transferable to other practice settings. It was also not clear from the article how the momentum for using the MOHO would be sustained, after the study ended. The authors advocated strongly for both communities of practice and PARS, when academics and practitioners had sustained engagement and indicated that these relationships were positive for integration of theory with practice.

Each community of practice described in this section used a single model to support the discussions held between academics and practitioners. Concepts found in each particular model were examined and discussed to develop a shared understanding of occupational therapy theory and how it could be used in practice. These findings reflect experiences described by Boniface *et al.* (2008) and Waygood *et al.* (2012), which also highlighted organisational and social dimensions of change to be key elements for creating links between theory and practice. In their published work there was acknowledgment that introduction of the CMOP required staff and key stakeholders to engage in a process of change (Walker and Thistlewood 2012 p. 107). Therefore, change management theory and processes are now considered.

2.4. Change management

There is a lack of consensus and accepted definition in the literature to describe what change management is, but there is with broad agreement that it is altering how things are currently being done (Senior and Swailes 2016; Hatch and Cunliffe 2013). Change requires people to think and work in a different way and, as Martin (2003) affirms, it involves effort from those who it affects, as any change involves some level of disruption. A crucial part of any successful change is for people to see the perceived benefits of it and to accept a level of upheaval. The choice for how change is undertaken is dependent upon the change required and the organisation undertaking the change. However, any change dictates that processes, tools and techniques will be needed to manage the change. In this county, the change process was led by a steering group, who provided guidance for implementation and created artefacts to support use of the model in practice (Waygood *et al.* 2012; Walker and Thistlewood, 2012 and Boniface *et al*. 2008).

2.4.1. Drivers for change

Senior and Swailes (2016) identify that there are many different reasons why change happens and these can often be in response to political, economic, social and technological factors. Drivers can be internal within an organisation, such as introduction of a new service or computer system or external, such as a reduction in funding for services. Change can be both predictable and unpredictable. Within any change process, organisations strive to maintain stability and balance, whilst responding to the external environment and internally managing the change. In the context of the experiences described by Boniface *et al*. (2008), the key driver for change was integration of occupational therapists across a range of health and social care settings into one service.

Martin (2003) identified that health and social care organisations, as they are public services, are particularly influenced by mandates of the government in power at a particular time and, therefore, need to be responsive to the changes expected of them from a range of internal and external sources. In particular, an increasing demand from the public for services, limited resources, growing advances in technology and medical treatments, necessitate workers need to adapt to a rapidly changing workplace. Equally, Martin (2003) recognises that many health and social care workers are tired of change, do not feel it is needed and that changes are made merely in response to political or government expectations. There is a suggestion that understanding why change is needed varies between individual workers significantly, and can lead to a discrepancy between the values the organisation tries to uphold, '*espoused*' values, and those demonstrated in action, '*enacted*' values (Martin 2003 p. 139). Planned change, they

suggest, is a management concept, a process, and does not take into account the role of human agency, subtle nuances of culture, politics and contextual factors. Thus, there can be unintended consequences of planned changes, and things happen that may not have done if these factors had been accounted for. Models of change processes do, however, provide a sense of order and control, to help those leading the change to consider aspects required for a successful change and these will be explored now.

2.4.2. **Change management process**

Perhaps the most well-known change management process is Lewin's three stage model of change (Lewin 1950, cited in Hatch and Cunliffe, 2013 pp. 290-291). Lewin, proposed a theory for the management of a planned change, when there is a 'transient instability interrupting an otherwise stable equilibrium'. In this process Lewin simplifies change to three stages for moving from stage A (where we are now) to stage B (where we want to be). These stages are:

- *Unfreezing* – there is a short amount of time where everything can be flexible to accommodate change, so pre-planning is important and people need to accept the need to change. At this time, there is a process of destabilising the current pattern of behavioural activity.

- *Moving* – or transition, the time when it is possible to make the changes. Leaders need to influence 'the direction of change' in the now destabilised situation. Strategies 'include training for new behavioural patterns, altering reporting relationships, introducing new styles of management.'

- *Refreezing* – movement continues until there is 'new balance between driving and restraining forces. Behavioural patterns become institutionalised' and the change becomes the new normal state. It is important that the changes are consolidated and accepted processes; otherwise people will be tempted to revert to previous ways of working.

Martin (2003) contends that the Lewin model is linear and risks over simplifying the change process when there are many contextual issues to consider. Senior and Swailes (2016) offer further criticism that refreezing, that is to say, cementing changes to become the new reality is not possible in an ever changing world. They suggest Lewin's process makes several assumptions, that the change is small scale, it is management led, and takes no account of

influences of organisational culture. However, the authors recognise Lewin's work helps to understand group behaviour and how groups work in organisations and society.

There is a consensus, that change follows a process and Kotter (1996) identified that successful change needs to go through eight stages, usually in a sequence. He describes that missing out any part of the process or going at an unsuitable pace can create problems. These stages are establishing a sense of urgency; creating a guiding coalition, developing a vision and strategy, communicating the change vision, empowering broad based action, generating short term wins, consolidating gains and producing more change and anchoring new approaches in culture.

Martin (2003) presents a similar process and recognises several factors, namely; the need to clarify who is leading the change, what needs to happen, what resources are required, with a clear understanding of how success will be identified and, crucially, that feedback must be given to those involved. Martin's approach appears to present a more cyclical, reflective process and, similarly, Senge (1996) and Senior and Swailes (2016) describe a cyclical collaborative process for change which identifies how important it is that those involved in the change are integral members of the decision making process. Waygood *et al*. (2012 p. 94) identified that in the leaders in the county at that time wanted to create a learning organisation and they employed collaborative principles espoused by Senge *et al.* (1999) to create a learning environment. The implementation of the CMOP in the county was shaped by the creation of effective communication systems, where key stakeholders were identified and appropriate networks created, so all practitioners were included in the decision making process, with the intention that they would own the changes being made (Boniface *et al.* 2008). This was a cyclical, reflective process rather than a linear process driven one, as described by Lewin.

2.4.3. **Culture, power and politics**

Culture is defined as how things are done in a particular setting, what are acceptable or unacceptable behaviours (Martin, 2003; Senior and Swailes 2016). Cultures, as Martin (2003) describes, have cognitive (thinking), feeling (affective) and behavioural attributes that are not always easy to recognise or describe. Within organisations, sub cultures exist reflecting different histories, personalities and professional norms. People learn to act according to norms and then enact out expected roles and behaviours. Organisations often talk about needing to change culture; however, culture is often deep seated in an organisation and is resistant to change. Culture cannot be controlled in the same way as work and often is viewed as a barrier to change. However, understanding cultures can help or support change and in order to influences changes positively, change leaders need to take account of culture when introducing

any change. Both Waygood *et al*. (2012) and Walker and Thistlewood (2012) identified that practitioners had a variety of experiences, held individually unique attitudes and values, and worked in a range of settings and teams with individualised, contextually dependent, cultural norms. These authors described that each of these factors needed to be considered when implementing the CMOP.

Power is part of organisational culture and Senior and Swailes (2016) describe it to be a means to influence people to behave in a way that they would not necessarily have chosen to. Equally, it has been described as a way to both control the flow of information to others and in decision making processes (Hatch and Cunliffe 2013; Martin, 2003). A crucial point when considering power in organisations is that formal and informal power structures exist and people who hold power are not necessarily those who occupy managerial positions (Senge, 1996; Martin, 2003). Power is a function of relationships and exists when one person has something another person values, for example, when one party has more knowledge or expertise. This can be considered in the context of the steering group versus the wider group of occupational therapy practitioners in the county, where members did not necessarily hold senior or managerial positions, yet were looked to for guidance or advice on how to use the model (Waygood *et al*. 2012 p. 95). It could be suggested that group members were in a position of power, as they were viewed to be more knowledgeable than their colleagues and could influence how the model was used.

2.4.4. **Resistance**

Another important factor to consider it that not all change is successful and can be met by resistance. There can be many reasons why people resist change and a case study conducted by Cutcher (2009) in Southern Australia, with members of a credit union bank who introduced changes into the workplace, revealed some interesting ideas. She found that the workers extended the roles they held in the organisation and these became an integral part of their own personal external identities. She concluded that whilst some resistance could be explained, in part, by managerial inconsistencies when introducing the change, it was not the complete answer. These external factors impacted upon self-identity both in and out of work and were part the explanation for why this group resisted change. Martin (2003) equally, recognised that understanding resistance is multi layered with organisational, personal and professional influences that inform responses in any given situation, which are routed in a multiplicity of culture.

Therefore, it should be acknowledged, expecting to meet resistance, and seeking to understand why it is there, is an essential process for successfully introducing change. Effective

communication and explanation are vital in reducing misunderstanding. Equally, involving all partners to develop a vision, recognise and understand the need for change and being part of it, rather than having it imposed upon them are key ways to overcome resistance. It is clear that, change requires a level of cultural adjustment which cannot be achieved quickly. Cultures develop through social interactions, on a frequent basis, and whilst they can be viewed as a barrier to change, anchoring the change into new accepted social norms and shared values, as part of a culture, means that the changes will become how things are done here. In the work published by Boniface *et al*. (2008); Waygood *et al.* (2012); Walker and Thistlewood (2012), where experiences of implementing the CMOP in the county were described, shared understanding of the model was supported by effective communication systems being set up and led by the steering group. Artefacts were created to be used by practitioners, in the hope that the model would become viewed as an integral part of practice.

2.4.5. **Management and leadership**

Kotter (1996) and Martin (2003) describe how managers and leaders have different and distinct functions and purposes. They describe the role of a manager to be one that seeks to budget, organise, control and keep processes running smoothly. Leaders, however, inspire people to think and work differently, anticipate and respond to obstacles, maintain services, and keep up momentum for change. Both Kotter (1996) and Martin (2003) identified there will be difficulties if emphasis is only placed upon management, rather than leadership. If attention is turned towards only managing people then problems can go unaddressed and, subsequently, any future change may become hard to implement. Managers who fail to value leadership can stifle innovation and extend the gap between a vision and actual reality. Senge (1996) and Martin (2003) identify that leaders have an ability to inspire others to commit to change, as part of a social process. However, Senge (1996) crucially makes another important point, that leaders, those who influence how people think, crucially, may not necessarily have formal power in an organisation. These leaders he describes as internal networkers or community builders, whose essential role is to support the delivery of change and development of new cultures. Locally, the steering group with members from all grades of staff and all parts of the county, served a leadership role and espoused to be a learning organisation (Waygood *et al* 2012 p. 94).

2.4.6. **Does change end?**

Complexity of organisations raises the question of whether change can be a planned process (Senge, 1996; Martin, 2003; Senior and Swailes 2016; Tsoukas and Chia 2002). Arguably, it is not always possible or desirable to bring closure to a change process, particularly in an era

of rapid change, where new issues require a person to quickly learn to work differently, or adjust their current ways of working. Continuous change is not the same as a planned change and the processes previously described are not necessarily appropriate for ongoing, enduring change.

An opinion paper written by Tsoukas and Chia (2002) makes a clear distinction that whilst organisations are 'sites of constantly evolving action' (p. 567) with ongoing processes of change internally, it does not mean that organisations are constantly changing. The authors present a reasoned argument that, for stability, organisations create rules with meanings and categories that predict and direct how individuals are expected to behave and represent a particular organisation. These categories serve to make the behaviours of human actors, those who undertake the work of the organisation, more predictable. Yet, whilst categories are stable structures with definable features, which all members must possess for a shared understanding, humans are unique and individual and how they enact these behaviours can vary. Humans, therefore, whilst being agents of the organisation, introduce an unstable element to how the work will be undertaken and this introduces a different aspect to the concept of change. To work successfully and engage effectively agents need to adapt their knowledge, and modify actions taken in the outside world, to reflect the local context of each situation. Each action is modified and altered in response to each individual situation, involving specific choices being made and, consequently, introducing a subtle and ongoing change process. Therefore, it could be suggested there is a subtle change in the 'theory', what is expected to happen and the 'practice', what actually does happen, which is influenced by human agency and the external environment. This important concept means that to understand organisational identity we need to consider identity to be a social process. This process of change is subtle and involves actions and reactions of many different people in the organisation, sometimes too small or minute to see, that may only recognised when individuals reflect back and become aware of them (Hatch and Cunliffe 2013).

Tsoukas and Chia (2002) explain change is caused by exogenous and endogenous factors. Internally, change can occur at a local level only, and whether it extends to an organisational level is dependent upon the power of those effecting the change. The important point they make is that leaders need to be sensitive to subtle differences from ongoing change, which can alter understanding of categories. Whilst local changes may never be fully accepted or, arguably, needed in the wider organisation, understanding these smaller changes is important. They suggest that focusing only upon understanding and examining wider organisational changes misses out on understanding microscopic changes, which are continually happening

within organisations and which are important for understanding change. They make a significant point that:

‘ noticing how members reweave their beliefs and habits of action in response to local circumstances and new experiences and how managers influence and intervene into the stream of organisational actions is a perspective organisational scientists must take if they are to understand organisational flow.’ (p. 580)

That is to say, how things happen and how organisations evolve, develop and respond to the world in which they are being operated within. I believe that, our understanding of change needs to include research that is conducted at both local and organisational levels of change. This will help to increase understanding of change processes and be able to explain why and how things happen. Whilst I agree that there is a need for understanding change processes, without wider understanding of other influences upon change management, the social processes and human agency, organisations will not be able to fully anticipate how to respond and adapt. Organisations or any social group where changes are taking place are multi- layered and evolving, rather than being simple, episodic and fixed (Hatch and Schultz 2002; Mead, 1934). Therefore, it could be said, that whilst Lewin (1947) classic ‘unfreezing- moving and refreezing’ model provides guidance on processes it does not fully capture the subtle nuances of change. It could also be argued that, whilst the process of implementing a model has been described by both Boniface *et al.* (2008) and Wimpenny *et al.* (2006; 2010), there does remain a gap in understanding how momentum is sustained when a model is introduced to a changing organisational environment. There is a need to research contextual factors surrounding the use of models in practice, to enhance our understanding of this area.

The next part of the literature review will discuss the research relating to the use of CMOP in practice and its use as a theoretical framework.

2.5. Part two: Use of the CMOP as a model in practice and theoretical application of the CMOP to literature based papers

2.5.1. Use of the CMOP as a model in practice

Two studies were identified that considered the CMOP in practice. Warren (2002) conducted a UK based qualitative study, and recruited seven participants who worked in three NHS Trusts with clients who had a functional or organic mental health diagnosis. The aim of the

research was to develop an occupational therapy assessment form based on the CMOP, and incorporating the associated outcome measure, COPM. The study was in two parts; initially Warren conducted semi structured interviews and used the information gathered to design an assessment form. The assessment form was then piloted for six months by the interviewees. A second interview was then conducted, in which there was a discussion regarding the practical application of the form and identified which element facilitated or challenged practitioners. Warren's findings suggested that practitioners found framing the document around the CMOP provided a clear structure for capturing areas of concern; it helped to identify clients who required occupational therapy; a tool for defining the occupational nature of the role, and focused information presented in ward rounds. A particular point Warren commented upon was that use of the CMOP encouraged practitioners to have a client-centred focus. However, a criticism of the study could be that it was a small convenience sample. In addition, reflexivity and her role with the participants were missing, which reduces the reliability and validity of recorded data. Warren (2002) offered some useful insights into the practical application of the CMOP in a British setting, but it was within a mental health setting and took place over ten years ago. Health and social care services in Britain have undergone significant changes since 2002 and there is a need for further exploration of the conclusions made by Warren, and to build our understanding of how the CMOP is used in practice. In particular, more scrutiny is required, to understand the impact of contextual or local factors.

A study conducted by Clarke (2003) focused upon the practical application of the CMOP. Clarke (2003) conducted an observational study which critically evaluated application of the CMOP within a forensic rehabilitation hostel. The focus of the study was how the CMOP could be used to demonstrate value and effectiveness of interventions in the hostel. The study did not indicate how the CMOP was used to guide service provision nor how it was evaluated, which was a weakness of the paper. The author concluded that application of the CMOP could assist occupational therapists to demonstrate the effectiveness of therapy provision to mental health clients in a forensic hostel, close to discharge.

Clarkes' study concurred with Warren (2002), that a strength of the CMOP was how it supported practitioners to distinguish between appropriate and inappropriate referrals; used language which was easy to understand; could be used as a framework to help practitioners follow the occupational therapy process, and encouraged wider consideration of a client's environment. Clarke, unlike Warren, did not feel it could be used with those who are cognitively impaired, mentally unstable, or who could not make informed choices about their needs and goals. She proposed that it may be hard to implement in larger units with the medical model in situ, such as secure hospitals.

Each study described how the CMOP used in practice created positive changes. In particular, they identified how documentation framed around the model helped practitioners to follow the occupational therapy process and have wider consideration of an individual's unique environment. Other points identified were that the use of shared terminology supported practitioners to articulate their role to others; present information in ward rounds; enhance multidisciplinary working; service evaluation and activity analysis. Of particular interest was the agreement that use of the CMOP encouraged client-centred practice. Whilst, Warren and Clarke offer useful insights into the practical application of the CMOP in a UK setting, they took place in mental health settings over ten years ago. Both studies contribute to our knowledge, but they do not provide enough depth to fully evaluate the contribution the CMOP can make to practice. Caution must be given that two small studies based within a single culture and context could perhaps have a disproportionate influence upon our understanding of how the CMOP is used in practice, without a clear understanding of whether the findings can be translated to other settings. Findings of their work is strengthened, however, as there are similar conclusions made in the study conducted by Wimpenny *et al*. (2006; 2010), who also identified the need for; understanding of a shared language base, assessment tools and resources to support a conceptual model being used in practice. Each study appears to indicate that learning how to use a model in practice is part of a social process. However, it needs to be noted that all of these studies were conducted within mental health settings. This seems to accentuate how there is a paucity of research examining the use of models in practice in a range of clinical, particularly physical settings.

2.5.2. Theoretical application of the CMOP to literature based papers

The CMOP was used as a theoretical framework for a range of clinical areas. Analysis of these papers revealed a number of key themes. Each theme, listed below, is presented and discussed:

- A structure for identifying areas of concern for occupational therapists
- Working more effectively within the multidisciplinary team
- Clearer documentation of interventions
- Supports client-centred practice
- A stronger professional identity

2.5.3. A structure for identifying areas of concern for occupational therapists

The Canadian Association of Occupational Therapists (CAOT) suggested that CMOP is a generic model with universal applicability to a variety of clinical settings (Craik, Davis and Polatajko 2007). International literature was reviewed to examine ways in which the CMOP had been used to structure documentation used in practice and to conduct literature reviews.

In Auckland, a service review was undertaken by Blijlevens and Murphy (2003), to create a new documentation that specifically reflected the work of occupational therapists, and they used the CMOP and International Classification of Function and Disability (ICF). The review revealed that the original documentation based upon SOAP notes did not provide a contextually clear picture of meaningful occupations for an individual client. In the new documentation, components of the CMOP were used to structure documentation and incorporate principles of the ICF. It was interesting to note how the authors decided to reflect the CMOP components rather than the ICF. In particular, 'activity' was replaced with 'occupational performance' to convey a difference in understanding of terminology between occupational therapists and their colleagues. The final documentation was structured so occupational therapists were required to explain how occupations were performed by their clients and capture unique contextual or environmental elements. The authors emphasised how the changes to documentation overtly displayed to external partners the occupational therapy role. That documentation could be used to explain the role and function of occupational therapists was similarly identified in Warren (2002). Whilst acknowledging some criticism could be made, that overt description of the occupational therapy process is over complicating matters, the authors believed it made a clear link between a therapist's clinical reasoning and the client's Occupational Performance Issues (OPIs).

Three studies used the CMOP as a framework for literature reviews (Grant and Lunden 1999, Imms 2004, Woodland and Hobson 2003). In each, components of the CMOP were used as a structure to organise and interpret the literature. The model was used in each paper, to broaden perspectives on what could be potentially be offered by occupational therapists in future. The CMOP was used to identify the impact of a particular illness or impairment upon a client's occupation. Each study identified that the action of being occupied, was a unique, dynamic, individual experience, which was much more than a simple physical activity. It was interesting to note that whilst the client groups for each study traversed a range of ages and clinical conditions, the CMOP framework was successfully used as a way to capture and explain an

occupational person, identify gaps in current knowledge and identify relevant clinical areas for occupational therapy practice.

Grant and Lunden (1999) examined the occupational impact of osteoporosis on post-menopausal women. The paper studied the issues of osteoporosis using headings of the model and related these to existing knowledge of the disease. Components of concern, namely; spiritual, physical, affective cognitive and environmental were used to organise identified literature conducted by a range of professions, which predominantly came from, America and Canada.

Imms (2004) used the CMOP in a similar way to conduct a review of the international literature of children with congenital heart disease (CHD). The review was presented under the headings; person, occupation and environment. Imms accepted that, whilst she did not find her search terms fitted neatly into the CMOP categories, it did present a useful framework for both teasing out dynamic interactions between the three components and client-centred intervention planning. Both studies conducted by Grant and Lunden (1999) and Imms (2004) identified that the focus of interventions for their particular client groups were upon the physical requirements, with little attention or understanding of any wider occupational needs of clients and was a potential area of future work for occupational therapists.

A review conducted by Woodland and Hobson (2003) of predominantly American falls prevention literature, for community dwelling older adults, also used the CMOP as a framework. A weakness of this study is that no description of the methodology was given. However, the authors identified that the literature focused primarily upon the social and physical environmental factors that contributed to falls. Cultural, economic, political and legal factors, which may equally contribute, were overlooked.

These studies described how the CMOP was used as a framework for a range of ages and clinical groups, which appear to concur with Craik, Davis and Polatajko (2007) for the generalisability of the CMOP. However, it should be noted that how this theoretical application could be translated into practice is not clear.

Another literature based study conducted by Desiron *et al.* (2013), examined three conceptual models of practice, namely, the CMOP, MOHO and Person, environment and occupational performance model (PEOP), and sought to identify which conceptual model could be used by occupational therapists as a theoretical framework in practice, when working with breast cancer patients who wish to return to work (RTW). Whilst the review concluded that no one model was suitable for this client group, the CMOP was not deemed as appropriate as it did

not present a clear focus upon work and productivity. This observation was surprising given that one of the components of the CMOP is productivity. The review placed emphasis upon the tools and instruments for each model and although it found the Model of Human Occupation (MOHO) to be the most appropriate, it was interesting to note that the conclusion identified that this would also need to be adapted for the client group. This seems to suggest that any successful translation of theoretical concepts needs to be adapted to be contextually relevant. A weakness of the paper was that all the models were not used in practice with the client group and the review focused upon theoretical application.

In principle, a study conducted by O'Brien, Dyck and Mortenson (2002) agreed that use of the CMOP supported comprehensive consideration of each individual client's needs. In their discussion paper, the authors suggested there was little evidence that practitioners look beyond the immediate social and physical environment. A limitation of this paper is that these conclusions are not based upon research of practitioners, but theoretical application to three case studies; an older person with bipolar condition; a man with HIV/ AIDS and parent of a child with a severe disability. The authors explicate their ideas that the environment for these three individuals was wider than merely their physical setting. They concluded that the 'wider environment' was routinely not considered by practitioners. Although they make a valid point, a study which examined practitioner's views of environment would have been more valuable and that these conclusions were drawn from only a theoretical perspective weakens the conclusions of this paper.

Environment was the focus of a study conducted by a Hall, McKinstry and Hyett (2015), which scrutinised eleven pieces of international literature, which examined positive mental health amongst young people under three components found in the COPM-E: personal factors, environmental and occupation. The authors identified that the positive impact of the social environment (an individual's relationship with their peers) upon mental health for this client group. They described how participation and engagement in meaningful occupations as part of a dynamic interaction with their social environment was beneficial.

In general, each study reviewed indicates a level of applicability of the CMOP to a range of clients. Each gave a description for how the model was used as a structure; to identify areas of concern for occupational therapists, in particular, identifying environmental factors and further areas for research. A drawback of the papers reviewed, is the limited ways in which the CMOP has been applied, with only Blijevens and Murphy (2003) having used it to structure documentation in practice. Nevertheless, all the papers reviewed in this section theoretically identify that the CMOP is applicable to a variety of client groups and settings. However,

theoretical application does not provide understanding of the subtle nuances of context when models are used in practice, indicating a gap in knowledge and an area for further research.

2.5.4. Working more effectively within the multi-disciplinary team

The International Classification of Function and Disability and Health (ICF) (WHO 2001) was created to integrate the medical and social model and create a bio-psycho-social approach. The underpinning belief was that use of the ICF in a multi-disciplinary team would facilitate shared understanding and language (Cole and Tufano 2008). The main principles of the ICF are that a person's functioning and/or disability are a 'dynamic interaction' between a health condition and participation in daily life, within a specific context (Polatajko *et al.* 2007; Cole and Tufano 2008). Strong links have been identified between the ICF; occupational therapy models and the American OT practice framework to enhance multidisciplinary working (Cole and Tufano 2008).

Stamm *et al*. (2005) conducted a literature review where the authors studied the similarities and differences between three conceptual models of occupational therapy practice; the Model of Human Occupation (MOHO), the CMOP and the Occupational Performance Model (Australia) (OPM) (A) and the ICF. Forty one concepts contained in these three occupational therapy models were linked to the four main components of the ICF; body functions and structures; activities and participation; environmental factors and personal factors. Whilst, the CMOP was found to link to every area of the ICF, it was interesting to note that it included 'cultural environment', a concept not found in the ICF. The authors concluded that whilst use of the ICF could improve communication in a multi-disciplinary team, use of the ICF alone would not be sufficient to support the practice of occupational therapists and use of occupational therapy models such as, the CMOP provided a wider perspective of a person. Polatajko *et al.* (2007) similarly identified that the CMOP-E shared several principles with the ICF but, notably, they identified that the ICF did not refer to the subjective experience of an individual. The concept of understanding unique, individual experiences is an integral component of the CMOP and whilst the ICF described participation, as an activity which is performed by an individual, the model understands the term to have a wider contextual meaning called occupational performance. Occupational performance is the dynamic interaction of an individual with particular personal and contextual factors in a unique environment. To understand the distinctive experience, to comprehend and explain the personal significance participation in a particular activity created in an individual, is an important principle of the occupational therapy practice. To be able to explain and document

the occupational therapy process was equally identified in the Blijlevens and Murphy (2003) study.

It has to be acknowledged that generic models, such as the ICF, with broad principles applicable to a range of professions, can improve communication and create a shared focus which is important, although Joosen (2015) provides some cautionary notes in an opinion piece. She suggests that research from outside occupational therapy can provide vital information; however, it is essential that the knowledge does not become the sole focus of interventions. Application of external evidence needs to remains congruent to the occupational therapy paradigm; that is to say, interventions need to remain occupationally focused. Essentially we can assume that, whilst models can be adapted and modified for a specific context in which they are being used, the focus needs to remain upon occupation, particularly within inter-professional teams, so the occupational therapy role is valued and understood by others.

These studies indicate that, whilst communication within multi-disciplinary teams can be enhanced by the use of generic models, such as the ICF there is still a need for occupational therapists to articulate core professional concepts in order to work effectively with clients and MDT colleagues. Practitioners need to be able to focus upon and understand the difference in meaning between occupation and activity. Occupationally focused models, such as the CMOP, could potentially be a useful framework to support practitioners in a range of clinical settings. Yet, there is a lack of empirical research from practice to evidence and support this.

2.5.5. Clearly documenting interventions

Various authors state that interventions documented by occupational therapists should be written in occupational terms (Joosen 2015, Bryant and McKay 2005, Blijlevens and Murphy 2003). An opinion piece written by Bryant and McKay (2005) retrospectively considered one author’s personal experience of adapting a kitchen and two cases from her clinical work using the CMOP. As part of a discussion the authors suggest that a standard framework could support systematic collection of information, using a language and structure which, if explained, could be understood by others. Yet, they provide a caveat that there is a risk that individuality and uniqueness of interventions may be lost through standardisation.

The reviewed papers support a conclusion reported by Warren (2002) that appropriately structured documentation is an important way of capturing or describing what the occupational therapist does. Townsend *et al.* (2007) observed that decisions made about services, efficiencies and efficacies of role and practice are often made by stakeholders who simply look

at, and review, what is documented. Therefore, they emphasise that it is important that documentation reflects occupational therapy practice. In particular, they note that if there is no standardisation of documentation, it is difficult to remain accountable and demonstrate the worth and value of occupational therapy.

2.5.6. Supports client-centred practice

A study conducted by Schleinich *et al*. (2008) used domains of the CMOP to develop a questionnaire with a panel of experts who wanted to identify priorities for rehabilitation for palliative care patients. The questionnaire was piloted with forty palliative care patients across four settings. It showed that being listened to by therapists was one of the most valued parts of patient care. The study used peer review to develop a questionnaire, with feedback from one of the authors of the CMOP to ensure underlying theory of the CMOP was incorporated prior to being piloted.

The findings concur with other studies that use of the CMOP enhances the client-centred practice (Warren 2002; Clarke 2003; Blijlevens and Murphy 2003; Piškur *et al*. 2015).

2.5.7. A stronger professional identity

Literature reveals that the CMOP was used as a framework to explain the occupational therapy role (Blijlevens and Murphy 2003; Imms 2004; Grant and Lundon 1999; Warren 2002; Clarke 2003; Wilding, Curtin and Whiteford 2012). A study conducted by Guay *et al*. (2012) in Quebec described how components of the CMOP were used to create criteria to identify cases that could be assessed by support workers. The study suggested that the CMOP could be used to differentiate between the occupational therapist and support worker role, create a common language and increase shared understanding across all grades of occupational therapy staff. The authors acknowledged limited external validity of their findings outside of Quebec, however, the process was clearly described and the methodology could potentially be applied to other settings. Further research was indicated to enhance understanding as to whether the CMOP could be used to support both occupational therapists and support workers to understand and explain occupational therapy. Point of interest from the examined literature contained in part two is summarised in the *Table 2.1* overleaf;

Table 2.1: Scholarly papers and literature from between 1980- 2015 that provided relevant literature to the research area

	Author(s) Year , journal	**Study Design, sample size**	**Points of Interest**
1	Blijlevens and Murphy (2003) New Zealand Journal of Occupational Therapy (NZJOT)	Service Review One site Rehabilitation service with over 65 year olds	Changes to documentation overtly displayed to external partners the role of the occupational therapist. Through documentation they are able to make the link between therapist's clinical reasoning; the clients Occupational Performance Issues (OPIs) and, therefore, convey the complexity of occupational therapy practice.
2	Bryant and McKay (2005) British Journal of Occupational Therapy (BJOT)	Opinion piece	Standardised assessments could enable information to be gathered in a systematic way, using a language and structure, which if explained can be understood by others.
3	Clarke (2003) BJOT	Observational study One site Forensic hostel	Supported individuals to distinguish between appropriate and inappropriate referrals. The CMOP used language which was easy to understand, written in a way which helped practitioners to follow the OT process and encouraged wider consideration of an individual's environment. Supported articulation of the occupational therapists role to others; Service evaluation and development; Activity analysis.

	Author(s) Year , journal	Study Design, sample size	Points of Interest
4	Desiron,*et al.* (2013) Journal of Occupational Rehabilitation	Literature Review Breast cancer patients	No one model has all the characteristics required in a model, to be used with return to work breast cancer patients. Identified that the CMOP- E did not present a clear focus upon work and productivity.
5	Grant and Lunden (1999) Canadian Journal of Occupational Therapy (CJOT)	Literature review Osteoporosis	The CMOP was used as an organisational framework to existing knowledge of osteoporosis. Components of the model were used to organise the literature. These were spiritual; physical; affective; cognitive; environmental. Interventions in the main focused upon physical aspects of osteoporosis. The impact of osteoporosis upon a person was unique and part of a dynamic interaction between an individual, their occupations and their environment.
6	Guay, *et al.* (2012) BJOT	Literature review and survey questionnaire in Quebec Bathing criteria	CMOP-E used as a theoretical framework for identifying the core characteristics of a person, their occupations and their environment. The model could be used to create a common language, for shared understanding across all grades of occupational therapy staff.
7	Hall, McKinstry and Hyett (2015) BJOT	Literature Review Mental health amongst young people	CMOP-E used as a theoretical framework under the components: personal factors, environment and occupation. The important impact of the social environment on mental health and wellbeing. Positive mental health is achieved through participation and engagement in meaningful occupations, as part of a dynamic interaction with their social environment.

Author(s) Year , journal		Study Design, sample size	Points of Interest
8	Imms. (2004) CJOT	Literature Review Children with congenital heart disease (CHD)	CMOP used as a theoretical framework under the components: person, occupation and environment. Was used to tease out dynamic interactions between the each component. Generally found that interventions focused upon physical needs. The model provided a mechanism for client-centred intervention planning. Could be used to evaluate outcomes.
9	Joosen (2015) Australian Journal Of Occupational Therapy (AJOT)	Opinion piece	Research from outside OT needs to be examined in the context of the professional paradigm and not become the focus of the intervention. Documentation should be occupational focused. Models can be adapted and modified to the specific context in which it is being enacted.
10	O'Brien *et al.* (2002) CJOT	Discussion Paper	Whilst the CMOP supported consideration of a person's needs, there is little evidence that practitioners do look beyond the immediate social and physical environment.
11	Piškur *et al.* (2015) (Scandinavian Journal of Occupational Therapy)	Focus group discussions with nine occupational therapists who adopted the principles in the Enabling Occupation II book (Townsend and Polatajko 2007; 2013)	Client-centred principles from Canada are equally applicable for the practice of Dutch practitioners.

Author(s) Year , journal		Study Design, sample size	Points of Interest
11	Schleinlich *et al.* (2008) Palliative Medicine	Survey questionnaire. Four sites. 40 palliative care patients .	The CMOP was used to structure a questionnaire sent to palliative patients. Findings identified that having therapists listen to them was one of the most important parts of patient care.
12	Stamm *et al* (2005) Australian Journal of Occupational Therapy	Literature review.	The CMOP linked to every area of the International Classification of Function and Disability (ICF). The CMOP included the cultural environment not found in the ICF. Could be used with other models to encourage better communication within the MDT.
13	Warren (2002) BJOT	Research conducted with 7 occupational therapists who used the CMOP in practice, with clients with a functional mental illness	The CMOP provided a clear structure for capturing areas of concern; helped to identify clients who required occupational therapy; was used as a tool for defining the occupational nature of the role; focused information presented in ward rounds; encouraged a client-centred focus

2.6. Reflections upon findings

The review of the literature in this chapter revealed that use of the CMOP in practice was limited to two empirical studies, undertaken over ten years ago in mental health settings. Whilst they make a contribution toward enhancing our understanding how the CMOP was used, there have been significant change in health and social care in the intervening years and, therefore, caution is needed when making generalisations about the applicability of findings to all areas. Whilst their conclusions are strengthened by more recent work, including our own action research (Boniface *et al.* 2008) and that conducted by Wimpenny *et al.* (2006, 2010) , it needs to be noted that the majority of research pertaining to use of a single conceptual model in practice was conducted in predominantly small scale, local studies. Therefore, it could be argued, based upon available evidence, models may not necessarily be applicable in all practice settings. The CMOP has been used as a framework in a range of settings, including children, older and working age adults with physical needs. Yet, this evidence is from theoretical application of the model, predominantly opinion pieces or literature reviews, which were small in number and variable in quality. There is little evidence from practice to support the assertions provided by the authors of these papers. Therefore, whilst it has been recognised by this range of authors that, potentially, the CMOP can be used to structure and focus domains of concern for occupational therapists, work effectively in multiagency teams, format documentation, clarify professional identity, and focus interventions upon client-centred practice, limitations of the papers need to be acknowledged. The reviewed literature merely accentuates a paucity of research exploring the use of conceptual models in practice, from a number of perspectives. More research is needed with primary data collection, either quantitative or qualitative studies, to create a body of evidence for using models in practice.

Other literature examined related to academic and clinical partnerships, and change management. The papers reviewed describe the importance of partnerships between academics and practitioners, to create discussion about models and a shared understanding of terminology. In general, they seemed to indicate that these partnerships were positive, to encourage reflection on practice which led to changes in practice. However, there was acknowledgement of cultural challenges when principles of a model created in another county were discussed in relation to individual practice. Predominantly, change management literature depicts change management processes, suggesting that through understanding each discreet and distinct stage, leaders will be able to successfully make changes. However, the literature also identified that, individuals exhibit human agency, which means that they subtlety alter and interpret changes in response to the context and situation they are in, and can

actively resist change. Some authors suggested that any change has a local variation and there are discrete, local social processes that take place. To understand these subtle local changes requires further research that specifically examines in detail the contextual factors, to understand what influences the process. This has resonance in relation to my own research interests. Examination of the earlier research work conducted in the county (Boniface *et al.* (2008) and that undertaken by Wimpenny *et al.* (2006, 2010), describe clear processes where a single conceptual model was introduced as part of a community of practice. Whilst these published works are a valuable source of insight to increase understanding in the subject area, I wanted to understand how momentum was maintained for the CMOP to be used by practitioners in an integrated health and social care setting. There is broad acknowledgement in these papers that practitioner roles adjusted and altered with the introduction of a model. However, they do not specifically examine contextual factors, and no other studies have specifically examined local influences and how these impact upon use of models in practice, indicating a gap in the knowledge.

2.7. **Chapter summary**

The aim of this study is not to advocate for one particular model or suggest that practitioners should only use one model of practice. Indeed, as discussed in the introduction and literature review chapter there is an ongoing scholarly debate within the profession about effective translation and use of theory in a practice setting (LeClair *et al*. 2013; Kielhofner, 2005; Turpin and Iwama 2011) and equally, about whether practitioners should use one model or more (Mosey, 1985; Creek, 2003; Ikiugu, Smallfield and Condit 2009). This study seeks to understand practice, from a local perspective, within one county who adopted the CMOP and to build upon the previous action research conducted (Boniface *et al.* 2008). In the absence of any studies that explore contextual aspects, I wish to examine factors that influence how the CMOP is used in practice, to elucidate understanding. My research seeks to understand the inter-relationship between three factors namely; the steering group who led the research process, the artefacts they created and individual practitioners who used or resisted using the model. Understanding these factors within the particular contexts in which the occupational therapy practice is being enacted will present insights to enhance knowledge in this area.

3. Methodology

3.1. Introduction

In this chapter, the research methodology which underpins this study is introduced and with a description of why the study design was chosen. An overview of data collection approaches used, and methods of analysis employed, is presented.

3.2. Aim of the study

The research focuses upon understanding the relationship between theory and clinical practice and, specifically, how the CMOP has been integrated into working practices of occupational therapists. The research question is:

"How does using the Canadian Model of Occupational Performance (CMOP) influence occupational therapy practice?"

Sub research questions are:

(1) How does the CMOP help occupational therapists to address the Occupational Performance needs of clients?

(2) How does the organisation influence the occupational therapists use of the CMOP?

(3) How does the CMOP contribute to the understanding of occupational therapy practice?

To be able to address the subject area, it was necessary to determine the best way to approach and answer the research question.

3.3. Qualitative research

Qualitative research is a term used to cover a wide range of approaches and methods. It is a method of naturalistic enquiry that aims to study people in their natural social setting, and focus upon the meaning individuals attach to their social world (Denzin and Lincoln 1994). It

can be a rich source of information, to understand a social world and provide explanations which can enhance understanding of a phenomenon of a particular social situation that can support development of theories or strategies (Bowling, 1997; Ritchie and Lewis 2003). Qualitative research seeks to understand the 'what', 'why' and 'how', rather than simply focusing upon outcomes. Qualitative researchers are interested in how study participants view their world, and meanings they give to their particular reality (Blaikie, 2000). I wanted to know was what actually happening within practice and have a deeper understanding of the relationship between the CMOP, steering group and artefacts created to support practitioners. Qualitative research methodology was an appropriate choice for my study, as a way of understanding the reality of practice rather than the process of how it was introduced, which was part of earlier work (Boniface *et al.* 2008; Waygood *et al.* 2012; Walker and Thistlewood 2012). To answer my research questions I needed to understand how the CMOP was used in the local context and setting.

3.4. Researcher role

Whilst I was the researcher, I was in a unique position as I worked in the county as an occupational therapist with a responsibility to support several teams who worked in both community hospitals and integrated community teams (ICT). I was the CMOP steering group chair from 2006. Although this created unique opportunities to obtain insights and to access material an outsider might not be aware of, it meant I needed to be cognisant of my own biases and influence upon the research. I recognise and acknowledge that my own views of the CMOP are positive and I did not want the study to be regarded as simply verifying my own opinions. I was aware that the CMOP was viewed negatively by some practitioners and it was important to hear and understand the perspectives of others. Qualitative research is a subjective process and, as a researcher, I needed to acknowledge my own personal values, assumptions and beliefs about the CMOP, my own place of work and the practice of my colleagues (Braun and Clarke 2006, 2013). As part of my preparation for conducting the study, I needed to consider how I used my own subjectivity and its influence upon the research through reflexivity.

Finlay (1998, 2002) described reflexivity as 'thoughtful analysis', which encompasses continual evaluation of both our subjective responses (personal reflexivity) and our method (methodological reflexivity). Through constant reflection, questioning and evaluation the researcher can, in fact, turn a perceived problem of subjectivity into an opportunity. Finlay emphasises the importance of accepting and recognising that the researcher is a central character who influences the collection, selection and interpretation of data and that, rather

than questioning *whether* they should be doing it, need to question *how* to do it, and ensure they do it well. Finlay acknowledges limitations of reflexivity, in that too much or too little can be problematic, suggesting the researcher needs to decide the best way of exploiting the reflexive potential of their research. Self-reflection or reflexivity, is a means of understanding the impact of the researcher's views and beliefs upon the study, and is a valid means of adding credibility to qualitative research that should be subject to the same scrutiny as the other data in the study (Mason, 2002). Researchers cannot be neutral, objective or detached from the knowledge and evidence being generated, and instead should seek to understand and explain their role in the process.

I was aware that I needed to manage any tension between my work and researcher role. Part of my preparation was to consider, and pre-empt, how I would manage and respond to things that I heard or read that I did not agree with. My interpretation of the data would not be value free and would be influenced by my own perspectives and interests (Braun and Clarke 2006, 2013). I had been actively involved in the steering group and worked within the county in which the study was being conducted and, as such, without careful management, pre-existing prejudices and assumptions could prevent me from seeing important points in the data. Such research bias could threaten the credibility of the analysis and overall validity of the study. Therefore, it was important during all stages of the research process, preparation, collecting and analysing data, and writing up, to acknowledge that my own personal views and values have impacted upon my interpretation of findings. For each stage of the research process, I have taken account of my own assumptions and values, and explanations have been given for the impact they had upon my interpretations. It is not possible for me to suspend my views and instead I have managed them, and recognised myself own role in the research.

I have a unique understanding of the world, constructed by my own personal reality, influenced by my experiences, social status and roles, and these shaped the data collected (Burr 2015). In addition to reflexivity, I needed to consider in what way my recognised role as a manager may influence participant responses to me during interviews, specifically how we both positioned ourselves during interviews. Every social interaction goes beyond the immediate social event and within every communication, power relations are being carried out (Burr, 2015). Whilst, I could not prevent participants from reacting to me and providing responses they thought I wanted, rather than providing their own views, I needed to be cognisant of this, to ensure that the voices of my participants were heard. I managed this by conducting interviews on my non-working days with those whom I did not directly manage. I deliberately dressed casually and emphasised to all that their views would be anonymous. In general, the participants were open with me and did not appear to be uncomfortable in revealing to me their perspectives and

realities for using the CMOP. Only one participant was hesitant, and I reflected in my diary how I felt very conscious of my managerial role during the interview and deliberately did not probe as deeply as I may have if I had been an external researcher. I was conscious that if I had explored in more depth that she may have adopted a position where she provided answers that she believed I wanted to hear, rather than those she felt comfortable with sharing. Equally, when analysing the steering group minutes and artefacts, I needed to ensure that I described the contents, rather than simply explaining from my own perspective. Rich descriptions are provided for each unit to help the reader to understand the findings from the data and my own observations. My personal experiences when conducting the research made me aware of the complexity and subtle influence my own role had in shaping the data generated.

3.5. Theoretical perspective

When research is conducted, the choices made by a researcher are influenced by their own view of society, and that what is seen is dependent upon what is looked for and what previous experiences have taught an individual to see (Kuhn, 1970). A method of investigation is based upon two factors, firstly, the researchers own assumptions about society and, secondly, which method will be most suitable to answer the research question (Morse and Field 1995). As a researcher, I acknowledge philosophical influences upon my study and my ontological perspective is that the world is socially constructed. Social constructionism is a sociological theory of knowledge and 'not believing in the existence of objective truth out there' for us to discover, but instead understanding that meaning comes from our own interactions and interpretations which create our reality (Berger and Luckmann 1991). This perspective posits knowledge to be a social and cultural construction, that reality is socially constructed by humans in a historical moment and social context. I believe that people do not live in isolation, but explore their world in a social context and through interaction with others.

My epistemological assumption is that, to understand the socially constructed world, I must enter it and seek to interpret its meanings. An integral part of the interpretation process required me to take account of my own assumptions and values, to understand and explain how they have impacted upon interpretations made. It is not possible for me to suspend my views and they are managed as part of the process.

3.6. Introducing case study

Case study research has a long history within social sciences and has increasingly become more popular in the fields of sociology and psychology (Hamel, Dufour and Fortin 1993).

'Case study' is a term which can be used to describe both the research process and the end result. Case study is a research method that enables the researcher to use multiple methods of data collection and analysis from within a natural setting. Collection and presentation of detailed data from various sources can enhance understanding of particular groups, individual's societies or organisations (Yin, 2009). Analysis undertaken as part of a case study can provide contextual detail and a rich description of findings can be used as a way to explain something (Yin, 2009, Stake, 1995; Hamel, Dufour and Fortin 1993).

I firmly believed that, through use of the CMOP, occupational therapists were able to articulate their role and identity. Earlier research in the county (Boniface *et al.* 2008) suggested that the CMOP was an overt way to make a link between theory and practice and I was interested in a rich description of how the CMOP was being used in this context and setting. The research focused upon understanding the relationship between this conceptual model and clinical practice from a number of interrelated perspectives. This required more in-depth understanding of the complex interactions between these individual factors and the case being examined in order to answer the research questions. This would not be possible using other methodologies, such as grounded theory, which purports to start from a naïve theoretical position or phenomenology which intends to explore an individual's unique experiences.

Yin (2009 p. 18) describes case study research as:

> *"An empirical inquiry that investigates contemporary phenomenon within its real-life context when the boundaries between phenomenon and context are not clearly evident."*

3.6.1. Case study criticisms

In the literature, Flyvbjerg (2006) identified and addressed criticisms that case study research can be simply used to verify a researcher's preconceived ideas, has little scientific value, is not generalisable and is of questionable quality. Flyvbjerg (2006) refuted these criticisms and contended that being so close to the subject under investigation, researchers can challenge personal assumptions, preconceived notions and initial hypotheses through rigorous interrogation of data. A high level of scrutiny of the phenomena can lead the researcher to gain new insights, learn new things and have a deeper understanding of the subject under investigation. The important point is to establish rigour (trustworthiness) so criticisms can be addressed. Trustworthiness is discussed in more detail later in this chapter, in relation to my study. Table 3.1 below presents each misunderstanding, with the response given by Flyvbjerg

(2006). I have included in the table personal reflections in relation to my own study, which are in italics.

Table 3.1: Flyvberg (2006): Misunderstandings, interpretations and considerations about case study research

Misunderstanding	Flyvbjerg (2006) interpretation and consideration given for my study
General theoretical (context independent) knowledge is more valuable that concrete practical (context dependent) knowledge.	Learning the expected 'theory' in a given subject area is an important part of developing expertise to a beginners level. To learn knowledge and rules in a context independent way is an important part in the learning process. Context dependent knowledge presents an opportunity to learn the nuances of human behaviour that people do not always do things in a predictable ordered way. We need both types of learning, so we can become aware of changes and challenge predictable way of thinking. *The CMOP was a theoretical model which was learnt in a context independent way at college. I was able to understand how the CMOP was used in one geographical location and the findings will help to develop our understanding of contextual or local factors which impact upon use of the CMOP.*
You cannot generalise from one case study.	It is incorrect to say that you cannot generalise from one case. Galileo rejected Aristotle's view on gravity, based upon one case, which disproved the theory the 'black swan' (Kumar, 2010) and falsification. This was a critical case and other studies were conducted to refine the evolution of the theoretical account. Other cases can either prove or disprove the theory. Single studies present a perspective that other studies can either prove or disprove which equally add to the knowledge base. Yin (2009) advised that theoretical generalisation, building upon single cases, can enhance understanding

	if subsequent studies verify or falsify the original study. *My study seeks to develop the theoretical knowledge about the application of the CMOP. Other cases using my methodology can subsequently verify or falsify my study.*
Case study is most useful for generating hypotheses as the first stage of research, whereas other methods are more suitable for hypothesis testing and theory building.	This misunderstanding derives from the previous misunderstanding that you cannot generalise from a case study. Findings from one case study can direct researchers to selecting critical cases which are most likely (well suited to falsification and disagreeing with the original findings), or least likely (suitable for tests of verification) to confirm ideas. The validity of a case often depends upon the claims a researcher places upon the findings from their study. *This study seeks to develop and explain how the CMOP was used in practice which can be used to enhance understanding.*
Case study contains a bias towards verification of confirming the researcher's preconceived notions.	Awareness of criticism makes us sensitive to them, which means we are able to address them. Being in close proximity to the subject under review, forces the researcher to challenge their own misconceptions and falsifications as they arise. It is falsification not verification that characterises the case study. It is only when the researcher places themselves in the situation and context of what is being studied that they truly understand the viewpoints and behaviours of those being studied. More discoveries are made from observations in the real life situation than studying statistics. *Through a rigorous scientific process using Yin's methodology (Yin, 2009) I challenged my own misconceptions. I used a process of reflexivity allowed the data to speak, rather than simply my own voice being heard.*
It is difficult to summarise and develop presuppositions and	Case studies often produce, 'thick' narrative type data and the researcher should not assume the role of

theories based upon a single case study.	narrator, but allow the story to unfold from many conflicting sides which have been presented. In this way the reader, dependent upon their background can draw their own interpretations. The goal is not to make the case study one thing to all people, but to allow it to mean different things to different people. There is a danger that important things may be lost if we summarise. *This study presents an account of the influence of the CMOP upon occupational therapy practice and explains my own interpretations to contribute to theory building (Salminen, Harra and Lautamo 2006)*
Flyvbjerg (2006).	

3.6.2. Defining the case

Miles and Huberman (1994) define a case as something which occurs in a bounded context. They suggest there needs to be a '*heart*' (Miles and Huberman 1994 p. 25) of the study and a boundary for the case, which shows what will and will not, be part of the study. The case and focus of this study was identified to be occupational therapy practitioners in one county who use the CMOP to underpin their practice. The focus of my study was to understand the influence of the CMOP from the occupational therapist perspective, not to study interactions between practitioners and clients. The study aimed to describe, understand and explain the case 'occupational therapy practice' and answer the research questions. This study built upon earlier research undertaken in the county that described the action research process of implementing the CMOP (Boniface *et al.* 2008). I used a single embedded case study design.

Limited literature exists which describes case study methodology (Stake, 1995; Yin, 2009) and few give explanations about how to undertake case study research. Some criticisms are that case studies lack credibility when there is an inadequate explanation of the procedures used by a researcher. Yin (2009) provides a clear description of structure, terminology and the methods which can be used in case study research and have been used in this study to provide a transparent, auditable, research design and process.

3.7. An overview of the study design

This section of the chapter will provide an overview of the methods used and the research process. *Figure 3.1* illustrates the research process and each stage of the study.

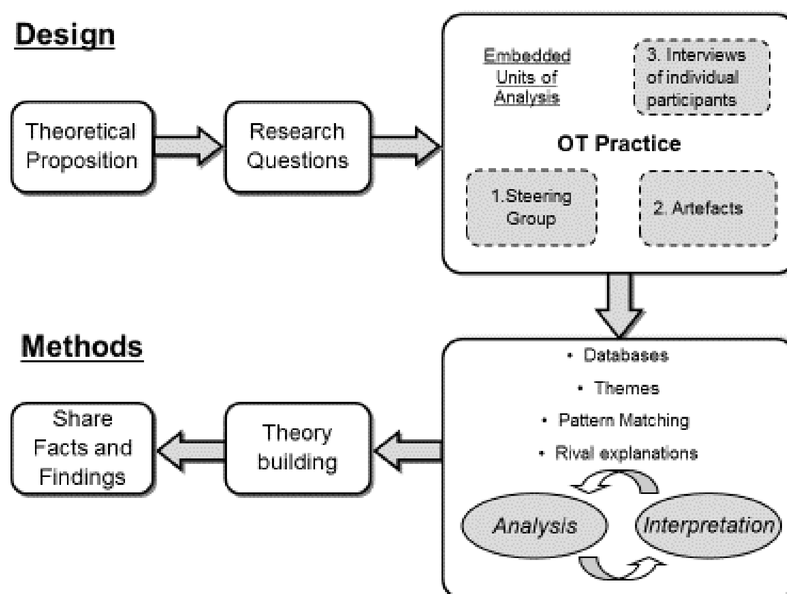

Figure 3.1: Application of Yin's methodology to each stage of the study to illustrate the research process used.

3.7.1. Theoretical proposition

The purpose of a theoretical proposition is to 'direct attention towards something which should be examined as part of the study' (Yin, 2009 p. 28). Development of propositions guides what data should be collected in order to answer the research questions, to 'focus the attention of the researcher on certain data and to ignore other data' (Yin, 2009 p. 130). This was an integral part of preparing for the study, to decide what data is required to answer the research question. My presuppositions can be found in the rationale contained in introduction and literature review. My presuppositions led me to consider the steering group, practitioners and artefacts to be data sources required to answer the research questions.

3.7.2. Research questions

Yin (2009, p. 27) suggested case studies should answer either a 'how' or 'why' question, usually targeted towards a number of limited events and their inter-relationship. My questions

were linked to my presuppositions and clear research questions determined the units to be examined as part of this study. My overarching question was:

"How does using the Canadian Model of Occupational Performance (CMOP) influence occupational therapy practice?"

Sub research questions were:

(1) How does the CMOP help occupational therapists to address the Occupational Performance needs of clients?

(2) How does the organisation influence the occupational therapists use of the CMOP?

(3) How does the CMOP contribute to the understanding of occupational therapy practice?

Overleaf, figure 3.2 depicts the development of the case from theoretical proposition to building.

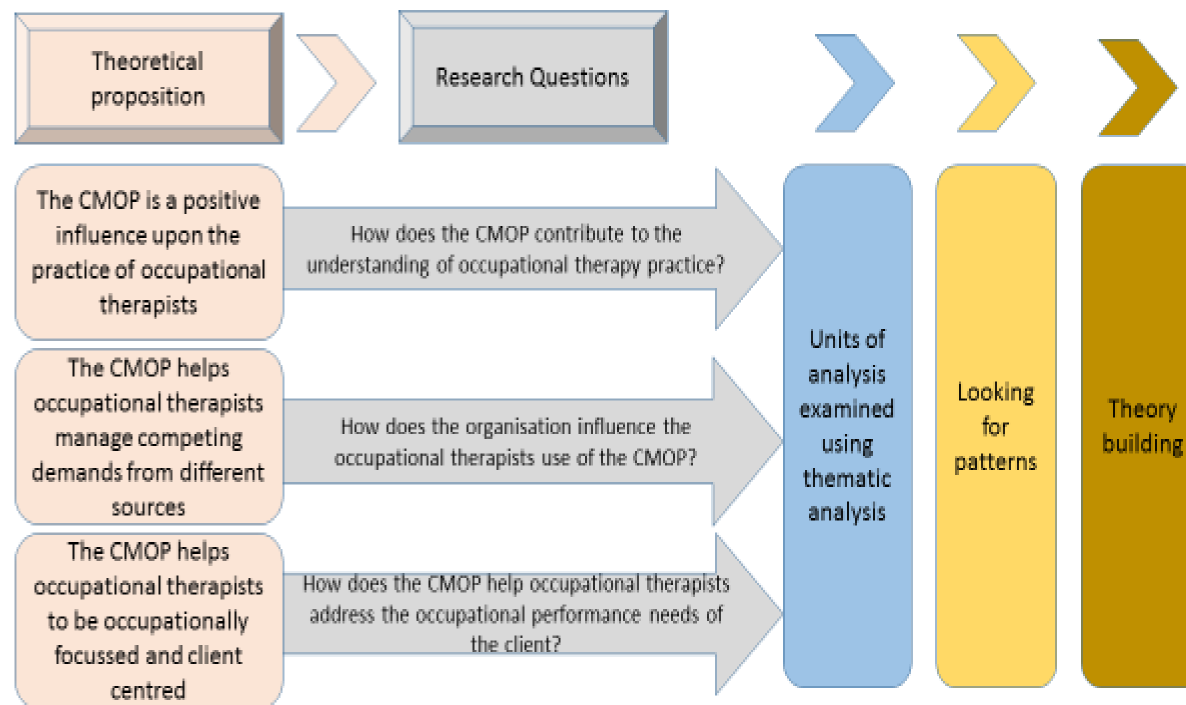

Figure 3.2: Development of the case from theoretical proposition to theory building

3.7.3. Data collection and analysis

In order to answer the research questions, I considered how data would be collected and analysed.

3.7.4. Introducing documentary evidence

Yin (2009 p. 101) states that documentary evidence is likely to be of relevance for every case study and are an important source of data to augment or corroborate evidence from other sources. Described by Braun and Clarke (2013) as 'textual data', it is information used to inform the research questions that is already generally publically available in written or audio-visual form. It is data which has not been produced for research purposes and exists in different formats, such as leaflets, newspapers, minutes, videos, blogs (Braun and Clarke 2013 pp. 152-153). This type of data can be used to understand contextual, cultural factors or perceptions held by people at a specific period of time and a snapshot of realities of particular groups of people. In this study, the minutes from the steering group and artefacts formed documentary evidence for the research.

3.7.5. Introducing interviews

Focused interviews are guided conversations rather than structured queries (Yin, 2009 p. 107). They add an alternative dimension to the research questions and seek to understand experiences and accounts of participants. Rubin and Rubin (2005) describe the aim of a research interview to be the acquisition of knowledge, which help you to understand a particular subject area. Through conducting interviews, a researcher can understand another person's experience of events that they did not participate in, and understand personal experiences or opinions of a situation. A fundamental part of my research was to understand participant views, opinions and experiences of using the CMOP. Literature and personal experience of conducting interviews were used to develop a protocol to conduct the research interviews (appendix 4)

To ensure that the participants' perspectives were heard, I needed to manage both the interview process and myself. Miles and Huberman (1994) advised that keeping a reflective log, and completing a contact summary sheet after each interview helps the researcher to balance demands. A reflective log, fieldwork diary and reflective diary were kept and used to capture my own reflections, intuitions and thoughts, as crucial components for the study.

3.8. Method of analysis

3.8.1. Thematic analysis

Qualitative research produces a large volume of data and this data needs to be analysed systematically to answer research questions. Braun and Clarke (2006, 2013) described thematic analysis as a method of qualitative data analysis for identifying, analysing and reporting patterns within data, which is flexible and can be used across a range of theoretical and epistemological approaches. Table 3.2, overleaf, defines thematic analysis terms used by Braun and Clarke (2006, 2013), who assert that, how data is interpreted relates to active decision making by a researcher and, to describe themes as 'emerging from' the data, denies their active role in identifying patterns and themes. The researcher actively selects data which is of interest to answer the research questions. Thematic analysis can be used to present links or patterns between variables and create a chain of evidence.

Table 3.2: Defining thematic analysis terms used by Braun and Clarke (2006, 2013)

Term	Meaning
Code	A process of identifying aspects of the data that relate to your research question (Braun and Clarke 2013 p. 329).
Central Organising Concept	An idea or concept that captures a meaningful pattern in the data and provides a succinct answer to the research question' (Braun and Clarke 2013 p. 328).
Overarching theme	An overarching theme used to organise and structure which captures the idea from a number of themes which tends not to contain its own codes or data (Braun and Clarke 2013 p. 333).
Sub themes	Captures one aspect of the theme and shares the central organising concept of the theme (Braun and Clarke 2013: 337).
Theme	Organised around a central organising concept that captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set (Braun & Clarke, 2013:337).

Braun and Clarke (2013) described how thematic analysis comprises of 6 stages; coding data as a way of managing the volume of information; searching for themes and patterns; reviewing potential themes; defining and naming themes and producing a report. The purpose of thematic analysis is to answer research questions and interpretation of data is influenced by the researcher's perspective. My theoretical perspective was that the world was socially constructed and through the use of an interpretivist approach, I sought to understand the reality of occupational therapy practice in this county. My theoretical perspective influenced how I viewed and analysed the data.

3.8.2. Pattern matching

Yin (2009, p. 136) described pattern matching as one of the most desirable techniques for analysing the data and integral for establishing internal validity in a case. Convergence of evidence requires a researcher to search for patterns across all units of analysis and to look at data from multiple perspectives. I used a particular type of pattern matching called explanation

building (Yin, 2009 p. 141), where the eventual explanation is the result of a series of iterations that required me to compare the findings of the case against the initial proposition. The building of an explanation was a gradual refining of ideas and consideration of rival explanations, to either support or refute my findings. Rival explanations explore alternative reasons for why patterns may have occurred, usually from the literature which is used to strengthen explanations. Analysis of data may identify different stronger patterns which differ from those predicted. In those situations, the researcher has made a theoretical replication across the case, which contributes to theory building (Figure 3.3).

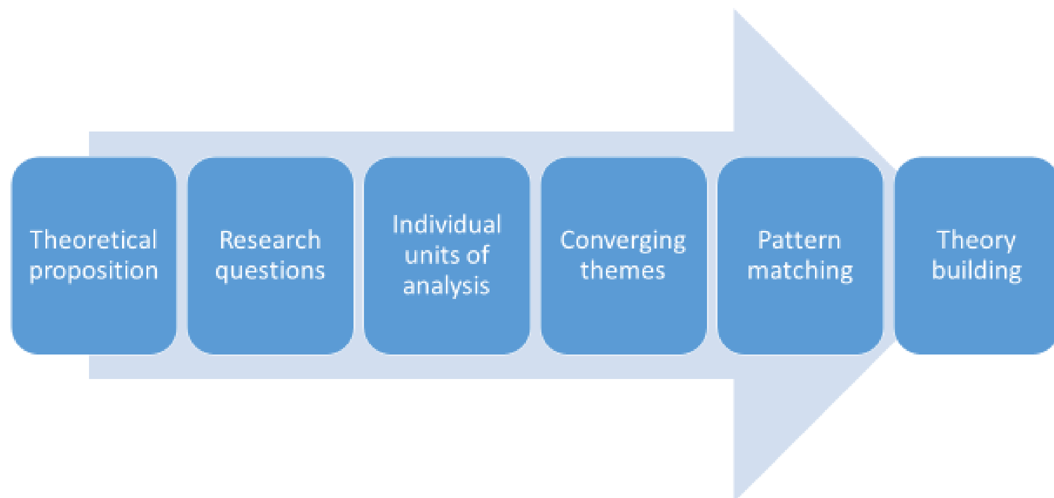

Figure 3.3: Systematic research process used in this case

3.9. Units of analysis

Yin (2009) described data sources as the units of analysis which are needed to answer the specific questions raised. He advocates the use of multiple methods to access different types of information that can be used to answer the questions. The study had three units from which data was collected. These are now described:

3.9.1. Unit 1 Documentary evidence steering group minutes

Minutes taken by the steering group between 2004 -2013 were examined. The minutes provided evidence of the role of the steering group in implementing the CMOP. They were analysed using an inductive thematic analysis procedure described by Braun and Clarke (2013).

3.9.2. Structure of analysis

Initially, all documents both paper and electronic were collated. A data collection form was created to capture points of interest and included a separate section to capture my own reflective comments (appendix 5). At times my thoughts were expanded in my reflective diary where I questioned the findings. Early on, I recognised a potential problem was that the minutes spanned a nine year period and other units within the case study did not. Whilst analysed as a separate unit, the steering group minutes were situated within an embedded case study, which relied upon convergence of evidence to help corroborate emerging patterns and themes. Analysis as part of a time ordered matrix (Miles and Huberman 1994) would not be suitable to use in conjunction with the other units. The aim of analysis was to identify themes from within the minutes which captured the purpose, function and output of the group (see appendix 6 for an example of the minutes). The minutes were analysed using an inductive thematic analysis procedure described by Braun and Clarke (2013). Firstly, I read through the minutes (data) carefully to familiarise myself with the content, noting items of interest. Initially, I coded chunks of data and gave each a title to capture the essence of the data and 30 codes were created. I soon became aware that these 30 codes were not specific enough and were open to variable interpretation. This error was, I believe, explained by my naivety with the research methodology and, following discussion with my supervisory team, I began the analysis process again. The data was manually analysed and this time, I coded data by identify interesting features in the text and used a word or phrase to captured its content. Some of the data had more than one code attached and 139 codes were identified. Similar codes were grouped together and central organising concepts created. A database was created for each category, to create an audit trail and identify why a particular quote was placed into any category. I looked for patterns to create themes and refined themes, collapsing some and discarding others. Themes were created from several categories and collected together. The original data was revisited several times to ensure context and understanding of the data was correct and that the categories created the most appropriate themes. Finally, the data was reviewed to ensure that the themes described in the 'steering group' chapter worked in relation to the research questions.

3.9.3. Unit 2 Artefacts, visual and documentary

Yin (2009) described artefacts as a '*physical or cultural artifact - a technological device, a tool or instrument, a work of art of some other physical evidence'* (p. 113). Included in this study was a supervision DVD, six editions of a study day, two editions of a manual, a policy document and a support worker training package. Whilst, arguably, the study days did not

neatly fit into this description, they were a tool developed by the steering group to create understanding of the CMOP and, as such, were analysed as part of this unit. Examination used principles of thematic analysis to understand observable meanings contained within each artefact, and themes were identified across the dataset.

3.9.4. **Structure of analysis**

During analysis I used principles of thematic analysis and I asked myself key questions:

(1) What message were the authors trying to convey?

(2) What contribution was the artefact making towards a shared understanding of occupational therapy?

(3) What are my intuitive feelings?

The artefacts were primarily analysed to understand observable meanings each contained. During analysis, all observations and reflective comments were recorded separately on an artefact summary form (appendix 7). I was, therefore, able to identify my own thoughts from the themes I found so each could be accurately reported. Initially, each artefact was analysed separately and then themes across the dataset were identified.

3.9.5. **Unit 3 Semi-structured interviews:**

Interviews were conducted with eleven participants to understand participant perspectives of the CMOP and its influence upon their own practice.

Inclusion criteria: Registered occupational therapists in one county who used the CMOP as part of their work.

Exclusions criteria: Support workers; occupational therapists who were bank or agency, staff on fixed term contract or those not permanent employees of the organisation; newly qualified occupational therapists who had fewer than three months experience of using the CMOP within the county, and staff I appraised.

Method of contact: As an employee in the same county, I did not want to make direct contact with potential participants as this may unduly influence those who were recruited. Initial contact was made via Community Managers, Matrons and Acute Trust Lead, through an invitation letter (IL [1] appendix 8). This letter asked for all staff interested in participating in the study, who met the inclusion criteria, to contact me directly through a reply form. No direct

contact was made with any potential participant until they had indicated an interest in taking part in the research.

A time limit of two weeks was given to respond to the IL [1] and I received twelve expressions of interest. One respondent who I appraised was excluded. Eleven respondents were contacted by me within two weeks of replying via email, which was the preferred method of contact for all, to confirm they were still interested in taking part. After checking they still wanted to be involved we agreed a mutually convenient time and place to meet. Prior to each interview, we discussed the participant information sheet (PIS [1] appendix 9) and consent form (CF [1] appendix 10), any questions raised were answered and signatures were obtained. Each was assured of confidentiality and anonymity, also confirming their right to withdraw at any time. They were all advised that if they chose to withdraw, permission will be sought to use data already provided. A semi structured interview template was created based upon the research questions.

Interview format Open ended interviews were conducted with the eleven self-selecting participants. Each interview was digitally recorded and transcribed verbatim by a transcription company. Each written transcript was reviewed carefully and compared with the original recording. The interviews were analysed using thematic analysis (Braun and Clarke 2013).

3.9.6. Structure of analysis

I coded two interviews in early December 2014. I had attended a thematic analysis two day workshop provided by Braun and Clarke in July 2014 and during my analysis I tried to create, as suggested in the workshop, a label for pieces of the raw data which interested me and then devise 'pithy' catchphrases for data. I did not find this successful. I was concentrating too much upon a catchphrase and not the data so decided to change my strategy. I reflected upon previous experience, when I analysed the steering group data and had made a mistake by oversimplifying the codes and needed to restart analysis. Subsequently, I created codes which reflected my immediate impression for the meaning of words or phrases, which proved much more successful. Initially, coding the interviews lacked flow and I struggled to immerse myself in analysis on two non-sequential study days. I took a period of leave from work and had 10 days together, which helped to fully immerse myself in data analysis, during January 2015. Interviews were coded in the order in which they took place.

I created 429 codes. Some codes, when reviewed, were very similar and could be explained by the initial gap between the first two and the final nine interviews. This slight variance did not have a significant impact upon the analysis process and similar codes were grouped

together, with the creation of central organising concepts. I started to examine patterns for themes and refined themes, collapsing some and discarding others. Verification of themes was through discussion in supervisory meetings. Use of my reflective diary was vital for managing me in the research process and I noted on 5th October 2014 that it was important that I did not collude with informants.

3.10. Individual unit data management

Case study research generates a large amount of data from multiple sources (Yin, 2009) and I needed to carefully manage the information, so I did not become overwhelmed by the volume and lose sight of the research questions. Therefore, prior to data analysis, I created databases for each unit to organise and categorise the data. A document summary form was created and this was used and adapted for each unit. All electronic documents were kept on an encrypted computer and paper documents were kept in a locked cabinet. An index was created of coded data to provide an audit trail of the analytical process (Miles and Huberman 1994).

3.11. Trustworthiness

In qualitative research, one of the biggest challenges is to assure the quality and trustworthiness of the research study being presented (Finlay, 2006). Qualitative research is concerned with subjective reality, individual experiences and meanings they attribute to them. Used as a methodology to develop understanding of a phenomenon, it has been suggested that quality or rigour can be established if the case study can describe, understand and explain events and the influences and actions of the researcher (Koch, 2006; Yin, 2009). Yin (2016) advocates that providing readers with a clear understanding of the research protocol can demonstrate how it has been followed from design, data collection, analysis, thus the conclusions and findings, accurately represent the phenomena studied. Stake (1995) depicts the role of a case study researcher to be that of an interpreter, who provides rich descriptions of the phenomena being studied so readers can make their own generalisations. He suggests that the criteria for judging quality of a study should come from within the case itself and by the explanations the researcher gives.

Qualitative researchers have sought to move away from more positivist terminology for trustworthiness; reliability, validity and generalisability, as these concepts are not easily transferable to the ‘naturalistic setting’ (Lincoln and Guba 1985). As an alternative, other methods can be used to strengthen credibility and trustworthiness of qualitative research. A qualitative researcher is instrumental in conducting the research, and through clear use of

explicit criteria readers can identify any strengths or limitations and understand a researcher's personal values and interests (Finlay, 2006). Yet, whilst there is agreement about the importance of critical evaluation of research through an applied criteria, there is not one criteria used in qualitative research. Lincoln and Guba (1985 pp. 289- 331) describe quality of design has as trustworthiness, credibility, confirmability and data dependability. I have used Yin's (2009 p. 41) terminology in my study to provide a transparent and auditable research design and those described for trustworthiness have been used in this study, namely validity (internal, construct and external) and reliability.

3.11.1. **Validity**

Yin (2016) described this to be when the data has been properly interpreted and the reader can understand the conclusion drawn and relevance to the phenomenon being examined. He describes this in terms of construct, internal and external validity.

3.11.2. **Construct validity**

Multiple sources of data collection were used to establish a chain of evidence (Yin, 2009 p. 41). The thesis presents clear descriptions of the case which provided an audit trail.

Initially, each unit was described separately, with rich descriptions of the data and use of verbatim quotes taken from documentary evidence or from interview participants. To ensure that each interview was conducted consistently, I asked the same questions of each participant. Whilst this did not preclude other questions being asked if an interesting point was raised, it ensured that I was treating each participant in the same way. The dataset was then examined, to establish themes and patterns to establish a chain of evidence and build analysis of the case.

A number of techniques were used to manage myself in the research process and understand the influence of my own thoughts, assumptions and biases. This was particularly pertinent given my dual roles of researcher and worker in the county where the study was being conducted. I was particularly conscious of the issue of power in both these roles, particularly when interviewing colleagues and how my being the researcher may have had a positive or negative impact upon who volunteered and the responses given to me. Equally, as a chair of the steering group and key creator of some of the artefacts, I consciously and consistently questioned my own findings, to ensure they were coming from the data and not simply verifying my own assumptions. Reflexive techniques included a fieldwork and reflective diary, which I used to examine and question my influence upon the study, consider personal insights, dilemmas and thought processes throughout the study. The diaries provide an audit

trail of choices made and development of my case. At times, I captured comments made in passing by colleagues, which resonated and warranted further consideration in my researcher role, such as:

"I think of the client always when I am working with them and don't need a model I use it because I have to."

"I view the model as Christianity. I am not a believer but I practice the religion." [23rd May 2013]

Supervision was equally important, my supervisory team consisted of academic and clinical membership with whom I met regularly, to review progress and discuss findings and ideas. The meetings were ideal opportunities for me to challenge my discoveries and my supervisors encouraged me to justify any decisions I made. We discussed alternative perspectives to ensure that my understanding was data driven and not from a person perspective, where I was simply verifying my own biases and assumptions. As my analysis progressed they encouraged me to validate themes that I had identified and explore rival explanations for my findings. Yin (2016) describes rival explanations to be more than alternative interpretations and suggests that researchers should question whether events are as they appear to be. This point particularly resonated with me when I conducted the interviews. I found myself questioning if the participants were being open with answers provided so my assumptions were correct, particularly with those who knew me, and being able to consider rival explanations was particularly helpful during analysis.

Yet, equally, my role as researcher and practitioner provided me with a unique understanding of occupational therapy practice, and my starting point as researcher was different from someone who was not familiar with the service area and how it worked. Costley, Elliott and Gibbs (2010) identify that, whilst this will mean the researcher has an inbuilt bias and reduced objectivity; this can be addressed through supervision and critical analysis of any findings. My role offered a unique perspective, which was an important element for the study. I used supervision, my own personal reflections and a technique called bracketing to help me to both understand and manage myself, and make clear and distinct to readers, my own voice and that of the data.

Bracketing is described as a technique for a researcher to use where they acknowledge personal biases and assumptions before entering into the research process (Holloway, 1997). Described as a way for researchers to manage their own beliefs, it can be a technique used to sensitise an investigator to the dominance of their own voice and how it is presented in a study, (Tufford and Newman 2010; and Gearing 2004) acknowledged the challenges, when there is no single definition for 'bracketing', and multiple definitions of the term exist. However, they advocated

that use of bracketing has the potential to enrich data collection, research findings and interpretation, through crucially recognising the researcher is an instrument in the process. (Gearing, 2004) described how bracketing is often used in qualitative research in a vague, superficial way, lacking uniformity and standards and he proposed six different forms of bracketing. The choice of which type of bracketing suits a study is dependent upon the epistemological position and ontological perspective of the researcher. I considered Gearing's work for my research and used a technique he described as reflexive bracketing, which acknowledges the improbability of the researcher to hold in abeyance their suppositions in the investigation of the phenomenon. Using Gearing's strategies, I was able to acknowledge my suppositions (personal values, judgments, culture and history) and be consciously aware of my influence upon the phenomena under investigation. Each unit of analysis contains some bracketed data, used to enhance findings and includes some personal recollections that I thought would provide a different perspective and enrich the study. My own thoughts are clearly identifiable and are shown in a different font.

3.11.3. **Internal validity (converging data analysis)**

An important part of establishing validity and reliability of a case study is to use multiple sources of evidence that corroborate a pattern or 'fact' (Yin, 2009 p. 117; Stake, 1995), which strengthens assumptions made about the case and increases credibility (Moule and Goodman 2014). Triangulation of evidence is viewed as successful when you ask the same question of different sources of data and each point to the same answer (Yin, 1993 p. 69). Data analysis was conducted for each unit and the themes identified were subject to cross analysis, to converge the data and identify patterns. I had four databases, one for each unit and one for converged data. Each contained an index which indicated where the original data came from, and a summary form to capture any specific points of interest which helped when trying to locate evidence. Analysis was an ongoing, iterative process and my original propositions were confronted by the patterns and findings within the dataset and through addressing rival explanations (against external variables), to build the case and contribute to theory building.

3.11.4. **External validity (transferability).**

Yin (2009 p. 43) described this as the extent to which findings in one situation can be translated into another. Both Stake (1995) and Flyvberg (2006) recognised that the applicability of findings to other situations is dependent upon a reader's opinion and background. Each reader has a unique and individualised perspective of reality and this influences how they interpret the data presented to them and whether they believe it to be applicable to other settings and situations. My goal was not to make the case study one thing to all people, but rather I wanted

to allow it to mean different things to different people, through thick descriptions, including my own interpretations, which contribute to theory building (Salminen, Harra and Lautamo 2006). In this study, rather than making a claim to be statistically or analytically generalisable, I wanted to understand a unique local situation (Yin, 2009, 2016). The aim of my study was to understand occupational therapy practice in one county in more detail and, therefore, generalisability of findings is not the major focus. I wanted to contribute to scholarly discussions about use of the CMOP in practice, through examination of local influences in one setting. Subsequent cases that use my methodology can verify or falsify my findings. The insights from this case study can be used to inform other similar situations and if new studies support my findings this will increase confidence in my conclusions (Yin, 2016; Stake, 1995; Lincoln and Guba 1985).

I examined patterns from within each database and then across the dataset in relation to research literature, to determine any links between the two. This was an important part of the research process to consider rival explanations and this helped to explain my findings or refute any earlier assumptions. These were discussed with my supervisory team to ensure that alternative explanations were thoroughly explored. This critical discussion was vital to ensure I took a balanced view, considered alternative interpretations of my data and deliberated any rival explanations carefully.

3.11.5. **Reliability**

To strengthen the reliability of a study there should be a clear audit trail for readers to follow so they can understand the findings (Yin 2009 p. 45). The final thesis is not all the evidence of the research process and it is important to have clear descriptions of thought processes, thinking and decision making of the original researcher, in a similar way to an auditor so they can understand any reported findings (Yin, 2009). Databases for each unit contained the original raw data; coded data captured on document summary forms, which was transferred into tables which were systematically refined through analysis to identify themes and patterns in the data. The interpretation of findings for each individual unit, were presented. Patterns across the dataset were captured in a converged unit. These patterns were strengthened, through establishing links and chains of evidence between the data and literature. Fieldwork and reflective diaries captured my thought processes throughout the research process. The reported thesis contains rich and thick descriptions, including verbatim quotes and there is a clear distinction between my own views and those from the data.

3.12. Ethical considerations

As both an employee and researcher in the organisation in which the study was being conducted, I adopted techniques to reduce my influence upon those who participated in interviews as part of the study. To some, I had previously been their manager, although I did not line manage them now, others knew me through my role as the CMOP steering group chair, and another group had not met prior to the interviews. The ethical issue of power when research is conducted is considered by Costley, Elliott and Gibbs (2010), who ascribe the use of a constant reflexive process for researchers, when a study is being conducted within their own workplace.

In this study, to address the issue of power I did not approach anyone directly to take part in the study and participants were advised they could leave at any time they wished. When interviewing, where possible, I consciously wore casual clothing to present myself in a different way to that of my normal managerial or clinical role. Prior to starting each interview I emphasised to participants that I did not want to simply verify my own opinions and have captured and reported the opinions and verbatim quotes provided by participants. Although potential for bias cannot be eliminated, I applied a constant reflexive approach. My thoughts and opinions are clearly identified as my own in the text in a contrasting font. I was attentive to any participant concerns and assured them that I wanted to hear their own opinions and perspectives. In one interview I had some reservations about a participant, a junior member of staff, who I felt viewed the interview as a ‘test’. Being sensitive to her anxiety I did not probe as much as other participants and adopted an ethic of care, using my discretionary power as researcher to be sensitive to her apprehension about the interview (Costley, Elliott and Gibbs 2010).

In the event that a participant withdrew I would have asked them if I could use any data collected, although this was not necessary for my study. No actual names and working locations have been included in the study and each participant has been given a pseudonym.

Prior to each interview, consent was obtained, confidentiality was confirmed and data anonymised. The research was kept on an encrypted and password protected computer. All research data will be kept securely for five years before being destroyed, following guidance in the DH (2006) NHS records management guidelines.

Under the terms of The Freedom of Information Act 2000 (FOIA) minutes, agendas and terms of reference minutes from the steering group and artefacts were obtained. All personal information was anonymised under the Data Protection Act (1998).

Ethics committee approval was given for this study in July 2011 by South West 3 Ethics committee (Rec reference number 11/SW/0119) (appendix 11). The University of the West of England Health and Life Science Faculty Ethics Committee (appendix 12) and NHS Gloucestershire (PCT) confirmed approval for the study to proceed (appendix 13).

3.13. Evolution of the case study

NRES approval was obtained in July 2011 and for personal reasons I suspended my studies from August 2011 – February 2013. During my suspension, there were substantial organisational changes, which necessitated some minor changes to my consent form and PIS to reflect role and managerial changes. Ongoing agreement was given to host the study by NHS Gloucestershire (PCT) R and D Consortium, who confirmed approval for the study to proceed in February 2013.

In September 2013, I undertook my progression exam where it was increasingly evident that the focus of my study had evolved.. My research questions were subsequently revised in conjunction with my supervisory team. Yin (2009 p. 90) described how the case study method often does not fit with a rigid predesigned protocol and plans can change and are to be expected and can be accommodated without biasing the case, if done correctly.

Data collection and analysis took place between June 2014 and November 2015. I initially planned to conduct the research on non-sequential study days and continue with my clinical and managerial roles on the other days. However, I found that my ability to switch between these two roles difficult and I struggled to engage fully with the research. I managed to overcome this through taking blocks of leave from work, usually about 10 days each time, which helped me to fully immerse myself into the data analysis.

3.14. Summary

The chapter has presented the research methodology which underpinned this study and why the study design was chose. An overview of the data collection methods, and analysis, has been presented with more detail about the application to be found within each relevant chapter. Ethical considerations have been described. I have discussed how I managed my own role in the study through reflexivity.

4. Steering Group

4.1. Introduction

I have examined minutes of the steering group meetings from between 2004-2013 and identified key points of interest within the text, which will now be discussed in this chapter. Whilst the steering group continued to meet after this date, bounding of the case was an important part of my methodology, and to include minutes once I started analysing the data was not practical. Initial data analysis took place in June – September 2014. The data was revisited in June 2015 for final analysis.

4.1.1. Acknowledging myself in the context of the steering group

To make this a transparent process, so the reader can understand and follow the assertions made, I acknowledge myself to be at the centre of the interpretative process and utilised a reflective process during analysis of the steering group minutes. I understand my knowledge is subjective and objectivity is not possible given my role within the steering group, and I have some emotional involvement with the data. I recognise that I view the world in a particular way, with my own critical lens shaped by my own personal and sociocultural influences. At times I recalled as a steering group member, heated and involved discussions on some points yet, the minutes only revealed a brief account of the meeting. A discrepancy between my recollection of events and the minutes being analysed created some dilemmas for me as a researcher. I recognise that I have my own values and assumptions and this needed to be accounted for in my analysis of the data. I reflected upon my multiple roles, that of researcher, member and, later on, chair of the steering group and worker within the county where the research was being conducted. My researcher role, therefore, whilst presenting some challenges equally, presents opportunities for insights which may not be apparent to a researcher who does not work in the county. I have included, at times, my own opinions which are clearly described and acknowledged throughout this chapter.

4.1.2. Documentation as a source of evidence

I recognised the flaws and bias of documentation as a data source and that they would be influenced by socio- political events of the time. It was important to remind myself that the minutes were not produced for research purposes or to be a data source for my case study. The

minutes were points that the minute taker elected to capture and, as such, they may not necessarily provide a complete or even accurate account of events. The minutes examined were found to be variable in quality, detail and format.

4.2. Background –the steering group

The steering group was set up in 2004 and was initially viewed as a short term group to oversee the implementation of the CMOP to underpin occupational therapy practice. The best way of doing this, and to represent all grades of staff, was believed to be through an action research steering group (Boniface *et al.* 2009). The purpose of the group was to fulfil the four key stages of the action research process, namely planning, acting, observing and reflecting (Carr and Kemmis 1986). Despite original intentions to be a short lived group, the group has continued to meet monthly during the intervening nine years with a more recent move to six weekly meetings. Membership varied over the years, but always sought to represent all grades of registered staff from each locality and had a small core of constant members. Typically, the membership, at any one time, was approximately twelve members, consisting of Head of Service, occupational therapy managers, band five and band six clinicians and academic lecturer from a local university. I was a member of the steering group since it launched, albeit I did have periods of absence. I was not present from 2004 - 2005 and became a regular member from 2006, and the chair at the end of that year.

Individually, each member had their own sense of who they were and presentation of the occupational therapy role was based upon personal interpretation. Terms of reference revealed a key function of the steering group was to create shared understanding and use of the CMOP, a Canadian model that originated from a different country and culture, in this British setting. Members needed to bring together individual viewpoints and understanding of the CMOP and create a shared identity in this particular social world. The minutes revealed how the group responded to external changes and demands and that the ongoing use and understanding of the model was a dynamic, temporal process. It was not simply something introduced, which then ‘just happened’ despite original intentions. The group introduced the CMOP to occupational therapists who had existing socially constructed cultures and identities, and this workforce was not static. The minutes showed that introduction of the CMOP required interactions with numerous stakeholders who, at times, both guided and conflicted with the steering group. In my definition, stakeholders were both the collective group of occupational therapy practitioners and colleagues, and managers. To differentiate between these two groups non occupational therapists are described as external stakeholders and occupational therapists

outside of the steering group are stakeholders. Responses of the group were shaped by the social situation at each particular time which influenced the course of action was taken.

> *Reflective comment:* I was particularly struck when analysing the terms of reference and minutes of a dichotomy whereby, on one hand, the group sought to embed the CMOP through a shared understanding and co-constructed meaning of the model yet, at other times, adopted a more authoritarian attitude towards occupational therapy colleagues. The group worked together to agree definitions and meanings on relevant issues of the time. Once they had consensus and understanding themselves there was evidence of how they questioned and challenged the practice of colleagues. Group members were from a variety of grades and for some this meant challenging peers or senior colleagues about their practice. This made me think that the steering group were not simply managers of an implementation process; rather their role was a more complicated multi-faceted professional discourse.

Through a discursive process which took place in the meetings, consensual meaning evolved for a shared understanding for how the CMOP should be used in practice. Artefacts were created by steering group members to share understanding and develop consistency of practice. The group minutes presented a process of ongoing actions and reflections which, when required, responded to changes within the social world in which the CMOP was being used. With each change, time was taken to create consensus of shared meaning and, if required, time was then needed to create artefacts. Some of the changes took years.

> I found myself thinking about why this was and noted in my reflective diary on 6th May 2014:
>
> I have always felt how dynamic we were as a collective group. Yet it takes years to make changes, implement something, and review things. Is this poor leadership, to which as chair I would need to hold my hand up, or do other things take over?

An example of steering group minutes can be found in appendix 13.

4.2.1. **Local changes**

The steering group was leading and guiding implementation of the CMOP in a dynamic organisation, a site of evolving actions and subtle variations, where practitioners were expected to actively engage in changing their own individual practice (Tsoukas and Chia 2002;

Walker and Thistlewood 2012). The role of the steering group was to encourage practitioners to use the CMOP and overcome any issues encountered. It took on a variety of roles; negotiator, communicator, encourager to keep up momentum and at times challenged current practice. Functions of the group were to respond to local changes and from 2004 -2011 included a Head of Service, who had power to support the actions and decisions taken by the group, despite any local organisational changes or variations. Whilst some of these actions needed negotiation with external stakeholders such as, obtaining financial support for printing manuals or changing documentation, minutes from the meetings do not suggest any particular issues with gaining required agreements. Although the minutes do indicate some required some negotiation. Therefore, during this time the steering group and its leaders were able to make autonomous decisions and changes.

Significant organisational change in 2011 devolved the previous occupational therapy service into smaller groups and teams. Some practitioners, such as those working in adult social care and community hospitals, were now under a matrix management structure, which meant they had an operational manager who may not be an occupational therapist and a non-operational professional advisor. Others, such as those working in the acute hospital and children's service, remained within an occupational therapy service structure with managers who fulfilled a professional and operational role. The overall Head of Service role was vacant. This change impacted greatly upon collective decision making by the group. The minutes reveal how unilateral group decisions were no longer possible. Some members had a clear structure to take requests for events, such as holding a study day, but for others there was not one homogenous group of managers to go to and gain agreement for actions. A timeline of local changes is included in appendix 14.

The key themes extracted from the steering group minutes are identified in Table 4.1.

Table 4.1: Key themes from analysis of the steering group minutes

30 – Codes		
Review and reanalyse		
139 – Codes		
Refining process		
21 - Central Organising Concepts		
Refining Process		
Overarching theme – 'Keeping the Conversation alive'		
	Theme	**Sub theme**
1	**Using the CMOP to define occupational therapy**	Shared understanding of terminology
2	**Using the CMOP to present a shared understanding of occupational therapy**	Understanding your role in this organisation • Support worker and occupational therapist • Steering group relationship with occupational therapy managers Let me help you understand • Study days • Manual • DVD • Documentation
3	**Networks**	Publishing and sharing Conferences

4.3. Overarching theme: 'keeping the conversation alive'

The overarching theme captures the primary function of the steering group was to create a consensus and shared understanding of the CMOP in all parts of the service. This was achieved

through ongoing discussion and debate in response to changes in the socio- cultural world of the wider social world. There are three main themes; *using the CMOP to define occupational therapy; using the CMOP to present a shared understanding of occupational therapy and networks***.** Each theme is now presented.

4.4. Theme 1: Using the CMOP to define occupational therapy

This theme described how the group created a shared understanding of the CMOP in this county. The CMOP was used as a platform for understanding and describing the occupational therapy role, and the steering group shared their interpretations and understanding with the wider group of occupational therapy practitioners:

> *"..the use of a Model of occupational therapy is a way of focusing on what occupational therapy is about and in evidencing its efficacy. It will give occupational therapy staff a common vocabulary." [2004:3]*

4.4.1. Shared understanding of terminology

The minutes disclosed discussions within the group to agree understanding of terminology used in the model:

> *"Discussed definitions, "Enabling"… [2004:29].*
>
> *"Discussed Uniform Terminology and defining Occupational Performance." [2004:31]*
>
> *"Spirituality. A source of will and self-determination, what makes the individual tick." [2006: 3]*

A significant point of note is a change in 2008 when the group sought to create their own definition of occupational performance. Minutes reveal that they felt collectively that neither the Canadian or College of Occupational Therapists (COT) definitions for occupational performance and client-centred practice suited practice locally:

> *"…Need to establish definition for occupational performance… Action: All send their own definitions of occupational performance to X." [2008:86]*
>
> *"Definition of Occupational Performance – Z's was felt by all members to be the clearest. Addition to 6th line 'different balance of occupations over time.' Addition to*

last sentence was agreed "This is where OT comes in, identifying Occupational Performance issues." [2009:3]

Once the group had agreed their definition, it was then incorporated in the new version of manual:

> *"X is updating the manual and has written a definition of OT - occupationally based, client centred definition. Has also used COT definition." [2010:39]*

Reflective comment: I was particularly struck by the timing of this change, which came shortly after the publication of '*Enabling Occupation II*' (Townsend and Polatajko 2007; 2013). In this edition the Canadians altered their definition of occupational performance and it is interesting that occupational performance has locally been altered perhaps reflecting that practice is dynamic.

The minutes capture how use of both written and verbal language, to explain occupational therapy to stakeholders, was consistently discussed. The group agreed how the occupational therapy role could be explained to stakeholders and they provided guidance, and advice, on how this could be improved:

> *"…what we should be precious about in terms of the language which is specific to OT and articulates our business." [2008:16]*

> *'Teams using terminology in notes and discussions with other members of MDT (helping OT's to justify clinical reasoning." [2006:11]*

> *"M said past experience demonstrated OT staff were poor at explaining their role. Therefore with shadowing and supervision it would be useful to spend time with staff." [2006:70]*

> *"Discussion regarding how OTs introduce themselves using the CMOP framework…. empower an individual to …..voice what they want from the service." [2007:8]*

Redefining and agreeing terms was a recurrent theme, with the most recent being in 2011 when occupational performance issues (OPI) s were part of group discussions.

4.5. Theme 2: Using the CMOP to present a shared understanding of occupational therapy

This theme describes actions taken by the steering group to instil collective beliefs, values and understandings of occupational therapy identity. The minutes reveal how the group questioned roles and developed relationships with occupational therapy managers who, they identified, were integral for their work to be successfully cascaded. Essential for these actions was development of artefacts.

Minutes from the early years show that, initially, the group directed each clinical area to work through the CMOP workbooks in local groups. An authoritarian attitude is conveyed for this activity:

> *"…meetings to work through the workbook should be compulsory." [2004:43]*

However, subsequently the minutes reveal that was not successful in all areas:

> *"…they feel they are struggling and don't have the expertise. It is felt the implementation is partly working but not with the wider staff group. They were requesting advice from the steering group." [2005:9]*

Whilst some practitioners looked to the steering group for support and advice, others were less engaged:

> *"…some areas are positive and moving forward with CMOP there are a lot of part time staff who are finding it harder….If people don't want to they won't (sic) so no point wasting too much energy." [2005:34]*

At this early stage of implementation, whilst the steering group acknowledged some occupational therapists were not engaged with the CMOP, they did not challenge these practitioners. In later years, the group became more confident and challenged lack of engagement by some:

> *"There was some feedback given about some Occupational staff still being reticent/ refusing to embrace CMOP….All staff to be made aware that it is the expectation of the OT service in ………that CMOP will be used in everyday practice… CMOP countywide steering group members to clarify champions….. to enthuse and equip champions to then go back and empower peers/ colleagues to continue putting CMOP into practice on a day-to-day basis."* [2008:11-12-13]

The minutes indicate how the CMOP was presented to external stakeholders and is seen as important:

> "*When articulating practise [sic] to senior managers and MDT colleagues that CMOP is supporting OT professional practise not a separate piece of work." [2011:72]*

4.5.1. Understanding your role in this organisation

The steering group discussions introduced a collective thought for the occupational therapist role. Their agreed definitions were then shared with the wider occupational therapy group to explain how the role was to be presented to external stakeholders, clients, colleagues and managers.

4.5.2. Support worker and occupational therapist

Through discussions about the occupational therapist role, the minutes reveal that the group became aware of discrepancies in the support worker role:

> *"OTA's – inconsistency in role across the County." [2006:17]*

During 2006, the support worker role was extensively discussed and defined, and these deliberations formed a significant part of the minutes of that year. Differences in role were debated with the CMOP and used as an integral part of the discussion. A key decision was that support workers would address 'problems', whereas occupational therapists would work upon 'occupational performance' needs. An audit conducted by some members of the steering group culminated in the creation of a delegation and assignment document, which clarified the support worker role:

> *"It was agreed that a document such as the one presented by X could be a helpful tool in providing clarity required in all areas. Are the client's needs occupational or are they performance related issues…." [2008:6]*.

Interpretation and understanding of the support workers role, a new delegation and assignment document, and a training package needed to be shared with all practitioners. After these had been made public, with an expectation they were to be adopted by all, the minutes recorded some anxieties which had been raised:

"…There was some feedback given that some registered Occupational Therapists felt they lacked confidence about what was left for them to do after work had been assigned to occupational therapy support workers. …" [2008:7]

The minutes showed the response of the steering group, with a clear message of expectations:

"Need to ensure clarity in articulating the differences and expectations……Critical area to define." [2008:63]

Reflective comment: I was involved in this piece of work and remembered some challenging conversations, particularly when the document and training package was shared with my colleagues. Some were passive and wanted the steering group to deliver the training and did not see their role in this work, others did not want change and did not want to challenge the current support worker role. I remember feeling concerned at a lack of understanding of the difference in role voiced by some practitioners. However, now the steering group were aware of the issue they were in a position to support and explain to all parties why roles clarification was needed.

The minutes examined from 2009 and 2010, in particular, revealed ongoing discussions that newly qualified therapists needed support to challenge practice of experienced support workers:

"X advised that, in spite of training, Band 5 OTs are still struggling with delegating to support workers in practice. It was agreed by the group that CMOP has made us think about delegation issues and these will need addressing even though it may be challenging." [2009:69]

4.5.3. Steering group relationship with occupational therapy managers

There was evidence that the steering group engaged with all occupational therapy managers. The Head of Service, a member of the steering group from 2004 – 2011, viewed the CMOP as integral to all levels of service delivery and wanted her managers to understand and support the work of the steering group:

"*Need to ensure the importance to link to other groups in aims and topics to ensure CMOP underpins all levels of practice/service delivery….*" [2005:1]

> *“Encourage senior staff to create a culture where a learning environment exists and questioning of practice can occur. Lead OT’s.*” [2008:14]

Yet, not all occupational therapy managers were fully engaged with the work of the steering group:

> “*…… Decided that a session on supervision/CMOP and HPC guidelines for DTM/Heads would be useful to enthuse them*!” [2008:33]

> Reflective Comments: The minutes themselves do not explain why this session is needed, but I recall issues being raised about leadership and the needs for a shared understanding of the CMOP, which led to the several away days over the years for managers.

Steering group members were practitioners from a range of clinical areas and grades. The minutes capture how, at times, the group collectively reviewed membership to ensure representation from all grades of registered staff and from all parts of the county. Varied membership was vital for effective communication networks and meant that the steering group could both respond to changes in the sociocultural world of practice, and be meaningful to a wider group of practitioners. Leadership provided by the group was not purely managerial; rather members were ‘champions’ who supported colleagues to use the CMOP in practice.

4.5.4. Let me help you understand.

The group created a number of artefacts to instil a shared understanding of the CMOP and occupational therapy role. This work dominated group discussions and often the agreed work took place outside of the meeting. The main artefacts created were study days; a manual, supervision DVD and documentation. The artefacts are analysed separately and, within this section, will be discussed in the context of why they were developed by the steering group.

Study days

The steering group were advised by practitioners at an early stage of implementation, of the difficulties they had in using externally produced workbooks to understand the CMOP in relation to their own local practice. One member of the steering group developed a training package to support colleagues to use the CMOP, which had proved successful in her clinical area to increase enthusiasm and understanding of the model. The steering group made a collective decision to share this training with all practitioners.

Reflective comment; the steering group could see how the CMOP was being eagerly accepted in a clinical area where practitioners had been initially opposed to it. The group could see that this training enthused a number of sceptics, and believed that sharing the training with all practitioners could create a wider understanding and willingness to use it in practice.

The steering group made it mandatory for all occupational therapists to attend the study days which members would take turns to facilitate:

"Training package-.....CMOP steering group will need to present to lead OTs so it becomes part of mandatory induction for new staff and so they [leads] commit to providing trainers." [2005:43]

Compulsory attendance presented an opportunity for the group to be much more directive and ensure that practitioners engaged with the CMOP on some level. The sessions were times for reciprocal conversation between the steering group members and practitioners. The study days were updated and altered in response to feedback:

"Training Package Changes have been made in light of the feedback from the last round of training. There is much less presentation and it is much more interactive.....X would like to put some dates in for October." [2007:29]

It was interesting to note a number of name changes for the study days:

"Name is important – not to be called training but CMOP induction." [2006:25]

"Training Package This has been reviewed and is now a day called CMOP Education. Links CMOP with code of ethics, current drivers and more focus on writing OPIs etc. It is in a mixed taught and workshop format. "[2011:21]

These study days were run regularly from 2005 -2011 when there was organisational change. There is evidence that the group wanted to continue with the education sessions:

"CMOP training package. Discussed numbers of new starters, and the need for refresher sessions. "[2012:20]

The minutes indicated that, for some areas, study days have not taken place since 2011, despite requests being made for them to be held, as relevant approval from key stakeholders was difficult to obtain.

Manual

Practitioners asked for day-to-day guidance and this led to creation of a user manual:

> *"Staff are wanting the manual to back up the refresher sessions so it is important that it is sent out ASAP. Need date for when manual is ready to go out." [2006:46]*

Two editions were produced by the steering group, the first in 2006 and a second edition in 2010 (Boniface et al 2010). Production was funded by senior managers:

> *"X had confirmation of funding for manual. Hopefully to be available soon." [2007:10]*

The minutes reflect that group members wanted to revise the manual periodically:

> *"....it will need dating and reviewing periodically it will be a dynamic document aimed as a guide not something set in tablets of stone." [2005:44] [2006:47]*

The most recent update was planned in 2010 but, following organisational change, the issue of funding was an issue:

> *"Replacement manuals where [sic] is the budget." [2013:12]*

With no budget to replace manuals the group directed:

> *"Agreed to give out manuals to staff who cannot locate their manuals on understanding this is required as part of their practice but any further losses they would be expected to buy their own." [2012:26]*

DVD

A DVD was created by three members of steering group as an audio-visual tool to encourage occupational therapists to discuss the CMOP in supervision:

> *"Necessity of supervisors being trained so that in supervision, cases can be discussed and questions asked in the light of occupational participation and the Model." [2004:27]*

Whilst the DVD was periodically mentioned in the minutes, there was little reference for how, or even if, it was being used in supervision.

Reflective comment: Lack of reference to the DVD in the minutes is equal to a lack of awareness of it by practitioners. Attempts to introduce it were limited by lack of IT available for it to be viewed in teams.

Documentation

Documentation is the paperwork used to capture the assessment. Initially, practitioners requested the CMOP headings to be included within documentation:

"OT's want documentation to support CMOP." [2005:40]

This was resisted by the steering group, who wanted understanding by practitioners of the concepts of the CMOP rather than simply being viewed as a format for documentation. Whilst ownership of documentation was viewed by some members of the group as a way of accepting and understanding the CMOP, the minutes show it created debate and contrasting opinions:

"Group decided that working through paperwork is part of the process of acceptance and use of the model." [2006:63]

"…Concerns that not enough focus on the model influencing practice, rather it is on the paperwork." [2008:78]

"Using the paperwork should be about showing what we, as OT's, do. Should emphasis also but put on other important methods of communicating with members of the MDT such as verbal feedback?"[2009:10]

Over time, the steering group came to recognise that understanding of the CMOP seemed to be enhanced through use of documentation as an aide memoire. Initially, it was agreed that each area could develop their own documentation to support the use of the CMOP. This process of development was viewed positively by the group and feedback revealed:

"In some areas….headings have been integrated into paperwork- discussion as this seems to be encouraging more verbosity from OT's!" [2005:33]

Not all areas wanted the CMOP format to structure their documentation and some, such as the Integrated Care Teams, did not feel it suited their areas of work. The minutes captured that all documentation created, irrespective of area, was similar in layout, which led the steering group to limit the number of variations permitted. From 2006, they wanted an overview of documentation, with any changes now requiring relevant agreement from all stakeholders, before they could be made:

"…There needs to be agreement at all levels to use this paperwork and once agreement is made it will be the assessment paperwork….XX and YY use." [2006:40]

Changes to documentation created a considerable amount of debate and conflict. Some changes were initiated by the steering group, whilst others were requested by external stakeholders. Any alterations to the documentation required engagement with interested parties for consensual agreement. The level of negotiation varied across different parts of the service. Within health, the paper based documentation designed by practitioners, was ratified by a documentation policy group. Within social care, which used an electronic based system, changes needed to be agreed by senior managers. Discussions about documentation between key stakeholders and steering group members revealed expectations and attitudes held by both parties about the CMOP. The minutes describe how steering group members, in general, viewed the model as integral to both documentation and assessment for identifying occupational needs of clients. External stakeholders, however, wanted to regulate which documentation was used so it conformed to organisational requirements. A number of colourful discussions on the subject between some stakeholders and the steering group were found in the minutes.

A particularly heated exchange was captured in the minutes during 2008-09 with the introduction of new documentation in social care. Occupational therapy managers were told that practitioners needed to complete generic documentation. The minutes reveal exchanges that took place between the steering group and some external stakeholders:

"Process Group saying not using CMOP on XXX." [2009:29]

There were extensive conversations with some social care managers who attended several steering group meetings, and group members emphatically described the CMOP documentation to be integral to their practice. Finally:

"It has been agreed that OT's can have a separate Professional Assessment for governance and professional practice." [2010: 27]

The agreement, however, still required practitioners to complete parts of a generic documentation, as well as the professional assessment documentation. This led to an increase in paperwork for practitioners and feedback in the minutes observed:

"YY– there have been some comments that the quality of referral has decreased since the new forms' introduction…..Some comments that completing CMOP

and YY documentation is too time consuming. It seems OTs are not completing them appropriately…..the general assessment feeds into the professional assessment rather than the other way round. A pragmatic way to support staff in completing both is required. Suggestion that reviewing supervision and its policy might be appropriate re use of proportionate assessments and CMOP." [2010:77]

Within health, the documentation changes were much more straight-forward and any changes were ratified by a policy group. In later years, with a move towards generic records, group members from health described how they were starting to engage with stakeholders for agreement on what needed to be included in documentation.

Another document which created much discussion was the home visit report. The steering group engaged in extensive discourse to develop a collective understanding for the purpose of the report. The home visit report was primarily used by hospital based practitioners and became the subject of ongoing discussion for nearly a year:

"General feedback is that the home visit report is lengthy, repetitious and paperwork focused. Need to be clear about the added value that this report gives. Need to focus on OTs way of thinking and how they articulate their practise [sic]." [2008:38]

The value and purpose of reports was extensively deliberated, with a final consensus for their purpose being reached. A home visit report was an assessment of the home environment only; whereas an occupational therapy report was about the wider occupational person and included other aspects of the individual's life. The debate included:

"Why do we do HV reports? Where do such reports fit into the OT process? Who is the report for? Discussion re: whether it is an OT home assessment report or an OT report….Discussion that the document needs to be workable and useable." [2009:9]

The group developed guidelines which were included in the second edition of the manual to indicate the purpose of the report, how and when they should be used, and how to complete.

Reflective comment: I was particularly involved in this debate and it was my questioning which brought about the discussions initially. It was at a time where documentation was being scrutinised, occupational therapy was viewed as slowing down discharges in

my area of practice when reports were being produced. This deliberation helped to clarify in my mind the purpose of them.

4.6. Theme 3: Networks

Networking was an important theme within the minutes and over the years the group established links with universities, the College of Occupational Therapists (COT), a number of Canadian authors and other organisations. In particular, was the ongoing, enduring relationship with an academic partner from a local university, who was an integral member of the group. The minutes reveal the value the collective group placed on this relationship when, at times, in her absence from a particular meeting, if a point needing her input for a decision to be made, it would be deferred until the next meeting.

4.6.1. Publishing and sharing

Part of the function of the steering group was to share their own work:

"To present at conference/publish aspects of the implementation." [2004:12]

The minutes refer to actions when they presented work at national conferences [2005; 2006; 2010], hosted local conferences [2005; 2007], engaged in professional discussions with COT and other colleagues [2009], published articles [2008] and contributed to book chapters [2012]. The support of an academic partner within the group was evident in contributing to and leading the output. This work raised the profile of practice within the county and steering group members saw their output to be relevant for external practitioners:

"ZZ noted that ……shire is seen as leading OT services. Article written by ……shire OTs was the 2nd most downloaded article on web model that underpins practice." [2012:5]

There is indication of a possible hierarchy within the group, particularly when publishing or presenting work externally, with discussions about whose names would appear:

"Need to be clear on whose names are going on the articles." [2007:42]

Networking also took place within the organisation with stakeholders:

"Dr …. has asked X for a presentation on CMOP. This was agreed to be very positive." [2007:24]

The networking and sharing of the work created a demand by practitioners' from outside of the organisation to purchase the created artefacts:

"We are receiving requests for paperwork (………) to talk to S regarding selling with training package…..Need to consider this when printing manual as we might want to include copyright notice." [2006:50]

"People are asking about purchasing manual and training package." [2006:60]

Reflective comment: External demand was unexpected and a contractual marketing agreement between the local university and employing organisation at the time was drawn up, to sell the artefacts. One of the concerns I had was that it had taken us years to understand the model and this was an ongoing process. To simply sell the artefacts and expect them to be understood negated the process we had undergone to create a shared understanding.

4.6.2. Conferences

The steering group hosted conferences in 2005 and 2007, which were supported by senior managers within the organisation at the time. In 2011 the group started to prepare for another conference, but this was put on hold when all stakeholders were facing organisational changes:

"X e-mailed Y and Z to say ……consider postponing it until 2013." [2011:69]

Since 2011 the group has not published or presented any work, apart from a book chapter published in 2012, which was submitted at the end of 2011.

4.7. Summary

The aim of this study was to understand how the CMOP influences occupational therapy practice. This chapter presented key themes extracted from thematic analysis of minutes that revealed the steering group to be highly influential in driving the implementation of the CMOP, for it to be used by practitioners as an integral part of practice. Through a discursive process, the steering group sought to understand the theory surrounding the CMOP and used it to define local occupational therapy practice. In particular, the terminology was interpreted so there was a shared understanding of terms and, of particular note, that occupational performance was given a local definition. This shared understanding was conveyed both

within the county and with wider networks. Communicating experiences included writing articles and the hosting of, and presentations at professional conferences. At times, use of the CMOP created conflict within the steering group and external stakeholders in the county. Of particular significance was the issue of documentation. Artefacts were created for two main reasons, firstly, in response to requests from practitioners to help them to use and understand the CMOP, and secondly, to sustain momentum to ensure that the model was an integral part of practice. The minutes revealed responses the group made were guided by changes that took place within the county, which suggests practice is dynamic and socially constructed.

5. Artefacts

5.1. Introduction

In this chapter I present my findings, following examination of key tools, developed by members of the steering group to assist occupational therapy practitioners to use the CMOP. The tools comprised of study days, two manuals, a DVD and one policy document. Yin (2009) described artefacts as a '*physical or cultural artifact**- *a technological device, a tool or instrument, a work of art of some other physical evidence'* (p. 113). Whilst the study days do not neatly fit into this description, they constitute a tool developed by the steering group and in this thesis tools are referred to as artefacts. The artefacts were examined during September and October 2015.

5.1.1. Managing myself in the context of artefacts

I was aware how important it was to be objective and that analysis should be based upon findings within this unit. This created particular challenges given that I had a direct role in the development of some of the artefacts, namely, the study days, the manual and a support worker training package. Equally, my part in developing and delivering the artefacts presented an opportunity for unique insights and understanding of the data, which may not be apparent to an external researcher, Costley, Elliott and Gibbs (2010). I used my knowledge of the data as an opportunity to enrich the chapter, to offer a wider analytical perspective and, where relevant, have included my own personal reflections, which are clearly identifiable. It was important to examine the artefacts objectively so all meanings were conveyed and I was not simply presenting my own views and opinions.

5.1.2. Artefacts analysed

The artefacts consisted of an audio-visual tool [DVD], physical artefacts [PowerPoint presentations] and documentary material [manual and policy document]. These were, in the main, created between 2006- 2009 by the steering group. These are can be found in Table 5.1.

Table 5.1: Artefacts which were analysed

	Artefact name	Date produced
1	***Study Day*** CMOP Refresher Programme	August 2006 [full day session]
2	***Study Day*** CMOP Refresher Programme	June 2007 [full day session]
3	***Study Day*** CMOP Refresher Programme	2009 [full day session]
4	***Study Day*** Occupational Therapy CMOP Education Programme	2011 [full day session]
5	***Study Day*** Occupational Therapy COPM Education programme	2012 included the COPM. [half day session]
6	***Study Day*** Canadian Model of Occupational Performance Education Day	2013 adapted by GHT and shared with steering group but only delivered to GHT not in Care Services
7	**Manual [first edition]** '*Manual for Using the Canadian Model of Occupational Performance in Occupational Therapy Services'*	October 2006
8	**Manual [second edition]** *'A Gloucestershire Interpretation for Implementing the Canadian Model of Occupational Performance in UK Setting: a User Manual' (Boniface et al. 2010)*	July 2010
9	**Supervision DVD**	March 2007
10	**Delegation and Assignment Framework**	December 2007
11	**Support Staff Training Programme**	2009

Other artefacts developed by the steering group, such as, a quarterly newsletter, output from local conferences and minutes from away days, were not available. The artefacts examined are representative of those produced by the steering group.

5.2. Background – why were artefacts developed?

The steering group created artefacts to support the use and understanding of the CMOP by all practitioners, not just those who were part of the steering group. Agreement and consensus as to how the CMOP was to be used, by all practitioners, across a range of settings, required engagement, so principles of the model became mutually agreed and accepted. The steering group wanted a consistent presentation of the occupational therapy role by individual practitioners, to ensure that a client being seen in any clinical area in the county could expect to receive a similar level of service.

Whilst some artefacts were used to support discussion between steering group members and colleagues about practice, they all described an expectation, irrespective of personal views, that the CMOP was to be used, in particular, on the study day. This was an interesting dichotomy whereby, on one hand, the group sought to embed the CMOP through agreement of its meaning, whilst equally conveying an expectation that it was to be used irrespective of personal views. Each artefact contained principles found in the CMOP for practitioners to be occupationally focused and client-centred. Descriptions of key changes to each artefact can be found in appendix 15.

5.3. Main Findings across the artefacts

Table 5.2 presents the key themes identified through analysis of the artefacts from across the dataset.

Table 5.2: Key themes from analysis of the artefacts

	'Overarching' **Let me help you to understand how to use the CMOP in practice**	
	Theme	**Sub-Theme**
1	**Understanding occupational therapy role requirements, to work here**	Occupation is our business Articulating what you can offer A duty to question and signpost Reflective practitioner Boundaries of roles
2	**Being client-centred**	Showing an interest in other people's lives A three way partnership Understanding what makes someone tick
3	**We need consistency when using the CMOP**	This is how we do it here Documentation provided is there to help you

The overarching theme was that artefacts were created to promote shared understanding and application of the CMOP. The message found in each artefact was that use of the CMOP would help practitioners to fulfil role requirements. Each artefact used different mediums to convey messages, visual, participatory and documentary.

5.4. Theme 1: Understanding occupational therapy role requirements to work here

This theme captures the strong message found in each artefact, that the CMOP would support the understanding of role expectations.

5.4.1. Occupation is our business

A key theme within each artefact, in particular, study days, concentrated upon understanding 'occupation' and 'occupational therapy' as theoretical concepts, and subsequent versions included defining and understanding 'occupational performance'. Attention was made to

identifying and then documenting occupational performance issues. The manual focused upon defining occupational performance and emphasised the importance of written documentation using occupational terms. The manual contained examples of how to write occupationally focused plans [2010 manual p15- 16]. Similarly, the DVD concentrated upon occupation, and supervisees were urged to think of an occupational person rather than simply the problems the referral presented. The examples contained clear concepts of the CMOP, which was embedded in each artefact, and highlighted how practitioners should think beyond what was needed for discharge from an acute hospital, or immediate requirements on an urgent social care visit. There was emphasis upon a professional duty to signpost on, as required. Occupation was explained and defined in the support workers training package, and delegation and assignment framework, to clarify the occupational therapist role.

5.4.2. Articulating what you can offer

This theme considered how the CMOP could support practitioners to be able to explain the occupational therapy role. Each artefact identified that, without explanation, neither a client nor employer would necessarily get the best service or use, to best advantage the skills of a practitioner. In particular, an exercise included at the start and end of the study day asked participants to think about why it is important to be able to explain the occupational therapy role to stakeholders. Explaining the full breadth of the role was explored in detail in the supervision DVD.

5.4.3. A duty to question and signpost

This theme was particularly explored in the supervision DVD. Through role-play, the actors demonstrated that asking closed questions prevented clients from opening up and revealing their needs. The 2006 study day included a session where the experiences of a client who had been in hospital, which had been transcribed by a therapist, were read out to participants. They were asked to think about how this lady felt when she revealed that she felt no-one considered her needs beyond the immediate here and now. The client described how she wanted to drive and work and yet no one had asked her about future aspirations. The message given to participants was that, even if you cannot meet the needs, you must signpost onwards.

5.4.4. Reflective practitioner

The importance of being reflective was contained within all artefacts, most obviously within the supervision DVD. Individual practitioners were advised to use supervision, think

retrospectively about events, to take time to discuss, and adjust future practice in response to their own learning.

5.4.5. Boundaries of roles

This was emphasised most obviously in the delegation and assignment framework and support worker training days. The focus was upon clarity of role competencies and for support workers to have strong supervisory relationships with occupational therapists.

5.5. Theme 2: Being client-centred

This theme captures the expectation that practitioners needed to be client-centred. Each artefact included a theoretical definition, visual demonstration and practical exercise for practitioners to participate in, to develop skills in being client-centred. Each was advised to apply these principles to their own practice.

5.5.1. Showing an interest in other people's lives

An important message contained in each artefact, to understand each unique client and their own particular circumstances, was an important component of client-centred practice.

5.5.2. A three way partnership

Each artefact emphasised that client-centred practice did not mean abdication of professional responsibilities, or to simply acquiesce with what a client wanted. This was particularly evident in the content of the study days and manual, with reference to the three way partnership between the individual client, occupational therapist and employing organisation.

5.5.3. Understanding what makes someone tick

Whilst the concept was described in the manual, it was explored in some depth in the DVD in scenario 5. It was also particularly evident in study day 1, when describing the experiences of the lady with the traumatic amputation, when explaining her views and experiences. This was subsequently replaced in the study days with a more general question about understanding spirituality.

5.6. Theme 3: We need consistency when using the CMOP

Whilst each artefact identified the need for consistency, each provided a slightly different emphasis. The DVD and study days primarily used dialogue to encourage shared understanding of requirements, whereas the manual provided practical guidance, to be referred to as part of day-to-day practice.

5.6.1. This is how we do it here

Emphasis was upon understanding the CMOP and then how to apply the occupational focused and client-centred principles in a consistent way. How to present the role to others, verbally and in written form, was found in all artefacts.

5.6.2. Documentation provided, is there to help you

Examples of completed documentation were found in both the study days and the manual. There was a marked variation in styles used to complete documentation between the 2006 and 2010 manuals. The changes indicated an evolutionary process for understanding of the CMOP and documentation altered as understanding developed.

5.7. Summary

This chapter presented key themes extracted from analysis of artefacts created by the steering group, with a brief account of each and summary of themes from across the dataset. The steering group specifically created artefacts in response to the needs they perceived were necessary for the wider group of occupational therapy practitioners; to understand and use the CMOP in practice. In particular, they wanted to engage with practitioners, gain a consensual understanding of the occupational therapy role and terminology used in the model. Whilst there was potential variance of practice influenced by unique context and individual interaction each was to be underpinned by this shared understanding and local interpretation of the CMOP. Two clear enduring themes found in each artefact were the requirement for practitioners to be occupationally focused and client-centred, which were core concepts found in the model. The number of revisions and amendments to frequently used artefacts, such as the study days, suggest that to have a current understanding of the CMOP these artefacts needed subtle changes, which were made in response to the local world of practice.

6. Interviews

6.1. Introduction

In this chapter, I present the data and themes extracted from interviews conducted with eleven self-selecting participants, who worked in a variety of clinical settings and included a range of experiences and grades. The interviews were conducted in October 2014, transcribed by an independent transcription service, which I reviewed by listening to each interview and studying the written transcription. This was to check for accuracy and, when appropriate, alterations to inaccurate parts of the transcriptions were made. Data analysis took place between December 2014 and May 2015.

6.1.1. Structure of interviews

The interviews were guided by my research questions (appendix 4) which were designed to capture participants' views and opinions of the CMOP. Whilst the questions indicated areas for discussion, this did not preclude extending the conversation to include other interesting points participants raised. Within the literature there is a consensus that, in order to elicit information, the interviewer needs to engage and motivate the participant using everyday language, so they are understood (Rubin and Rubin 2005). Answers should be probed, so the interviewer understands the perspective of their participant and the interviewer should aim to facilitate the conversation, so that the majority of speaking is done by the participant whilst, crucially, eliminating cues which may make the informant feel they need to respond in a particular way (King and Horrocks 2010; Robson, 2002). Equally, I needed to remember that whilst gaining the information was important, I also did not want to make participants feel uncomfortable for revealing their opinions to me (Kvale and Brinkmann 2009).

6.1.2. Participants

Table 6.1 presents the number of years of experience and current practice areas of work for the interview participants. Each has been given a pseudonym to protect their identity.

Table 6.1: Participants and pseudonyms

	Pseudonym	Years of experience	Clinical Area
1	**HELEN**	10+ years	Integrated Community Team [ICT]
2	**SANDRA**	10+ years	Acute Hospital
3	**JAMES**	2 years	ICT
4	**CHRISTINE**	7 years	ICT
5	**MICHAEL**	10+ years	ICT
6	**JEAN**	7 months	ICT
7	**ALICE**	10+ years	Paediatrics (community)
8	**JANE**	5 years	Acute Hospital
9	**EMILY**	3.5 years	ICT
10	**MADDIE**	10+ years	Community Hospital
11	**CHARLOTTE**	10+ years	Acute Hospital

6.2. Conducting the interviews

The interviews were conducted at times and places convenient for participants and were mainly within their own workplace. Each participant was asked to book a quiet room so the interviews could be audio taped. Interviews lasted from between 25 minutes to one hour and provided data for this unit of analysis. Following each interview, I completed a set of field notes to capture my immediate thoughts and feelings.

6.2.1. Acknowledging myself in the context of the interview

It was important that the interviews were considered separately and that analysis needed to be based upon findings from within this unit only. I intended to use reflective techniques to manage myself, yet was surprised that I could not recall themes from the steering group and noted this in my diary on the 17th November 2014.

I was particularly aware of my roles both as researcher and employee in the county where the research was being conducted. To some, I was seen as an 'expert' in understanding the model and it was widely recognised that I believe the CMOP to be a positive influence upon practice. I managed my role and influence upon the research by using reflexive and bracketing strategies (Finlay, 1998; Gearing, 2004). Braun and Clarke (2006; 2013) contend that themes do not simply 'emerge' from research and the researcher is instrumental in deciding what interview questions are asked and reported, and which themes and issues they choose to examine. I was aware of my own perspectives and wanted to minimise my influence. Self-reflection helped me to manage potential issues and I used a reflective diary to capture thoughts and feelings. Other strategies adopted to facilitate the interviews can be found in sections 3.4, 3.9.5 and 3.12.

Each interview began with a general question to encourage a natural conversation for the rest of our discussions. Most interviews flowed in a conversational manner, but one participant was particularly nervous and, despite trying to put her at ease, provided closed answers to my questions, asking if she could think about some of them and come back to me at a later date with ‘answers’. This suggested to me that she viewed our interview as some kind of ‘test’. I wanted participants to feel reassured that I was listening to, and understanding, their views and I was not merely interested in those that were similar to mine, however, I did not want them to feel uncomfortable following our discussions. With this participant I was conscious that I did not elucidate her answers as much as I had with other participants. I commented during analysis in my reflective diary dated 6th January 2015:

> Reflective comment: ‘I did not probe her as much as I should have done and as such the data sample was not as rich as I would have liked.’

Appendix 16 provides an example of thematic analysis of the interview data. Table 6.1 overleaf captures the thematic analysis process and themes, which are presented including verbatim quotes from participants.

Table 6.2: Key themes from analysis of the interviews

<table>
<tr><td colspan="2">429- Codes</td></tr>
<tr><td colspan="2">Refining process</td></tr>
<tr><td colspan="2">82- Central Organising Concepts</td></tr>
<tr><td colspan="2">Refining process</td></tr>
<tr><td colspan="2">Overarching theme – ‘I know how to act on this stage’</td></tr>
<tr><td>Theme:

Creating a shared world</td><td>Sub themes
Interpretation of CMOP in this county
We don’t want other models
Newer versions of the model, do they matter?
We need to talk to about the CMOP
Consistency and governance
Can’t learn more than one model
Gives me confidence to do the job
Recruitment and an attractive place to work</td></tr>
<tr><td>Leaving university behind</td><td>Universities
Learning only becomes relevant in practice
Sharing learning with the wider world</td></tr>
<tr><td>Documentation is a double edged sword</td><td>Captures what I do
Documentation and the CMOP are linked
How documentation is viewed by others</td></tr>
<tr><td>I am an Occupational Therapist</td><td>Profile
Duty to see beyond the referral
Client-centred
I focus upon the occupational needs of clients
Using the model is a gateway
Focuses what I do
I am more creative
Clarifying the role of the support worker in a team.</td></tr>
</table>

6.3. Overarching Theme: 'I know how to act on this stage'

The overarching theme contained four main themes; *creating a shared world; leaving university behind; documentation is a double edged sword; I am an Occupational Therapist.* Each theme is presented.

6.4. Theme 1: Creating a shared world

Participants clearly expressed that occupational therapists needed to understand role requirements and expectations for working in this county. Yet, whilst they shared that they understood expectations of how the role was to be enacted, there is also evidence of individuality, that each participant interpreted the CMOP to support their own particular way of working, unique view of the world and distinct clinical area.

6.4.1. Interpretation of the CMOP in this county

All participants described how they adapted and altered the model within their clinical area. Without exception, all described changes they had made to it to suit their individual practice. This is illuminated:

> *"..you're not going to be able to use it if it's so firmly fixed that it has to be in its purest form and that, you know, there might have been an element that just would not fit with an acute hospital. Then, we just wouldn't be able to use it and that would be such a shame because it's got so many benefits....but you don't want to change it too much that you'd lose what it was trying to achieve…" [Sandra 2:130 - hospital].*

> *"It is a broad model, but sometimes we do need to tweak it to make it appropriate to our areas of practice. And you never really know what works until you try it." [Emily 9:48 - social care]*

Helen described the role of the steering group in guiding interpretation:

> *"[The steering group] were very aware that it's a Canadian model, that it was written within their culture and that perhaps yes, our culture here is different, our legislation is different… we were very aware of that and how we looked at it and kind of, yes, interpreted the model." [Helen 1:68]*

6.4.2. We don’t want other models

I was particularly struck that all participants described the versatility of the CMOP, which they reported could be used in most clinical areas with the exception being, in Maddie’s view, palliative care. The dominant view of participants was that they did not want to use other models. Alice and Michael went further and specifically said they would not want to use the Model of Human Occupation (MOHO) (Kielhofner, 1985, 1995, 2002, 2008). The degree of opposition to MOHO was particularly interesting given that, in the main, no participants had a working knowledge of it. Christine and Sandra observed MOHO was mainly used in mental health settings, with Jean and Helen commenting that the language it contained was technical. Maddie suggested MOHO assessments were too specific and would not suit her setting or ways of working.

6.4.3. Newer versions of the model do they matter?

Participants were asked for their views and understanding of the CMOP-E (Polatajko *et al.* 2007). Whilst all had an awareness of the CMOP-E, none could explain the differences between it and the CMOP. The majority of participants had not read the latest book and most did not see it as relevant to their own practice where they had adapted the CMOP:

“I sort of use it [CMOP] to suit the way I practice and that works for me.”
[Michael: 5:35]

Helen commented that students on placement struggled to explain differences between the CMOP-E they learnt about in college and the CMOP they observed being used in practice. Alice offered a caveat that more interest may have been shown in the CMOP-E if practitioners had big issues with using the CMOP.

6.4.4. We need to talk to about the CMOP

Helen and Charlotte described the importance of ongoing discussion to sustain shared understanding and interpretation of the CMOP:

“The important thing is we’re sitting here after 10 years and we’re still discussing it. There are other changes we would've said, “Oh, that happened in 2003, let’s forget about it.” We’re still discussing it. We’re still trying to find a way forward with this so it must be working.” [Charlotte 11:90]

Without exception, all participants referred to ongoing changes within their particular places of work, how they needed a clear role focus, and valued discussions they had with other occupational therapists. Specifically, leadership was identified as crucial to support practitioners to use the CMOP in practice:

> *"..you need people that are confident and you need people that are passionate about it. Because otherwise, you don't pick up that sense of 'want to try'. And I think it's really important for people perhaps who don't feel confident with using it or people who perhaps have been…in the profession a long time and they're new to using it that they've got a place that they can go to ask questions." [Jane 8:88]*

Some participants had experienced significant changes in leadership. This was particularly evident amongst ICT and community hospital participants. Maddie, Helen and Michael, in particular, described the impact of these changes upon local discussions about the CMOP:

> *"……I think when we had our OT structure and management structure as well, we used to get fed a lot of information….. informal discussions because ….your OT manager was around. And you just sometimes have very informal conversations but I think it's those little informal conversations that I miss greatly, certainly from my perspective because it's just another...it's just another person to bounce OT stuff off of, if that makes sense." [Maddie 10:179]*

Universally, all participants described challenges of a busy workplace. Charlotte, Maddie, Jane, Alice and Sandra, in particular, described emotional pressures, with particular references to facilitating speedy discharges from hospital and managing waiting lists in social care:

> *"[CMOP can help]… particularly at times of pressure when there's pressure on beds ….it is really hard because you want to do the best for that person but you do have to move them through because there is somebody always in A&E who needs to come into hospital." [Jane 8:36]*

Each participant described how the CMOP supported them with ongoing changes in their workplace. Michael, Sandra, Jane and Maddie, in particular, described how they used the model to make them feel more confident in describing their role, illustrated by:

> *"I think the model is quite good because it provides you with some sort of security because when things are changing all around you, it's an anchor for your practice." [Michael 5:107]*

All participants said occupational therapists were expected to use the CMOP in this county and each commented that use of the CMOP supported a shared set of core values, beliefs and customs. Charlotte, Helen and Michael identified that not all practitioners were positive about the CMOP. However, they reported that, even though it was not universally accepted or liked, colleagues now saw it simply as part of what they did. This suggests a socialisation process:

> *"It was in our paperwork, that's what we did. And to me it's just part of what I do." [Alice 7:42]*

The CMOP terminology was labelled by some participants as full of jargon, and for others a means to promote shared understanding by others. All agreed the Canadian terminology needed to be adapted for their own particular setting:

> *"I think very much setting out your stall every time you go and see somebody....So it's accessible, so we need to ....actually explain it in a way that's accessible to other people." [Michael 10:76]*

Sandra, Helen, Charlotte, Emily, Michael, Christine and Alice described how the CMOP was important to support and develop individual practice. Christine, in particular, discussed that feedback from a record keeping audit created an opportunity to talk about her own individual use of the model. Participants valued conversation and feedback with other occupational therapists as a way to develop mutually accepted and co-constructed meanings of the occupational therapy role.

6.4.5. Consistency and governance

Participants described that having one model created consistency in practice across a variety of practice settings. Broadly described in three ways; having a shared language for discussions, framing documentation and structuring interviews with clients:

> *"when I do an assessment I like to keep it structured because with some people they will just go off track and so I use it as a tool to actually say 'this is what we need to do.... and I find that's the most efficient way that I can illicit the information, but it also means that I actually..... put into practice equal service ....delivery because I'm asking everybody the same questions." [Michael: 5:62]*

Yet, whilst participants spoke of consistency in positive terms, Jean and Helen observed that individual practitioners did not necessarily use the model in a way expected by professional leaders. Helen, in particular, suggested some practitioners did not conduct full assessments or

complete expected documentation. This point is explored more fully in the sub theme 'documentation is a battlefield' later in this chapter.

6.4.6. Can't learn more than one model

The majority of participants' commented that whilst practitioners should use conceptual models to inform practice, to use more than one model was simply not practical. Reasons given for using one model included a consistent approach for clients, and commitment towards a shared understanding of the principles of that model. Commitment to one model only, did create some tension:

> *"...I know we probably should be using lots of different models and I kind of -- my idealist says I don't agree with that because I do like how holistic the CMOP is, but for actual modern day practice and all the pressures that are on us it might be useful to explore having more focused models in different settings; it's just all logistics on how it would work." [Emily 9.60]*

Practicality was the main reason provided by participants for using one model. Only one set of learning tools would be required to create shared understanding and agreement across a range of settings. A caveat was given by Helen and Charlotte, that, practitioners who did not want to use any model said they wanted to use several, or described their practice as eclectic, simply accentuated an ongoing inarticulacy within the profession.

6.4.7. Gives me the confidence to do the job

The CMOP was described by all as a tool or framework to support practitioners to be confident in their workplace and fulfil role expectations. Participants referred to the CMOP as a framework for documentation, an aide for thinking, integral for professional identity, and a support for junior staff to advocate for, and represent views, of clients rather than simply acquiescing with the decisions of colleagues:

> *I think that helps like our support workers and our new Band 5's to stop and not be railroaded." [Sandra 2:96]*

Yet using models in practice was not seen by all as a panacea for instilling confidence in practitioners to explain roles. Jean observed that those who were not taught about conceptual models at university may be unfamiliar with their purpose and feel more challenged when asked to use them in practice. Helen described how there had been considerable work to

support practitioners understand and use the CMOP yet, ultimately, each interpreted the model to support their own particular way of working and unique view of the world.

6.4.8. Recruitment and an attractive place to work:

Reflective comment; this sub theme was a surprising discovery from the data when two participants revealed that use of the CMOP in the county influenced them applying for a job.

Jane and Emily identified their desire to work in this organisation was influenced by the services overt link with the CMOP:

"..one of the things that I quite liked about applying for a job in ……shire was that it was using a model." [Jane 8.12]

6.5. Theme 2: Leaving university behind

The majority of participants described 'theory' to be something taught in universities and 'practice' as their clinical work. Comments revealed a dichotomy where participants believed there was a clear disassociation between each, whilst at the same time recognising stronger links were mutually beneficial and needed. Once they joined the workforce, participants described a need to distance themselves from university and be socialised into understanding their role requirements within the workplace.

6.5.1. Universities

Three points of view were identified by participants; firstly, universities prepared undergraduates for work, secondly, academics needed to work with practitioners and form partnerships that together contributed towards professional theory building, and finally that both parties benefited from having students.

Jane and Michael observed that occupational therapy theory taught in universities is constantly evolving and there is no one agreed definitive theory base. Both commented that the conceptual models they were taught were dependent upon the preferences of their tutors and that, in the absence of universal agreement, they believed practitioners adapted learnt theory to suit individual practice. Helen and Charlotte viewed the relationship with universities from a slightly different perspective and described a responsibility for practitioners to contribute towards the development of professional theory. In particular, they commented upon the links

with a university being mutually beneficial. Jane highlighted student and practitioners benefited from placements:

> *"..having had a student, I realise how much things have changed just in five years. So, it was good to learn from her and I was just honest with her and said that those things that she knows that I don't and I valued her thoughts on hearing what was going on. But what she did say was that she liked the fact that we used a model because again, though she had a theory, she didn't know how it was used in a setting. So she appreciated being able to see it in use and how people are using it to help with decision-making." [Jane 8:90]*

6.5.2. Learning only becomes relevant in practice

Michael, Helen and Jane described how the CMOP was used to unify a wide range of work and educational experiences across a variety of clinical settings, to create a shared understanding of role requirements within each setting. Sandra, Emily, Jane, Michael, Christine and Maddie believed that theory only became relevant when used in practice:

> *"..when you are at university, you kind of learn all these models and they're great but you've got nothing to apply it to but then, when you start working, it just helps you have a language that you can articulate what you're seeing and be consistent in that language. It's a way of documenting what you've observed in assessments." [Sandra 2:8]*

Reflective comment: I observed that participants described the model in several different ways; as a tool, framework, model of practice, even calling it the COPM.

It was clear participants were not particularly interested in any nuances between these separate terms and a remark by Michael perhaps summarises a disconnect between his own practice and academia:

> *"…the thing with academia is, different people trying to carve their own professions and are coming out with different terms to describe virtually the same thing. So a framework is something that gives you guidance on how you're going to do something, so I'm using it the same as model." [Michael 5:29]*

6.5.3. Sharing learning with the wider world

Helen and Charlotte described a professional duty to share experiences of the CMOP outside of the county. Yet, despite this assertion, Charlotte acknowledged it was not happening in a way it should be, providing as explanation:

> *"...it does indicate that, you know, are we putting it up there as a priority to get into place with all the other pressures. So we still see it as important but I'm not sure we give it enough time." [Charlotte 11.97 11:102]*

6.6. Theme 3: Documentation is a double edged sword

This theme revealed contrasting opinions of the participants. Historically, individual clinical areas developed documentation to create ownership which, despite a varied group of creators, was very similar in appearance and layout. The level of autonomy to create paperwork varied dependent upon clinical setting. Social care participants were limited in being able to make any autonomous changes to documentation, which had to be agreed with senior managers. A possible explanation is that documentation is electronic and changes are not easily made. Participants described documentation as a tool or framework of practice. Participant commented that documentation could be used to describe and support individual assessments and support their interpretation of the CMOP. For wider consistency, participants acknowledged it should be completed in the mutually agreed way.

6.6.1. Captures what I do

Comments revealed documentation had different meanings for participants. Some used it to structure the interview itself, whilst others conducted the interview and then used the documentation to summarise the assessment. Where to record information on the document was a particular challenge for Christine, Jean, Michael and James, who saw it as slowing their work down. Each described how they had a professional duty to document their assessments. Emily, Sandra and Jane described how documentation structured around the domains of the model helped to organise information in a clear, logical way and avoided the assessment looking like simply storytelling. Michael, Emily, Jean, Jane, Christine and Maddie articulated how it created consistency of assessments:

> *"I think a lot of us like the paperwork because …without it no matter how long you've been practicing I still think you can form bad habits. And I think the paperwork keeps us true to what we're supposed to be finding out from the*

client and working towards and with the client. So I think it's an important part of our assessment is to write it out like that." [Emily 9:54]

Whilst Christine and Michael viewed the CMOP documentation as complementary to the assessments process, James and Jean reported that the documentation did not flow with the face-to-face assessment:

"I think it's a difficulty with the model itself. It's the wording. It's the question. How you question from talking about like a typical day, and talk me through what your particular difficulties are. And then, you're transpiring that into a lot of different sections. I think that's where I'm coming from, isn't it? ....actually, there's a lot of repetition throughout those different sections.....you know, jump across....." [James 3:123]

Another element James, in particular, struggled with was using self-care, productivity and leisure as headings in documentation, and this was particularly difficult for capturing interdependencies:

'Interdependencies. I always think ...the Canadian model of occupational performance just doesn't make up interdependencies…… it's trying to capture that within there [the assessment], because it falls across so many of the other different areas. And actually that could be your key one of your key goals. And so, it sounds easy when you're explaining it here….when you're in a middle of an assessment and you have this is being the issue, and those words aren't being directly used, the model doesn't offer you a way of directly, pulling that out either.' [James 3:97]

6.6.2. Documentation and the CMOP are linked

Two participants presented different perspectives when they described the relationship between the model and documentation. Emily viewed documentation and the CMOP to be integral and both influenced her practice:

"I think people treat them separately and think sometimes this is my intervention and I've got to put it in to fit that slot. But actually I think quite a lot of the paperwork that we do, because it's based on CMOP, actually influences what our initial assessment is…... it's just an ideal; it keeps the ideas in your head but doesn't necessarily mean that you have to use those sections or that language. It just literally just kind of guides your information searching

and how you engage with a client and what information you seek from the client to inform what your intervention will be." [Emily 9:124-30]

Conversely, Helen viewed the CMOP and documentation as separate. She described that, primarily, the CMOP should support clinical reasoning and believed that, if too much focus was upon documentation, then there was a risk that understanding the model's core principles would be lost. Whilst recognising issues with documentation, Charlotte, Maddie and James acknowledged structure was needed. Both Maddie and James had worked previously in departments where occupational therapists did not use a framework in document and, as this comment highlights:

"....I really, really, really struggled with it. Really struggled. ...because there was nothing on there...." [James 3:173]

Reflective comment: That documentation could be viewed as both separate to and integral with the CMOP made me consider my own perspectives. When I started my research, I shared Helen's view that documentation and model were separate, but Emily's account made me reconsider this opinion, when listening to her views gave me a wider understanding of how it could be used to support, rather than inhibit practitioners especially when I reflected upon my own practice.

6.6.3. How documentation is viewed by others

Some participants described how they had heard negative comments by managers who questioned the value of the CMOP for practitioners. Yet, they equally recognised a responsibility for practitioners to explain the CMOP:

"It [the CMOP] may be seen as a hindrance by some higher managers, but then that's not the fault of the model, that's the fault of the OT profession for not promoting it better." [Michael 10:74]

Helen identified that completion of documentation in an agreed way was a useful way of elucidating occupational therapy to others. In her interview, she described a conversation which had taken place with a manager who challenged the efficacy of the CMOP, after reading notes made by some occupational therapists in his team. He based his understanding of the model upon what he read in the documentation. Helen went on to say:

".... it's all very well using the paperwork, but you've got to have that understanding of the principles of the model behind it. And so what he was judging was the -- I suppose again -- the quality of the information on a form and he didn't feel that the quality was there.....So he'd made a sweeping judgement "that the model's -- what's the point of that, really". And it wasn't the model he was making a judgement on, it was the quality of the information that happened to be framed on a form." [Helen: 1:103-105]

So, whilst practitioners may cite a lack of time, preferring instead to write brief generic notes, they run the risk of being misunderstood by other stakeholders. A point of note is that this manager who challenged the use of the CMOP was a non-practicing occupational therapist in a management position. This conversation may, in part, explain Helen's views on documentation and the function of the model being more than what is documented and, as such, should being viewed separately to the CMOP.

6.7. Theme 4: I am an occupational therapist

This theme presents how the CMOP was used by participants to support their occupational therapy identity.

6.7.1. Profile

Each participant described their own personal responsibility to explain the occupational therapy role, and how they used the CMOP to explicate to clients and colleagues. Each described how important it was that their role was understood to be broader than simply 'equipment providers' or 'discharge planners', citing that colleagues and clients often misunderstood their profession. The model was seen as a platform to explain occupational therapy in terms of identity and status:

"...it gives you professional identity. And I think as occupation therapists, we've been fighting for our own identity for quite a few years and I think because we're such a broad profession that if people find it difficult to understand. So it kind of can help your reputation." [Jane: 8:100]

6.7.2. Duty to see beyond the referral

Without exception, all identified a professional duty of care towards their clients. This was described as looking beyond the request on the referral form, with a clear sense that as

professional practitioners they should consider all the client's issues and concerns and to signpost onto other agencies, as required. Advocacy and understanding the wishes of a client were viewed as imperative. Sandra presented a vignette in her interview, where she described a time when ward staff wanted to hoist someone out of bed into a chair, despite the client wishing to remain in bed. Sandra advocated for and represented her client's views, making this powerful observation of her role on the ward:

> *…"just try and bring that person back that they are human in amongst all of these medical investigations and tests and awful diagnoses that are going on. There is a person sat in the middle of it……even if the only thing you could do is spend a bit of time. And even that's limited. But then, I feel that you're advocating ….but ultimately, you're not going to be able to address that. So it is…difficult." [Sandra 2:14]*

Reflective comment: this really resonated with me and captured the quote in my reflective diary dated 1st December 2014. As a practitioner I was all too aware of the emotive demands of the workplace and how easy it could be to simply focus upon the discharge of someone from hospital and not the person who has a life outside of the ward setting. When a practitioner directly attributed her ability to advocate for a client through use of the CMOP it felt a very powerful statement.

All participants acknowledged the challenges of a busy workplace, where there is an increasing demand for services whilst balancing finite resources. Participants who worked in ICTs described pressure to see those awaiting assessments quickly, whilst those working in a hospital felt a pressure to discharge speedily. There was acknowledgment this could impact upon the thoroughness of assessments:

> *"I think we go in there with great intentions to be assessing the needs of the client and advocating for the needs of the client. But we're in an environment where there's lots of pressure and there's lots of firefighting to clear the beds. And there's lots of pressure around the fact that if we don't get the beds cleared potentially we cancel, elective surgery, we cancel patient's chemotherapy. So there's quite emotive issues." [Charlotte 11:48]*

Yet, Michael was very clear that, despite pressure to resolving cases quickly, he personally gave clients as much time as required:

"I take pride in what I do and I have a duty of care and if -- and I will do things and if a manager doesn't agree and I think I have to do it out of a duty to care I will do it. That's what we get paid for." [Michael 5:68]

His comments captured the conflict felt by all participants to balance both professional and organisational responsibilities.

6.7.3. Client-centred

All participants were positive about the client-centred principles found in the CMOP and, for some, being client-centred required a level of compromise which they were not necessarily comfortable with. Michael described how his understanding the CMOP helped him to manage his own views when clients did something he disagreed with:

"….CMOP model client-centred practice 'such and such has made an informed decision to do X behaviour against my advice'. And that's the way it is. We're not responsible for people, we're responsible for actually providing the best service we can under the resources we're given and to provide good advice, but we're not there to spoon feed people…… I personally, I think maybe you should stop taking risk and stop people taking risks, but under client-centred practice, I don't have to do that, so there's a slight conflict of my values, but you have to respect there-- so that would me be behaving in a prescriptive way." [Michael 5:68-70]

Jane and Emily suggested that, at busy times, the views of clients can be lost, and that use of the CMOP reminded them that it is important to be client-centred, and Jane gave a powerful account:

"I try and think how would I want to be treated or how would I want my relative to be treated and what's important to me? So I kind of try and apply that to the people that I meet because I feel like my life isn't just whether or not I can wash and dress, whether I can make myself a hot drink, there's so much more to me and then there's so much more to everybody else as well. And like I think that's one of our niches in our profession is that we do think of the person as a whole and everything that is important to them." [Jane 8:34]

Helen felt that professionally, occupational therapists were vulnerable if viewed simply as equipment providers or discharge planners.

6.7.4. I focus upon the occupational needs of clients

Without exception, all participants described that the focus of occupational therapy practice should be upon occupation. The majority described that, through use of the CMOP, they were clearly focused upon occupation and able to articulate this to others:

"I do think it helps to, other people to understand what you're doing, why occupation's important." [Jane 8:16]

Reflective comment: I cannot necessarily attribute these comments to using the CMOP and agreed with Jean, who makes an observation that an occupational focus should be implicit for all occupational therapists. The interesting point is that the majority of participants attributed use of the CMOP to be able to describe this focus upon occupation.

6.7.5. Using the model as a gateway

The CMOP was described as a flexible and adaptable tool used to support both clinical reasoning and consistent assessments. Emily, Michael, Christine and Maddie defined consistency in terms of what clients can expect to be asked during their assessment:

"a model does help define what you're profession does and actually gives you guidance on how to go about your job and it actually means that if we all adopt the same model, we're all talking from the same hymn sheet which is important." [Michael 5:10]

Maddie, Jane and James described how the CMOP supported their clinical reasoning. In particular, Emily, Christine and James and Maddie highlighted that they felt more confident through using the CMOP. The model was used either formulaically during assessments and then as they became more confident:

"Using self-care, leisure, productivity just as a framework in my head to then shape all my questions around and thoroughly explore all those areas, I was able to unpick…It's constantly...it just kind of in the back of your brain at all times. Isn't it? ...it shapes your questions." [James: 3:25]

6.7.6. Focuses what I do

All participants identified that use of the CMOP directed how they enacted their role. In particular, in a fast paced world, it supported practitioners to be focused during interventions:

"I'm probably even more reliant on the model because you just don't have the time and the luxury that you had before so you've got be really clear really quickly. And it just gives you that something to, as I said before, you got that language and that structure like I've done this assessment, what have I observed? Right, it fits in these areas. What do I need to think about next?" [Sandra 2:100]

6.7.7. I am more creative

Three participants identified how using the CMOP made them think and work in a different way:

"I think you know that introducing a model has,……it really has sort of brought back a spark to practice because it's mainly very focused and the feedback from patients says that." [Charlotte 11;26]

"I think that the CMOP really encourages people to think outside the box." [Emily: 9:14]

"…It is very creative actually, it's very creative practice, or it can be if you're able to use your problem solving skills." [Michael 5: 8]

Reflective comments: I was particularly surprised to hear these comments and it made me think the influence of the model is wider than I initially believed. I had not expected the model to be described in this way.

6.7.8. Clarifying the role of the support worker in a team

Participants described variable understanding and use of the CMOP by non-registered colleagues, with no consistency between hospital and ICT settings. The hospital teams used the CMOP to clarify roles:

"In terms of support workers, we're making sure that in the main, the cases that they handle are predictable outcomes. They have the supervision support.

It's making sure that the OT's got an overview. So they may have their own cases. They may feel that they've got their own wards. But it's very much making sure the OT's accountable. We do want them to work within the language of CMOP so, we do have some support worker training. We feel that's important so that when we go back to the ward, we are constantly having a language that is representing OT therefore I think it's important for them to know about it…." [Charlotte 11:76]

Conversely, ICT participants did not identify how the CMOP was discussed with the support workers.

6.8. Summary

This chapter presented the key themes extracted from analysis of interviews with eleven participants who discussed the influence of the CMOP upon their own practice. Their comments present a core set of values and understanding of roles, which they attributed to the CMOP yet, the descriptions provided suggest individual choice for how the role was enacted. Core principles of the CMOP to be client-centred and occupationally focused were integral components of the practice of these participants. Use of the CMOP had shaped and informed their professional identity. They presented a socially constructed world in which the CMOP was integral and that was contemporised by the individual reality of each participant. Shared understanding of the CMOP was maintained through ongoing discussion, which suggests practice is dynamic. Particular reference was made to the importance of conversation and leadership, to create an agreed co-construction of understanding for the occupational therapy role in this busy shared world. To understand role expectations in the county necessitated distancing oneself from universities and to be socialised into the world of practice. Yet, there was acknowledgement that relationships with universities were important. Another point of particular interest was documentation, and participants revealed multiple, contrasting views when asked how they used it personally and how it was viewed by colleagues. Documentation was recognised to be a visible representation of the model, with the suggestion that it created conflict, at times, with other stakeholders.

7. Convergence

7.1. Introduction

In previous chapters, I presented themes from within each unit. An important part of establishing construct validity and reliability of a case study is to use multiple sources of evidence, that corroborate a pattern or 'fact' (Yin, 2009 p. 117), which strengthens assumptions made about the case. Triangulation of evidence is viewed as successful when you ask the same question of different sources of data and each point to the same answer (Yin, 1993 p. 69). Pattern searches across the case require the researcher to view the data from multiple perspectives (Eisenhardt, 1989). In this chapter I present themes from patterns I have detected from analysis and triangulation of the data from all three units. Chapter 8 will discuss the converged themes in more detail and will consider rival explanations and relevant literature, in relation to my findings, to answer my research questions. Four converged themes have been identified which directly relate to the research questions and propositions.

7.1.1. Structure of analysis

As a clinician I struggled in the earlier stages of my study to combine researcher and clinical roles. I had more success when I took a period of time from work to immerse myself in the data and I adopted this strategy again to analyse the dataset. Initially, I spent time re-reading my previous work and reflective diary, making notes of things which stood out to me for further examination. These were captured in a 'points of interest' database for each unit. This process enabled me to engage fully with the data and immerse myself in the research process. I was cognisant that I wanted to minimise my impact upon the data and used principles of reflexivity to manage myself, to help me to engage in subjective exploration of the case. It is not possible for me to suspend my own views, but my reflexive position helped me to recognise that my interpretations are not 'value free' and that the truth and reality being presented is constructed from my perspective of the world at this particular historical moment and social context. This reflective, analytical process was used to identify patterns across the dataset units.

When examining the data, if I found a potential theme, I asked myself if the evidence was present in the other units, to corroborate a pattern across the dataset. Themes found in each unit were refined and some were discounted, such as the theme '*leaving university behind*',

which only was visible in the interview unit. Other themes, such as, '*documentation is a battleground*' contained data visible within each unit and there was a clear pattern across the dataset. Four converged themes were identified - '*This is what we do here'*, '*Can we talk?*', '*Setting out my stall'* and *'Documentation is a battleground'*.

The themes have been described in two ways. Firstly, diagrams are provided for each unit, namely; steering group minutes (figure 7.1), artefacts (figure 7.2) and interviews (figure 7.3). Arrows show how the sub themes feed into themes and how these then feed into the converged themes. Analysis is a highly iterative process and diagrams visually display the themes coming from within each unit to one of four converged themes. They are intended to increase reliability and assist the reader to understand how I interpreted patterns within the data to, understand the reality of occupational therapy practice in one county, rather than simply verifying my own subjective opinions. Secondly, the four themes are briefly described to explain what each theme represents. This chapter does not interrogate the themes in relation to the literature and the iterative development of the case is described in more detail in the discussion chapter.

7.1.2. Diagram: The steering group

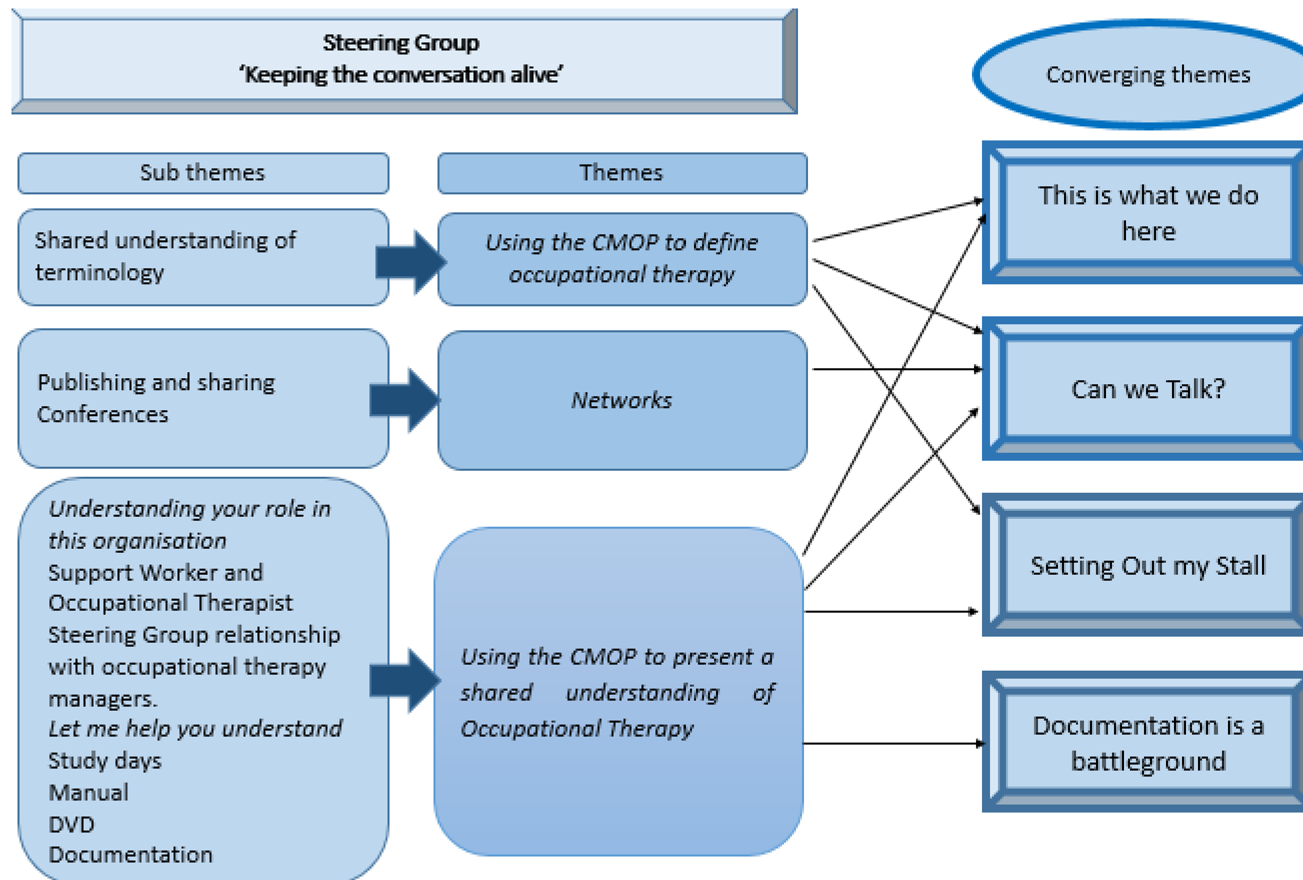

Figure 7.1: Diagrammatic representation of steering group themes into the converging themes

7.1.3. Diagram: The artefacts

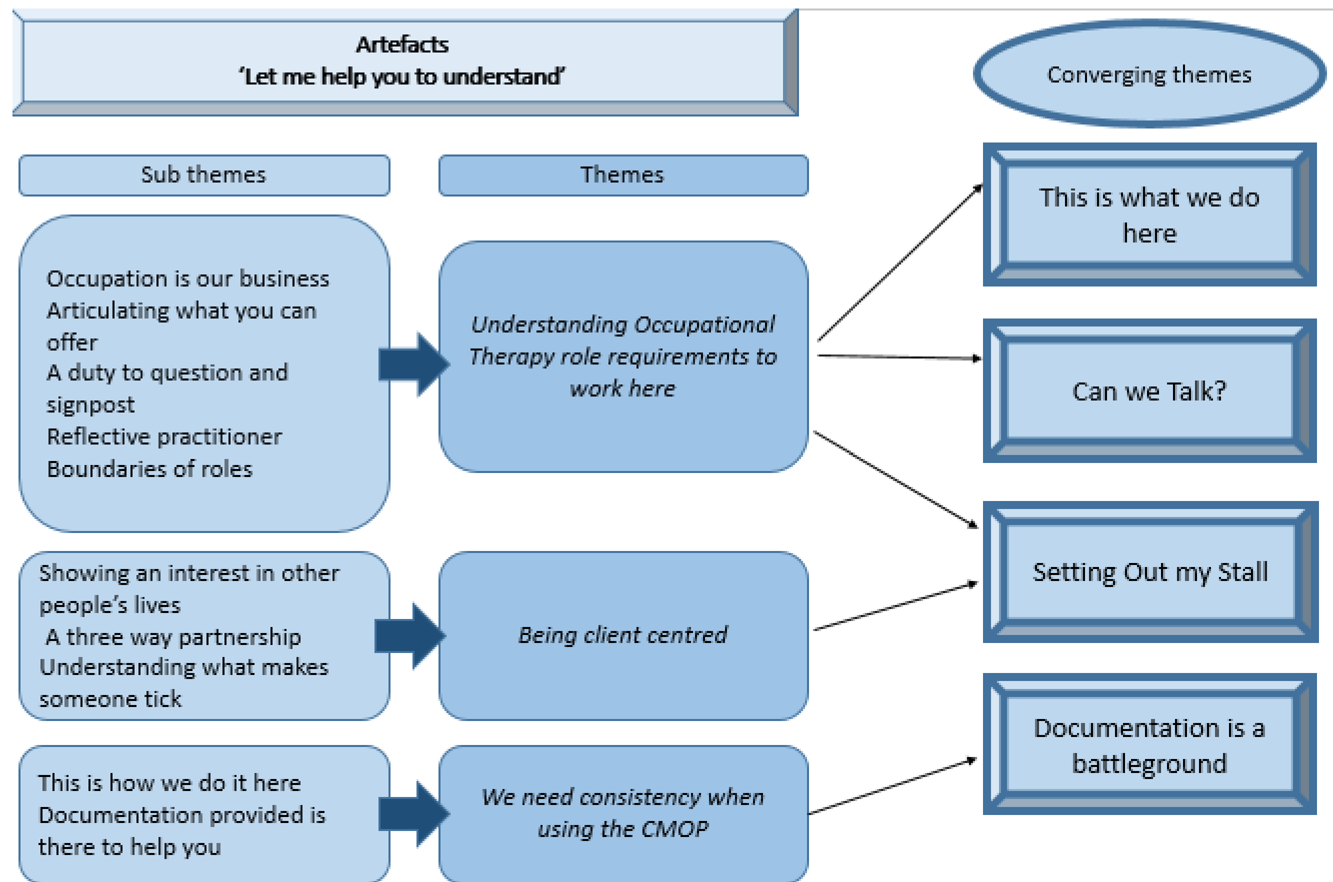

Figure 7.2: Diagrammatic representation of artefact themes into the converging themes

7.1.4. Diagram: Interviews

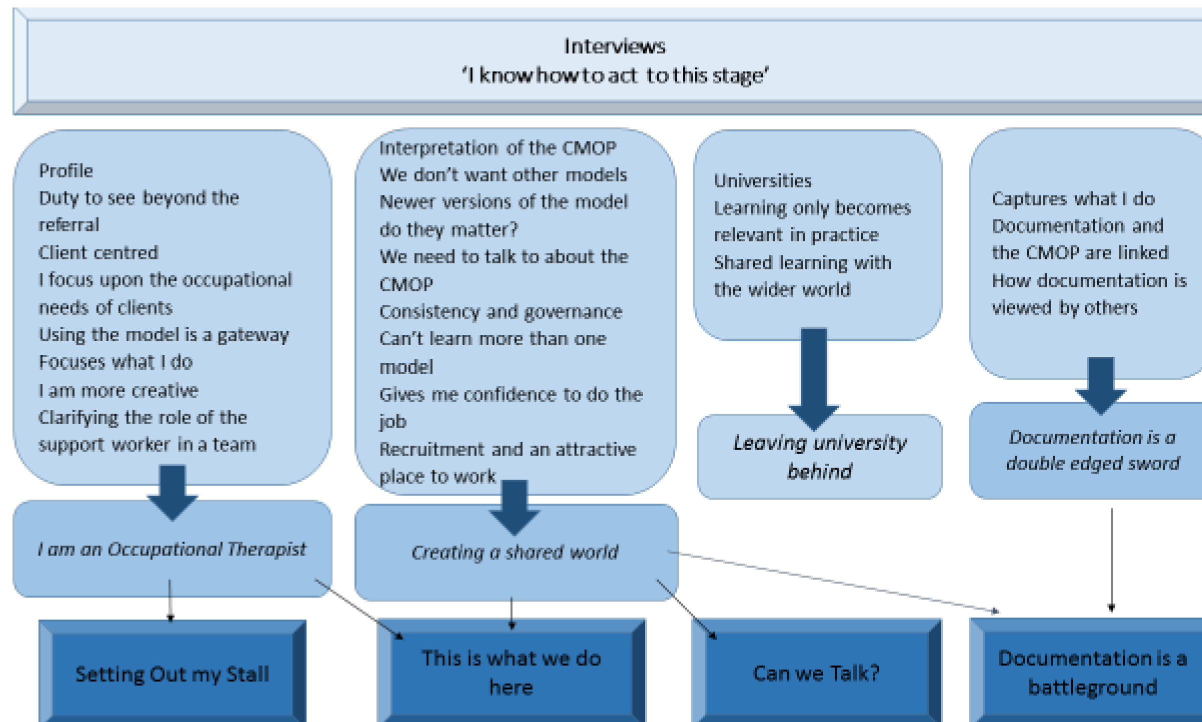

Figure 7.3: Diagrammatic representation of interview themes into the converging themes

7.2. Theme 1: 'This is what we do here'

This theme describes an expectation for all practitioners to use the CMOP within the county, irrespective of their own personal views of the model. The steering group assumed an overseeing role, for translation of theoretical concepts found in the model into the working practice of practitioners. Through a discursive process, which took place in group meetings, a consensual meaning evolved. Shared understanding of terminology was then used to instil an agreed use of the model with all practitioners. In particular, there was local adaption of the term 'occupational performance'. Artefacts were created for two reasons; firstly, to reinforce a shared perspective on the world and secondly, to support practitioners to be confident in articulating and understanding the occupational therapist role.

The CMOP was used to create structure and practical guidance for practitioners who worked across a range of settings. The implicit aim of the steering group was to create consistency of occupational therapy practice, with agreement about role function and purpose. In the process of seeking a shared understanding of the occupational therapist role, the steering group found themselves questioning the support worker role. The group then created guidance for all practitioners on the purpose and function of a support worker, and a support worker training package was produced.

Participants themselves described the CMOP as a structure to work within, that sustained a routine for practitioners in a busy, changing workplace. Sandra observed that:

> *"I'm probably even more reliant on the model because you just don't have the time and the luxury that you had before so you've got be really clear really quickly. And it just gives you that something to, as I said before, you got that language and that structure like I've done this assessment, what have I observed? Right, it fits in these areas. What do I need to think about next? "[Sandra 2:100]*

Yet, equally participants acknowledged not all practitioners were positive about the CMOP, that it was not universally accepted or liked, however, everyone simply viewed it as part of what they did. This suggests a socialisation process. However, there are hints that despite attempts to support practitioners to use CMOP consistently, individuals interpreted the model to support their own particular way of working and unique view of the world.

7.3. Theme 2: ‘Can we talk?’

This theme introduces the concept that the influence of the CMOP did not simply happen once the decision had been made to adopt it. There was an enduring need for discourse to reaffirm shared understanding. Participants described how they valued conversations, both formal and informal, as Maddie observed:

> *“[ ]….it’s just another person to bounce OT stuff off of, if that makes sense.” [Maddie 10:179]*

Conversations took place both in individual teams and within the steering group, to create local interpretation of the CMOP. There was an ongoing need for examination and discussion of the central components of the CMOP, to maintain a shared understanding of the model by practitioners. Initially, these were conducted within steering group meetings and there were hints that contributors to these conversations were not equal, in particular, some decisions were deferred in the absence of the academic member, Head of Service or other key members.

Demand for discourse did not end once the model had been implemented as part of practice and new members of staff needed to be socialised into understanding local interpretation of the CMOP. Conversations were used by steering group members to both support and challenge how the occupational therapy role was presented. Artefacts used documentary, audio visual and participatory methods to perpetuate a shared interpretation of the CMOP. Yet these were not simply created and used. There was an ongoing need to reconstruct the meanings for each artefact. In particular, the study days were altered in response to changes in the sociocultural world of practice.

7.4. Theme 3: ‘Setting Out my Stall’

Taken from a direct quote by Michael, this phrase captures the concept that the CMOP was used as a way to introduce the occupational therapy role to stakeholders. Participants described integral components of their role was to be occupationally focused and client-centred. There was a strong suggestion that they attributed use of the CMOP with their identity:

> *“…it gives you professional identity. And I think as occupation therapists, we’ve been fighting for our own identity for quite a few years and I think because we’re such a broad profession that if people find it difficult to understand. So it kind of can help your reputation.” [Jane: 8:100]*

However, there was acknowledgement that participants adapted the model to suit their individualised way of working. Additionally, there were also hints that consideration of all occupational needs and a professional duty towards clients put them into conflict with other stakeholders, such as managers, when there was pressure to vacate hospital beds or reduce waiting lists.

Being occupationally focused and client-centred were concepts initially explored by the steering group and evidence of these discussions can be found within the minutes. The local interpretation was evolutionary and, in particular, the manual and study days were updated to reflect a renewed understanding or as a response to changes in the sociocultural world of practice.

One point of particular interest was that some participants attributed the CMOP as instrumental for encouraging them to reflect upon their practice, to think and work in a different way:

"I think that the CMOP really encourages people to think outside the box."
[Emily: 9:14]

Inconsistencies in the role of support workers across the county were identified in the minutes from the early years of the steering group. Through a discursive process, there was a consensual meaning and understanding of the support worker role, which was shared with all practitioners across the county. The steering group created artefacts, namely a delegation and assignment framework and support worker training package, to reinforce the new interpretation of the role. There were intimations within the minutes that this interpretation was not necessarily assumed by all practitioners and that, in some areas, individualised actions were being taken, leading to an inconsistent presentation of the role.

7.5. Theme 4: 'Documentation is a battleground'

Theme four introduces the concept of conflict in the role and function of documentation and how it was viewed by both the practitioners and external stakeholders. Participants revealed that documentation had individualised meanings for each of them and it was the most emotive theme and revealed divided opinions.

The minutes captured how, initially, the steering group resisted changes to existing documentation, finally acquiescing after receiving feedback that integrating the CMOP into documentation supported interpretation. Whilst, at first, there was agreement that clinical areas could create their own paperwork, this was subtly changed with a requirement that any change needed to be brought to the steering group for agreement. The steering group assumed a

leadership role for interpretation of the CMOP and documentation was a visible manifestation of local interpretation of the model. Over the years, any alterations to documentation required engagement and discourse with relevant stakeholders and there is evidence that, at times, this led to conflict, in particular, between the steering group and some stakeholders.

Documentation used the CMOP as a framework to structure and guide, both the assessment process and how this assessment was presented to others. The manual reinforced how the documentation should be used, with a clear objective from the steering group that completion should be in a consistent way. Yet the minutes and participants' accounts reveal that documentation was not completed or used consistently.

Meaning of documentation varied, with it being described as an aide memoir during the assessment, to make sure that all occupational needs of a person were considered and not forgotten, and as a structure to capture a client's needs. For some, assessments did not fit into neat self-care, productivity and leisure boxes, in particular, issues were identified with capturing interdependencies. Opinions were divided on whether documentation was integral or separate to practice, with the majority view that it was integral.

7.6. **Summary**

This chapter has presented an overview of the converged themes from three units, which are related to the research questions and propositions. The iterative development of the case and theory building are discussed in more depth in the next chapter.

8. Discussion

8.1. Introduction

In this chapter, I discuss my findings in relation to the original propositions, which presented my original views on how the CMOP influenced occupational therapy practice in one county. The previous chapters presented findings from each unit and a converging chapter captured patterns from across the dataset. To prevent early conclusions being made, an important part of the discussion is to interrogate findings, with rival explanations from the literature, to challenge suppositions and minimise bias. I used a particular form of pattern matching called explanation building (Yin 2009 p. 143) and compared my findings against the initial propositions. During this iterative stage of analysis, it was important that I did not simply draw early conclusions, so I asked myself some important questions:

(1) What was I expecting to see?

(2) What did I see that was unexpected?

(3) What was not there?

(4) Was there another explanation for my findings?

(5) How did my findings relate to the literature, did they corroborate or refute them?

Four converged themes were identified which directly relate to the research questions and propositions, *'This is what we do here', 'Can we talk?', 'Setting out my stall'* and *'Documentation is a battleground'.* The research process and examination of data revealed that use of the CMOP was a complex multifaceted social process. The influence of the CMOP upon culture, identity and role were evident as the case developed. To help readers understand the findings discussed in this chapter, figure 8.1 is provided to visually present key elements of the research process. These are the initial thoughts and opinions (propositions); analysis and convergence across the dataset (four converged themes); main findings when interrogated against literature for rival explanations (role, stakeholders, identity and culture) and finally, generalisation (occupational therapy is a social act). The figure makes evident the case study followed a structured analytical process and that I was not simply verifying my own thoughts and opinions. The initial propositions of the researcher are given and then four converged themes from analysis of the dataset are shown. Two converged themes; '*can we talk'* and

'documentation is a battleground' came from analysis of the dataset which, arguably, strengthen trustworthiness of the research. Arrows from converged themes indicate that, when the themes are interrogated against literature, they do not conveniently feed into culture, identity, role and stakeholder as separate and distinct elements of the social world of occupational therapy practice. Instead there is overlap, suggesting a dynamic, complex, social process. Whilst the main purpose of my study is not to generalise, the final stage of the case is to develop theoretical knowledge about the application of the CMOP in practice. The diagram shows the contribution of this study to theoretical generalisation, proposing that occupational therapy practice is a dynamic social act.

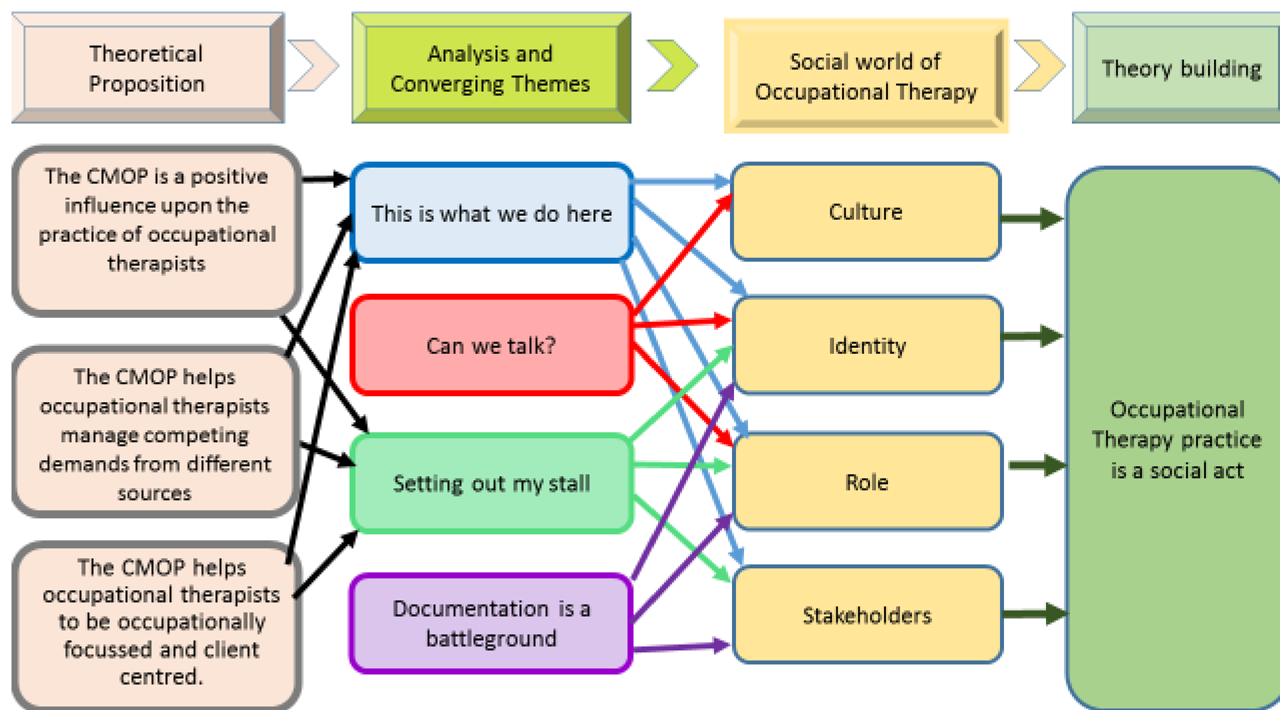

Figure 8.1: Diagrammatic presentation of the case development from theoretical proposition to theory building

As anticipated, all units confirmed that use of the CMOP was an expected part of practice:

'All staff to be made aware that it is the expectation of the OT service [ ] that CMOP will be used in everyday practice' [steering group 2008].

'[ ] it's just part of what I do" [Alice 7:42]

The manual 'strongly advised' practitioners to use the documentation provided [manual 2006, p21 manual 2010, p20].

These data sources supports evidence from earlier published works, that the model was expected to be used county-wide (Boniface *et al.* 2008; Waygood *et al.* 2012; and Walker and Thistlewood 2012). It was interesting to observe how similar participant's accounts were when asked to describe the influence of the CMOP upon their own practice. Each described how the CMOP supported them to explain their role to others, be client-centred, occupationally focused and fulfil a professional duty to advocate for clients. Participants indicated that professional values of being an occupational therapist were irrefutably connected to conceptual features of the CMOP. Exposure to the CMOP had socialised them to have shared understanding of the occupational therapy role, which was so embedded that for some, but not all, the CMOP became an integral part of their social identity. Social identity is multifaceted and relates to understandings people hold about themselves, who they are and how they are viewed by others (Giddens 2001). This is separate to personal identity, which includes understandings we hold about ourselves. Use of the CMOP was part of the social identity of the occupational therapy group and influenced how the role was presented to external stakeholders, such as, clients, colleagues and managers.

8.2. Occupational therapy practice is a social act

At the start of my research journey, I was not aware of the relevance or impact of socialisation and external influences upon the creation of a shared identity. Through analysis, my understanding of the case developed. I identified that the CMOP was a component of a dynamic and complex social process. Whilst the CMOP was integral to the creation of an occupational therapy culture, how the model was interpreted and occupational therapy role enacted, in different clinical situations and contexts, it was influenced by many other factors. This complexity created some dilemmas when I considered how to answer my research questions. The original analytical construct of answering three questions as separate concepts did not seem to mirror the reality that the evidence was portraying. The social act of practice was a complex, nuanced and layered process.

Whilst participants described a shared understanding of concepts of the CMOP, they openly described how they adapted and altered the model within their clinical area and, without exception, described changes they had made to it to suit their individual practice. Enactment of the role was individualised for each participant in their unique contextual environment. In the study conducted by Wimpenny *et al.* (2010), practitioners adapted the Model of Human Occupation (MOHO) in a mental health trust, and the researchers identified that therapists needed to be able to exercise autonomy to modify and adapt the model to meet their own practice needs. In this study, participants identified that changes they made meant that the way they used the CMOP was not necessarily something they felt comfortable with. They described how time consuming it was to be fully client-centred, when there was a pressure to vacate beds or reduce waiting lists. Helen described that, for some, choices were made to not complete expected documentation, which meant that the CMOP was not necessarily viewed positively by external stakeholders. The impact of external stakeholders, contexts and individual circumstances upon how a model is used was similarly identified in a study by Melton, Forsyth and Freeth (2012). In an opinion piece, Greber (2011) also identified how many therapists view their work from the perspective of their day-to-day practice and that practice is influenced by what is observed daily. In this study, participants identified that they adapted the model to suit their own requirements and those of the external stakeholders, with whom they worked closely.

8.3. Relationships with others

Understanding the relationships and social actions between occupational therapy practitioners and stakeholders who they worked with was an interesting part of my analysis. Exploration of my findings was guided by the work of Hatch and Schultz (2002), who created a process model for organisational identity. I used concepts found in their model to interpret the connections between occupational therapists and external stakeholders. Whilst guided by the principles in their model, I examined the data and translated their definition of organisational identity to mean occupational therapy identity. By doing this, I have departed from the original definition of ‘organisation’, which viewed anyone outside of a company to be an external stakeholder. In my definition, occupational therapists are the ‘organisation’; external stakeholders are other members of the workplace, such as, colleagues and managers.

8.4. Influence of the work of George Herbert Mead

Ideas presented by Hatch and Schultz of organisational identity are influenced by the work of George Herbert Mead (1863-1931). To understand the work of Hatch and Schultz (2002)

requires an understanding of the original concepts found in Mead's work (1934). Mead was an American philosopher, a forefather of the pragmatic movement and pioneer of sociology, who taught at the University of Chicago. Mead understood identity of individuals to emerge from, and be intertwined within, the social context in which it is being enacted and has two distinguishable components, the *I* and the *me*. Mead's work defines the *me* to be embedded in the social self, a conventional, habitual individual who has internalised roles, is a member of a social group and represents the values of that group (Mead, 1934 p. 197, 214). The *I* is the novel, creative non reflective response which the individual is not aware of (Mead 1934 pp. 173-175). When an individual is seen by other members of a society, the *generalised other* (Mead 1934 pp. 155- 156), to belong to a certain group they undertake societal expectations of the role, the *me*, that being a member of that group is expected to fulfil. Awareness of the *I* only comes through reflection, the objectification, in the past tense and from a historical perspective (Mead 1934 p. 174). Once it has been reflected upon and part of conscious actions, the *I* becomes part of the *me* and assumes a habitual role, which may predict responses of an individual (Mead 1934 p. 175). Whilst the *me* allows anticipation for the likely responses of an individual, they do not wholly determine which course of action an individual will take. Mead (1934) identifies that having a *me*, being part of a group which fulfils certain roles, does not negate individual choice to how to act in any given circumstance. This means individual acts can be either expected or unexpected. Together the *I* and the *me*, are essential for development of 'self' and reflect the dynamic process, which takes place in each individual when partaking in any social act. Described in terms of conversations within an individual between the *I* and the *me*, intertwining of both creates a set of reactions and responses, a dynamic social process which continues throughout an individual's life. Social meanings are constructed through social actions and 'social acts' are when gestures called out by one individual call out a response in another (Mead 1934). Through conversations, these *gestures* are how social meaning is constructed and when there is a shared understanding, and mutual acceptance of meaning, they become *significant symbols* (Mead 1934 p. 47). Language, was viewed by Mead to not only be verbal, but a:

> *'multiplicity of signs and symbols that evoke social meaning' (Simpson 2009 p. 1335).*

These symbols can be reinforced or disrupted, but they are a way for creating shared understanding. They allow us to '*stand in someone else's shoes'* and anticipate likely responses and as a way of moderating social conduct (Simpson 2009 p. 1335). Yet, crucially, the self is constructed from the *I* and the *me*, which means that reactions may not be predictable and individuals make choices on how to act.

8.5. **Organisational identity**

Hatch and Schultz (2002) used analogous reasoning and adapted Mead's ideas which related to the individual, to present a process model for organisational identity which pertained to groups of people. In their paper, the authors applied Mead's concepts to describe a complete organisation. The process model defines the *I* as the organisational '*we'* and the '*us'* as the organisational equivalent of *me*, which both together form organisational identity. The *me* is formed by what the members of that organisation assume are the *images* held by external stakeholders, *the others* about them (Hatch and Schultz 2002 p. 995). The *I* is the contextualised assumptions, beliefs and values held by members, the *culture*, used to create internal meaning and self-definition that members are not aware of (Hatch and Schultz 2002 p. 996). Together they form organisational identity described as an ongoing:

> *'…multi-directional plurality of intertwining meanings and meaning makers.'*
> *(Hatch and Cunliffe 2013 p. 313)*

Identity is not only in relation to what others say about them but who they perceive they are (Hatch and Schultz 2002 p. 1000), which is either reinforced or changed through a process of reflection in relation to deep cultural values, beliefs and assumptions. External stakeholders have an image of '*what they think we do'* (Hatch and Cunliffe 2013 p. 315). Any changes to how the image is perceived provokes reflective questioning of '*who are we?*' (Hatch and Cunliffe 2013 p. 315) by members of the organisation, who interpret the image they are presenting. If the group are happy with their image, there is no change, but if they respond and change, then there needs to be a new understanding of identity.

My definition of organisational identity is the collective group of occupational therapy practitioners who are the *I*, and colleagues and managers are external stakeholders, the *me*. In my interpretation, the CMOP informed the culture of the occupational therapy practitioners, which influenced their identity and how the role was presented to external stakeholders. These external stakeholders had expectations of how the occupational therapy role would be enacted, based upon the identity presented.

Occupational therapy practice presents as a social act which is a complex, nuanced and layered process. There is a dynamic interplay between identity, both individual and professional, a shared culture and understanding of role. These, in turn, are influenced by external stakeholders when practice was being enacted. Figure 8.2 overleaf presents a schematic representation of this concept. The arrows reflect the dynamic, interrelated social process of practice.

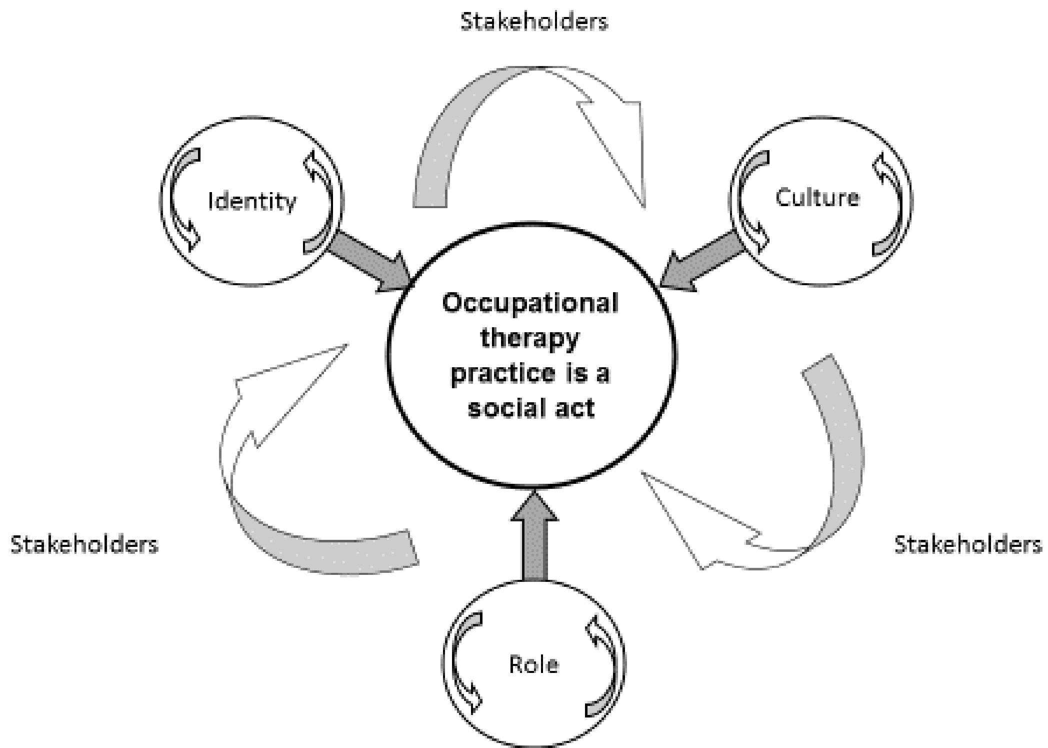

Figure 8.2: Diagrammatic presentation that occupational therapy practice is a social act

8.6. Creating a social world

It became apparent that the CMOP was used to support thinking and define the scope of practice, which has been identified in the literature as an integral purpose of a model (Turpin and Iwama 2011). The idea that use of the CMOP was integral for practice was not present in 2004 when the model was adopted. Identity comprises what we believe about ourselves and those characteristics attributed to us by others (Duncan, 2006; Giddens, 2001). Prior to implementing the CMOP, each individual practitioner held their own view of who they were and presentation of the role was based upon personal interpretation. The *me*, the role of occupational therapist presented to external stakeholders, was highly individualised and influenced by cultural setting, external stakeholder requests and the individual practitioner's personal assumptions of the occupational therapy role. This was unique to each particular clinical setting in which the occupational therapy role was being enacted. Whilst individualised practice itself is not necessarily negative, the CMOP was adopted to ensure governance and consistency of practice (Boniface *et al.* 2008; Waygood *et al.* 2012). Models serve as a way to enhance accountability, guide practice beyond a particular setting and provide a systematic way of collecting information (Townsend *et al.* 2007; Turpin and Iwama

2011). In this study the CMOP contributed to a clear collective identity of '*this is what we do here'* and how the role was presented, '*setting out my stall'*.

The CMOP had only existed as theory prior to 2004 and in this study participants described it as being integral and mandatory for the practice of all. Initially, the steering group assumed an overseeing role, for translation of theoretical concepts found in the model into the working practice of occupational therapists. Through a discursive process, which took place in group meetings, a consensual meaning evolved. Shared understanding of terminology contained within the CMOP was used to instil an agreed interpretation, which informed a collective identity. It was interesting to note that, in the early days, all occupational therapy practitioners outside of the steering group were judged by group members to be external stakeholders. As time passed the CMOP became *'this is what we do here'* for all practitioners and was an integral part of the identity presented to external stakeholders, who were clients, colleagues and managers. Interview participants described how they attributed use of the CMOP to creation of their identity. Discourse using the CMOP as a platform created a structure and shared social world. However, participants described how they each interpreted the model to support their own particular way of working and unique view of the world. Despite the uniqueness of each individual social act, participants all described as integral to their practice, components found in the CMOP, namely, to be occupationally focused and client-centred. That these were viewed as integral to their own practice suggests that features of the model were so embedded in the culture it became '*who we are'* (Hatch and Cunliffe 2013 p. 315). From the outset, the steering group were overt in their intentions to bring together individually held perspectives on occupational therapy, to adjust, modify and create a shared set of values, beliefs and behaviours, and occupational therapy culture (Waygood *et al.* 2012; Boniface *et al.* 2008; Walker and Thistlewood 2012). Culture is a concept for learned rather than inherited values, beliefs and behaviours and for how members of particular groups, such as occupational therapy, are expected to work (Duncan, 2006; Thompson, 2000; Giddens, 2001; Sumsion, 2006). Cultural beliefs simply become everyday habits and routines, which can be used as a way to control behaviour, so members internalise values of a group and perform in a desired way (Hatch 2013). The principles of the CMOP were internalised by the occupational therapy group and just became a cultural norm.

The steering group created artefacts that became symbols of occupational therapy identity. The manual, study days and the DVD, in particular, were used to create a consistency of practice. Hatch and Schultz (2002 p. 1001) described how artefacts can be viewed as symbols of identity by virtue of the meaning given to them by the collective group, so that even though meaning can be re-interpreted each time the artefacts are used, some of the original meaning

is still embedded in and carried by the artefact. In this sense, meanings attributed to artefacts can be used as a powerful way to communicate identity. The study conducted by Wimpenny *et al.* (2010) described how tools were used to support practitioners to use and interpret the MOHO. In this study, the created artefacts were used to support understanding of the CMOP by all practitioners, not just those who were part of the steering group. Agreement and consensus as to how the CMOP was to be used, by all practitioners across a range of settings, required engagement, so principles of the model became mutually agreed and accepted. The steering group wanted a consistent presentation of the occupational therapy role by individual practitioners, to ensure that a client being seen in any clinical area in the county could expect to receive a similar level of service. The artefacts held clear messages that aimed to convey a shared understanding of identity and how the role should be enacted. The artefacts were designed to be used by occupational therapy practitioners either individually, such as the manual, or for group learning, such as the study days and DVD. Primarily, the artefacts were developed to create a shared culture, viewed only by the occupational therapy group. The exception was documentation, which carried the collective understanding of identity from within the cultural group and was seen by external stakeholders. Documentation was part of the occupational therapy image and part of the image held of them by others.

Socialisation was integral for collective understanding the CMOP. New members who joined the workforce were expected to attend study days and were given manuals to support them to use the CMOP on a day-to-day basis. Existing practitioners were equally welcome to attend these sessions which, at one point, were called 'refresher sessions'. Newly qualified practitioners left universities with a set of predominantly theoretical values and beliefs, which needed to be applied and understood in the workplace. Attending study days and having the CMOP as a framework for documentation was an important part of the socialisation process. In particular, some participants described how the CMOP helped to create confidence in less experienced practitioners to explain the scope of the occupational therapy role to others, as this comment identifies:

> *I think that helps like our support workers and our new Band 5s to stop and not be railroaded." [Sandra 2:96]*

In the literature, other studies similarly identified how the CMOP could be used as a framework to clearly and confidently explain the occupational therapy role (Warren, 2002; Clarke, 2003; Blijlevens and Murphy 2003).

Discussing the model with occupational therapy colleagues was an important element to instil collective beliefs, values and understanding of role. Taking time to converse with other

occupational therapists, and reflect upon personal assumptions, was similarly identified in other studies (Wimpenny *et al.* 2010; Melton, Forsyth and Freeth 2012; Forsyth, Duncan and Summerfield Mann 2005). In this study, participants described conversations which took place in their own workplaces where the CMOP was discussed; Jane in particular, identified that having people that were confident in understanding the model, created enthusiasm in her and other colleagues to use it. This study identified that *'can we talk about it?'* was an important constituent to create shared, cultural cohesion and understanding of role. These were integral for collective identity of the occupational therapy group. Study days and group use of the supervision DVD created opportunities to bring together groups of practitioners, the model could be discussed and reflected upon. Through conversation, personally held beliefs could be adjusted, which in a changing dynamic world was vital to sustain ongoing shared understanding of the CMOP. This discourse ensured that the CMOP was adjusted and modified as part of a dynamic, social process. Mead (1934 p. 47) described how social meaning is constructed when there is a shared understanding and mutual acceptance of that meaning. This is a dynamic process and, as Thompson (2000) observed, simply putting components in place does not necessarily mean they will work. Instead, there needs to be continual small adjustments, modifications and reconstruction of understanding which reflect changes in the sociocultural world in which the role is being enacted.

Study days were regularly held, to encourage a shared understanding of the occupational therapy role and artefacts were adapted in response to changes in the sociocultural world of the workplace, HCPC registration requirements and local understanding of the model. My study identified that time away from the workplace, to reflect upon practice using the CMOP, was an important component for creating a shared identity and this was perceived as valuable by participants. Yet, participants revealed that access to study days was variable after 2011 and minutes from 2012 capture these discrepancies. Prior to 2011, decisions for training were taken by managers within the occupational therapy group, without engagement with external stakeholders. Following reorganisation, external managers, who were not a homogenous group, influenced whether the study days could be held. The minutes capture how requests were made to the steering group for study days to be held and that the steering group were not able to respond collectively. Study days were valued by practitioners, evidenced by them being requested in the minutes. Yet, following reorganisation, the steering group no longer had the power to act without wider engagement with external stakeholders, who either did not have a shared understanding of why they were needed, or were faced with socio-political changes, which reduced their capacity to agree to the days being held. Some steering group members, who worked in the acute hospital, were able to act without external stakeholder approval and continued to run, and even altered, the study day packages to reflect changes needed in their

clinical area. This was the first indication of an inequity in socialisation and highlighted the impact of external stakeholders upon the socialisation of occupational therapy practitioners in the county. Whilst no obvious differences were revealed in identity between participants in this study, as Thompson (2000) observed, past success of socialisation is no measure of future success. He describes socialisation as a dynamic ongoing process which is contextually dependent. Mead (1934) similarly expressed that individual identity is formed from the social situation around us. Potentially, inconsistencies in socialisation could lead to a fragmented interpretation of the role in the county.

8.7. **Socialisation needs leadership**

Creation of a shared identity was led by the steering group to introduce a collective thought for the occupational therapy role. The CMOP was used to create structure and provide concrete guidance for practitioners who worked across a range of settings. The implicit aim of the steering group, when it was created in 2004, was to create consistency of occupational therapy practice, with agreement about the function and purpose of the occupational therapist role. The timing was significant and, at that time, there was a tightening of regulatory body requirements and government direction of travel (DH 2007; 2008; 2010; HCPC 2004, 2007; 2013; COT 2006, 2015). The steering group challenged individualised views and usual practice and, as they reflected together, asked '*who are we?*' (Hatch and Cunliffe 2013 p. 315) in an attempt to create a shared culture. An integral part of the discussion was to consider how the role was perceived by external stakeholders, '*what do they think we do*?'(Hatch and Cunliffe 2013 p. 315). The group used the CMOP as a platform for discussion and the minutes revealed how members challenged existing practice, habits and routines, through a discursive process which took place in group meetings, and a consensual meaning evolved where there was a new shared understanding of role. Through a reflective process, they adjusted and modified practice for all occupational therapy practitioners, including that of support workers, as Charlotte observed:

> *"The important thing is we're sitting here after 10 years and we're still discussing it. There are other changes we would've said, "Oh, that happened in 2003, let's forget about it." We're still discussing it. We're still trying to find a way forward with this so it must be working." [Charlotte 11:90]*

The views presented in this study seem to contradict the literature that argues against use of one model (Creek, 2003; Ikiugi, Smallfield and Condit 2009).

The steering group continued to lead the implementation of the CMOP for over ten years. Practitioners came and went; external changes in both organisational structure and service direction dictated a collective, ongoing need within the occupational therapy group to maintain a shared understanding of identity. Despite original intentions to be a short lived group, whose initial purpose was to oversee the implementation of workbooks, the steering group received ongoing requests from practitioners for support and, at times, they identified that practitioners needed to come together to strengthen shared understanding of the CMOP. Wenger (1998) suggests that integration of theory into practice is complex and not simply a case of introducing theory and, as a consequence, practice will change, but it is a dynamic, ongoing process. Correspondingly, artefacts were revised in response to changes in requirements requested by practitioners' or altered socio-political needs, such as registration requirements. An interesting point to note was the length of time this leadership went on for. Other similar studies who introduced the MOHO into a collective group of staff did so over a shorter time period (Wimpenny *et al.* 2010; Melton, Forsyth and Freeth 2012: Forsyth, Duncan and Summerfield Mann 2005). A possible explanation for the length of time the steering group was in existence could be explained by the size of practitioner group the model was being introduced to. This study had 350 practitioners who worked in a variety of settings and across a large geographical area.

Although the steering group had a collective leadership role for practitioners, not all roles were equal within the group. Some decisions were delayed until the Head of Service, academic partner or other members were present. Through reflective conversation and, in particular, those which included these certain members, the steering group seemed to have increased confidence when they reflected upon practice and thought about ways to improve it. In research conducted by Wilding, Curtin and Whiteford (2012), a community of practice was created between academics and practitioners to review chapters in the *Enabling Occupation* book (Townsend and Polatajko 2007; 2013). The researchers reported that practitioners had increased confidence to consider their practice when discussions took place as a collective group with academics. In this study, academic input was a positive influence upon these discussions and development of practice in the county.

8.8. Socialisation requires interpretation

The CMOP was not simply introduced and used; there was an ongoing need to reconstruct its meanings in response to changes in the sociocultural world of practice. In particular, local interpretation was made of familiar occupational therapy concepts found in the model, to make them relevant for local practice. In particular, in 2009, the steering group changed their

definition of 'occupational performance' to reflect local understanding of terminology and was different to the one provided in '*Enabling Occupation'* (Townsend *et al.* 1997; 2002). At a similar time, they renamed the manual, where they described their use of the CMOP to be an interpretation. The timing for these actions was interesting as the Canadians had updated the CMOP model, which was now called the CMOP-E (Polatajko *et al.* 2007). There are no accounts of any discussions about the CMOP-E to be found in the steering group minutes and when participants were specifically asked for their views on the CMOP-E, there was a noticeable indifference towards it. However, Alice added a caveat that more interest might have been shown if practitioners had struggled to use the CMOP. In the literature, an interesting observation was made by Egan (2003) that models should not be changed for changes sake. Mackey (2007) presented a slightly different perspective and in her observation paper, argued strongly that professional identity should be local and contextually relevant. She argued against a global professional identity created by academics or professional associations. Participants' lack of interest in adopting the CMOP-E may be explained in two ways. Firstly, the majority of practitioners were comfortable with using the CMOP and, with competing demands on their time this was an acceptable link with professional theory. Secondly, that local interpretation over a number of years of the CMOP had become so firmly embedded in the professional identity of practitioners that they saw no need to adopt an updated version created in a different country.

8.9. Influencing how the role is presented to others

Participants attributed use of the CMOP to explain and articulate their role to others and this was primarily captured within the theme of *'setting out my stall'*. Occupation and client-centredness were so embedded it became '*this is what we do here'*, (Hatch and Cunliffe 2013 p. 315) a culturally accepted norm, integral to the role and simply '*who we are'*(Hatch and Cunliffe 2013 p. 315). It was a particular surprise to hear comments by several of the participants, who attributed that use of the CMOP, encouraged them to be more creative in their role. In the literature, some criticism has been made by scholars that use of a single model encourages routine, non-reflective practice (Creek, 2003; Ikiugi, Smallfield and Condit 2009) and comments made by several participants in this study, seem to refute this. The findings in this study concur with those made in other studies that use of the CMOP created a useful framework, to both broaden perspective and ensure all occupational needs of a person are considered (Warren, 2002, Clarke, 2003, Blijlevens and Murphy 2003).

Being client-centred did not necessarily mean that participants felt comfortable with the decisions a client made and the study indicated some conflict between professional

responsibility, personal judgments for risk taking, and what they could statutorily provide in the role they were enacting. Consideration of wider occupational needs of a client also, at times, put participants into conflict with external stakeholders. Several participants described how they used their CMOP assessments to advocate for, or challenge, expectations of external stakeholders and described a professional duty to consider wider needs of a client. In particular, Sandra gave a powerful account:

'[ ] ...just try and bring that person back that they are human in amongst all of these medical investigations and tests and awful diagnoses that are going on. There is a person sat in the middle of it….' [Sandra 2:14]

In a paper presented by Pettican and Bryant (2007), the authors describe how conceptual models of practice can be used as a way of advocating occupational therapy to stakeholders and, in a generic team, can support practitioners to present the unique focus of the role upon occupation. In 2011, a number of practitioners in the county had become part of integrated, multi-professional teams. Some of these were interview participants and they described how they used the CMOP to maintain an occupationally focused role in these new teams. Other studies equally recognised that the CMOP could be used to support practitioners to describe their role (Warren, 2002, Clarke, 2003).

Some participants, in particular those were more recently qualified, used the CMOP documentation as a concrete framework for both conducting the interview and writing up assessments. The majority of practitioners viewed documentation as integral for use of the model, and minutes from the steering group capture how practitioners wanted changes to be made to documentation from early in 2005. For a small number of participants, the model was described as a virtual framework in their head, that they used to structure interview conversations with clients and as a way to ensure that all needs were discussed.

It was noticeable that experience of participants influenced how the CMOP was interpreted and actions taken. Michael described the way he used the model to stop him taking on too many cases, whereas a manager had a more pragmatic approach:

'I think we go in there with great intentions to be assessing the needs of the client and advocating for the needs of the client. But we're in an environment where there's lots of pressure and there's lots of firefighting to clear the beds……' [Charlotte 11:48].

Helen identified that some practitioners chose not complete documentation and that she felt, as a consequence, the value of the role was not realised when external stakeholder could not

see a full assessment in the paperwork. Each of these examples indicates that enactment of the occupational therapy role was not a simple process and how actions were influenced by contextual factors. Mead (1934) describes how distinct social acts are taken which depend upon individual interpretation of the situation. Each time the occupational therapy role was enacted there was engagement with external stakeholders, practitioners made decisions for actions, which meant that the role whilst predictable was not necessarily carried out in the way it was expected to be.

Participants rejected the idea of using several models and, whilst the adoption of several was described by some as ideal principles, this was simply deemed to not be practical within the workplace. This perspective is in contrast to those presented by participants in a study conducted by Maclean *et al.* (2012), who described that the needs of the patient should determine which model is used.

8.10. **Relationship with external stakeholders**

In this study, there was little evidence of external stakeholders being involved in the socialisation of occupational therapists to use the CMOP, apart from providing agreement and financial support for hosting and attending conferences, and production of manuals. There was no evidence of any comments made by stakeholders about the more visible changes made to the support worker role. Documentation, however, provoked strong responses from within the collective occupational therapy group and external stakeholders, and was reflected in the theme '*documentation is a battleground*'.

The decision to incorporate the CMOP into documentation made theoretical concepts visible to both occupational therapy practitioners and external stakeholders. Alterations were made to documentation overtly, using terms found in the CMOP and this was a very visible presentation of occupational therapy identity to all stakeholders. Changes to documentation were initially resisted by the steering group, who wanted a theoretical understanding of the model first. The rationale behind this decision was based upon previous experience of some steering group members whose attempt failed when they tried to implement the Canadian Occupational Performance Measure (COPM) into practice (Fedden, Green and Hill 1999). This failure was attributed to a lack of understanding of the associated model, the CMOP. Participants revealed that documentation had individualised meanings for each of them and it was the most controversial theme, with divided opinions. Within the literature, authors have identified that the function and purpose of documentation is complicated and, whilst it is a way to structure notes and support effective communication, it is not the only form of

communication that is used (Shayah *et al.* 2007; Mann and Williams 2003; Berg, 1998). Documentation was described as an important way of capturing the occupational therapy assessment, yet participants indicated how it was a struggle to do so successfully. James sagely observed in his interview that people do not neatly fit into the self-care, productivity and leisure boxes. Similarly, Hammell (2009) questioned if occupations can inevitably be organised into these categories, which are not necessarily culturally relevant or client-centred. She identified that interdependencies, that is to say that needs of one person are so intertwined that they cannot be considered without thinking of another, do not neatly fit into boxes. The issue with capturing interdependencies on the documentation was particularly identified by James in his interview.

Alterations to documentation required engagement with interested parties to seek a consensus and, at times, created a considerable amount of debate and conflict. Yet consensus between the steering group and practitioners was that the CMOP should be incorporated into documentation. It appeared to be a visual reminder of the model, the level of negotiation required for decision making varied across different parts of the service and who the external stakeholders were. This was the one area where the shared identity between external stakeholders and the collective occupational therapy group was not necessarily agreed upon. There was one particular debate of interest that served as an example of what Hatch and Schultz (2002 p. 1006) describe as '*organisational narcissism'*. This is where a group becomes so self-absorbed they focus only upon who they are, and what they stand for, and forget that they should be adapting and engaging with stakeholders. In this example, I believe the steering group became so wrapped up with protecting their 'CMOP identity' and insistence that the model must be integral in documentation, that they forgot to consider the impact of this decision upon the collective group of occupational therapy practitioners and external stakeholders. They did not enter into negotiation with all parties to seek shared understanding for the purpose of documentation and failed to remodel understanding of documentation with all parties. This led to the different interpretations for the function and purpose of documentation by practitioners and external stakeholders.

The minutes depict a triumphant air when external stakeholders agreed that the CMOP could be part of documentation in social care. However, minutes from later in the year capture complaints by practitioners in social care about the level of documentation now expected to be completed, as they were still required to complete generic paperwork. Helen revealed a manager's comment, which dismissed the CMOP as unnecessary for practitioners based purely upon incomplete documentation he had read. This failure to agree a shared understanding for the function of documentation, with all parties, influenced the image held by some

stakeholders of the CMOP. Some internal stakeholders, occupational therapy practitioners, faced an increased amount of paperwork and consequently made choices to complete it or not, citing lack of time as a factor. Equally, there were some external stakeholders who viewed the CMOP only to be a framework for documentation and consequently dismissed its value when it appeared to not support documentation. Blijlevens and Murphy (2003) describe how documentation has a complicated purpose and that, whilst overt description of the occupational therapy process can be seen as over complicating matters, it articulates the practice of an occupational therapist. Similarly, other authors describe it as a way of accounting for practice which can be reviewed without a therapist being present (Townsend *et al.* 2007). If practitioners do not document their assessments, arguably, they are not able to articulate to stakeholders the function of their role and this may in turn mean the breadth of interventions are not valued by stakeholders. Participants indicated that they continued to practice in the best way they could although, crucially, this was not always documented. Mattingly and Fleming (1994) described documentation to be an important component for capturing activity and remain credible with stakeholders. If practitioners do not document activity they run the risk of simply resorting to what Mattingly and Fleming (1994) describe as '*underground practices'* (p. 296). This is where practitioners continue to work in a particular way that both they and a client value, but simply do not document these interventions, as they wish to still appear credible. Failure by the steering group to engage with all stakeholders was damaging and led to a disconnect between all parties, for consensual agreement about the function of documentation in some areas of practice.

The timing of this episode was interesting, it was when the steering group were publishing work externally and entering in a marketing agreement with academic colleagues to market artefacts nationally. Members of the group appeared to be so focused upon these external professional relationships that they forgot the importance of maintaining local identity and relationships. Time should have been taken by the steering group to articulate why they wanted documentation to be integral to practice with local stakeholders.

8.11. Summary

This chapter has explored the findings from the case and explanations have been given from within the literature. This has been a highly iterative process and with a high volume of data it is difficult to capture all points. I have concentrated upon challenging my presuppositions and conclusions drawn from the case to indicate, in particular, the importance of socialisation to create a shared identity. The inter-relationship between the steering group, artefacts and individual practitioners was evident and testimony that use of a model was a dynamic process,

which required commitment and leadership. Professional growth, in particular within generic teams, requires occupational therapists to be able to articulate their worth and adapt. The CMOP was an integral part of the creation of a professional identity for occupational therapists in this study. Understanding relationships with external stakeholders were equally relevant when exploring the social world of occupational therapy practice. The research process and examination of data revealed that use of the CMOP was a complex multifaceted social process. There was clear evidence of the influence of the CMOP upon culture, identity and role.

9. Conclusion

9.1. Introduction

The focus of this thesis was to understand the influence of a conceptual model of practice upon occupational therapists in a British health and social care setting. This was explored by case study methodology and was conducted in one county in England who implemented the CMOP (Townsend *et al.* 1997, 2002). In this chapter I will address the research question, "How does using the Canadian Model of Occupational Performance (CMOP) influence occupational therapy practice?" Examination of the case revealed that occupational therapy practice was a complex, dynamic, multifaceted social process. Actions taken were made in response to the world in which practice was being enacted. The original analytical construct of answering three questions as separate concepts did not seem to mirror the reality that the evidence was portraying. Practice was a social act complex, nuanced and layered and, as such, each question, therefore, could not necessarily be considered separately. The influence of the CMOP upon the creation of a shared culture, identity and role were evident within the case.

9.2. Reflections on the study

An integral part of interpretation of the case is to reflect upon the study and consider its limitations.

9.2.1. Personal reflections

The study took place at a time of significant organisational change and was suspended for eighteen months. At the start of the research process, all practitioners worked under one management structure, albeit within different organisations. On return from suspension, practitioners worked within very different team and management structures. I took time to renegotiate with several new managers, unfamiliar with me and my work, to gain permission to continue the study and access participants. Personally, a familiar support network was not available and I needed to rebuild and make new contacts, which was challenging. After a period away from studying, I found it difficult to immerse myself into my studies and balance my various, often conflicting, roles of clinician, manager, mother and wife, with being a researcher. Discussions and negotiations with family, supervisory team and managers helped me to understand the best way for me to successfully balance these roles. Subsequently, I took

whole weeks away from work regularly, which created the concentrated periods of time I needed to immerse myself completely into the research. Further changes occurred within my supervisory team and my director of studies changed. However, I was fortunate that I was able to rely upon relevant support continuously throughout the study.

This was a single case study conducted by myself as a sole researcher. I acknowledged at the start of this thesis and at this stage now how I, as researcher, needed to take account of the way in which my own assumptions and values have impacted upon the research process and interpretations made. It is important to acknowledge both the positive and negative impacts upon the study. Firstly, positive benefits; this study took place in the county I worked in and, as such, once relevant agreements had been reached, I was able to access data that may not be immediately recognisable to an external researcher. My own reflections and challenges to personal presuppositions add to rich, thick descriptions of the case, which may not have necessarily been recognised by other researchers. However, as an employee in the county, I was known to be involved with the implementation of the CMOP and have positive views on the CMOP. I was anecdotally aware that not all practitioners shared my positive opinion of the model. Yet, whilst the interview participants alluded to colleagues who had negative views, they did not necessarily present any to me and there was little evidence provided for why, during discussions. I, therefore, recognise that my role as researcher may have dissuaded some potential practitioners from being interviewed and the eleven participants interviewed did not necessarily reflect a complete range of views and opinions in the county. One explanation may be that I could not prevent participants from reacting to me and providing answers they thought I wanted to hear, rather than providing their own views. In an attempt to address this I employed strategies that minimised my influence. Firstly, all volunteers prior to starting the interview were told that I wanted to understand their own views and perspectives, and not merely verify my own. I advised each that our conversation would contribute towards the knowledge base underpinning our profession. Secondly, I conducted the interviews, where possible, on my non-working days, deliberately dressing informally to further distance myself from how I appeared in my work role. Finally, all who were interviewed were advised of confidentiality from our discussions, to make them feel more at ease in revealing their opinions to me. My reflective diary revealed changes in my own understanding through conducting the research, when I discovered things I had not necessarily been expecting to see. This indicates that conducting research contributed to my own personal learning. In particular, I remember challenging my own, long held view, that the model was separate from documentation. Following my interview with Emily, I reflected upon her perspective, a different one to my own, which I would not necessarily have done before and, as a consequence, challenged my own beliefs.

9.2.2. Reflections on case study as a methodology

Case study methodology can be used to examine complex multifaceted systems in a real life situation. I believe a strength of using Yin's methodology, was that it provided structure for my research, to focus my examination upon interrelationships between three units and identify patterns across the dataset. I was able to identify how the CMOP influenced practice, to understand contextual factors, through scrutiny of the interrelationships between different sociocultural and political layers, rather than simply focusing upon processes for implementing the model in practice. Earlier research in the county had described action research to implement the CMOP (Boniface *et al.* 2008). This study has built upon that work, to explore how momentum was maintained in a continually changing health and social care system. Understanding contextual influences expands our knowledge for why things happen and this study, conducted using case study methodology, enhances understanding of those subtle, nuanced factors that influence use of a model in practice.

Research conducted in a natural setting with a subtly changing environment does create challenges and Yin's clear methodology created structure for the research process. The structured research protocol was particularly helpful when I returned after a period of absence and I was able to quickly refocus upon my study. Without a clear structure, with other demands upon my time, I believe that my focus may have been lost when collecting and analysing the data, as well as producing a clear, auditable report in the form of this thesis. Rich descriptions of the data help readers to understand my interpretations and explanations of how the CMOP was used in this setting. A process of reflexivity allowed the data to speak to readers, rather than simply my own voice being heard. I was able to challenge my own personal misconceptions through use of a rigorous, scientific process.

9.3. Limitations

The study took place in one county, with a small cohort of participants who volunteered to be interviewed. As I have previously acknowledged, I was easily identifiable in my work role as being an enthusiast of the model and this may have deterred some people from responding to my initial request to participate in an interview, which may not have been the same experience for an external researcher. The sample interviewed was a small section of occupational therapy practitioners and there is potential that views presented do not fully represent those of all practitioners. Future research in the county, conducted by a different researcher, may potentially draw out different responses. Whilst I have used reflexive techniques, the themes did not simply emerge from the dataset and I recognise that as a researcher my interpretation

of data was influenced by my own values and beliefs [Braun and Clarke 2006; 2013]. The study took place over a longer time period than initially anticipated and potentially my findings would be different if they had been conducted in a shorter timeframe, in particular, if it had been completed prior to organisational change in 2011.

It is important that I address criticisms made of case studies that you cannot generalise from one case study. Yet, arguably, I have made no claim for the generalisability of this case to other areas of practice. This study seeks to present an account of the influence of the CMOP upon occupational therapy practice in one county, explain my own interpretations and make a contribution to theory building and understanding (Salminen, Harra and Lautamo 2006). There is no suggestion that my case study is transferable to the practice of all occupational therapists, however, it increases understanding of context dependent factors that influence use of the CMOP in one area of practice (Yin, 2009). Further studies, will potentially either support or contest my findings and this study contributes one perspective to this under-researched area.

9.4. Further areas of research

My study examined the influence of the CMOP upon occupational therapists in this particular context and setting and I have presented my own observations and analysis. This study seeks to deepen and explain how the CMOP was used in practice and build upon earlier research in this county (Boniface *et al.* 2008). Further exploration of my finding in different contexts and settings will support development of understanding and theory building (Yin, 2009).

- Further research in this area is needed to build upon the ideas presented in this case and enrich understanding of socialisation to create a shared identity.
- It is proposed that further studies should be conducted with different groups of occupational therapists who work in a range of settings, who have adopted the CMOP, to continue theory building in this area.
- Other studies using the same methodology should be conducted with practitioners who do not ascribe to use any one model, to understand the social process of their practice and compare that to this study.
- Alternative methodologies, such as phenomenology, could be used to explore the views of participants who use the CMOP and examine their intervention with clients, to further develop understanding of the influence of the model upon practice.

9.5. Contribution to knowledge

This study revealed that in this county the CMOP was a component of a dynamic, complex social process and occupational therapy practice is a social act. Whilst the CMOP was integral to the creation of an occupational therapy culture, how the model was interpreted and occupational therapy role enacted, in different clinical situations and contexts, was influenced by many other factors. My contribution to new knowledge in this subject area is:

Leadership is fundamental for the creation of a shared culture, to maintain ongoing discourse and a shared understanding in an ever changing sociocultural world. Simply introducing a model does not change practice and there is an ongoing, enduring need for socialisation and engagement.

My study identified that introduction of the CMOP created a platform on which practice was discussed and reflected upon. Adoption of a single model required in-depth interpretation and understanding of the central tenets contained within the model, and local decisions were made to translate 'theory' into meaningful 'practice' for occupational therapists within the county. However, practice did not simply change when a decision was made to adopt the CMOP. Creation of a shared identity was led by the steering group, with academic support to introduce a collective thought for the occupational therapy role. The CMOP was used to create structure and provide concrete guidance for practitioners who worked across a range of settings. Practice is a dynamic, iterative process and there is a need for ongoing socialisation. As Thompson (2000) observed, simply putting components in place does not necessarily mean things work. There is a need for understanding of how these things, and here we mean the CMOP, will work in the context in which it is being used. The steering group represented all grades of occupational therapists and all parts of the county to avoid it being viewed as a 'top down' process. Yet, some decisions inevitably required leadership or management agreement for actions. This was particularly evident if activities had a financial implication or impacted upon how the role was externally presented to stakeholders. Therefore, effective leadership for using the model has multiple requirements, namely, being able to make decisions and changes, and to influence and enthuse colleagues.

To be an accepted part of practice the CMOP needs to be adapted and interpreted in response to demands made by practitioners. Adaptation of the model was through discourse with others to initially create, and then maintain, a shared understanding of its impact upon identity, culture and role. Importantly, it did not negate practitioners being able to exercise individual actions.

Dialogue, in particular with colleagues in clinical settings and within the steering group, were important for the creation of a shared understanding of identity. However, whilst interview participants described a shared understanding of concepts of the CMOP, they illustrated how they adapted and altered the model within their clinical area and, without exception, described changes they had made to it to suit their individual practice. Enactment of role was modified by each participant to suit their unique practice in their own specific clinical environment. Actions taken suggest practice was complex and unpredictable and that maintenance of a shared culture and identity required an ongoing need to agree principles of role interpretation. Yet, despite broad agreements for how the model was to be presented, individual practitioners made personal choices for how they presented the occupational therapy role to others. For the CMOP to be effectively used in this study, it needed to be adapted for the context it was used in. This finding was similarly described in other studies (Wimpenny *et al.* 2010, Melton, Freeth and Forsyth 2012). My study indicated that participants were not subjugated by the CMOP and felt confident to adapt the model to suit their own way of working, and participate in individualised social acts. Yet, equally, participants recognised that integral to their practice were components found in the CMOP, namely to be occupationally focused and client-centred. These elements were described as fundamental constituents of their occupational therapy identity and an integral part of their own practice. They were culturally accepted norms and simply '*who we are'* (Hatch and Cunliffe 2013 p. 315). Participants identified that they had a broader professional responsibility to consider all needs of their clients, not merely those presented on a referral and, for some; this was described as being more creative. In the literature, the CMOP has been used theoretically to examine the potential breadth of the occupational therapy role for specific clinical conditions (Grant and Lunden 1999, Imms, 2004, Woodland and Hobson 2003). This study indicates that the CMOP can be used in practice, to support practitioners to present a wider understanding of their role to others and this finding agrees with those presented in studies conducted by Warren (2002) and Clarke (2003).

Adoption of a single model was dictated by pragmatism and the necessity to develop artefacts to support use and shared understanding. The CMOP was an integral part of professional culture and identity which underpinned role presentation to external stakeholders in this county.

Development of artefacts was an important component for creation of a shared social world for all practitioners, not just those who were part of the steering group, to understand role requirements and create consistency of practice. These artefacts were not simply created and used, without alteration; they were reviewed and revised in response to changes in both the

socio- cultural world and practitioner understanding of the model. Agreement and consensus for use of the CMOP by all practitioners, across a range of settings, required engagement so principles of the model became mutually agreed and accepted. The artefacts were used to deliver messages from the steering group for how the occupational therapy role should be enacted by individual practitioners, to ensure that a client being seen in any clinical area in the county could expect to receive a similar level of service. Principally, the artefacts were viewed only by occupational therapy practitioners, with the exception being documentation, which carried the collective understanding of identity from within the cultural group and could be seen by external stakeholders. Documentation made theoretical concepts visible to both occupational therapy practitioners and external stakeholders and, at times, this created conflict. The study identified how failure to agree upon a shared understanding for the function of documentation between the steering group and some external stakeholders subsequently created a negative image of the CMOP by some. This example correlates with evidence found in the literature, that successful creation of a shared image with external stakeholders is crucial for professional identity (Hatch and Schultz 2002). In my study, there was a dynamic interplay between identity, both individual and professional, a shared culture and understanding of role which were, in turn, influenced by external stakeholders and the environment where practice was being enacted. The importance of maintaining a shared understanding and image was evident in this study, which identified consequences when there was dissent between stakeholders. Thompson (2000) similarly observed how past success is not an indication of future success, and that maintenance of relationships was crucial for ongoing success. In this study the CMOP needed to be modified, in order for it to effectively contribute towards successful relationships with a range of stakeholders, with an ongoing requirement to reaffirm shared understanding of identity, by all parties.

The CMOP was used to created consistency of practice between a range of practitioners who had different levels of experience.

The CMOP was used in a variety of ways by participants and depended upon the level of experience and individual requirements. For some, the CMOP was a concrete framework used to conduct and capture assessments and, for others, it was a virtual framework to support thinking. This study identified that the CMOP was adaptable and supported practitioners who had a broad range of experiences, and encouraged consistency in how the role was presented to external stakeholders. Interview participants described how they did not use the CMOP in a routine, formulaic way and individually they made choices for how they enacted the occupational therapy role. The CMOP was an integral part of professional culture and identity,

which underpinned role presentation to external stakeholders. The study identified that use of the CMOP encouraged practitioners to reflect upon and develop practice in the county.

This study identified that use of a single model, the CMOP, actively encouraged practice development in this county and was a dynamic and multifaceted social process.

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February 29 2016

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Figure 1: (CMOP) Canadian Model of Occupational Performance. Enabling Occupation: An Occupational Perspective, CAOT 1997a; 2002 p.32

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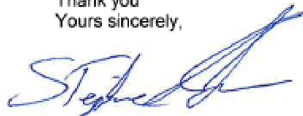
Thank you
Yours sincerely,



Stéphane Rochon
CAOT Publications Administrator

100-34 Colonnade Road, Ottawa, ON K2E 7J6 Canada
Tel: (613) 523-2268 • 1(800) 434-2268 • Fax: (613) 523-2552 • www.caot.ca

Appendix 2 Literature review search terms

Databases searched: 1980-2015

Search	Search topics
1	Occupation* Therap*
2	Occupation* Therap* AND conceptual models of practice
3	Occupation* Therap* AND conceptual models of practice AND CMOP
4	Occupation* Therap* AND CMOP
5	Occupation* Therap* AND Canadian Model of Occupational Performance
6	Occupation* Therap* AND CMOP NOT COPM
7	Occupation* Therap* AND CMOP NOT Canadian Occupational Performance Measure
8	Occupation* Therap* AND Canadian Model of Occupational Performance NOT COPM
9	Occupation* Therap* AND Canadian Model of Occupational Performance NOT Canadian Occupational Performance measure
10	Theory and practice gap
11	Occupation* Therap* AND theory
12	Occupation* Therap* AND theory AND practice
13	Occupation* Therap* AND theory practice gap
14	Occupational Performance
15	Occupational performance AND models
16	Occupational performance AND CMOP
17	Occupational Performance AND Canadian Model of Occupational Performance
18	Occupation* Therap* AND occupational performance
19	Organisation* influences AND Occupation* Therap*
20	Influences on Occupation* Therap* Practice
21	Occupation* Therap* AND CMOP-E
22	Occupation* Therap* AND Canadian Model of Occupational Performance and engagement

Search	Search topics
23	Occupational performance AND CMOP-E
24	Occupational Performance AND Canadian Model of Occupational Performance and engagement

Appendix 3 Critical appraisal tool

	Date of Review
Citation details:	**Authors:** **Year:** **Title:** **Publication:**
Purpose:	*Was the purpose of the paper clear?* *Was the research question clearly stated?*
Literature:	*Describe the justification of need for the study. Was it clear and compelling?*
Study design -	*What was the study design?* • *Phenomenology* □ • *Ethnography* □ • *Grounded research* □ • *Participatory action research* □ • *Other* □
Was a theoretical perspective identified?	*Describe the theoretical or philosophical perspective for this study e.g. researcher's perspective*
Methods used:	• *Participant observation* □ • *Interviews* □ • *Document reviews* □ • *Focus group* □ • *Other* □ *Was the methodology appropriate for this study?*
Sampling? **Was the process of purposeful sampling described?**	*Was the process of sampling described and appropriate?*

Was sampling done until redundancy in the data was reached?	*Are participants described in adequate detail? How is the sample applicable to your practice or research question? Is it worth continuing?*
Was consent obtained?	• *Yes* □ • *No* □ • *Not addressed* □
Data Collection: **What was the relationship between the researcher and participants?** **Identification of assumptions and biases of the researcher**	*Was there a clear description of* • *Site* □ • *Participants* □ *A description of how the data collected?* *Describe the context of the study. Was it sufficient for understanding of the whole picture?* *What was missing and how does it influence your understanding of the research?*
Procedural Rigour	• *Yes* □ • *No* □ • *Not addressed* □ *Did the researcher provide adequate information about the data collection process; access to the site; field note; training data gatherers*
Data Analyses *Analytical rigour* **Data analyses were inductive?** **Findings were consistent and reflective of the data?**	• *Yes* □ • *No* □ • *Not addressed* □ • *Yes* □ • *No* □

	What were the key findings?
Auditability **Is there a decision trail?** **Process of analysing the data was adequately described**	 • *Yes* □ • *No* □ • *Not addressed* □ • *Yes* □ • *No* □ • *Not addressed* □
Theoretical connections: **Did a meaningful picture emerge of the phenomenon under study emerge?**	*How were the concepts under study clarified and refined and relationships made clear? Describe any conceptual frameworks that emerge* • *Yes* □ • *No* □
Rigour:	*Are the results trustworthy?* ***Credibility*** *(time of data collection; variety of methods for collection; reflective approach; triangulation; member checking)* ***Transferability*** *(whether the findings can be transferred to other situations)* ***Dependability*** *(consistency between the data and findings)* ***Confirmability*** *(reflective, peer review, data checking with colleagues or participants)* *What are the strengths and weaknesses?* Acknowledgement of its weaknesses small sample size and client group. *What meaning and relevance does this study have for your practice or research question?*
Conclusions and Implications:	*Were the conclusions appropriate to the study?* *Do the findings contribute to the development of future OT practice?*

	What are the practice implications?
Additional comments:	*Is there a comprehensive range of references?* *Are there any other noteworthy features?*

Adapted from:

Letts L; Wilkins S; Law M; Stewart D; Bosch J and Westmorland M (2007) Guidelines for Critical Review Form: Qualitative Studies (Version 2), McMaster University downloaded 9/11/15: www.srs-mcmaster.ca/wp-content/uploads/2015/04/Critical-Review-Form

Appendix 4 Interview structure

(6) How does the CMOP help Occupational Therapists address the Occupational Performance needs of clients?

(7) How does the organisation influence the Occupational Therapists use of the CMOP?

(8) How does the CMOP contribute to the understanding of Occupational Therapy practice?

Pre-Interview Checklist

- Welcome the informants and thank them for their time.
- Complete consent form and patient information leaflet.
- Remind them of their right to withdraw from the study at any time.

Interview Questions

No.	Question	*Topic*	
1	What made you want to be an Occupational Therapist?	*Introduction Question*	*S*
2	How long have you been working as an Occupational Therapist?	*Introduction Question*	*S*
3	Why do you think models of practice are used?	*Views on models of practice*	*S*
4	Can you tell me your thoughts on whether a model of practice is part of or separate day-to-day OT practice?	*Views on models of practice*	*S*
5	[if you use it] Can you tell me how do you use the CMOP in your own day-to-day practice?	*Influence on own practice*	*S*
6	Have you observed any changes in your own clinical practice [if you use it] since introduction of the CMOP?	*Influence on own practice*	*S*
7	[if you use it] Do you feel the CMOP supports you with your decision making and if so how?	*Influence on own practice (clinical reasoning)*	*S*
8	Can you tell me whether using the CMOP encourages you to use different language or words to describe what you do?	*Influence on own practice (language)*	*JA*
9	Do you see a connection between the CMOP and occupational performance?	*Understanding the model*	*JA*

10	Have the various organisational changes over the years affected how you personally use the CMOP?	*Organisational Influences*	*JA*
11	Do you have any particular challenges with using the CMOP in your own setting?	*Organisational Influences*	*JA*
12	Has using the CMOP has been challenged by others?	*Organisational Influences*	*JA*
13	Do you think the CMOP has been locally interpreted in Gloucestershire?	*Development of practice*	*JA*
14	Are you able to develop the use of the CMOP in your setting and if so how have you done this?	*Development of practice*	*JA*
15	Do you think other OT's share your views about using the CMOP?	*Finishing question*	
16	Is there anything else you would like to say or comment upon?	*Finishing question*	

Appendix 5 Document summary form

Location:

Document number:

Date reviewed:

Name and date on document:

Item	Data extract	Coded Summary	Where did the data come from?
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Item	Data extract	Coded Summary	Where did the data come from?
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Comments	

Themes	

Appendix 6 Example of steering group data – minutes from September 2009

XXX SERVICES

OCCUPATIONAL THERAPY SERVICE

Minutes of CMOP Meeting held on

Thursday 24th September 2009

Present: HA, MA, LA, NA, WA, CA, GA, AA

THESE MINUTES MAY BE MADE AVAILABLE TO PUBLIC AND PERSONS OUTSIDE OF THE GLOUCESTERSHIRE NHS COMMUNITY AS PART OF THE COMMUNITY'S COMPLIANCE WITH THE FREEDOM OF INFORMATION ACT

Item	Minute	Action
1.	**Apologies:** SA, TA, EA, HB	
2.	• Introductions to new people joining the steering group – AA and LA (replacing NA) • Discussed representation on CMOP steering group…..Need to ensure there is representation from all parts of the county • HA ensuring updated distribution list for CMOP minutes etc.	**HA**
2.1	**MA / GA Feedback on Kielhofner – client centred practice session.** Possibilities for advancing practice. No depth, Did not really address title.	

	Around communication. Case studies – impairment related case studies. 'Reductionist', Not enough emphasis on 'client-centred' practice. * GA – Find out more about 2 days 'Kielhoffner' course and feed back to steering group.	**GA**
2.2	**<u>Manuals and Marketing</u>** GA and HA had an e-mail from commercial division at X – they have sorted signed legal contract between …..Commercial division not taking responsibility for creation so Cardiff agreed to support funding for creation of manual, DVD, training package and manage finances. Considering launching at COT conference – links to abstract. Need to decide costing of manual, DVD and training package. Need to decide how much it will cost to cover cost/produce. Manual any changes to appendices give to HA by 12th October. Then going to GA for 19th October. GA to bring to 22nd CMOP meeting. Consider article in a couple of years' time to evaluate where we are. Will fit in well with the launch of DVD, manual and training package.	**Steering group**
2.3	**<u>Away Day</u>** Discussion about second away day. HA sending out delegation training for package to leads with clear instructions about support workers dissemination. Don't want to lose feedback from themes – send something out about what we have learnt as a steering group, which will inform the information collected from the two days and look at the way forwards.	**HA**

	Focus at CMOP meeting on 22nd on feedback from 2 x CMOP days. Send e-mail to leads to inform that feedback will be sent after next CMOP meeting. Discussion about links with Txxxx Trust re: debate around what we get out of having a model embedded/managing staff feelings about having a model.	**Steering group** **HA**
2.4	**Band 3 Working Across the County** Review COT support workers framework and define locally at November meeting. GA to look at Band 3 and Home Assessments as discrepancy across the county. GA to pull together some themes and recommendations to come back to CMOP group.	 **Steering group** **GA**
2.5	**Documentation** Looking at generic paperwork need to consider what do people need to know. CA, GA and JA and SA to discuss feedback at next meeting.	 **GA/CA**
2.6	**Writing Up and Publishing** Abstracts in for book. GA brought feedback for writers. Deadline for first draft of chapter is March.	 **GA, SA, MA, TA, GT, CP, JW, HH**
2.7	**Abstracts for Conference** Three abstracts: 1) A model: simplistic tool or a means for developing a complex intervention. 2) Using a Model – how do we do it ourselves?	 **GA, SA, MA, TA, GA, CA,**

	3) Can referrals for Occupational Therapy ever be assigned to a support worker? Ask to be round tables or workshops. Well done HA and TA, pulling together article abstracts for COT!	**JA, HA, AA, WA**
2.7	**<u>COPM</u>** COPM Meeting – Monday 28th September 2009.	
3. 3.1	**<u>Any Other Business</u>** WH keen to write a piece for OT News……. All the best NA.	 **WA?GA**
4.	**<u>Date and Venue of Next Meeting</u>** 22nd October 2009, 10.00am…. JA to share xxxxxx at the next meeting.	

Appendix 7 Artefact summary form

Location:

Artefact name:

When was it created:

Date reviewed:

Mason 2006: **Literal** *'where is this located? What does it look like?; what are the characteristics of the 'client population'?*	**Reflexive** *'what impact am I having on the process?; any tensions or pleasures in role?*	**Interpreted** *'inferences evaluations beyond just describing?'*

	Observed symbol /Message/ Salient point *Main things that struck me from the data* *What I got/ failed to get* *Anything else which was interesting*	**Expected/ potential learning from the message** *Symbol/point or meaning being made*	**Location of data extract**
1	i.e. learning/ teaching about the model	Shared understanding	
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Appendix 8 Invitation email

IRAS Submission 68113/211752/1/735 Invitation letter (IL[1] Version (3) 16th September 2013

Dear Colleague

Thank you for taking time to read this invitation email.

My name is Heather Hurst I work part time as a Professional Team Lead for Occupational Therapists in the Forest of Dean and Tewkesbury Localities and Chair the CMOP steering group. Currently I am undertaking a Professional Doctorate in Health and Social Care (DHSC) at UWE. Part of my doctorate involves conducting a research study. The study title is:

Understanding the influence of the CMOP upon occupational therapy practice. A case study enquiry

The case study seeks to explore the clinical practice of Occupational Therapists (OTs) who are using, the Canadian Model of Occupation (CMOP) (Townsend *et al.* 1997, 2002). The focus of the study will be upon understanding the relationship between using a theoretical client centred model and clinical practice from a number of interrelated perspectives using a variety of data gathering methods. An important part of the study is to interview Occupational Therapists who use the CMOP as part of their work within the organisation. Gloucestershire Care Services NHS Trust has agreed to host the study and it has been reviewed and given a favourable opinion by the NRES Committee South West – Frenchay.

Due to practicalities and focus of the study I need to restrict the participants eligible for interview. Therefore, support workers, bank or agency Occupational Therapists, staff on fixed term contracts or not permanent employees of the organisation, newly qualified Occupational Therapists who have less than three months experience of using the CMOP within the organisation will be excluded from the study.

I am hoping to interest a number of Occupational Therapists from a variety of grades and various clinical backgrounds in the research. Due to practicalities I will only be able to conduct 12 interviews for the study. Therefore it may be necessary for me to select a small number of participants who reflect a range of clinical backgrounds and grades of staff.

However, if you are an Occupational Therapist who uses the CMOP as part of your work and may be willing to participate in an interview with me I am seeking expressions of interest. I hope it will provide an enjoyable opportunity to discuss issues relevant to our professional practice.

If you are interested in finding out more and participating in the study please can you complete the attached form and email it to me at the following address Heather.hurst@uwe.ac.uk by **15th September 2014.**

Thank you for taking the time to read this email.

Many thanks

Heather Hurst

Appendix 9 Participant information sheet

IRAS Submission 68113/211752/1/735 Patient information sheet (PIS) Version **(5) 16th September 2013**

Title of Project:

Understanding the influence of the CMOP upon occupational therapy practice. A case study enquiry

Researcher: Heather Hurst (Chief Investigator)

Thank you for responding to my invitation email and indicating you are interested in participating in this study.

1.1 Invitation

Before you decide to take part in this study you need to understand why the research is being done and what it would involve for you. I am seeking to conduct an interview lasting approximately one hour with a small number of Occupational Therapists who use the Canadian Model of Occupational Performance (CMOP) as part of their work. Please take time to read the following information carefully. Talk to others about the study if you wish.

1.2 What is the purpose of the study?

In 2003 Occupational Therapists (OTs) in Gloucestershire adopted the CMOP to underpin practice. This study seeks to explore the influence of using the CMOP upon OT practice through examining it from a number of perspectives and understanding their inter relationships. This will include examining tools developed looking at notes and documentation and interviewing individual OT's.

1.3 Why have I been invited?

You are invited to participate in the study because you meet inclusion criteria which is registered OTs who use the CMOP as part of their work. I am interested in your views to understand how the CMOP influences your practice.

1.4 Do I have to take part?

Taking part in the interview is entirely voluntary and it is up to you to decide. I will describe the study and go through this information sheet with you. If, after having all your questions answered you decide to participate, I will ask you to sign a consent form to show you have agreed to take part. If you decide not to take part you do not need to give a reason. You are free to withdraw from the study at any time without giving a reason and I will at that stage, ask you if the anonymised data can be used.

1.5 What will happen to me if I decide to take part?

If you agree to take part I will contact you to arrange a date and time at your convenience. The interview will take place at a mutually convenient time and location. The interview will take about an hour and will be like having a conversation about your experiences with me. It will be helpful to tape record the conversation so that I can listen several times to what was said.

1.6 What about travel expenses?

Any claims need to claimed back through normal travel expense claims

1.7 What are the possible disadvantages and risks of taking part?

The research content means the risks of taking part are relatively low. However, I do need to highlight to you that if I am told something which may involve risk for others, which I cannot keep confidential or it compromises our code of ethics or standards of proficiency I may need to share this information outside of the interview.

Additionally, your participation in an interview will mean time away from clinical work which may be inconvenient.

1.8 What are the possible benefits of taking part?

I hope our discussion will be an enjoyable opportunity for us to consider issues relevant to our practice.

1.9 Will my taking part in the study be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence.

Only the person typing up the conversation will listen to the tape recordings. The person transcribing the transcripts will sign a confidentiality agreement. You will be allocated a number in the study which will be used instead of your name. The tape recordings will be kept safely in a locked cabinet in the researcher's office and destroyed after 6 years in accordance with UWE guidelines.

1.10 What will happen if I don't want to carry on with the study?

If you decide to withdraw from the study you will be free to do so at any time. If you have already had the interview, I will ask if I can keep and use what you have said. The interview will then be destroyed with all the other information we collect after 5 years.

1.11 What if there is a problem?

If you have a concern about any aspect of this study you should contact Dr Theresa Mitchell who is my academic supervisor and Director of Studies. Dr Mitchell's contact details are on the last page of this information sheet.

1.12 What will happen to the results of the research study?

I hope the results of this study will be of interest to OTs and other healthcare professional in this country and overseas. I intend to share the results at conferences and in published work nationally and internationally. You will not be identified from anything you tell me.

I have a duty of confidentiality to you as a participant and will do my best to meet this duty.

1.13 Who is organising and funding the research?

The research is part of a doctorate registered at The University of the West of England. I also work part time as an Occupational Therapist for NHS Gloucestershire Care Services.

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee. Their role is to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given a favourable opinion by the NRES Committee South West – Frenchay.

Again thank you for taking the time to read this study. If you have any enquiries about this study please contact me.

Heather Hurst
Dean House
Cinderford
Glos GL14 2JF
Tel: 01594 820564
Email heather.hurst@uwe.ac.uk

Thank you for taking the time to read this information sheet.

If you wish to complain about the conduct of this research please contact in the first instance;

Dr Theresa Mitchell, Director of Studies
Theresa.Mitchell@uwe.ac.uk
(793) 7271

Appendix 10 Consent form

IRAS Submission 68113/211752/1/735 Consent Form (CF)[1] Version (4) 16th September 2013

Title of Project; ***Understanding the influence of the CMOP upon occupational therapy practice. A case study enquiry***

Researcher; Heather Hurst (Chief Investigator)

		Please initial box
1.	I confirm that I have read and understand the Participant Information Sheet Version 5 dated 16th September 2013 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason.	
3.	I understand and agree that the interview will be audiotape recorded	
4.	I understand I will be given a pseudonym to protect my identity and the data will only identify my clinical area and not be a named workplace.	
5.	I understand that the results of the research will be shared with healthcare professionals and published, but that my identity will be protected.	
6.	I agree to take part in the study.	

____________________	____________________	____________________
Participants Name	Date	Signature
____________________	____________________	____________________
Researchers Name	Date	Signature

(**please print**) When completed, 1 copy for participant; 1 copy for Researcher

Appendix 11 NRES Ethics approval

See over.

National Research Ethics Service
NRES Committee South West - Frenchay
South West Research Ethics Centre
Level 3, Block B
Whitefriars
Lewins Mead,
Bristol
BS1 2NT

Telephone: 0117 342 1334/ 0117 342 1382
Facsimile: 0117 342 0445

04 July 2011

Mrs Heather Hurst
Head Occupational Therapist
NHS Gloucestershire Care Services
Occupational Therapy Department
Dilke Hospital
Cinderford
GL14 3HY

Dear Mrs Hurst

Study title:	**Understanding the influence of a client centred model upon occupational therapy practice. A case study enquiry**
REC reference:	**11/SW/0119**

Thank you for your letter of 30 June 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

- Please amend the Committee name on the invitation e-mail and PIS to read 'NRES Committee South West – Frenchay', not 'National Research Ethics Service Committee (NREC) South West – Frenchay'.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering Letter		30 June 2011
Evidence of insurance or indemnity		16 July 2010
Investigator CV		19 April 2011
Letter from Sponsor		06 May 2011
Letter of invitation to participant	2	29 June 2011
Other: Reply form	1	01 May 2011
Participant Consent Form	3	29 June 2011
Participant Information Sheet	4	29 June 2011
Protocol	7	01 May 2010
REC application		12 May 2011
Response to Request for Further Information		30 June 2011

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

Notifying substantial amendments
Adding new sites and investigators
Progress and safety reports
Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

11/SW/0119	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Dr Mike Shere
Chair

Email: ubh-tr.SouthWest5@nhs.net

Enclosures: "After ethical review – guidance for researchers" – sent via e-mail

Copy to: *Ms Leigh Taylor*
Mr Mark Walker, Gloucester Hospital NHS Foundation Trust

Appendix 12 University ethics approval document

See over.

UWE BRISTOL University of the West of England

Faculty of Health & Life Sciences
Glenside Campus
Blackberry Hill
Stapleton
Bristol BS16 1DD
Tel: 0117 328 1170

Our ref: SE/lt

22 July 2011

Mrs Heather Hurst
Head Occupational Therapist
NHS Gloucestershire Care Services
Occupational Therapy Department
Dilke Hospital
Cinderford
GL14 3HY

Dear Heather

Application number: HSC/11/06/69
Application title: Understanding the influence of a client centred model upon occupational therapy practice. A case study enquiry
REC No: 11/SW/0119

Your NHS Ethics application and approval conditions have been considered by the School Research Ethics Sub-Committee on behalf of the University. It has been given ethical approval to proceed with the following conditions:

- You comply with the conditions of the NHS Ethics approval.
- You notify the Faculty Research Ethics Sub-Committee of any further correspondence with the NHS Ethics Committee.
- You notify the Faculty Research Ethics Sub-Committee in advance if you wish to make any significant amendments to the original application.
- Please note that all information sheets and consent forms should be on UWE headed paper.
- If you have to terminate your research earlier than planned, please inform the Faculty Research Ethics Sub-Committee within 14 days, indicating the reasons.
- Please notify the Faculty Research Ethics Sub-Committee if there are any serious events or developments in the research that have an ethical dimension.
- Please be advised that as principal investigator you are responsible for the secure storage and destruction of data at the end of the specified period a

Please note that your study should not commence at any NHS site until you have obtained final management approval from the R&D department for the relevant NHS care organisation. A copy of the approval letter(s) must be forwarded to Leigh Taylor in line with Research Governance requirements.

We wish you well with your research.

Yours sincerely

Simon Evans
Chair
Faculty Research Ethics Sub-Committee

c.c. Theresa Mitchell

Appendix 13 NHS Gloucestershire (PCT) approval

See over.

Gloucestershire

% Gloucestershire Research Support Service
Leadon House
Gloucestershire Royal Hospital
Great Western Road
Gloucester
GL1 3NN
Telephone: 0300 4225463
Facsimile: 0300 4225469
Email: Mark.Walker@glos.nhs.uk

Our Ref: 13/004/PCT

Friday, 15 February 2013

Mrs Heather Hurst
Training & Development Co-ordinator for Occupational Therapists
Dilke Memorial Hospital
Speech House Road
Cinderford
GL14 3HX

Dear Mrs. Hurst,

Study Title: **Understanding the influence of a client centered model upon occupational therapy practice. A case study enquiry**

REC Ref: **11/SW/0119**
R&D Ref: **13/004/PCT**

Thank you for forwarding information on the above study. I can confirm the approval of NHS Gloucestershire (PCT) for this study to proceed. Your project will now be added to the Gloucestershire Health Community Research Register which will identify the following:

- Title : **As above**
- CI: **As above**
- Sponsoring Organisation: **University of West of England**
- Host Organisation: **NHS Gloucestershire (PCT)**

It is important that all research conducted with NHS patients and/or staff complies with the Research Governance Framework. In relation to this I would like to take the opportunity to remind you of some of your responsibilities under this framework.

1. **Health and safety:** You are reminded of your responsibilities for health and safety at work under the Health and Safety at Work Act 1974. You have a legal responsibility to take care of your own and other people's Health and Safety at work under the Health and Safety at Work ACT 1974 as amended and associated legislation. These include the duty to take reasonable care to avoid injury to yourself and to others by your work activities or omissions, and to co-operate with your employer in the discharge of its statutory duties. You must adhere strictly to the policies and procedures on health and safety.

2. **Codes of confidentiality/Data Protection:** Anybody who records patient information (whether on paper or by electronic means) has a responsibility to take care to ensure that the data recorded is accurate, timely and as complete as possible. It is vital that you conduct your research in accordance with the principles of the Data Protection Act 1998 and codes of confidentiality.

3. **Liability and Indemnity:** Indemnity for your study will be as described in any applicable Clinical Trial Agreement or other Research Contract.
   Where such an agreement is not available, the Trust will indemnify its employees and researchers holding NHS Honorary Contracts for the purposes of Negligent Harm.

NHS Trusts cannot provide cover for No Fault or Non-Negligent claims. Where this is required, it is expected that the Research Sponsor will provide such indemnity.

4. **Intellectual Property:** Intellectual Property is defined as the tangible output of any intellectual activity that is new or previously undescribed. It can include the following:

    i. Inventions, such as new medical devices, software;
    ii. Literary works, such as software, patient leaflets, journal articles;
    iii. Designs and drawings, such as posters, leaflets;
    iv. Brand names, such as logos and trademarks; and
    v. Trade secrets, such as surgical techniques.

    For projects originating from outside of the NHS Trust with which this agreement is made, Intellectual Property rights will remain with the Lead Site/Investigator unless developed from observations made outside of the scope and influence of the project. The rights to Intellectual Property generated in such a fashion will remain with the Host Trust unless an agreement to the contrary has been signed by both parties. Where a Clinical Trial Agreement or other Contract exists, this will take priority over this clause.

5. **Adverse Events/Incidents:** Any adverse events you witness or suspect to have happened *must* be reported to your supervisor or manager as soon as you know about them and dealt with as described in the research protocol.

6. **Fraud and Misconduct:** Any suspicions of active fraud or misconduct *must* be reported to your supervisor or manager immediately and will be treated in the strictest confidence. The monitoring of research will also seek to reduce incidents of research misconduct and fraud.

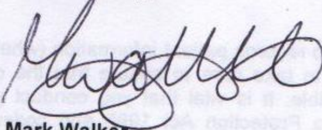
7. **Monitoring:** As part of the Research Governance Framework, during the course of your research you may be monitored to ensure that procedures in the protocol approved by the ethics committee are being adhered to. For locally sponsored studies this will be undertaken by the R&D Office. For externally sponsored studies this is likely to be arranged by the appropriate sponsor.

8. **Dissemination:** The Framework also requires the dissemination of research findings to the research subjects, NHS staff and the public. On completion of your research you will be expected to produce a summary of the project and an indication of how the results from the study will be disseminated. For studies where publication of research results is not the responsibility of the local Investigator, requests for such information will be made to the sponsor.

9. **Termination of Agreement:** The Trust also reserve the right to terminate the agreement for your research to proceed if, at any time, you are found to be in breach of the clauses in this Approval Letter or fail to adequately meet the requirements of the Research Governance Framework.

I wish you every success with your project.

Yours sincerely,

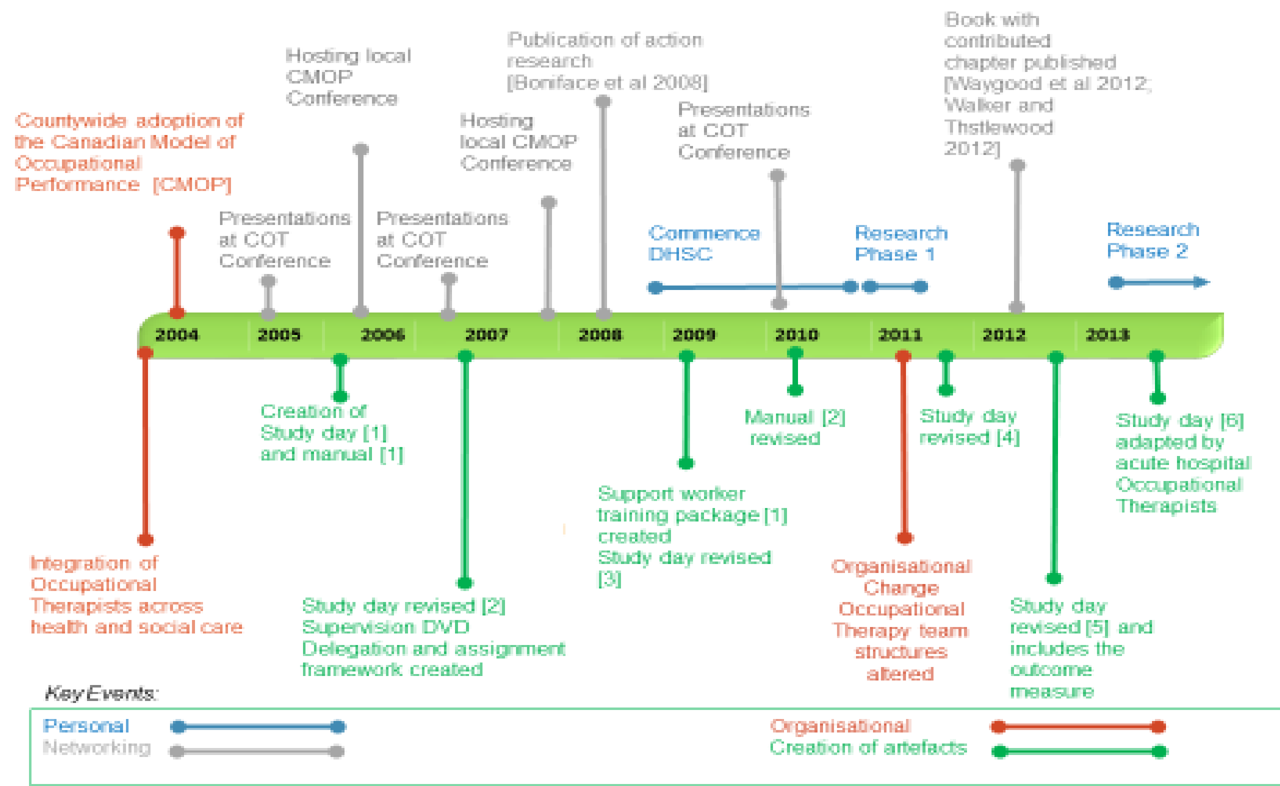


Mark Walker
Senior R&D Manager
(Gloucestershire R&D Consortium)

Cc: Dr. Theresa Mitchell-Academic Supervisor –UWE.
Dr. Ruth Wain- Head of Nursing, Gloucestershire Care Services.
Ms. Liz Fenton-Deputy Head of Public Health, Gloucestershire.

Appendix 14 Timeline

See next page.


Countywide adoption of the Canadian Model of Occupational Performance [CMOP]
Presentations at COT Conference
Hosting local CMOP Conference
Presentations at COT Conference
Hosting local CMOP Conference
Publication of action research [Boniface et al 2008]
Presentations at COT Conference
Commence DHSC
Research Phase 1
Book with contributed chapter published [Waygood et al 2012; Walker and Thstlewood 2012]
Research Phase 2
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
Integration of Occupational Therapists across health and social care
Creation of Study day [1] and manual [1]
Study day revised [2]
Supervision DVD
Delegation and assignment framework created
Support worker training package [1] created
Study day revised [3]
Manual [2] revised
Organisational Change Occupational Therapy team structures altered
Study day revised [4]
Study day revised [5] and includes the outcome measure
Study day [6] adapted by acute hospital Occupational Therapists
Key Events:
Personal
Networking
Organisational
Creation of artefacts

Appendix 15 Artefacts description of changes and personal reflections

10.1. Study days

10.1.1. Introduction:

The first training package was created by a steering group member with colleagues in the acute hospital. When it became apparent that engagement and understanding of the CMOP was greater in this clinical area a decision was made, that the study day should be made available for all practitioners and in 2005 and 2006 attendance was mandatory. Between 2006- 2012 six editions of the study day were developed. As a member of the steering group I was involved with both the development and delivery of these study days. Delivered bimonthly from 2006-2011, mandatory for new starters, existing staff were given the option to attend as a 'refresher' session. Since 2011 the study days have not, as far as I can ascertain, been delivered to new starters in community hospitals or ICTs. The acute hospital have continued to run study days and conducted the most recent changes to the package in 2013.

After several sessions were run in 2006, the steering group recognised the need for consistent facilitators to deliver the study days. The rationale was that some steering group members lacked confidence when asked to train colleagues who may be a more senior grade. As chair of the steering group and a more experienced trainer, I was nominated to run the sessions. Initially this was with different group members, but by 2009 the study days were delivered by me and one other steering group member.

> Reflective comments: I recalled how I did not initially feel confident delivering the training package. I felt apprehensive particularly if I was being asked specific questions about the model. Would I give the 'right' answer? Despite anxieties about my own teaching abilities I was motivated to present this work of the steering group and in the early years, used extensive notes to help me. My own confidence grew over time and I particularly liked being involved in revising the content in response to feedback from participants. I noticed I became more confident when responding to participant queries and do recall some very challenging conversations. In particular, I remember one participant telling me she didn't like the model and I wasn't going to 'make' her use it. She participated in

> the study day, and my fellow facilitator and I answered her queries and discussed her challenges as we exchanged views. At the end of the day she explained that she had a better understanding for why it was being used and that she would be more willing to use it in future. This emphasised to me the importance of dialogue if we wanted people to actively engage with something they did not necessarily value or had some misunderstandings about.

During each study day facilitators gave details about the CMOP and defined how it could be used to support practitioners and for consistency of practice. The facilitators sought an agreed understanding of the model with participants, through explanation, practical exercises and discussion.

Whilst the study days varied in name, the format remained constant through each edition. All included:

- An introduction.
- *Background information* – included why a model was chosen, its influence, this became briefer with each revision.
- *Explaining the CMOP* - in the 2006 version the CMOP was described in full, whereas from 2007 all participants were asked to do pre-reading of the manual and prompt sheets before attending the study day. These included explanation of terminology of the CMOP.
- *Client-Centred Practice* - from 2007 this section combined previous separate sections, which were 'choice, risk and responsibility' and 'enabling'.
- *Occupation*– from 2009 the focus went from occupation to occupational performance.
- *Case Studies* (applying the theory to practice) this section was altered each time the study day was revised.
- *Finishing comments* –ongoing work was reported with emphasis upon how to take the work forwards into each practitioners own place of work, through supervision, journal clubs, reflective exercises.

A summary of significant changes for each year now follows. It was noted that the biggest change was with practical case studies section. For each year the changes to the case study are identified.

10.1.2. **2006 changes**

2006: The format strictly adhered to the CMOP as it was described in the '*Enabling occupation*' book (1997, 2002). Extensive facilitator notes were developed which described exactly how the package was to be delivered.

Case Study: uses Mrs A. Group work to consider the client using the OPPM [SD: 2006 PPT 7: 2-4] followed by facilitated discussion.

> Reflective comment: I remember how I struggled with understanding the OPPM. Whilst this was not the CMOP itself it was the process model included in '*Enabling Occupation*' (1997, 2002) to support implementation. Participants, myself included, did not find it helpful to use the OPPM to apply the CMOP to our own cases. As a facilitator I found this a challenging section to run and was relieved when the collective steering group made a decision to change the case study in the 2007 package.

10.1.3. **2007 changes**

2007: Changes to the study days were made in response to feedback from participants and the package was adapted to encourage more dialogue between facilitators and participants, rather than attendees being taught the CMOP. The facilitators told participants how the CMOP underpinned all parts of occupational therapy service delivery [TP2007: PPT2: 2, 4, 6-11]. In particular they spoke about; recruitment, appraisal and supervision (TP2007: PPT2: 4, 7, 8]; DVD [TP2007: PPT2- 7]; documentation [TP2007: PPT2-7 and TPPPT6- 3].

The CMOP is no longer described in detail and participants are advised to do some pre-reading of their manuals [TP2007: H1]. The '*what is the CMOP*?' chapter contained a quiz [TP2007: H6] and included facilitated discussions on specific queries or issues raised by participants. Some suggested questions were provided in the facilitator's notes if questions were not forthcoming:

'do people understand the terminology?'

'how do you explain the model to a colleague or service user?' [2007: PPT3:2]

Case Study: Three examples are provided, one from social care, one from hospital and one from paediatrics. Facilitators ask participants to think about how they should complete the documentation in an occupationally focused way [2007: PPT6: 3-7].

> Reflective comment: I recall that participants struggled with the case study exercise who suggested that too much background detail was missing from the outlines to do the activity effectively. When asked to fill in the gaps from personal experiences there was then much discussion about what these details could be which took the emphasis away from the purpose of the exercise.

10.1.4. **2009 changes**

2009: The background chapter explaining why the CMOP was chosen was delivered in less detail [2009: PPT 1-16].

> Reflective comments: The background section was created primarily for new starters to understand why the CMOP was adopted. This revision was made in response to feedback from existing staff who attended and said that this information in this section was included in the manual and asked for it to be shorter.

For the first time wider professional expectations from the HCPC were included, with advice that the CMOP could support practitioners fulfil requirements to use theory in practice [2009:PPT2:6].

Case Study Practitioners were told to use the exercise as an opportunity to reflect upon their own personal practice, to be occupationally focused, rather than on what they needed to include on documentation [PP6:3-4]. There was an emphasis was upon role differences between Occupational Therapists and support workers [2009: PPT2-14; PPT6: 1-11].

> Reflective comment: At this time other pieces of work had been created and shared by the steering group namely, the delegation and assignment document and support worker training package, which clarify the support workers and Occupational Therapist roles. The study day was changed to reflect these definitions of role.

10.1.5. **2011 changes**

2011: The package was copyrighted. This was a response to requests from outside of the county to buy artefacts created by the steering group.

> Reflective comment: I recalled a discussion to change the name of the study day from 'CMOP training' to 'CMOP education'. This name change was a conscious decision based upon a belief by members of the steering group that training suggested learning a

specific skill whereas, education was a broader concept and that being educated equipped one with skills to question and reflect.

The study day made overt reference to three points; firstly, expectations from professional bodies for practitioners to be reflective lifelong learners [TP2011: PPT2:7; PPT4:9]; secondly, client-centred practice was a partnership between practitioners, the client and employing organisation; thirdly, the importance for practitioners to identify the unique occupational therapy role [TP2011: 3-5]. There was particular emphasis in the day that stakeholders may have difficulty understanding the occupational therapy role if the breadth of it was not explained and the CMOP could support [TP2011: PPT4:12]. The study day emphasised how the CMOP could help individual practitioners to fulfil professional and organisational roles [TP2011: PP2: 9-12]. The study day explored the idea that theory and use of the model was a dynamic process which was integral to practice.

Occupational performance was the focus of the 'occupation' and 'case study' sections [TP2011: PPT6: 6- 8; 2011: PPT7: 3-10]. The 'occupational performance' definition given is that found in the manual [TP2011: PPT: 6- 6].

Case Study: whilst focused upon occupational performance the emphasis has moved away from completing documentation toward understanding of the concept of occupation. A single paper case is used and for the first time a segment from the supervision DVD is presented '*teasing out occupational performance issues'* [TP2011: PPT7: 11].

10.1.6. **2012 changes**

2012: Pre-reading now included both national and organisational expectations for the practitioner role [TP 2012: H1]. The study day was condensed to half a day and considered how to use both the CMOP and COPM. Emphasis was upon use of evidence to inform practice and a requirement to be reflective practitioner [TP 2012: PPT1: 13].

The presentation included a description on why the CMOP-E was not used in the county. It emphasised that the CMOP had been locally interpreted and practitioners were engaged with their own socially constructed version of the CMOP. [TP 2012: PPT2- 6].

There was a practical session to practice writing measureable occupational performance goals

10.1.7. **2013 changes**

2013: The study day is now named the 'Canadian Model of Occupational Performance Education Day'. The practical session discusses how occupational goals should be written in reablement plans [TP 2013: PPT1- 9; PPT5-13].

<u>*Case Study:*</u> Individual participants are required to bring their own case studies which are worked upon in groups [TP 2013: 6:16].

> Reflective comment: participants were asked to bring a case study in an attempt to manage previous difficulties encountered when theoretical case studies were used.

10.2. **Manuals**

Requests for a manual as a reference tool that could be used in any setting were made in February 2005.

> Reflective comment- steering group members were regularly asked questions about applying the CMOP to practice. Whilst individual group members provided responses to individual practitioners, there was an appreciation by the steering group that, if one practitioner was asking questions, ostensibly others were potentially asking the same questions. A consistent response to a wide group of practitioners would be achieved by production of a manual.

The first edition was distributed to registered Occupational Therapists in October 2006 with a review date of 2008. Entitled '*Manual for Using the Canadian Model of Occupational Performance in Occupational Therapy Services'* it was written on cream paper with a red spiral binding. The front cover included both health and social care logos. Each page had a copyright notice.

> Reflective comment: The choice of colour for the manual was made following a discussion on how we could make the manual 'stand out' on a practitioner's desk and prevent it from becoming lost amongst other paperwork. A decision was made to copyright the manual as practitioners and students from outside of the county were asking purchase the artefacts. The steering group members wanted their work to be acknowledged.

The second edition was published by Cardiff University in 2010. The title was: 'A Gloucestershire Interpretation for Implementing the Canadian Model of Occupational

Performance in UK Setting: a User Manual' (Boniface et al 2010). In contrast to the 2006 manual, which was created by the steering group collectively, this edition listed three editors. The cover in cream included a dynamic drawing which depicted pieces of a jigsaw with the letters 'p' 'e' and 'o' appearing to come together on the front cover. This picture was described in more detail on page 13 of the manual:

> *'…all of these components [performance, environmental and occupational] should be seen as components which can be considered separately, but in actual fact in Occupational Therapy fit together in a whole or 'holistically' as is demonstrated by the figure.' [manual 2010:p13]*

> Reflective comment: This diagram was drawn by a member of the steering group, who was asked by the group to visually represent occupational therapy as a dynamic process and how locally the CMOP was viewed.

Differences are evident in each edition but in essence both versions included:

- An *introduction*- describing why the CMOP was introduced.
- *What is a model*? - a theoretical chapter with explanations for theoretical terminology.
- *An overview of the Canadian Model* - the second edition included the steering group own definition of occupational performance [Manual 2010: p11].
- *Aims of Using the Model* - focused upon defining occupational performance.
- *Evaluation and clinical reasoning* – emphasised justifying, explaining and reflecting on actions.
- *Frequently asked questions* (FAQ) designed to answer queries raised by practitioners on how to use the CMOP in practice. This section expanded from nine questions in 2006 to fourteen in the 2010 manual [manual 2006: p22-25; manual 2010: p20-29]. See appendix 13 for changes in FAQ between 2006 and 2010 which reflect both development in thinking of the group and questions being asked by practitioners.
- *Conclusion* – reaffirms that using a model is dynamic and the manual will need to be updated to reflect these changes.

- *Appendices*: (described as applying the theory to practice). Included aims of the steering group; prompt sheets and completed documentation examples from a variety of clinical areas.

One noticeable difference between the two manuals was the removal of the OPPM and a vignette from the second edition.

The manual explained the steering group's interpretation of the CMOP. Each edition comprised of two distinct parts a 'theory' section [manual 2006; p5-27; manual 2010; p3- 30] and a 'practice' section [manual 2006; p 28-72; manual 2010; p31-73]. Part one included an explanation of why use of occupational therapy theory was important; a description of the CMOP and a FAQ section. The summary of this section introduced part two and included examples of documentation. Whilst the authors suggested that the documentation they had included may not suit all clinical areas, they strongly advised practitioners to use the examples given before creating their own [manual 2006; p21; manual 2010; p20]. The examples of documentation provided were from a variety of clinical settings; social care [manual 2006; p32-36; manual 2010; p35-37]; health; [manual 2006; 48-68; manual 2010 p38-63]; paediatrics [manual 2010 p64-68] and intermediate care [manual 2010 p69-73]. Documentation examples were expanded in the 2010 manual and included guidance notes and completed examples of the occupational therapy and home visit reports. Aims of the steering group [manual 2006: p29-30 and 2010; p31; manual 2010; p31] and prompt sheets to describe terminology [manual 2006; p70-71 and p73] were included.

> Reflective comment- I found it a challenge to read the examples of documentation in each edition of the manual without being critical. I was aware I needed to review the manuals in the context they were written, to examine messages they intended to portray from that time and not comment upon the quality of the content based upon my views of the model contextualised by the here and now. I felt the quality was inconsistent in both editions. I recalled discussions within the steering group after publication of the 2006 manual that recognised the variable quality of the examples contained within it. Development in understanding of the CMOP influenced the way in which documentation was completed.

The 2010 manual (Boniface *et al.* 2010) **presented evidence that the CMOP had been interpreted locally.** Firstly, a change in the title change which now included the word 'interpretation'. Secondly, a local definition of occupational performance *[2010 manual: p11]*.

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Whilst these are not vastly different to the definitions included in *Enabling Occupation* (Townsend *et al.* 1997, 2002) , the manual captured how the authors sought to make the model relevant to local practice through adaption of terminology.

The manual described reasons why an Occupational Therapist may become involved with a client [2010 manual: p11]. Both editions emphasise how practitioners needed to reflect upon their own individual practice so they are able to meet future demands.

10.3. **Supervision DVD**

The DVD was produced by three members of the steering group in 2007. The opening scene described the aim of the DVD, to encourage Occupational Therapists to discuss the CMOP in supervision. The 55 minute DVD has six scenarios. Practical exercises accompanied each scenario with advice to watch it in small groups and complete exercises together [supervision notes p1].

Each scenario included role play, the role of supervisor and supervisee for each scenario was enacted by these three members. Supervision took place in a studio type setting which looked ‘set up’ and ‘sterile’. The background had a grey curtain and the supervisor and supervisees sat on a chair separated by a coffee table.

The DVD introduced how the CMOP had been interpreted by the steering group members. The actors emphasised the importance of individual reflection to support practitioners adjust and adapt the occupational therapy role in response to changes in their own particular clinical settings. The choice of scenarios represented a variety of clinical settings; acute hospital [DVD scenario 1; 4; 6], social care [DVD scenario 2] and paediatrics [DVD scenario 3; 5]. Whilst the cases pertained to particular clinical areas there was a clear message that the principles were applicable across all clinical settings.

In each scenario the supervisee was asked to reflect upon a case being discussed and think about future actions. Reflection was the main focus of each scenario and suggested that practice is shaped and defined by the environment in which the activity is being carried out. In order to develop practice, each practitioner needed to retrospectively consider their previous actions and think about how they may act differently in future. The supervisor’s role in the DVD was to probe and question the actions of the supervisee. Exploration included understanding a client’s views; acknowledging a client occupational needs and the importance of signposting.

10.3.1. Explaining occupational therapy to service users [scenarios 1-3]

These three scenarios involved; a patient on the ward, an older client in the community and a child. In each scenario the supervisor facilitated the supervisee to understand the perspectives of their client, not simply other family members or ward staff. Considering all the client's needs, explaining occupational therapy and defining terminology of the model were messages found in each of these scenarios.

10.3.2. Teasing out OPIs [scenario 4]

This scenario described a "moral duty" for Occupational Therapists to consider the wider needs of an individual. The supervisee discussed to a 52 year old amputee currently in the acute hospital who was about to go home. To reinforce her message to the audience watching the DVD, the supervisor revealed a comment made to her at a COT conference by a member of the audience. The delegate pointed out that Occupational Therapists who worked in an acute hospital settings, had a "moral responsibility" to identify all occupational issues and not use lack of time as an excuse to ignore things that they did not have the time to address. The scenario emphasised that this should signpost onto other agencies.

10.3.3. Judging spirituality [scenario 5]

In this scenario a paediatric Occupational Therapist struggled with understanding the spirituality of a child she was involved with. The supervisor helped the supervisee to recognise that spirituality is not simply religion. She probed using words such as; 'what motivates or engages her? 'What is important to her? What makes her tick?' She got the supervisee to recognise that, despite the child being unable to speak, the Occupational Therapist had in actual fact been able to recognise her spirituality through listening to her mother and siblings and observing the child's actions.

10.3.4. Encouraging reflection on the model [scenario 6]

This scenario reinforced how important reflection is for practitioners. The supervisee considered a case which had been presented in scenario 4 and, through supervision, discussed the impact of her intervention when she had identified his needs beyond that required for discharge from hospital namely, his desire to return to work. The supervisee reflected that through exploring his wider needs and how important they were for his future quality of life gave her more job satisfaction. She revealed how her future practice would be different in

light of her new knowledge. The scenario signposted the supervisee to other Artefacts created by the steering group to support practitioners; namely documentation, the manual and study days.

> Reflective comment: I had not viewed this DVD for a number of years. It has never been reviewed since being made which, I believe was in part due to issues with production and IT. I recall my own attempt to run the sessions many years ago and a barrier was access to a DVD player and televisions to play the DVD on. I have not fully understood why this tool has not been regularly used by my colleagues, but suspect difficulties with access to IT equipment was a factor for my colleagues too.

10.4. **Document: Guidelines on the delegation to occupational therapy support staff**

This five page policy document was produced in 2007 to clarify the support worker role. The contents were discussed in detail during steering group meetings and the main author was a member of the group.

> Reflective comments: This document was created to produce a consistent understanding of the support worker role.

The version reviewed is named first draft and has no review date. The document instructed readers that;

> *'The occupational therapy service [in this organisation] works within the framework of the Canadian model of Occupational Performance to support client-centred, occupational focused and evidence based practice.' [p1].*

The document provided definitions for 'delegation', 'assignment'; accountability' and 'supervision'. There are practical examples of the sorts of cases that should be delegated to support workers in social care, hospital and paediatrics settings.

The document defines the role of support worker through illustration of typical cases they should be involved with. The relationship with registered Occupational Therapists is emphasised. The document uses some words frequently and these are shown below;

- *Competency* [p1-4] that support workers should only work within agreed competencies for their grade.

- *Skills and knowledge* [p1,2, 4]

- *Predictable care pathway* [1, 2, and 3] - case allocation is viewed as a dynamic process where changes in accountability can alter if the case becomes more complex.

- *Supervision* - effective communication with the registered Occupational Therapist through both formal and informal supervision.

- *Registered Occupational Therapists legal accountability* [p1].

- *Role variation* clarified the different roles for the varied grades of staff [Band 2, 3 and 4]

10.5. Support staff training programme

This half day programme was created by members of the steering group members in consultation with support workers to clarify relevant aspects of the CMOP to their own practice. Initially, the package was launched to Occupational Therapists and they were advised that delivery of the training to be given within individual teams.

> Reflective comment: I recalled discussions in steering group meetings that a programme needed to be developed to support the delegation and assignment framework document. The group members wanted all Occupational Therapists to understand and own the content of both the document and programme which clarified the support worker and Occupational Therapist roles. I presented the programme to my occupational therapy colleagues with a clear expectation that they would deliver the training package locally to their own teams. Whilst, some practitioners were positive and saw the training package as beneficial for supporting role clarification, others argued that experienced support workers may be affronted by the content and potential change in work. I recall interesting debates which focused upon understanding role requirement.

The presentation style of the programme aimed to answer questions with chapters title; 'Why do the OT's need to use a model? What is the CMOP?, What does it mean for my work? ' Noticeably, there was less opportunity for open discussion of the content of the training programme, with an exception being the 'client-centred practice' section, which was a modified version of the practical session contained in the registered staff study days [SWppt5: 5].

Appendix 16 Example of thematic analysis of interview data

See over.

Examples of Raw data	Coding the raw data. Process of refining and discarding codes	Creating Central organising concepts Organising into meaningful groups	Reviewing, refining and naming Data forms a sub theme	Theme
"I think it's about a duty of care. It's about identifying the need and then thinking what scope do you have to deliver that need. And it may not be within your remit and your ability of resources to deliver it. But I think you have a duty to identify and help support the patient either by referral on to other agencies or helping the patient find a way of perhaps breaking down.." [Charlotte 11:22] *"I think it's good in that it will bring up stuff that perhaps other assessments or model might not pick up but then again, it's what I said early. It's not always down to you if it's not a specific OT issue, I would try and sign post them on" [Maddie 10.83]* *"I try and think how would I want to be treated or how would I want my relative to be treated and what's important to me? So I kind of try and apply that to the people that I meet because I feel like my life isn't just whether or not I can wash and dress, whether I can make myself a hot drink, there's so much more*	415- Giving time helped to identify issues 375- Acknowledging what is important to the client 373- We have duty of care 344- Signposting is important 333- Listening to a person improves health and wellbeing 284- Handover and signposting are important 282- It's important to consider someone beyond that which is needed for discharge 147- We must voice what people want even if we can't address them 142-OTs need to look at all areas of a person's life	I have a duty to view the person beyond their immediate situation Models help you see beyond the reason for referral It may be busy but I've a job to do Lack of time has consequences	This was captured as: **I have a duty to see beyond the referral**	Became part of the wider theme and linked with identity: **I am an Occupational Therapist**

to me and then there's so much more to everybody else as well. And like I think that's one of our niches in our profession is that we do think of the person as a whole and everything that is important to them" [Jane 8:34] *"Yeah, it's the fact they can walk up and down the ward, we don't just take that. "Well, how did they get on their feet? What's the home environment like? What's...you know, who else is there? Is there a cat to fall over?"[Sandra 2:192]* *"I feel like it does because I'm, you're looking at the person, their core values right away through to their wider environment. I feel like you can be thorough then. You're not going to miss anything that might make going home difficult because what you don't want as a therapist is to get a call to say that discharge has failed because you've missed something." [Sarah 8:58]* *"..the CMOP really encourages you to engage with the client as an individual and helps you look at every aspect of their life and I think they are more inclined to work better with you because you are thinking like that and because you're responding to -- you're really engaging with them and I think it would come across as a much more caring approach as well." [Emily 9:24]*	138- Understanding the person beyond a hospital bed 135- Using a model helps us to remember people are human not just a diagnosis 134- A busy environment means we can't do everything but we should strive to at least assess 133- Using a model helps us to advocate for a person in a busy environment 74- OTs should look at the social and leisure needs of people 62- Model help to signpost to non - statutory providers 34- Staff need reminding of the wider scope of their role 357- My focus is broader when I have time to understand occupational needs 326- OTs feel like generic workers 304- Problem solving doesn't solve the issues 208- A busy environment means there is a danger the wishes of clients are missed	CMOP helped me to explore		

<table>
<tr>
<td>"I think we are under too much pressure and limited resources and everything, but surely patient experience is the important thing and making sure they're happy and everything else. And I'm not…I'm forever apologising for the only things that I'm able to do, but that's the same everywhere. So, but I still think you should be able to listen and document what's important to them even if you can't achieve it and then obviously normally you're signposting on anyway" [Alice 7:88]

"I think, if I didn't have the model, I don't know that I would necessarily bear that in mind as much? Because that's what makes us different to a nurse, or a physio or a social worker because that's what...I look at, you know, that's my particular role on the ward." [Emily 2:28]

"I take pride in what I do and I have a duty of care and if -- and I will do things and if a manager doesn't agree and I think I have to do it out of a duty to care I will do it. That's what we get paid for." [Michael 5:68]</td>
<td rowspan="2">200- Time is an issue to write notes

194- In a busy environment we need to use judgment for what needs to be assessed initially

150- OTs take risks in a non-risky way

143- Time means we can't deal with everything

331- Model supports me to probe function in detail

214- The model helps to frame how I talk to people

182- Self-care, productivity and leisure are the domains of OT

73- Re-engaging people with their community improves health and well being

289- CMOP is integral to my clinical reasoning

287- I would miss the model

266- CMOP is ingrained in thinking we don't know we're using it

190- The model is in your head</td>
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<tr>
<td>"I think if we'd never been taught the CMOP or if it had never been the foundation of our practice, I think people would probably be a lot more inclined to just go with problems" [Emily 9:22]</td>
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</table>

"To help frame therapist's thinking in relation to their assessment, and I suppose give them the framework, yes, give them the framework, I suppose, to provide as broad and holistic an assessment of the person as possible. So it just nudges staff to remind them that they should be assessing all areas of a person's life and well-being and not just concentrating on, I dunno, personal care tasks. So the model gives quite a broad range and looking at social and leisure activities as well as the home and environment"[Helen 1:8]	54- The model should influence OT thinking 15- Models are part of your thinking as a OT 346- Complexity of patients takes the time 345- Despite volume of patients I will give someone time 233- I am not prepared to compromise my own professionalism 16- OTs should look at all of people's occupations 11- Registered OTs should look at the person not just what's on the referral			
"...if it's quite complicated - the patient you're working with - then you have to make sure that your time is spent resolving that situation first and if other patients on the ward have to wait then they have to wait." [Maddie 10:87] *"I always document what I do so if I've got a reason for doing it, it would worry me more if I did something that I thought was unsafe just to cut a corner and to keep a manager happy which I haven't done to date and I hope I never will do. Because then, you know, in the long run it's not good for the client, it's not good for me because I'll worry about it and put the company in a legally vulnerable situation." [Michael 10:70]*				

"I know it might sound a bit weird, but I think that's another reason because everyone still wants to be holistic and wants to do best by the client and isn't willing to rush through it all, it might be a little bit of a reason why the waiting list doesn't go down as quickly as we want it to." [Emily 9:48]				
"I think if we'd never been taught the CMOP or if it had never been the foundation of our practice, I think people would probably be a lot more inclined to just go with problems rather than the person's -- well the other person really. I think you go in focusing heavily on what's wrong and fixing that problem. It's kind of a bandaid rather than looking at the whole situation… I think it would be quite a short sighted intervention really."[Emily9:22] *"I've balanced it off with actually you have to stop asking the question, because ultimately this is not in the benefit of the patient now. This is going through questions, because we think that this is what we need to capture on our system. So, you kind of think, right. We won't go down that route if it gets allocated, you know. It might be more appropriate at another time" [James 3:77]* *"I find that… it's a good way of doing things, it's.. time consuming so in terms of getting through the waiting list, it's*				

not the most efficient way -- or it might not be seen as the most efficient way -- to work by some people, but I tend to be you know a plodder and not a whizzer, but at the end of the day if you get as much information as you can to begin with a full assessment, I can save time later on. And I suppose .. my belief as ….. an OT is that I'm not going to be a number cruncher to keep higher managers happy, the best thing I feel I can do in providing the services is to provide people time to give them a full assessment, to fully understand their problems".[Michael: 5:62] *"part of you feels how could you make these pretty big decisions in such a...like 45 minutes? But you have to. Like a visit, we used to do home visits and access visits, that's reduced phenomenally. And that's quite a basis that you've got, again, for your risk taking and your judgement and reasoning." [Sandra 2:106]* *"Using self-care, leisure, productivity just as a framework in my head to then shape all my questions around and thoroughly explore all those areas, I was able to unpick, well actually, it's not dom care that you need. And then, a little bit of few assessments, physical assessments. And then, we were going to look up and put reablement in. So, yeah. It's constantly...it just kind of in the back of your brain at all times. Isn't it? It doesn't structure...it shapes your questions" [James 3:25]*				

Appendix 17 List of public output

Paper presentation- College of Occupational Therapists (COT) Conference 29th June 2016 session 24 11.30- 12.15: *'What has theory got to do with practice? Bridging the gap in Integrated Teams'*

Submitted abstract

There is no single understanding of Occupational Therapy; numerous explanations are in existence with no one widely accepted definition (Duncan 2006). Whilst this can be useful for practitioners, who work in a variety of work environments, conversely it can be an issue for a practitioner who is trying to succinctly explain their role in a way that it can be understood by stakeholders (Boniface 2012). The practice of occupational therapy can appear straightforward and so trying to describe the complexities of the therapeutic process can be difficult. Without being able to explain occupational therapy, practitioners could find themselves in a position where stakeholders have little understanding of the role and may hold a perception that their work can be completed by others.

This inarticulacy is becoming increasingly challenging for Occupational Therapists in physical settings, with moves towards integrated teams comprising of practitioners from a range of backgrounds. Whilst the benefits of integration have been extoled, concerns have been raised previously, by practitioners in mental health teams, about loss of core skills and professional identity. Pettican and Bryant (2007) described an overt theory practice link through applying professional models of practice, helped to strengthen professional identity. Yet many practitioners do not use models to underpin practice, describing that models do not reflect the 'real' world of practice and are created in isolation by academics (LeClair et al 2013).

Case study research with a focus upon understanding the relationship between using a theoretical client-centred model and clinical practice from a number of interrelated perspectives will be shared. It will discuss how it has supported transition into integrated working and its future challenges.

Working Titles for publication and potential journals:

1. Case study methodology

'Experiences of using Yin's case study method in a practice setting'

Journal: Qualitative Inquiry or Qualitative Research

2. Sharing results

'Understanding the influence of a single conceptual model on practice: a case study enquiry'

Journal: British Journal of Occupational Therapy Or Canadian Journal of Occupational Therapy

3. Consideration of the influence of George Herbert Mead on this subject area

'Occupational Therapy practice is a social act'

Journal: British Journal of Occupational Therapy