OCCUPATIONAL THERAPY NOW

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Table of Contents

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De Shakespeare à Molière, Services de traduction

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Everyday Stories . . . profiles of your CAOT colleagues

Sarah Bingler, BSc (OT), OT Reg. (Ont.)

Education

I started my post secondary education at the University of Guelph, enrolled in the Bachelor of Applied Science program specializing in Gerontology. I had an interest working in health care and the geriatric population appealed to me. After completing a year, I decided to apply to the occupational therapy program at the University of Western Ontario. I completed my Bachelor of Science in occupational therapy in the last year before it became Master's level program.

Career path as an occupational therapist

I began my career providing service to pediatric and adults clients in the community through a local Community Care Access Centre. This was a very challenging first position as a new graduate but I learned a lot in the process. I then worked in inpatient orthopedic rehabilitation. When an opening came up at the local community hospital near my house I was quick to apply. I have been working at Toronto East General Hospital providing services to inpatients for over ten years. I really enjoy working in this fast pace environment that presents me with new challenges every day. These challenges often require me to come up with creative solutions. For example, I once presented a reluctant patient with a handful of jelly beans after every successful therapy session.

Family life

I am married and have two boys who are aged six and nine. We live in semi-detached house with lots of character (aka old) in the East York neighbourhood of Toronto. I am lucky to be able to walk to work dropping my kids off at school on the way. My evenings and weekends are filled with hockey games, swimming lessons, trips to the library and spending time at our family cottage in the Kawarthas.

Hobbies/interests

I love to exercise and run regularly. I always tell people that the best feeling for me is the feeling when I have just finished a long hard run and I am completely exhausted and exhilarated at the same time. Last year I enrolled in my first full marathon and was very proud of myself when I was able to complete the distance. I am lucky that the hospital where I work offers a wellness program which includes access to a small gym and various exercise classes. I even had the opportunity to sign up for an eight week course in meditation offered at work. Unfortunately it turned out that I could never relax and would usually spend the entire class thinking about things like what I was going to make for dinner or how I was going to get the kids through their homework later that night.

Greatest influences to my occupational therapy practice

When I was little girl I was very close to my grandparents. We spent summers together at our family cottage or they would care for me because my mom worked full time. My grandmother had a lot of health problems which required her to have periods of rehabilitation or convalescence. It was through her that I was first exposed to the profession of occupational therapy. After my grandmother passed away I watched as my grandfather also experienced declining health and function eventually requiring admission to a long term care facility. I always feel so fortunate to have had such great grandparents who so significantly touched my life. I feel that it is in rememberence of them that I wanted to be involved in caring for seniors. I love hearing their stories of the lives, where they were born, what jobs they did when they were younger, where they have travelled and the wisdom that they have learned along the way. I truly believe in the lessons that can only be learned though living a long life and try to cherish this wisdom.

Note from the Editor:

Sarah's colleague, May Jee Yung, suggested her profile be included in OT Now: "I am a registered dietitian and I work with a wonderful [occupational therapist]. Her name is Sarah Bingler and she has been an [occupational therapist] for over ten years. She is extremely dedicated to her patients and will think of novel ways to motivate her patients. Sarah is a lively and vivacious person at work and outside of work."

What's new

Extended Insurance Lobby

Not all Canadians are able to access the health services that support their well-being and good health. One of the most significant gaps in coverage is the lack of access to the occupational therapy profession. CAOT invites all its members to contact their health plan provider to ask them to provide coverage of occupational therapy services. For more information on what you can do, please go to http://www.caot.ca/default.asp?pageid=59.

Connect to your MP

To strengthen the voice of occupational therapy, CAOT invites all occupational therapists to share CAOT submission to the 2012 Pre-Budget consultation with their MP. A copy of the submission is available at: http://www.caot.ca/default.asp?pageid=3953.

For information on finding your MP and how to reach him or her go to: http://www.parl.gc.ca/MembersOfParliament/MainMPsCompleteList.aspx?TimePeriod=Current&Language=E

Accreditation

A recommendation from the Academic Credentialing Council for a new seven year ongoing cyclical continuous quality improvement (CQI) accreditation process was approved by the CAOT Board of Directors in June 2011.

The CQI approach establishes a clear partnership between the accreditors and the school program in the accreditation process by working collaboratively to address program quality issues and to value and appreciate program strengths. Once entered into a seven year cycle, each school program will undergo a continual quality improvement process that includes a self-study, off-site and on-site review, and CQI plan using the CAOT academic accreditation standards. The review will result in identification of strengths and areas for improvement resulting in the development of a CQI plan. To find out more about the new structure, visit the CAOT website at http://www.caot.ca//default.asp?pageid=42

OTA & PTA Education Accreditation Program

Pilot site testing of the standards, policies and procedures for the occupational therapy assistants' and physiotherapy assistants' education accreditation programs will begin this Fall. Funding for this project was provided by occupational therapy assistant and physiotherapy assistant programs in Canada.

Elder Abuse

Elder abuse documents for occupational therapists will be available to CAOT members at www.caot.ca/elderabuse. The documents provide information on elder abuse that include primary indicators, prevention, assessment, intervention protocols, relevant legislation, regulatory requirements and resources for older adults.

OT Job Search Strategies

CAOT offers career listings and job finding strategies (www.caot.ca > Professional Practice > Careers in Canada). CAOT invites members to post success stories in finding new employment, search strategies and resources used to attain employment and/or contracts on CAOT's Facebook discussion page.

New CAOT Benefits!

The Member Assistance Program (MAP)

For $48/year, this program provides members and eligible family with access to free professional and confidential counseling, coaching and consulting services for management of personal, family, or work-related concerns. MAP can help with: legal advice, addressing depression or anxiety, coping with separation and loss, balancing work and family and recovering from trauma, harassment or abuse and much more. For more information, please contact Membership division at CAOT (membership@caot.ca).

HT Health Works

Access to the HT Health Works website allows members, family or clients to monitor personal health information (www.hthealthworks.com). Use and share the login 'CAOT' to enter this valuable resource.

Working in addictions: The development, implementation and evaluation of the pilot group *Career Exploration 101*

Anushka Darko-Mensah

As occupational therapists support clients who struggle with addiction issues in their journey of recovery, we move with them to a life where meaning and direction are rediscovered. It is a privilege to witness clients' strength, courage and resilience as they discover and rediscover who they are and their direction in life. As this discovery unfolds, individuals overcome fear and develop hope and self-efficacy. This article provides details of a program designed to enable clients within the Addiction Program at the Centre for Addiction and Mental Health (CAMH) to engage in the exploration of a work/career identity. Details include the development, implementation and evaluation of a program that aims to investigate how clients may achieve productivity (in a broad sense) success through a two month group program.

Context and evidence

Productivity was identified by the CAMH leadership team as an area for development as it was an unattended area in programming and was an important aspect of the organization's strategic vision. Given that occupational therapists enable clients to engage in identified productivity goals, the role of occupational therapy was seen as beneficial and much needed in the Addictions Program. A plan was developed to integrate occupational therapy into the Integrated Day/Residential service at CAMH, a 21-day treatment program to help clients develop skills for their journey of recovery. Focus groups were designed and clients recruited from existing services to gather expertise and insights to develop the role of occupational therapy within the program.

There were four focus groups with 24 participants. Participants were asked about employment, volunteer work, and school participation. Some examples of the questions being asked included:

1. What, if any are the challenges, barriers, issues you face in regard to employment/school?
2. What kind of things would be helpful to assist you with work/school issues?
3. If a group was to be held relating to work and school – what are the topics that you would like to include?

Participants said that as a result of being; 1) unemployed for a time, 2) engaged in illegal work, or 3) employed in high risk stressful work, they were unable to identify positive productivity-related interests that could support their recovery. Clients expressed enthusiasm in having the opportunity to explore their interests and discuss strategies regarding their fears and anxieties about the possibility of working.

In looking to the evidence, it was found that work (one aspect of productivity) is an important aspect of recovery within the addictions field. Work is linked to a reduction in relapse (Scorzelli, 2007), builds self-esteem, provides a legal source of income, and promotes structure and routine through non-using related activity (Reif et al., 2004). This evidence spoke to the benefits of having employment focused groups for people in treatment. With these ideas in mind, and taking into consideration the clients' expressed needs from the focus groups, Career Exploration 101 began.

Career Exploration 101

Career Exploration 101 was designed to be a self-discovery group that enabled individuals to develop self-knowledge in order to create an effective and relevant client-centred employment or educational action plan.

The pilot program consisted of four consecutive weekly group sessions, followed by one month allotted for individual sessions and a wrap-up group session. Clients completed the Canadian Occupational Performance Measure ([COPM], Law et al., 2005) and Readiness to Return to Work Scale

About the author

Anushka Darko-Mensah, BSc, MSc (OT), OT Reg.(Ont.), worked in the Medical Withdrawal Services and Integrated Day/Residential Services in the Addictions Program at the Centre for Addiction and Mental Health (CAMH) for approximately three years. Anushka is currently working in the newly developed CAMH Substance Management Program for injured workers who experience both chronic pain and addiction. Anushka can be contacted at anushka_darko-mensah@camh.net.

(Franche et al., 2007) as pre- and post-measures. The purpose of these measures was to identify needs, set goals, understand the client's readiness with regards to returning to work, and to review outcomes.

The explicit goals of the group were to: a) complete an interest inventory, b) support the client to identify a work related goal, c) create an action plan related to the identified goal, and d) link clients to community resources as needed. Sessions included: i) creation of a group resume, ii) completion the Career Exploration Inventory (Liptak, 2006), iii) review what client's have researched about their interest areas, iv) educate on goal setting and action planning, and v) have a peer support worker speak with the group about his/her own experience in addiction recovery with a focus on the employment aspect. Other topics of discussion included important issues of disclosure and accommodations. Relevant resources from the Canadian Mental Health Association were also provided to support client knowledge development.

Individual sessions were based on supported employment models of practice and therefore the content varied depending on the client's unique situation. Individual sessions were meant to facilitate further client exploration and planning. The goal was for the client to create their individualized road map for finding meaningful competitive work, education or volunteer opportunities. In addition, staff support was provided to clients as they worked through their action plan. These sessions included interviewing professionals who were currently working in their interest area; planning job shadowing opportunities; preparing funding forms; support in finding employment or connecting with relevant community resources; and providing support to clients to stay on course with their action plans.

The pilot program

Pilot sessions of Career Exploration 101 were run with English speaking individuals who were actively connected to a therapist within the CAMH Addictions Program. Non-English speaking individuals were excluded to ensure that the material being delivered and the process being utilized could be considered without the implications of language barriers. Like other programs within the Addiction Program, the hope is to have this program translated and delivered with cultural interpreters. The results of two of the pilot programs can be seen in Table 1.

Pilot Group	# of clients	# of dropouts	# working	# volunteering	# in school
Pilot 1	5	1	2/4	2	1
Pilot 2	5	2	2/3	0	1

Table 1. Outcomes from two pilot programs of Career Exploration 101.

Outcomes

Between July 2009 and January 2011, six Career Exploration 101 groups have run with a total of 35 people undergoing the initial assessment for this group. Twenty clients have completed the group, three clients did not participate as it did not meet their needs, six started the group however did not complete all sessions, and six others completed the group however for various reasons were not able to participate in the follow-up assessment.

Specific benefits have included; self-reported increased participation and engagement in client identified goals, positive change in 'performance' and 'satisfaction' on the COPM and Readiness to Return to Work Scale, and positive qualitative feedback on the exit surveys. Although six clients did not complete the program, the majority of clients engaged in schooling, temporary work, part- or full-time work in their identified area of interest, and/or were volunteering by the end of the group. Other participants progressed by taking steps toward their goal of working by preparing resumes and attending medical appointments in order to improve their physical health.

Statements from anonymous exit surveys regarding the group experience include:

"[Career Exploration 101 is responsible for]...pointing me in the right direction. I'm now working on my baby steps to be ready for the big step."

"Knowing one isn't alone is crucial for addicts, so I think the group format is ideal for this..."

"Having continuous feedback, ideas, thoughts on an individual basis was meaningful and helpful."

"This was a great experience for me in both ruling in and out options.... This actually made me more eager to follow through on my goals than when I started and I am grateful for that."

Data from this program indicated that clients can discover their potential when a forum is provided for them to attend to the area of 'productivity' in a focused and supported manner. Exploring and discovering vocational identity was clearly an important and necessary component to include in developing recovery-oriented services. Occupational therapists, with their unique skill set, scope of practice and lens, can contribute significantly to developing more recovery-oriented services in the area of productivity.

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A teaching resource for preceptors of occupational therapy students

Dana D'Cunha Sequeira

Clinical learning is an exciting aspect of education that can be both challenging and anxiety provoking. The literature indicates that clinicians have a significant influence on students' feelings of success or failure in clinical practice (Huggett & Warrier, 2008; Tang et al., 2005). The successful relationship between a student and teacher occurs when there is mutual respect and admiration between the two parties and is dependent on the teacher's attitude towards the student (Gaberson & Oermann, 2007; Tang et al., 2005). Occupational therapists working in a pediatric setting reported that, in their experience, students have commented on being very eager to practice what they have learned in school though they are concerned about how their performance will affect clients and how their performance will be evaluated (E. Fraser, personal communication, July, 2009). These statements were confirmed in a review of student's evaluation forms completed at the end of placements. In addition, therapists, specifically those who have been working for five years or less, reported that they were anxious to precept students and often felt unsure about their ability to meet the expectations and demands of clinical teaching (E. Lawson, personal communication, July, 2009; Scanlan, 2001). The teaching resource described in this article provides activity ideas that facilitate preceptorship which may be helpful for both the

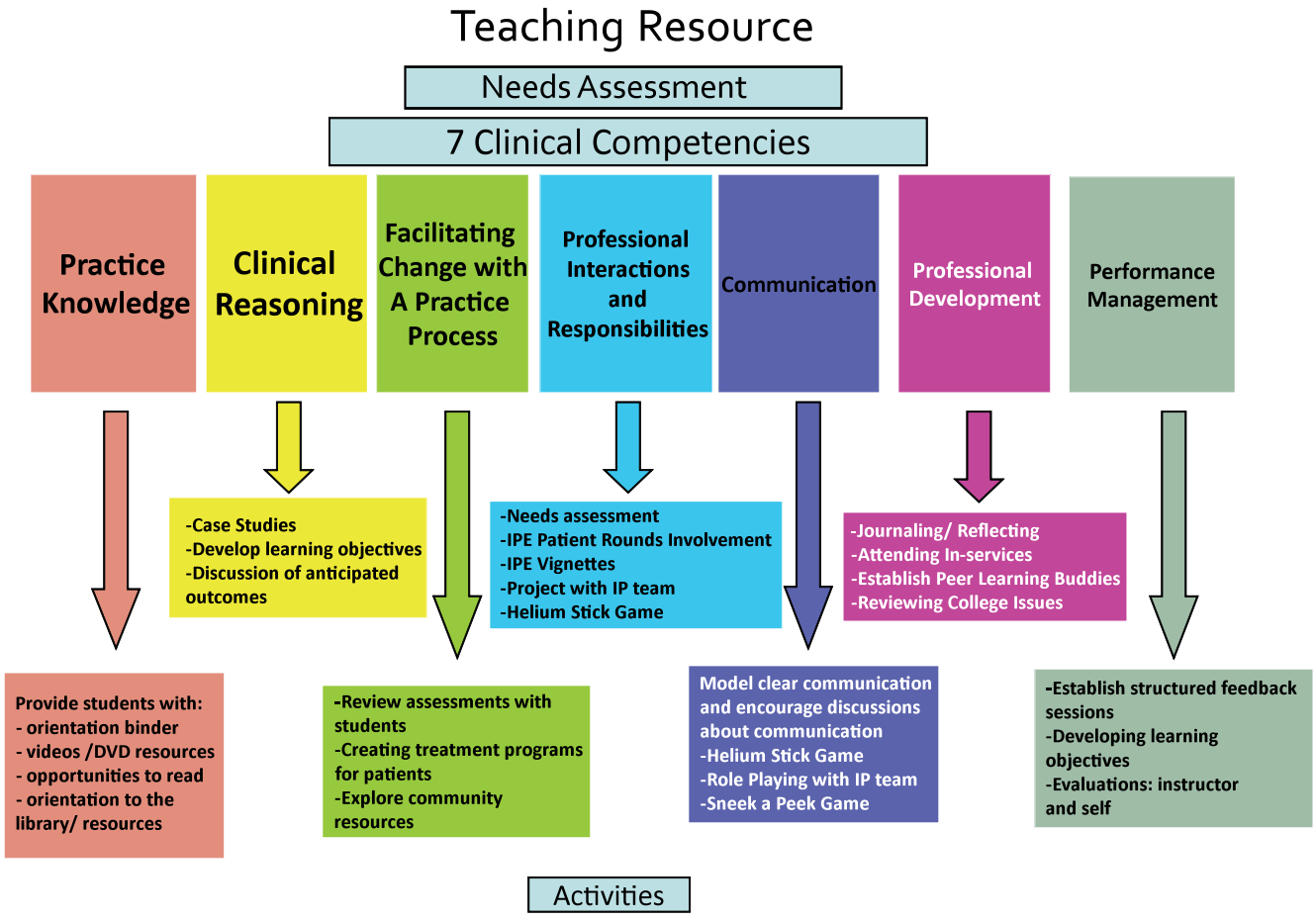

Figure 1: Teaching resource for rehabilitation professionals based on the Competency Based Fieldwork Evaluation.

occupational therapy student and the novice clinician.

Teaching resources are available for teachers to use when sharing knowledge with learners about specific topics. The resource in this article is based on the seven competencies of the evaluation tool Competency Based Fieldwork Evaluation (CBFE). The CBFE is used across Canada and has been used to develop the Essential Competencies required of an occupational therapist to practice in any province in Canada (COTO, 2003). The teaching resource outlines suggested activities for the novice clinical preceptor to facilitate a student's successful completion and/or growth within the seven competencies of the CBFE: practice knowledge, clinical reasoning, facilitating change in a practice process, professional interactions and responsibilities, communication, professional development and performance management. The resource also considers the importance of matching teaching with learning styles during preceptorship (Anderson, 1998; Lockwood-Raymermann, 2003; Pratt et al., 2001) and the importance of including interprofessional education experiences when learning in the clinical environment (Bandali et al., 2008; Byrick et al., 2009).

The teaching resource

Prior to addressing the CBFE's competencies, the clinician should complete a needs assessment with the student to match the teaching style with the learning style of the student, and for the teacher to learn the learner's level of knowledge. The teaching resource activities can be utilized once the teacher and learner have aligned their expectations.

The teaching resource, depicted in Figure 1, illustrates the seven clinical competencies of the CBFE. The arrows lead the clinician to activity ideas that can be used with the student to facilitate achieving each clinical competency.

CBFE competencies and suggested activities

Competency 1: Practice knowledge

Practice knowledge refers to a student clinician having the theoretical knowledge and clinical expertise to work with clients, colleagues, the clinical institution and the profession.

Suggested activities:

- Making resources available for student use. For example an orientation binder containing information about the facility and their processes such as their mission, vision, policies, and information about the specific area of practice. The orientation binder is demonstrative of taking a developmental perspective to teaching (Pratt et al., 2001) as it is planned and conducted from the learner's point of view. Other resources include videos, the medical library and the Internet, providing students with daily opportunity to read and use these resources to acquire the necessary practice knowledge is important.

Competency 2: Clinical reasoning

Clinical reasoning refers to the analytical and conceptual thinking, judgement, decision making and problem solving skills that are involved in daily clinical client care. Evaluating clinical reasoning skills can be challenging especially if one is still questioning their own as a novice preceptor. The activities in the teaching resource illustrate methods that teachers/clinicians can use to stimulate students to use their clinical reasoning skills within the clinical environment.

Suggested activities:

- Problem solving case studies verbally with students (Herman, 2002).
- Role playing with peers/colleagues or using simulations and objective structured clinical exams (OSCEs). These activities allow the student to clinically reason without having the client in front of them, but allows them to problem solve with teachers and provide follow up assessment and treatment ideas. These ideas can later be executed with the client.
- Clinical questioning (Herman, 2002); questioning students about their preparation and readiness for clinical practice.

Competency 3: Facilitating change with a practice process

The third competency examines the challenging process of clinical care; the process by which a student clinician is able to facilitate client care, from assessment through to discharge (Bossers, 2007). This process varies greatly and with an increase in diversity of health centres it is important for students and clinicians to be able to guide their clients through this process.

Suggested activities:

- Developing learning contracts or objectives to plan and implement learning activities (Gaberson & Oermann, 2007). It is an agreement between the teacher and the student that outlines specific learning goals, expected outcomes and criteria for evaluation.
- Designing home programs that allow the student to problem solve interventions for their client and after discussion with a preceptor, safely and confidently present the treatment program to their client.

Competency 4: Professional interactions and responsibility

Professional interactions and responsibility refers to the relationship between student clinicians, their clients and their colleagues, as well as a student's level of awareness regarding legal and ethical standards comprises the fourth competency.

Suggested activities:

- Participating in interprofessional rounds by having the student contribute their professional opinion towards making a team decision in client care.
- Active involvement in interprofessional vignettes as part of a student placement.
- Engaging in a placement project with students from other professional groups.
- Participating in games such as the Helium Stick game that is a team building activity where two lines of people face each other with a thin rod laying amongst all their fingers. As a group the team must lower the rod down to the ground without simply dropping it. This activity

encourages a group of people to work together as a team for a common purpose.
- Discussing client cases regarding legal and ethical standards that have arisen in the institution, highlighting the strengths and weaknesses of how they have been managed.
- Completing college modules to help ensure they are attuned to the key issues and practices of the profession (www.coto.org).

Competency 5: Communication

Effective communication in health care is vital as it can influence individual and community decisions that can enhance health (2010 Health Communication, 2000). This competency refers to verbal, nonverbal and written communication (Bossers et al., 2007).

Suggested activities:
- Demonstrating professional and respectful communication in one's own practice - 'walk the talk.'
- Asking students open ended questions to engage them to share ideas and arrive at decisions about issues that may arise (Gaberson & Oermann, 2007).
- Integrating discussions with other learning activities (i.e., role-play and simulations).
- Being flexible in teaching methods which allows the teacher to tailor the teaching style to the learner's style (Anderson, 1998; Lockwood-Raymermann, 2003; Pratt et al., 2001).
- Using games that are effective at teaching communication (Team Building, 2009):
  - 'Helium Stick', described in the fourth competency, can be used to facilitate communication skills.
  - 'Sneak a Peek' is an effective game to engage team members to communicate effectively with one another when working towards a common goal. In 'Sneak a Peek', one member of the team gets to look at a structure made out of blocks. They then return to their team and describe how to build the structure, without providing any hands on assistance (Team Building, 2009).
- For written communication, providing students with examples of Subjective/Objective/Assessment/Plan (SOAP) note writing and client reports can be helpful. Exercises involving fitting statements into the SOAP sections of a report are available in the SOAP writing manual, and provide extra opportunities for practice (Kettenback, 1995).

Competency 6: Professional development

Professional development refers to an individual taking the necessary steps to develop and grow as a professional (Bossers et al., 2007). It is important in health care as it is a way of maintaining standards of care, improving the health of the population and for recruiting, motivating and retaining high quality professionals (Brown et al., 2002). Skills that contribute to an individual's professional development include self-directed learning, identifying areas of future growth, demonstrating commitment to the profession and upholding its' core values, and demonstrating skills of self-appraisal.

Suggested activities:
- Journaling or reflecting.
- Encouraging and inviting students to attend/ participate in in-services.
- Establishing a 'peer learning buddy system' in which students can learn from each other is a non-threatening way to facilitate professional development. This 'buddy' system could be between the same profession or can incorporate interprofessional education (IPE) goals by involving different professions.
- Reviewing professional performance issues as directed by the college of the profession is a necessary component of professional development (i.e., COTO modules).

Competency 7: Performance management

Performance management refers to the process of setting goals and checking the progress of them. It refers to being able to organize oneself, being time efficient, using resources efficiently and demonstrating accountability for oneself and one's behaviours (Bossers et al., 2007).

Suggested Activities:
- Establishing structured feedback sessions to allow students to ask the clinician questions about their performance, to reflect on their performance and provide suggestions to alter their performance to improve their practice. This does not negate the use of spontaneous feedback, however ensures that feedback is not omitted in a busy clinical environment. The reverse transmission of feedback regarding the clinician's performance as a preceptor is equally important and is a necessary component of the activity for success in the placement.
- Developing learning objectives/contracts can facilitate performance management. Creating learning objectives for themselves allows students to actively engage in the process of setting goals and monitoring their progress. They require the student to demonstrate the organizational, time and resource efficiency skills as well as demonstrate accountability for their own learning.
- Completing a self-evaluation to encourage discussion between the two parties and allows both parties to reflect on the placement, the strengths and weaknesses for further self-development and continuous improvement.

In summary, the teaching resource presented in this paper (Figure 1) has been devised to help novice therapists facilitate student development in the seven competencies of the CBFE. The activities are a guide to provide the novice clinical teacher with initial thoughts on how to facilitate clinical education and are not inclusive of all activities. It is essential when choosing activities from the teaching resource to consider the needs of the student and to select the most appropriate teaching style to ensure a successful clinical learning and teaching experience.

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About the author

Dana D'Cunha Sequeira, BSc, BSc(OT), OT Reg.(Ont.), MHS, has been working at the Hospital for Sick Children in Toronto, Ontario for nine years. Dana has had the pleasure of preceptoring several occupational therapy students in various placements and has been a mentor for a group of occupational therapy students through the University of Toronto. Dana is an occupational therapy graduate from McGill University (2002), has a Status Appointment at the University of Toronto, and has recently completed her Master's in Health Studies and Leadership at Athabasca University (2011). She can be contacted at dana.sequeira@sickkids.ca.

OT THEN

COLUMN EDITOR: SUE BAPTISTE

Scholars and titans: Reflecting on conversations with some of today's great occupational therapy writers and thinkers in the nexus of science, art and technology

Lynn Rutledge

I am a reformed science girl. There, I said it, right out loud, and here in front of you on the written page, in black and white, out in the open for all to toil over, discuss and dissect. Had I selected a religion for myself somewhere along the way in my past 40 years, it would have been science. It is through a transformation of understanding in my own personal, professional and academic experiences that I have been able to see, sense and connect the intersections within the nexus of art, science and technology in occupational therapy. Through a position of reflexivity, I would like to tell you how some of my own experiences and conversations with a few of today's current great occupational scholars and titans have contributed to my interpretation of how this nexus weaves the tapestry of our profession.

My father was an exploration geologist and a brilliant man, even regrettably so described by his neurologist after Parkinson's had tempered away that brilliance. My father loved Oliver Sacks, the author of *The Man Who Mistook His Wife for a Hat* and many other science books that described our existence and the human condition. Being the impressionable youngest child, I followed suit and 'brain books' were one of my favorite past-times.

I loved to read about the brain, as the possibilities, idiosyncrasies and pathologies of human existence, mediated by the brain, seemed both endless and limitless. I remember being in Bible School as a little girl, on those occasions that our mother could drag us there kicking and screaming, and hearing about how all of the answers to our questions would be found when we went to heaven. I wondered, why wait until then when you could just find answers in the scientific literature? Surely, there must be some books somewhere with answers.

Science: Use the past to inform the present

After completing a science degree in university, I moved onto a degree in occupational therapy, and once again, was delighted to discover that science pervaded throughout the profession. The great occupational therapy scholars of scientific evidence, including Linda Tickle-Degnen in the United States, Mary Law in Canada and Annie McCluskey in Australia, were prophesying the monumental importance of evidence-based practice in deficit-ridden and increasingly accountable health care environments worldwide. Evidence-based practice (EBP) "incorporates elements of research utilization, professional judgment and preferences in the formulation of clinical decisions" (Dubouloz, Egan, Vallerand, & von Zweck, 1999, p. 445). Law (2002), Tickle-Degnen (2002) and McCluskey (2003) persuaded, cajoled and enticed occupational therapists to critically evaluate their assessment and intervention methods in reference to current research evidence.

To me, the message seemed clear. I was expected to reflect on what I did as an occupational therapist in light of the scientific literature, whether I referred to theorizing in books, randomized control trials, systematic reviews, case studies or experts in the field. Don't go it alone, look out into the great beyond and find the answers! Don't recreate the wheel, examine the past and recognize that others have experienced the same clinical irritations and anxieties and pondered the same research questions. However, there were stormy seas ahead as studies on EBP queried its effectiveness, and occupational therapists described many barriers and much resistance to EBP (MacEwan Dysart & Tomlin, 2002; McCluskey, 2003). Only a very limited number (<1 - 7%) of occupational therapists were seekers of evidence (Habouda et al., 2009) and too many seekers in the workplace could cause great strife (Korner-Bitensky & Menon, 2010).

Art: The conceptualization of professional artistry

As I settled into my studies in occupational therapy, I must admit there were many times when my long-established doctrine of science was challenged and in hindsight, with good reason. The term 'client-centred practice' was ubiquitous and, as Liz Townsend reminded me in my first year of this degree at Dalhousie University, I was not to say patient, it was to be client. I heard about focusing on the person rather than just the science, and adopting a professional artistry, including listening to the client and enabling occupation, which took me many years to really conceptualize. This professional artistry

involved using creativity, intuition and practical experience, as guided through reflection, to understand a client and their personal situation (Zimolag, French, & Patterson, 2002). I suppose that we could say with every ying, there is a yang. As evidence-based practice is to science, this professional artistry is to the art of the profession (Zimolag, French, & Patterson, 2002), as both contribute to and develop our construction of client-centred practice.

In my doctoral studies, I found myself suddenly straddling the post modern divide as I delved deeper and deeper into qualitative research. Denzin and Lincoln (2005) cautioned me against the dangers of my post positivist (scientific) leanings, that the Enlightenment was actually a dirty word, and that Cartesian dualism, in attempting to separate mind and body, was a rather unrealistic and somewhat caustic endeavor. I saw the parallelism between client-centred ideals and qualitative research approaches and I wanted to know more. I think I found myself somewhere between feeling a little miffed and really quite lost at Liz Townsend's retirement party in Halifax in the summer of 2010. Miffed as I felt that I was finally starting to get her message just as she was leaving, and lost as I did not know when there would be another scholar quite like her. Retirement? How does an occupational therapy titan retire?

Liz's crowning achievements include her enduring emphasis on occupational justice, understanding empowerment and enabling meaningful occupation not to mention being the recipient of the prestigious Muriel Driver Award. In retrospect, I had missed many of her contributions along the way, but I think I am beginning to understand some of them more deeply now, including her contribution to institutional ethnography in occupational therapy. She explored empowerment in the provision of occupational therapy mental health services in her book *Good Intentions Overruled*, examining how power and knowledge influenced this process. She pondered how we, as occupational therapists, may possibly be as much a part of the problem as the solution in the provision of care (Townsend, 1998). That is a question that I frequently ask myself as I grow older and hopefully a little wiser in my own professional career.

It is my own personal experiences in interfacing with healthcare firsthand, initially with my father and recently in being a caregiver to a close friend with a severe brain injury, that I reflect more deeply what it was Liz tried to tell us. Being on the other side of the fence, in being the recipient or friend/family member of the recipient of healthcare services, can be a very defeating and disparaging place. I must admit, at this point, that I don't really even like the terms client or patient and I simply abhor the ever popular auto insurance term claimant. I prefer person, people, personhood, or individual. Maybe the dividing lines that were meant to protect us and the recipients of our services in the form of professional boundaries ran too deep at some point? Maybe we ceased to understand and relate to one another as people, particularly as people in dire need or living in the wake of absolute devastation.

I wonder if occupational therapy knowledge needs to steep for a while, like a fine tea, before we fully conceptualize its intent. Appreciating occupational therapy knowledge requires practice experience, life experience and time to reflect. Perhaps, in the beginning, during our schooling, the great scholars try to teach us and to tell us their story but as young people, we really do not heed them, or can only glimpse a modicum of their message? I remember having a heated discussion several years ago with Mary Egan, one of my Master's thesis advisors, and a distinguished Muriel Driver recipient. My thesis looked at clinical decision making of occupational therapists in Ontario's auto insurance sector. I argued with Mary that client-centred practice did not always apply in this area, with the over-preponderance of insurance fraud due to seemingly nebulous health concerns like whiplash.

Alas, it was me who was mistaken, but I also should have known better than to argue with an occupational therapy titan. I think she was telling me to grasp the whole picture, to try to understand the reasons why people do what they do and that advocacy was a fundamental part of my role, regardless of the circumstance. I have the same discussions with junior occupational therapists now, but I soon abandon my arguments and leave them to their own devices, as I know that I do not have a titan's genius, persistence or patience. The process of modernization marches on, as it was the Baby Boomers providing tutelage to Generation X and now the Gen-X-ers trying to instruct the Millennials with a similar amount (and sometimes lack thereof) of success in regards to the fundamental tenets of our profession.

Technology: The precise details of occupational therapy

With the Millennials comes unprecedented access to and understanding of technology, in being both practical and techno-savvy (Boudreau, 2009). As with ying and yang, art and science need a middle ground; perhaps it lies in technology? Millennials and even impatient Gen X-ers and Baby Boomers embrace technology for its expediency, accessibility and specificity. I must admit I have embraced and even obsessed about technology and the technological aspects of my profession to promote my own efficiency and efficacy. Is this the right wheelchair and components, will this splinting material do what it needs to do or does this cognitive assessment have all of the sections that I need, without having too many? I conceptualize this as the technology in our profession; knowing the precise details and being able to mull them over endlessly in my mind, hoping to create something exceptional.

I have great admiration for those who can describe

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and explain the technological aspects of our profession accurately, precisely and with amazing clarity. One of my favorite references is a book by Pat McKee, a veritable deity in molding thermoplastics to the human body (McKee & Morgan, 1998). I have read and re-read this book many times, though; I have never once mentioned this while passing Pat McKee in the hallways of our department at the University of Toronto. She would think that I was a total nerd, and I like to keep that card close to my chest as long as humanly possible. In this book, the thermoplastic properties of many splinting materials are explained with ease, deftly assisting in clinical decisions regarding which materials to use and why. On second thought, I think that I do have a number of burning questions for Pat and I am quite sure that she won't mind. Oh dear, all I can do is ask.

Another great example of technological mastery is a book by Kelly and Snell (1987), *The Source Book* on barrier-free design. I have never seen another book quite like it and was fortunate enough to procure my own copy years ago. Again, this book uses precision in description, giving exact parameters for the widths of doorways, the correct angles of ramps and even for various transfers; far more information than I was ever able to discern from provincial building codes. In meeting Carol Kelly a few years ago at a traumatic brain injury course in Newfoundland, I asked when there would be a new edition of the book? She laughed and said that many other people still asked her that question. So, I am not the only admirer of mastery in the technological aspects of our profession.

The science, art and technology nexus

Well, I suppose that brings me to the nexus between science, art and technology in occupational therapy; the associated linkages between these concepts. I think that the interconnections and intersections of these concepts are ever changing and constantly being redefined by the great scholars and titans in our profession. I would guess that the great writers and thinkers in our profession have reflected on their own occupational therapy mentors, like Mary Reilly, Adolf Meyer, William Rush Dunton, and Eleanor Clarke Slagle; founding scholars described to me in the writings of Gary Kielhofner during my schooling. There have been many great contributors to our profession in the past and continue to be so now and many are accessible to you.

I think that exploring the nexus of art, science and technology is taking a little, or a lot from each of the great writers and thinkers in our profession. Sometimes their writings will make complete sense to us and at other times, we may not be able to grasp their message at all. I guess part of the post modern message, or even post post modern message (not that I am a post modernist!) is that there are many convolutions and complexities to human existence. And here it is from little old me, a reformed science girl from Northern New Brunswick, who ended up in the Big Smoke. I would like you to know that I have stopped along the way to have conversations with just a handful of the wonderful writers and thinkers in our profession and they have contributed greatly to my own personal, professional and academic knowledge and experience.

Today's great occupational therapy scholars and titans have simply published what they thought or were feeling at the time, so we would not recreate the wheel and so that we would take comfort in the commonalities of our existence. Considering the nexus is to reflect on those commonalties across our human experiences, from our monumental achievements to our own deep cavernous frailties and incorporating them into a more varied, interesting and fluid gestalt of occupational therapy knowledge. While education is intended to promote and develop knowledge, it is the reflection on experience; including academic, professional and personal; that cultivates knowledge to its full fruition, like the rising tendrils of a growing forest fire. Don't hesitate to ask a question, have a conversation, send an email or even snail mail to a great scholar or titan, if only just to acknowledge them and to let them know that you are reading, listening to and thinking about their many contributions. Who knows, some of them probably even know how to Twitter, though I know I surely don't!

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PRACTICE SCENARIOS

COLUMN EDITOR: MARY STERGIOU-KITA

When client-centred and family-centred approaches clash: A modified Conscious Decision-Making Framework to the rescue!

Evelyne Durocher and Tanya Glencross-Eimantas

Meet Sam

Sam is 12 years old and enjoys playing computer and video games with his brothers. He has a diagnosis of muscular dystrophy. Sam uses a manual wheelchair but is considering switching to power mobility due to increasing muscle weakness. He currently requires maximal assistance to go up and down stairs, which is getting more difficult. Sam uses all floors of his home as his room and bathroom are on the second floor, the television and video games are in the basement, and the computer is on the third floor. The occupational therapist recommends a lift device to enable access to all floors; however, Sam's parents prefer to install a stair-lift between the main and second floors. They intend to access charitable funding to cover the costs. The occupational therapist is conflicted. She feels the family's choice does not meet all of Sam's needs. She wishes to apply client-centred principles but her employer mandates a family-centred approach. Whose wishes and needs should she consider?

Introduction:

Occupational therapists have been practicing under a client-centred paradigm since the 1980's (Sumsion, 1999; Sumsion & Law, 2006). Recently there is increased dialogue about the differences between the philosophical paradigms of occupational therapy and the approaches to service delivery utilized in organizations that employ occupational therapists (Wilkins, Pollock, Rochon, & Law 2001; Law et al., 2003). Some organizations providing services to children or older adults have adopted family-centred approaches as opposed to client-centred approaches (Kyler, 2008). At times the two approaches suggest conflicting courses of actions, leading to ethical challenges for occupational therapists attempting to practice under both paradigms. The purpose of this paper and practice scenario is to briefly review client-centred and family-centred approaches and introduce a modified conscious decision-making framework to assist clients and therapists facing complex decision-making.

Client-centred care

Client-centred practice is a collaborative approach that promotes respect for clients' choices, client involvement in goal-setting and decision-making, advocacy with and for clients, and recognition of clients' experiences (Sumsion, 1999). Clients are active participants in the therapeutic partnership. The 'client' in 'client-centred' may be one individual, or may comprise a set of individuals (e.g., a family, group, or even a community, organization or population of individuals) (Townsend & Polatajko, 2007). Issues can arise however if individuals in the client group have diverging needs or interests.

Family-centred care

Family-centred care is also a collaborative approach involving a partnership between clients and therapists. In family-centred care the client is the family, including the family member receiving therapy (Leviton, Mueller, & Kaufman, 1992; Higuchi, Christensen, & Terpstra, 2002; Hyun, 2003). In the case of a child, the child's parent(s) or guardian(s) define goals and make decisions. Therapists using a family-centred approach consider parents to be experts in their children's care (Able-Boone, 1996). Family-centred care posits that optimal child functioning occurs within a supportive family environment and recognizes that children's well-being is greatly affected by the family's well-being (Law et al., 2003).

When client-centred and family-centred approaches don't match

While client-centred and family-centred approaches share attributes of collaboration and client decision-making, and mandate practice that is respectful, flexible and responsive to client needs, significant differences distinguish them. In client-centred care, clients are considered experts in their own care, have their own best interests at heart and are primary decision-makers. In family-centred care, the family is considered the expert in the child's care. The family is assumed to have the child's best interests at heart and is the primary decision-maker.

When a family-centred approach would suggest different actions than a client-centred approach, ethical conflicts can arise for therapists guided by client-centred tenets of occupational therapy, who practice in an organization mandating family-centred care. Whose needs are to be considered or prioritized? What if the child's needs are not met through the family's choices? Clients can make decisions that do not align with healthcare recommendations, but when the therapist is funded to provide services for a child's care needs, abiding by family choices that do not support the child's needs can cause moral distress for therapists.

Application of the Modified Conscious Decision-Making Framework

While ethical concepts may not supply answers, the application of ethical frameworks to a scenario can help to identify issues, underlying factors shaping these issues and values that may be in conflict. This process may assist in identifying options. In Canada, provincial occupational therapy colleges have codes of ethics to guide practice. We have modified the Conscious Decision-Making Framework put forth by the College of Occupational Therapists of Ontario Code of Ethics (COTO, 2002a; COTO 2002b) to make it more applicable to complex scenarios involving ethical decision-making (Table 1). Steps were combined and more guiding questions were added to incite further reflection.

Step	**Guiding questions**
Step 1: Describe the situation	What are all the facts of the situation? Who is the client? Who are the other stakeholders/players and what are their roles? Are all stakeholders and their interests/agendas identified? What is each stakeholder's wish/ recommendation and why? What are the underlying issues for each stakeholder? What are the client's best interests and from whose perspective?
Step 2: Consider if further information is needed and identify resources	Are there relevant regulation(s), guidelines or legislative concerns? What evidence exists to inform occupational therapists' actions or recommendations? Are there individuals with expertise in the area? Are there missing facts?
Step 3: Identify and consider all potential options	Be creative! What are ALL the possible options? What are the advantages and downfalls of each situation? What value is being upheld in each? Is there a potential option that will uphold more advantages and decrease disadvantages?
Step:4 Choose the best option and take action	Go!
Step 5: Evaluate the decision	What impact did the decision have on those involved? Was the anticipated outcome achieved? How did the outcome match or differ from the anticipated outcome? If there were differences between the anticipated and actual outcome, could these have been predicted? Would you make the same decision again or would you do something differently?

Table 1. Modified Conscious Decision-Making Framework

Stakeholder	Perspective/wish/choice/recommendation and why
Sam	Wants to independently access all floors Why? Wants to 'hang out' and play video/ computer games and watch television
Sam's parents	Want to install lift between main and second floor only Why? Do not wish for the home to appear institutional Are concerned about resale value of the home
Occupational therapist	Recommends a lift for Sam to independently access the whole home Why? Feels a client-centred approach suggests advocating to maximize Sam's independence Aims to protect Sam's physical safety Aims to address Sam's long-term needs Wants to maintain accountability with funding source and suggest recommendations that meet client need and fit into funder's mandate
Other healthcare professionals and healthcare system	Do not have a direct say in this situation but wish to maintain Sam's health and prevent hospital readmissions

Table 2. Stakeholders and perspectives

Applying the framework to Sam's situation

Step 1: Describe the situation
Sam cannot independently access all areas of his home. Table 2 outlines the stakeholders and their perspectives. Identifying Sam's best interests may be tricky because everyone may not agree on what these are. Sam may feel these are to continue his activities. Sam's parents may feel his best interests are to be protected from negative opinions and that the family's financial security is in the entire family's best interest. The occupational therapist may feel that Sam's best interests are to maximize his independence to continue leisure occupations. While these are the expressed views, there may also be additional underlying issues to consider. For example, do Sam's parents worry they will be uncomfortable with a lift? Does the occupational therapist worry she will look like a 'bad' therapist if Sam cannot independently access the home? Is she worried about liability if Sam or his parents fall on the stairs?

Step 2: Consider if further information is needed and identify relevant resources
Relevant guidelines include college standards of practice, the employer's policy and the funder's guidelines. As has been alluded to, these suggest conflicting courses of action.

Step 3: Identify the options
Looking at all options and being creative, the occupational therapist and family outline the options, advantages and downfalls (see Table 3).

Step 4: Choose the best option and take action
The family firmly chooses option 4: installing a stair-lift between the main and second floors and moving the electronics to the main floor. As informed consent is an important part of this process, the occupational therapist must initiate dialogue at the beginning of care about the occupational therapy role. The family should be informed that they may not agree with recommendations the occupational therapist will make. It is imperative that the therapist document all the steps of the informed decision-making process and subsequent discussions. The occupational therapist is asked by the family to write a recommendation letter to the funding agency. Because her recommendation differs from the family's choice, in her letter to the funder, the occupational therapist should outline all options and indicate the family's preference without endorsing any option.

Step 5: Evaluate the decision
In evaluating the decision the occupational therapist may continue to feel that the family's decision was a short term solution but maintaining the relationship was important to ensure an ongoing productive relationship. However, by making certain that the family was informed of the risks and benefits of their decision, she can feel that she did not compromise her professional accountability.

Conclusion
In this case, we illustrate how application of the modified Conscious Decision-Making Framework enabled the identification of a course of action that each stakeholder felt supported their needs and that the occupational therapist felt was compatible with both client-centred and family-centred approaches. By being clear about the occupational therapy role and the risks and benefits of interventions, the occupational therapist has satisfied professional standards and maintained her

Option	Advantages	Downfalls
1. Elevator installed	Sam can independently access all floors.	Substantial home modifications and cost; may affect resale value
2. Stair-lift installed between main and second floors	Sam can independently access the main and second floors; lift is removable; home is least disturbed.	Sam cannot access areas containing activities that are important to him; short term solution in light of deteriorating condition
3. Moving to a more accessible home	Sam's independence will likely be increased; fewer modifications necessary.	Significant change for all family members; potentially more implications (e.g., changing schools, changing commute to work, making new friends in neighbourhood, etc.); potentially costly
4. Stair-lift between main and second floors and television, computers and video games move to common area main floor	Sam can independently access main and second floors including the television, computers and videogames.	Is an adjustment for the family; short term solution in light of deteriorating condition

Table 3. Options, advantages and downfalls for Sam and his family.

relationship with the family. In writing a letter outlining all options without endorsing one, the occupational therapist has maintained accountability with the funder. Using decision-making frameworks may assist occupational therapists facing complex situations where they feel their professional values are being challenged by patient wishes and their occupational therapy roles and responsibilities.

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PRIVATE PRACTICE INSIGHTS

COLUMN EDITORS: CHRISTEL SEEBERGER AND JON RIVERO

Private practice occupational therapy: Reasons for making a difference

Christel Seeberger and Jon Rivero

There are growing numbers of occupational therapists in private practice in Canada. Private Practice Insights Co-Editors Jon and Christel have some thoughts to inspire you to consider becoming an occupational therapist in private practice or to motivate you through the challenges of self-employment.

Christel Seeberger is the owner of tOTal ability, a private occupational therapy practice she founded in 2002. Find tOTal ability on Facebook, follow tOTal_ability on twitter and learn more about Christel and her team at www.totalability.ca.

Christel's Top 10 reasons why she is an occupational therapist in private practice:

1. I get to do, be, become and believe what makes me feel like a hero every day.
2. Being in private practice helps me with my personal mission is to bring occupational therapy to the world.
3. My worst day in private practice/running a business is still better than my best day in public practice. And that isn't being critical of public practice!
4. Private practice is a 'just right challenge' for me.
5. It has given me the opportunity to lead and mentor in ways that I never thought I could or would.
6. I always thought my business name spoke to what I could do with my clients; but in fact "tOTal ability" really speaks to what my private practice has enabled me to do as an occupational therapist.
7. My favorite thing to help my team of occupational therapists (and anyone who asks) is by being a repository of occupational therapy information and resources.
8. I used to think I was afraid to fail and worked really hard to develop my occupational therapy skills so I wouldn't. But being in private practice, sometimes it really isn't that I am afraid to fail, it is that I am afraid to succeed in business, that scares me more!
9. Being in private practice serves my 24/7 obsession with occupational therapy like nothing else.
10. Occupational therapy isn't a job; it's a way of giving and living.

Jonathan Rivero is the Creative Director of Qi Creative Inc. Qi Creative is committed to empowering individuals and families of all needs to discover their passions and live their potential. To learn more please visit www.qicreative.com.

Jon's Top 10 reasons why he is an occupational therapist in private practice:

10. I creatively expand the role of occupational therapy by offering unique ways to translate theory into everyday practice.
9. I create a way of life that allows me to travel the world and learn from other cultures.
8. I am responsible and accountable for the exact amount of my financial success.
7. I am fully able to create a balanced way of life that integrates my spirituality, self-care, leisure, and productivity.
6. I create a practice in which I explicitly use my unique passion and talents to serve Qi clients and inspire Qi coaches to do the same.
5. I charismatically promote self-expression to youth locally, nationally, and internationally.
4. I am enabled to 'be the change' that I want to see in my world by enabling occupation for myself.
3. I continuously challenge myself to grow and I am committed to lifelong learning to better serve the world.
2. I do what I love and love what I do.
1. Everyday I wake up and say "thank you" for the opportunity to live undeniably with passion and meaning and reap the benefits of unlimited potential!

Whether people's passions or interests are the same or different, private practice occupational therapists are represented all over Canada and continue to make a difference in the lives of others in both urban and rural communities.

STUDENT PERSPECTIVES

COLUMN EDITOR: TOM GRANT

Sharing of wisdom (part II): If I knew then what I know now

Laura Thompson and Erin Fraser

We have now lived the experience of transitioning from the classroom to clinical practice. As mentioned in *Sharing the wisdom (part I): Shaping the transition from student to occupational therapist*, we found ourselves cycle through a myriad of emotions: excitement for the beginning of a new career, anxiety about our clinical roles, and finally emerging confidence in our skills and clarity about the meaning of being a clinician. Our experiences mirrored those of other newly qualified health care professionals that are recognized in the literature (Morley, 2006).

As a result of our experiences and reflections from our first year of practice, we compiled strategies that we found useful when adjusting to our new clinical roles – suggestions that would have been helpful if shared with us during our first few weeks as occupational therapists. We hope that these tips help facilitate open discussions among upcoming graduates, new therapists, and seasoned clinicians about the realities of practice and ways to embrace the transition process.

From two recent graduates to others in the same situation – some words of wisdom for your first year of practice:

1. Acknowledge your emotions

The transition from student to clinician is recognized as a challenging time (Toal-Sullivan, 2006). We found that by acknowledging our feelings, we were better able to put them into perspective and focus our energy on the clients we were serving.

2. Seek out mentors

Maintain relationships with past mentors and seek out new ones in your area of practice. Mentors are invaluable in terms of the experience they possess and depth of perspective on clinical situations. We found it useful to validate our own ideas and thought processes, and to work through challenging circumstances with them. Mentors are also a wonderful source of motivation and encouragement, and are readily able to point out areas of strength. Mentors helped us realize how much we have grown professionally and accomplished over the past year.

3. Connect with peers

Connecting with colleagues who were also new clinicians helped us to realize that we were not alone in experiencing these challenges during our first months as practitioners. It was helpful to discuss the obstacles we were facing, successes we were proud of, and strategies we were using to adapt.

4. Take time to reflect

Taking time to reflect on our journeys from the classroom to the working world has been invaluable. It has fostered increased awareness of how we developed skills and confidence, and overcame challenging situations. We found that keeping a journal helped to preserve thoughts, which could be re-read at a later time to demonstrate professional growth.

5. Go back to the books

Reading the literature on the transformation from student to occupational therapist was also a valuable process. We found several key articles that were quite informative, especially those discussing the stages of transition (e.g., Morley, 2006; Sutton & Griffin, 2000; Toal-Sullivan, 2006; Tryssenaar, 1999; Tryssenaar & Perkins, 1999). Although we appreciate that each of us will have a unique experience, learning about the predictable nature of the process helped us understand that the emotions, struggles, and achievements we were encountering were fairly typical. In fact, we found these articles so interesting that we shared them with former classmates – several commented on how much they could relate!

About the authors

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6. Occupational balance

In the initial weeks and months of learning how to juggle job requirements, studying for the national exam, and professional development activities, we both felt dangerously close to 'burning out'. We often became overwhelmed with the need to acquire information so that we could feel more assured that we 'had the answers'. It took several months to realize the extent of our occupational imbalance and the effect this was having professionally and personally. After gaining this insight, we both made a conscious effort to regain occupational balance. Ensuring that we made time for family and friends and meaningful leisure occupations, in addition to our professional roles, helped us stay motivated and energized for our client interactions.

7. Enjoy the journey

We quickly realized that professional development is life long – there are sure to be many successes and challenges along the way – so, enjoy the journey!

Note from the Editor :

Sharing of wisdon (part I): Shaping the transition from student to occupational therapist was published in the March/April, 2011 issue of *Occupational Therapy Now.*

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COLUMN EDITOR: ALISON SISSON

The urban/remote challenge: Improving the continuum of care for Nunavummiut

Katie Bellefontaine, Myka Riopel, Janna MacLachlan, Joanie Conrad, and Cathy McNeil

Nunavummiut (people of Nunavut)

Understanding clients' cultural, physical, social and institutional environments is essential to effective discharge planning. It can be challenging for occupational therapists who work in an urban setting to understand and appreciate the unique needs of their rural clients, particularly when those clients live in Nunavut's Baffin Region, home to some of the most remote communities in the country.

Therapists at The Ottawa Hospital (TOH) face this challenge regularly. TOH often treats clients from the Baffin Region who leave Nunavut to access services that are unavailable at the territory's only hospital in Iqaluit. Without specific knowledge of Nunavut's communities and their unique characteristics, occupational therapists working at TOH—a large modern hospital in the heart of Canada's capital—might easily assume that their Baffin Region clients will be able to access the same quality and scope of services as their southern clients following discharge. At the same time, unless they have had previous contact with TOH staff, occupational therapists practicing in remote settings might find it daunting to navigate urban hospital systems of tertiary and quaternary care such as TOH. Until recently, these two-way challenges frustrated therapists and, more importantly, hindered client care.

Occupational therapists in Nunavut and Ottawa have since collaborated to establish a successful partnership. The lesson is simple, yet worth repeating: communication and collaboration between urban and rural therapists helps everyone to provide comprehensive therapy and improve continuity of care for their clients.

Background

Nunavut's Baffin Region is composed of 12 fly-in communities spread across an area roughly the size of Ontario. The region's largest community, Iqaluit, has about 7,000 residents; the smallest, Grise Fiord, has less than 200 (Nunavut Bureau of Statistics, 2010). Of the region's nearly 17,000 residents, about 80% are Inuit (Statistics Canada, 2006a).

The practice context of Nunavut poses unique considerations and questions for clinicians: How can we improve the accessibility of homes built on stilts above the permafrost? Which wheelchairs and tires provide the best traction on snow? Which pressure-relieving cushions won't freeze or deflate in -50 degree temperatures? In Nunavut, where 62% of residents report their mother tongue as Inuktitut, the assistance of translators is a daily requirement (Statistics Canada, 2006b). As there are no equipment vendors in Nunavut, all equipment is brought from southern Canada by plane or during the short summer months by boat. Nunavut is also a place where "alcohol and drug abuse, high unemployment, family violence [and] high suicide rates" (Pauktuutit Women of Canada, 2006, p. 43) unfortunately affect many clients and families.

In the Baffin Region, two full time permanent positions exist in occupational therapy although they are not always filled. Therapists deliver all necessary services to the region, using a combination of telehealth, clinic and home visits, and once-annual visits to each community. At times, it is necessary for individuals to travel to the territory's capital city, Iqaluit, for health care, or in some cases – such as for major surgeries, rehabilitation, or special care that is not available in a primary care hospital – to Ottawa. TOH is comprised of three campuses of over 1500 beds. Occupational therapy services are delivered from acute care, rehabilitation centres and outpatient hand therapy clinics.

Challenges for TOH therapists

Occupational therapists at TOH often found discharge planning for clients from the Baffin Region challenging. Therapists felt they lacked important information about the culture and environmental context of Nunavut. They weren't aware of what resources and services were available to their clients at home and were unsure if their clients could receive follow up after discharge. Finally, some were unsure how to contact therapists in the Baffin Region to facilitate discharge planning.

Challenges for Baffin Region occupational therapists

Therapists in the Baffin Region received few referrals for post-discharge follow-up from TOH. Instead, therapists often learned of clients that needed follow-up weeks or months later when a referral was sent by a Nunavut-based nurse or doctor.

Unfortunately, clients often returned home from Ottawa with equipment that wasn't suited to their home environment (e.g., bed assist rails for clients who slept on mattresses on the floor, or wheelchairs set up with a low seat to floor height whose footplates would get caught in the snow). When generalist therapists in the Baffin Region encountered complex client issues, it was difficult for them to obtain information about previous or current interventions completed in Ottawa because they did not know who to contact, or how.

Partnership

Both groups of therapists working with Nunavummiut struggled to provide occupational therapy services because of a lack of important contextual information and communication between the two groups. At the 2008 Canadian Association of Occupational Therapists (CAOT) National Conference in Whitehorse the two groups of therapists took advantage of the opportunity for a face-to-face meeting to improve the continuum of care for clients returning to Nunavut. They continued to meet regularly over the phone to discuss challenges and potential solutions. Through these discussions, several projects were initiated.

Discharge planning tool

One project involved surveying TOH occupational therapists (including rehab, acute care and outpatient areas). The survey identified perceived gaps in knowledge regarding discharging patients back to remote Nunavut communities, and that therapists wanted to know more about the environment, Inuit culture and services available in the Baffin Region. Based on the results of the survey, a discharge-planning tool was created to guide therapists' clinical reasoning and discharge planning. The tool is intended to be a quick and easy-to-use resource that contains contextual information about the Baffin Region relevant to occupational therapy. It addresses specific occupational, cultural, environmental, and institutional topics to consider when planning discharges. For example, is the client able to tolerate sitting for a three and a half hour flight? What kind of wheelchair set-up works best in the snow? How does the funding for Inuit Canadians operate and what are the limitations? After trialing the tool for three months, initial feedback indicated that the tool is an important and educational resource that aids discharge planning for clients from the Baffin Region.

The locum experience

Another project resulted in two TOH occupational therapists completing short-term locums in Iqaluit. Sending locum therapists from Ottawa to Nunavut was mutually beneficial, providing Nunavut with therapists (which are often difficult to attract) and increasing knowledge about Nunavut and Inuit culture within the TOH team.

When reflecting on their experiences, both therapists identified the importance of cross-cultural learning that occurred through the locum opportunities. Working with translators taught the therapists to be mindful of how they worded their questions. One therapist recalled repeating a question when their client was not answering. In fact, the client was answering with a subtle raise of the eyebrows – a gesture for 'yes.' It was a lesson that quickly highlighted the need to understand cultural cues. Observing and participating in traditional Inuit and Northern occupations helped the therapists to understand some of the important cultural implications of occupation. Both therapists found that being creative was required because of limited resources and differing occupational performance issues as compared to their regular practice setting. For example, Inuit traditionally sit on the floor to cut up meat and eat a meal, which requires clients to be able to lower and raise themselves, highlighting the physical requirements of a dinner routine.

Upon returning to Ottawa, the therapists shared their experiences and new learning with the occupational therapy department. Colleagues considered these therapists important resources to improve their ability to work with clients from Nunavut. This facilitated discussion among team members and ultimately increased general knowledge of Nunavut among TOH therapists.

Interestingly, a former TOH therapist has now moved and is working in the Baffin Region and a former Baffin Region therapist has moved to Ottawa and is working at TOH. This could be considered an indirect effect of the partnership. Both sites welcomed the respective knowledge and experience of these therapists

Education sessions and collaboration

Informal and formal educational opportunities were organized by the partnership. This included a presentation to therapists at TOH about the context of the Baffin Region and occupational therapy specific information to improve the continuum of care. This session was conducted in person by a therapist from the Baffin Region at TOH and therapists had the opportunity to ask questions and discuss specific examples. Also, two TOH therapists from the hand therapy program visited Iqaluit to instruct a three-day education session, consisting of anatomy, pathology, treatment, and splinting.

Management at both sites supported communication between the two groups of therapists by exchanging contact lists. Therapists at TOH were encouraged to contact Nunavut therapists to ask questions and discuss discharge planning for clients. Such communication facilitated improved outcomes for clients. For example, it provided Baffin Region therapists the opportunity to assist with discharge planning and equipment prescription by emailing pictures of a client's home set-up. Therapists in Nunavut have found this type of information sharing helps to prevent the order of inappropriate equipment.

Future goals

The TOH/Baffin working group feels that giant strides have been made to improve communication and that this partnership can continue to strengthen. The final draft of the discharge-planning tool is currently being reviewed. The partnership plans to continue monitoring the learning needs of therapists and endeavours to share more resources, information, and experience. We recognize that we are not experts on Inuit culture and are developing relationships with Inuit organizations to learn more about Inuit culture and ensure our actions are relevant. Eventually, we hope to formalize and expand the partnership to include other disciplines such as physiotherapy and social work, and include other hospitals in Ottawa who have a similar contract with the Baffin Region. The team also hopes to collect formal feedback from our Nunavumiuut clients to find out how they perceive transitions between the north and south and how we can continue to improve services.

The creation of our partnership and the development of the discharge-planning tool has resulted in strengthened communication and collaboration, and has made us each more skilled and mindful therapists. TOH therapists have expressed that they feel they have more knowledge about Nunavut, and Baffin Region therapists report smoother transitions from urban back to remote settings. As a result, the quality and level of care we give to Nunavummiut clients is continually improving.

We feel strongly about the need to foster partnerships between urban and remote therapists who share clients. By sharing our experiences with OT Now readers, we hope that other therapists can reflect on their relationship with partner therapists, whether they work in the same community, for different organizations, or in opposite rural/urban environments.

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KT & OT

COLUMN EDITORS: HEIDI CRAMM AND HEATHER COLQUHOUN

KT and OT: A context for knowledge translation for occupational therapy

Heidi Cramm and Catherine White

Knowledge translation, often referred to as simply KT, is a complex multi-step process focused on bridging the know-do gap between knowledge production and its implementation (Graham et al., 2006). Described as an essential competency for occupational therapists (Law et al., 2007), KT is positioned to increasingly impact how occupational therapists develop and use knowledge in their practice as well as how healthcare, policy, and research systems engage in knowledge development and use. This article is intended to provide a context for occupational therapists around KT and introduces the OT Now column, KT and OT, an evolution of the former Theory Meets Practice column.

What is KT?

The body of scholarship exploring definitions, conceptual and theoretical frameworks, and applications of KT has mushroomed dramatically, with related Google hits increasing almost 400,000% in just five years (Campbell, 2010). Dozens of related terms like knowledge transfer, implementation science, and research utilization, diffusion, and dissemination have been used. In response, the Canadian Institutes of Health Research (CIHR), the preeminent health research funding body in Canada, clarified the term knowledge translation, a dynamic and iterative process to include:

> "...the exchange, synthesis and ethically-sound application of knowledge - within a complex system of interactions among researchers and users - to accelerate the capture of the benefits of research for Canadians through improved health, more effective services and products, and a strengthened health care system." (Graham et al, 2006, p. 15).

This definition emphasizes a collaborative relationship that allows knowledge developers and users to converge on the goal of improving health care. The collaborative process takes place not just at a single point, but through multiple punctuations from beginning to end with an overall intent of increasing the relevance and timely uptake of knowledge into practice.

In our daily work as occupational therapy clinicians, preceptors, educators, administrators, and researchers, regardless of our practice setting, we engage in KT whenever we move to "acquire knowledge, to synthesize it and to present it in a way that will be meaningful...to clients, families, team members, administrators, policymakers, and the general public" (Law, Missiuna, & Pollock, 2007, p. 3), as well as to student occupational therapists. How often in practice do our interventions involve sharing our knowledge—about community resources, intervention plans, consent, or new strategies? The use of KT resources has the potential to optimize our efforts in communicating with clients and enables us to understand why certain changes are difficult to implement in different circumstances (McGowan, 2010). KT can also help us better understand why we struggle as practitioners to implement what we learn from a journal article or a professional workshop (Ketelaar, Russell, & Gorter, 2008) - traditional 'push' knowledge dissemination strategies (Jacobson, Butterill, & Goering, 2003) that have been shown to have little effect on practice (Graham, Beardall, Carter, Tetroe, & Davies, 2003).

KT looks to redress the reality that research evidence remains inadequately diffused and underutilized, despite the system's emphasis on evidence-based practice (Ferlie, Fitzgerald, Wood, & Hawkins, 2005; Sudsawad, 2007). With its explicit and emphatic consideration of context, KT looks to tease apart how the context may change what knowledge is needed, how it would be used, and what strategies might be possible and effective in each particular setting to promote knowledge uptake. It expressly considers the fit "between the theoretical perspective and the context in which it is to be applied" (Estabrooks, Thompson, Lovely, & Hofmeyer, 2006, p. 33).

What does KT look like?

KT provides an overarching approach by which the therapist's knowledge from all sources is synthesized and brought to bear on the particular context of a specific client, either individual or system. The most widely recognized framework to articulate the KT process is CIHR's Knowledge-To-Action ([KTA], Graham et al., 2006) (see Figure 1), which integrates a range of existing theories into a two-part interactive process: knowledge creation and action. Knowledge creation is represented as a funnel wherein knowledge becomes more refined and useful through knowledge inquiry, knowledge synthesis, and the development of knowledge products. The knowledge inquiry phase may include individual

studies, information from primary sources, and experiential knowledge. The knowledge synthesis phase aggregates knowledge through systematic reviews, meta-analysis or meta-synthesis. The refinement of knowledge products such as practice guidelines or client-friendly tools occurs in a dynamic process between knowledge creation and action that translates the knowledge in a meaningful way to a specific context. The action cycle represents the steps that lead to the implementation or application of the knowledge, and is based on planned-action theories. This process involves identifying a problem, reviewing research, adapting the findings to the local context, assessing potential barriers, implementing necessary changes, and monitoring and evaluating ongoing use.

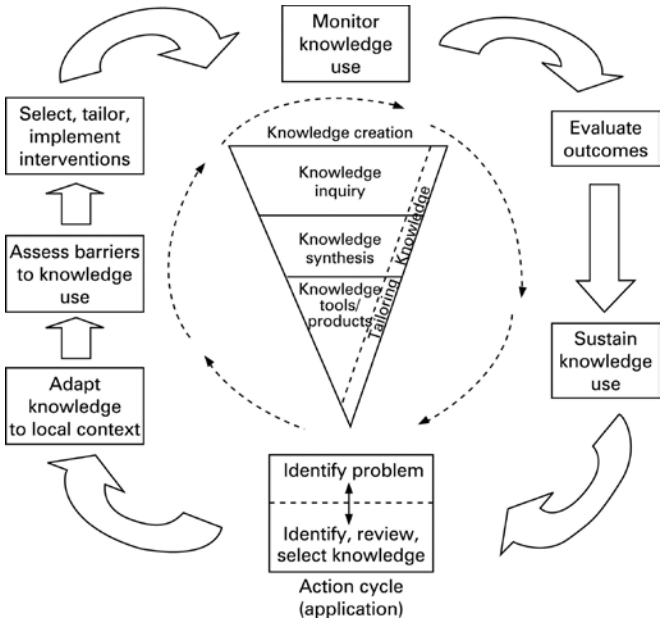

Figure 1: Knowledge-to-Action cycle

How can we expect KT to affect occupational therapy?

Occupational therapy has begun to consider how the KTA framework can be used or adapted to provide a flexible process to engage in clinical interactions, community development, organizational change, and collaborative research development. Metzler and Metz (2010) have adapted the KTA framework in the context of occupational therapy practice to clarify how the therapist, the therapist's knowledge, and the occupational issue identified with the client play out in a therapeutic interaction. We can draw on other recent KT efforts such as the Professional Interest Forum at the 2010 CAOT National Conference on developing KT strategies for Enabling Occupation II (Paterson et al., 2010) and the implementation of KT strategies to integrate the Assessment of Motor and Process Skills into practice (Moore & Lewis, 2008) to help guide future KT activities.

With traditional methods of continuing education having little impact on practice change (Kent, Hutchinson, & Fineout-Overholt, 2009; Ketelaar et al., 2008), KT is influencing how knowledge is generated and used across health disciplines. As health care professionals, we can expect and press for changes to the structure and delivery of professional development and continuing education opportunities. Continuing education can be designed to integrate KT strategies by drawing on models of intentional learning that consider how we explore, question, investigate, collect, organize, reflect, integrate and adapt (Countee, 2006). Such changes would complement incidental learning associated with conference attendance and journal reading, enhancing the relevance of professional development experiences by increasing interactivity and allowing therapists to tailor the education to their practice context.

Conclusion

KT, as "a powerful tool for leveraging our clinical resources to optimize health outcomes" (Hedges, 2007, p. 924), has become an expected component of research and practice. The CIHR has been explicitly prioritizing integrated KT strategies in its funding (Baumbusch et al., 2008), pressing the entire health care system to change how it generates and uses knowledge (Salbach, 2010). Interprofessional communication and collaboration will need to function more effectively than ever to converge on funding that will ultimately shape health policy (Zwarenstein & Reeves, 2006). Occupational therapists must purposefully engage in KT to remain competitive, competent, and relevant in the production and use of knowledge where shrinking resources and increasing clinical demands create difficult decisions for policy makers, administrators, and funding agencies (Kerner, 2006).

It will take reflection, time, and effort to engage in the KT paradigm shift. Theory development to advance KT is a necessary but ongoing process (Colquhoun, Letts, Law, MacDermid, & Missiuna, 2010), and the occupational therapy profession has many opportunities to benefit from and participate in the refinement of KT. Importantly, "[t]he way we

Website	Notable Features
http://www.cihr-irsc.gc.ca/e/39128.html	Four online knowledge translation learning modules .
http://ktclearinghouse.ca/	KT tools, glossary, KT Canada
http://www.ncddr.org/knowledge_trans_over.html	KT library, measures, presentations
http://www.iceberg-grebeci.ohri.ca/resources/enviroscan_websites.html	Links to all Canadian KT Centres

are conducting KT research is changing for the better, with the goal of making our efforts relevant to daily practice. So the next time a researcher invites you to collaborate on a project as a knowledge user, get involved! Together, we will make a difference" (Salbach, 2010, p. 294). The editors of the KT and OT column, Heidi Cramm (heidi.cramm@queensu.ca) and Heather Colquhoun (colquhhl@mcmaster.ca) welcome submissions that describe KT activities in practice, explore how to integrate knowledge into practice, or advance the theory and science of KT in occupational therapy.

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Occupational therapy making new developments in the transportation industry

Cheryl Evans, CAOT Communications Coordinator

In 2001, the World Health Organization (WHO) identified transportation as essential as self-care and communication. Transportation, in some form, is indeed necessary not only to accomplish many daily tasks such as attending school/work, medical appointments, and shopping but also for one's mental health and the importance of being part of one's community.

Transportation is emerging as a major area of practice for occupational therapists and Canadian Association of Occupational Therapists (CAOT) member, Teresa Fricke, has been integral in that development.

Teresa works as part of the Client Services Division of the Transit Department at the City of Winnipeg, developing and implementing functional transit skills and assessment tools. These specialized assessments focus on determining a client's eligibility for paratransit (door- to-door service), along the continuum of public transportation (fixed-route service [city buses] and paratransit). Fricke not only works closely with clients, families, and special interest groups but also liaises with health care professionals and vendors to provide education regarding key elements of transportation.

"The multifaceted issues of transportation have an effect on populations from pediatrics to geriatrics," says Teresa. "No matter the demographic, the goal remains the same – enabling transportation."

Teresa is also an avid advocate and promotes community mobility and engages fellow occupational therapists in getting on board with transportation issues. She has presented at conferences with special interest groups and hosted educational sessions for wheelchair prescribers and various health care providers to provide a greater knowledge of Paratransit vehicles, Transit buses, and the interface of mobility aids and securement systems. She also offers placements to students and enjoys the opportunity to exchange knowledge and promote new and innovative roles for occupational therapists.

Teresa credits CAOT for providing educational opportunities such as webinars that discuss popular topics and allow the opportunity for the participants to contact the presenter afterwards to address further questions and build networks.

"CAOT allows me to network nationally with therapists who hold similar interests and expertise," says Teresa. "Because of this, we are able to further our practices and in turn benefit our mutual clients."

With her dedication to the profession and the products and services available at CAOT, Teresa is hopeful that many more individuals with disabilities and health care professionals will be more informed about safe, independent, and accessible transportation options.

ENHANCING PRACTICE: OLDER ADULTS

COLUMN EDITOR: SANDRA HOBSON

Applying an innovative model of interprofessional team practice: The IMPACT model in action

Anne Medlock, Elaine McKee, Jenna Feinstein, Stephanie H. Bell and C. Shawn Tracy

The increasing number of older Canadians with multiple chronic conditions presents a challenge for healthcare providers. The expanding focus on interprofessional health teams demonstrates a growing recognition that the skills and expertise of multiple healthcare providers working together in close collaboration might well be what is required to deliver the best care to elderly clients with complex needs (Gage, 1997). The IMPACT clinic (Interprofessional Model of Practice for Aging and Complex Treatments) was developed to improve primary care for older adult clients with multiple chronic conditions and to enhance interprofessional training for those who will be providing this care.

In the first part of this article, Applying an innovative model of interprofessional team practice: The view from occupational therapy (Medlock, McKee, Feinstein, Bell, & Tracy, 2011), the development and implementation of the IMPACT model was described and the experience of the occupational therapist on the IMPACT team was explored. As noted in the first part of the article, the IMPACT model features a comprehensive interprofessional team. The role of the occupational therapist on the team centres on the comprehensive analysis of client vulnerability in the physicial/functional, cognitive and perceptual/sensory domains (Canadian Association of Occupational Therapists [CAOT], 1997). Further, the occupational therapist evaluates the impact of these domains on the client's self-care routines, safety at home and in the community, and leisure/productive activities. This article will focus on the experience of the client moving through the IMPACT process.

Highlights from one client visit

Mr. K was referred to the IMPACT clinic by his family physician owing to concerns around rapid deterioration and frequency of falls. Mr. K is an 89 year-old married man living with his wife in a condominium in suburban Toronto. He has been diagnosed with chronic kidney disease, bipolar disorder, spinal stenosis, aortic aneurysm, peripheral vascular disease, gout, complete incontinence secondary to a trans-urethral resection of the prostate, and has had numerous falls. Prior to the IMPACT clinic, Mr. K had been previously assessed, including a full neurological and orthopaedic assessment. It was the opinion of the orthopaedic surgeon that there were no surgical interventions that would benefit Mr. K. Likewise, the neurological specialist recommended no further interventions. In both instances, care was returned to the family physician.

Given the complexity of the Mr. K's condition, it became evident that a new comprehensive approach was needed to determine Mr. K's capacity to improve his current condition and to remain at home safely. In the IMPACT clinic, the interprofessional team discussed the various concerns with the client and his wife and, as part of this discussion, the top priorities for the visit were determined and a visit plan was developed.

To address the on-going decline in the client's safety and level of independence, the occupational therapist and community nurse jointly discussed different needs and options with the client and his wife. Some of the specific issues discussed were transfer safety, equipment needs, home safety assessment, and incontinence products.

The physiotherapist performed an assessment to determine the client's strength, balance, and potential for improvement as increasing falls was the client's primary concern and therefore a team priority. A customized exercise program was created for Mr. K and he was provided detailed instructions to take home.

Caregiver stress was another concern because the client's wife reported that she was experiencing an increasing burden of care. The IMPACT social worker validated and supported the wife in her role as caregiver and offered resources for her to gain support for herself while at the same time improving safety for her husband. Specific recommendations included in-home support and a two-way phone.

The team learned that one specific source of caregiver stress was difficulty with meal preparation. Mrs. K was responsible for meal preparation; however, she was experiencing a hard time selecting and preparing meals that were compatible with her husband's chronic conditions and medications. In conversation with Mrs. K, the IMPACT dietitian was able to provide helpful information to make mealtime both easier and healthier. The IMPACT pharmacist performed the final assessment and was able to build on the information collected throughout the course of the visit. All medications were reviewed with both Mr. and

Mrs. K so that they each had a greater understanding of the medications and how administration of medications could be simplified. Pharmacological contributions to the risk of falls were identified and medication changes were suggested to the family physician.

Following the final team discussion, a written plan in the form of a 'to do list' was developed for Mr. and Mrs. K. The family physician discussed these written recommendations with Mr. and Mrs. K and also reviewed the resource information and follow-up community referrals. A follow-up visit with the family physician was arranged in order to discuss progress regarding the newly-developed care plan. Mr. and Mrs. K reported feeling very positive about the visit and that their current concerns had been appropriately and fully addressed during the visit.

After Mr. and Mrs. K left, the team discussed and documented a follow-up plan for Mr. K's family physician. Each area of concern and goal was documented. For each concern, a task for the family doctor at Mr. K's next visit was created, as well as a plan for longer-term care. For example, Mr. K will be asked about whether the home safety assessment has been completed and about his start date for the falls prevention program to which he was referred by the IMPACT team. Also, in the longer term, his family physician will suggest the possible need for more supportive housing. A Montreal Cognitive Assessment (MoCA) will also be performed in order to assess further cognitive change in Mr. K at a future visit with his family physician.

Conclusion

The fast-growing number of frail and at-risk seniors living in the community demands new and innovative models of care. Interprofessional primary care teams are a promising approach to meet this present challenge; however, interprofessional models require further exploration and testing by healthcare providers, educators, and researchers. A formal mixed-methods evaluation of the IMPACT clinic is currently underway, including a retrospective chart audit and qualitative interviews with clients and family members. The IMPACT clinic represents a new practice model in which occupational therapy has made significant contributions, both in the development of the care model and in the education and training of future healthcare providers. Occupational therapists possess the requisite skills and training to be valuable members of interprofessional primary care teams. Indeed, occupational therapists are very well placed to advocate, collaborate, and participate in the development of novel approaches and more creative and effective models of care for individuals at risk.

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The Registered Disability Savings Plan and the Canada Disability Savings Grant and Bond

Human Resources and Skills Development Canada

As an occupational therapist working with people with disabilities, you know how important psychosocial, community, and environmental supports are to your clients' health and well-being. Not only do occupational therapists address the physical impacts of a disability, you also work hard to break down the barriers that may impede individuals from reaching their full potential.

We know that you are always looking for new opportunities to support your clients, and we would like to share some information about an important long-term savings plan that could benefit your clients with disabilities and their families.

You will find below information about the Registered Disability Savings Plan (RDSP), the Canada Disability Savings Grant, and the Canada Disability Savings Bond. We hope that you find this information to be valuable and that you will share it with your clients. For more information, please visit www.disabilitysavings.gc.ca.

Investing in the future

In December 2008, the Government of Canada launched the RDSP to help Canadians with disabilities and their families save for the future. Your clients may be eligible for this program if they are:

- under age 60;
- a Canadian resident with a Social Insurance Number (SIN); and
- eligible for the Disability Tax Credit (Disability Amount).

Parents or legal guardians may open a RDSP for a minor. There is no annual contribution limit to a RDSP; however, the lifetime contribution limit is $200,000. Friends and family can also contribute to a plan with the written permission of the plan holder.

The grant and the bond: More ways to save

To help people save, the Government offers the Canada Disability Savings Grant and the Canada Disability Savings Bond.

The Canada Disability Savings Grant is a matching grant that the Government deposits into the RDSP, paying up to $3 for every $1 paid into the plan, depending on the amount contributed and the beneficiary's family income. The Government will deposit a maximum of $3,500 each year, with a limit of $70,000 over the beneficiary's lifetime.

The Government will also pay a Canada Disability Savings Bond of up to $1,000 a year into the RDSPs of low-income and modest-income Canadians, with a limit of $20,000 over the beneficiary's lifetime. Contributions do not need to be made to the RDSP in order to receive the bond.

Grants and bonds will be paid into RDSPs until the year the beneficiary turns 49. Grants and bonds must remain in a RDSP for at least 10 years. Earnings accumulate tax-free, until money is taken out of the RDSP.

Your clients can apply for the grant and/or bond when they open a RDSP at a participating financial organization.

New measures providing more flexibility

The 2010 Federal Budget introduced two new measures that provide more flexibility to Canadians with disabilities and their families when saving for the future.

- Beginning in January 2011, plan holders can claim unused grant and bond entitlements from the past 10 years (starting from 2008, the year RDSPs became available). This applies to new and existing plans.

- As of July 2011, eligible proceeds (or a portion thereof) from a deceased individual's Registered Retirement Savings Plan, Registered Retirement Income Fund, and Registered Pension Plan can be rolled over, tax-free, into the RDSP of a financially dependent child or grandchild with a disability.

The RDSP and other government benefits

Money paid out of a RDSP will not affect a person's eligibility for federal benefits, such as the Canada Child Tax Benefit, the Goods and Services Tax credit, Old Age Security or Employment Insurance benefits. In addition, RDSPs will have little or no impact on provincial and territorial social assistance payments. More information can be found by contacting the provincial or territorial government of the plan holder.

Find out more

RDSPs can be opened at several financial organizations across the country. For a complete list, visit www.disabilitysavings.gc.ca

For more information on applying for the grant and bond
Call: 1 800 O-Canada (1-800-622-6232)
TTY: 1-800-926-9105
Visit: www.disabilitysavings.gc.ca
Email: rdsp-reei@hrsdc-rhdcc.gc.ca

For more information on opening a RDSP
Call: 1-800-959-8281
TTY: 1-800-665-0354
Visit: www.cra.gc.ca/rdsp

Update from the COTF

Why do I support COTF?

Someone I love died recently; he was young and he had cancer. As a healthcare professional witnessing the progression of his disease, I researched the evidence related to treatments and prognosis. As a friend supporting him and his family through this life-altering process, I engaged in occupations with him—up until his last week. Throughout his illness, continued engagement in meaningful occupations was the thing most valuable to him, his family, and to me.

In the past, I've donated to healthcare charities without much thought, but more recently, I've considered where and to which professional groups my donation dollars directly filter. While I do not underestimate the importance of finding cures and new treatments, this personal experience helped me realize that for the people already living with an illness, disease or disability, it is engagement in occupation with an illness that is most significant. While medicine's focus is on life and death, occupational therapy's focus is on living.

I want my research donation dollars to go toward enabling the occupations of lives affected by events, and still worth living. This is why I am a new monthly supporter of occupational therapy research through COTF.

Isabella K. S. Cheng, BHSc(OT), BSc, OT Reg. (Ont.)
Occupational Therapist
Sunnybrook Program of Assertive Community Treatment

Isabelle, a supporter of COTF, eloquently captures how occupational therapy can make such a significant contribution in 'living.' As an occupational therapist herself, she is able to also recognize and highlight the invaluable role that occupational therapy plays in assisting in 'living', in particular when it comes to end of life situations.

As occupational therapists, many of you have likely experienced similar situations, and can surely relate very deeply and emotionally to her testimonial. She clearly depicts the need and reason to support research in occupational therapy.

Update Your COTF Contact Information

Please inform COTF of any contact information changes. In particular, if you have an e-mail address, please share it with COTF. COTF is using e-mail when possible to communicate with donors in order to be respectful of the environment. Updates can be made by contacting amcdonald@cotfcanada.org or 1-800-434-2268 x226.