Professional development as an occupational therapist

The concept of reflection in learning is not new. It can be traced back as far as Aristotle's discussions of 'practical judgement and moral action' in his Ethics (Grundy 1982 cited in Boud et al 2005a P11).

In 1933, Dewy stated that there were two kinds of 'experiential process' leading to learning. The first process was 'trial and error' and the second was that of 'reflective activity' which involved the 'perception of relationships and connections between the parts of the experience.'(Boud et al 2005a P12). He explained reflection as a learning loop, continually feeding back and forth between the experience and the situation. (Boud et al 2005a).

In more recent times (1980's), reflective practice has been introduced and divided into three core components: 'Things that happen to a person, the reflective process that learning has occurred and the action that was taken from this new perspective' (Jasper 2003 p2). These can be summarised as experience-reflection-action cycle (ERA) and is a way that learning from experience can be understood and developed.

Kolb (1984 cited in Jasper 2003) developed an 'experiential learning cycle' which has been suggested to be the most effective way of learning from our experiences by linking theory to practice:

Observation-

Something that has happened to you

Or that you have done

Action Reflection - reviewing event or experience in your mind

Concept development/theorising-

Understanding what happened

(Kolb's experiential learning cycle 1984, cited in Jasper 2003 p3)

As illustrated, reflection is an important part of the learning loop. Another significant part of reflection is that the process of learning continues so that the learner changes from 'Actor to Observer', from 'specific involvement to general analytic detachment creating a new experience to reflect and conceptualize at each stage' (Moon 2005 p25).

It has been suggested that reflection itself can be identified into two types of ways 'reflection-on-action' and 'reflection-in-action' (Schon 1983). Reflection-in-action is reflecting while doing the action, which occurs subconsciously, instinctively and unconsciously, often seen in the more experienced practitioner who can monitor and adapt their practice simultaneously. Reflecting-on-action involves thinking about action after it has occurred, often seen in novice practitioners who need to step back and think about the situation over in their minds. (Finaly 2004)

Another style of reflection is Gibbs reflective cycle. It has characteristics of all other strategies/ frameworks for reflection that have been developed. However, Gibbs cycle stops at the stage of action and therefore does not provide a way to close the cycle or move to reflective practice in terms of taking action (Jasper 2003). This is because Gibbs framework had its foundations from an education context as opposed to a practice one:

Description

(what happened)

Action plan Feelings

(if it arose again (what were you what would you do) thinking and feeling)

Reflective cycle

Conclusion Evaluation

(What else could (what was good you have done) & bad)

Description

(what do you make of the situation)

Gibbs reflective cycle (1988, cited in Jasper 2003 p77)

Chris Johns model of structured reflection was developed in the 1990's. It has gone through many changes and the 1994 version is the easiest to use when beginning reflective practice. Johns says that the model:

'consists of a series of questions which aim to tune the practitioner into her experiences in a structured and meaningful way. It emerged as a natural sequence through which practitioners explored their experience in supervision' (Jasper 2003 p84).

The focus of John's model is about making us aware of the knowledge that we use in practice. This is taken as a core question, which is explored through five cue questions, that are further divided into detailed questions: 'description of the experience, reflection, influencing factors, could I have

dealt with the situation better and learning' (Jasper 2003 p85). The framework is presented in appendix one.

Many people have defined reflection, Johns (2009 p3) defined reflection as

'Learning through our everyday experiences towards realising ones vision of desirable practice as a lived reality. It is a critical and reflexive process of self-inquiry and transformation of being and becoming the practitioner you desire to be'.

Furthermore, Boud et al (2005a p18) suggested that 'reflection is a form of response of the learner to experience'. Where experience is the response of a person to a situation or event e. g. feelings, thoughts, actions and finishes at the time or immediately thereafter. The situation or event could be a course or an unplanned reason in daily life. It could be influenced by something external or an internal or evolve from discomfort.

Reid (1993 p305) proposes that reflection is 'a process of reviewing an experience of practice in order to describe, analyse, evaluate and so inform learning about practice'

There are many positive uses to reflecting on practice. Johns (2009 p15) suggests that the positive uses of reflection 'encourages the expression, acceptance and understanding of feelings' . He suggests that feelings of negativity can be looked into and turned into positive ones in order to understand future situations and learn new ways of responding. Furthermore he suggests that reflection is 'empowering', which in the end will lead to desirable practice.

Boud et al (2005b p11) suggested that In the case of reflecting on learning, firstly only 'learners themselves can learn and only they can reflect on their own experiences'. Boud et al suggest that teachers can support reflection, but only have access to thoughts and feelings by what individuals decide to reveal about themselves. Therefore the learner is in total control.

Secondly, reflection is a 'purposeful activity directed toward a goal and lastly the reflective process where both feelings and thoughts are interconnected and interactive. Negative feelings, can form major barriers toward learning'. Positive feelings and emotions can improve the learning process, keeping the learner on the task and providing a stimulus for new learning. (Boud et al 2005b p11)

Reflection can be used to support occupational therapy (O. T) principles and values, continuous professional development (C. P. D), ethical, legal and professional codes of conducts/standards of practice and it has suggested to be a 'core process competent, essential to O. T practice' (Bossers et al 1999 p116).

The College of Occupational Therapist incorporate the benefits of reflective practice in their learning strategies (McClure 2004). Reflection aids professional practice and the importance of this ensures high standards of care and is shown in documents such as 'A Vision for the Future' (Department of Health 1993). This is also shown in the Professional Standards of Practice (2007) which states that O. T's should maintain high standards of competence of knowledge, skills and behaviour (standard 4 -

professional development and lifelong learning and standard 1 - service quality and governance)

Ethically, lifelong learning and professional competence (standard 5. 4 and 5. 1) state that O. T's shall continuously maintain high standards of knowledge, skills and behaviour and be responsible for maintaining and developing their personal and professional competence. (College of Occupational Therapists 2005).

Reflection is also an important part of continuous professional development

(Fish & Twinn 1997, cited in Martin & Wheatley 2008) and is now a requirement for registration to practice, as is evidence based practice which is an 'ethical and professional imperative' (Duncan 2006 p8).

The O. T Codes of Ethics states that 'O. T's shall be responsible for maintaining evidence of their continuing professional development '(College of Occupational Therapists Code of Ethics and Professional Conduct 2005, 5. 3) therefore, this can be done through reflection. New learning and continuous professional development depend on how skilfully you can reflect on 'your and others practice, to gain new insights, see new relationships, make new discoveries and make explicit the new learning that occurs' (Aslop 2004 p114). Any new knowledge learnt from the experience will be saved for future reference for when similar situations arise. (Aslop 2004 p115)

To demonstrate reflective practice, In the following reflective account, I am going to use Johns model of reflective structure (1994) mixed with Gibbs reflective cycle (1988) and will be reflecting-on-action (Schon 1983). I feel

both are extremely valuable models and help to express different ideas/feelings in different ways at different points. Other models I could have used are Goodman's levels of reflection (1984), Bortons development framework (1970) and Fish et al strands of reflection (1991).

A mix of both Gibbs reflective cycle with John's model of structured reflection, will combine theoretical reflection and practice environment. John's model is helpful in having cue questions. It provides personal awareness of 'ourselves, our knowledge and actions' . It asks 'what you could do rather than what you will do' (Jasper 2003 p98). Gibbs reflective cycle provides a good framework for the reflective process e. g. learning by reflecting on an event and usually away from the scene of practice. It encourages a good description of the situation, looks at feelings and the experience, concludes where other options are considered and if the situation arose again, what you would do differently.

The following narrative describes a critical incident that had a significant effect on me which made me stop and think and raised questions. This incident was the role of occupational therapist's (O. T's) within social care and the impact of this upon a service user's journey. The names within this narrative have been changed to protect the innocent.

The role of O. T and Social worker have been combined within social care producing the title 'Self Directed Support Practitioners' (SDS practitioners)

Occupational therapy as a new profession is facing new challenges from the introduction of the Health Professions Council. The council want greater integration of health and social care provision and the College of

Occupational Therapists is preparing for these changes by seeking to refocus the organisations of the work of the O. T's by its strategic document ' from interface to integration' (Dimond 2004 P397). Hence the role of an S. D. S practitioner.

Brian was a 60 year old man, who lived in a bungalow on his own; with no outside help e. g. care packages or adaptations. His daughter visited him on regular occasions to take him shopping, to appointments and check on his health. Brian was admitted to hospital due to a fall last year whilst using the toilet. The nearby hospital released him about 2 months ago after he spent a few nights there. His daughter reported that Brian was still having problems with self-care, cooking and general mobility.

An S. D. S practitioner and myself carried out a home visit on Brian. We received a referral from Brian's daughter regarding his health and ability to perform activities of daily living (ADL's). Upon assessment of Brian, we found that he used the sink (which seemed to be coming off the wall) to aid standing from the toilet. His mobility was generally good but had difficulties raising and lowing himself in and out of the bath and rising his legs over the lip. He had slight problems in the kitchen due to mild arthritis when opening cans and jars, lifting heavy equipment and gripping cutlery. Brian's mood and motivation was very low and he seemed angry at life in general. His daughter said she could not cope with looking after Brian anymore and needed help with this. She also seemed very low in mood and appeared stressed.

When we assessed Brian, I was unsure and slightly confused how to assess in an S. D. S way. I was thinking about my O. T values and beliefs and how I could incorporate these within the assessment. This would involve me assessing in a holistic way, promoting independence, empowering and motivating him as well as using activity as a therapeutic tool. I was unsure how to implement social work values as they seemed to clash with my own, for example I found it difficult to establish when it would be appropriate to provide care packages. This made me feel extremely confused and concerned that I was not providing the best service for Brian when carrying out the assessment and going against my professional ethics of respecting autonomy (decision-making of service user), beneficence (benefits of treatment against risks and cost), non maleficence (do no harm) and justice (distributing benefits, risks and costs fairly) (Butler & Creek 2008)

Overall I was trying to achieve independence for Brian with the least amount of equipment and help necessary. When assessing Brian in the bathroom, whilst he was sitting on a bath board and using a grab rail, he managed to lift his legs over the side of the bath and had good sitting balance. His toilet transfers needed support, so we offered a toilet frame to aid this. When assessing his kitchen abilities, Brian struggled to lift heavy pots and pans and filling the kettle. He also had difficulty gripping cutlery and standing for periods of time when preparing food. The S. D. S practitioner suggested meals on wheels to overcome the problems Brian faced in the kitchen.

Throughout the assessment Brian was not very happy and laughed at his capabilities. He became very angry when we suggested that he used the equipment provided and he mentioned that he wanted a 'wet room' and 'why

could he not have one of these, as his friends had one fitted not that long ago'. We explained sensitively that funding would not allow this and he was very capable of transferring safely with the equipment in place. This made me think about funding and O. T's values and beliefs, which in turn made me feel unhappy as Brian could not have something he wanted and personally I can understand how comforting and aesthetically pleasing this would be. However installing a wet room could reduce Brain's mobility, as he would no longer need to lift legs over the edge of the bath, maintain unsupported sitting balance and therefore would lose those skill. Therefore this idea would go against my O. T and personal beliefs. Also due to funding he was not eligible for such a major adaptation.

The outcome of the event was not very good. Brian refused equipment and care packages and became angry. That made me feel sad as I wanted to help Brian, to live an independent life as possible and reduce the dependence upon his daughter. Due to Brian declining the equipment, we had to record and have him sign that he understood the risks of this.

Looking back at the event, I feel maybe I could have convinced Brian further to accept the equipment and care packages suggested. Although the care packages conflicted with my O. T and personal values, as they take away independence, skills and the use of activity as a therapeutic tool; I can see a place for these with extremely impaired individuals. In Brian's case I would have suggested adapting equipment within the kitchen, such as grips for cutlery, automatic tin openers, a kettle tipper and a perching stool.

The emotions I went through during this experience were anxiety, excitement, and inquisitiveness during the start of the event, followed by sadness toward the end. The most important emotion for me was sadness. I feel that I can learn and grow from this, to tackle the situation differently next time.

To evaluate, the good aspects of the experience was the enormous opportunities for continuous professional development as the role of O. T continues to grow. I also feel my understanding of O. T, social work, clinical reasoning and inter-personal/professional skills have been developed. I also feel more confident if I were ever to be in this situation again to promote and air my values and beliefs.

However, I feel that the role of an S. D. S practitioner causes confusion, loss of role identity and crossing over of professional boundaries. The S. D. S practitioners themselves were not happy with this title and their role which caused problems within multidisciplinary teams.

Although I feel not a lot went well, I believe if I had been more confident to contribute my O. T knowledge it would have aided the situation. The S. D. S. practitioner that I was with managed to balance out the professions well, but I feel provision of adapted equipment should have been encouraged. Her style of reasoning was perhaps due to little knowledge of O. T and herself coming from a social work background.

I am now more prepared for the role of an S. D. S. practitioner. If carried out again I would definitely gain more insight into the values and beliefs of social workers and be more vocal about my O. T ones. I would have tried to

encourage Brian to take the equipment and explained more as to why this was important. Perhaps reasoning with him that it was important for him not to lose his existing skills i. e.' use it or lose it'.

I have learnt that theory; personal, professional standards, values and beliefs, ethics and legal issues often influence practice. I have learnt the importance of reflecting in order to develop myself professionally and personally. My needs in order to develop my professional practice at this stage of my career are huge. I mainly need to develop my knowledge, communication skills, professional skills and clinically reasoning skills. I have also learnt the role which I play within a team and according to Belbins team roles (2010), I am a monitor-evaluator mixed with team worker. This means I try to see all the options and 'judge accurately, working co-operatively sensitively and diplomatically' (Belbin 2010).

In general, looking back over the situation, the role of an S. D. S practitioner promotes big ethical issues. In the code of ethics It states that 'O. T's can only provided services in which they have been taught to do so' (5. 1) and that 'O. T's shall recognise the need for multi-professional collaboration but not undertake work that is deemed to be outside the scope of O. T. ' (5. 3) (College of Occupational Therapists Code of Ethics and Professional Conduct 2005). Also ethically, are you doing good, doing no harm, promoting autonomy and justice (Butler & Creek 2008) by working in such a manner? Am I affecting the service user's human rights on freedom of thought, expression or conscience? (article 9 & 10) (Butler & Creek 2008).

Other issues that are concerned with S. D. S practitioner work is when working in such a way there is 'no team liability' (every professional is accountable for their own actions and cannot blame the team for negligence which has lead to harm), 'no defence of inexperience' (the patient is entitled to the reasonable standard of care whoever provides the treatment), 'determination of competence' (carried out by competent colleagues or external assessors), 'refusal to undertake activities outside scope of competence' (no O. T should undertake activities which are outside the scope of her professional practice) (Dimond 2004 P112).

To conclude, reflection can identify learning needs, and new learning opportunities. It can illustrate ways in which we learn best, differently and new courses of action toward an event. Reflection can help solve problems supporting personal and professional development and offers an escape from general practice. Reflection shows us the cost of our actions, reveals our competences to others and achievements to ourselves. From observations, reflection lets us build on our theory, helping us to make decisions or resolve doubt and empower or release ourselves as individuals (Jasper 2003).

However, reflective practice has been criticised for its lack of 'definition, modes of implementation and its unproven benefit' (Mackintosh 1998 cited in Johns 2009 p22). Platzer et al (2000, cited in Johns 2009 p22) noted that students may be opposed to to reflection that would involve talking about themselves. This was also highlighted by Cotton (2001 cited in Johns 2009 p22) who suggests that reflection becomes a type of 'surveillance, assessment and control'.

Appendix One

Johns Model of Structured Reflection. Core question - what information do I need in order to learn through this experience?

Cue questions (Jasper 2003)

1. Description of experience

Phenomenon

Casual

Context

Clarifying

2. Reflection

What am I trying to attain

Why did I get involved as I did

What were the cost of my actions for: myself, family, patient, colleagues

Feelings about experiences

Patients feelings

How do I know how the patient felt

3. Influencing factors

Internal influences on decision-making

External influences on decision-making

What knowledge influenced decision making

4. How differently could I have dealt with the situation

Choices available

Consequences of choices

5. learning

Feeling about experiences

The sense made of this experiences thinking of past and future practice

How experience changed my ways of knowing empirics, aesthetics, ethics and personal