

Adopting the Perceive, Recall, Plan and Perform Assessment into practice in Aotearoa New Zealand: Influences on Clinical Reasoning

Wendy Burrows

A thesis submitted to Auckland University of Technology in fulfilment of the requirements for the degree of Doctor of Philosophy (PhD)

Department of Occupational Science and Occupational Therapy

School of Clinical Sciences

July 2025

ABSTRACT

The Perceive, Recall, Plan and Perform Assessment (PRPP-A) is a standardised, contemporary occupational therapy assessment of occupational performance and cognitive strategy application. In recent years in Aotearoa New Zealand, there have been growing numbers of occupational therapists completing the PRPP-A training. Despite this interest in the PRPP-A, however, there is a scarcity of information about the practical application of the assessment, including the relevance, affordances, and utility of the PRPP-A in practice. Further, neither the clinical reasoning involved in using the PRPP-A, nor its cultural applicability for cultural practice in Aotearoa New Zealand is well understood.

Currently occupational therapists receive PRPP-A training without information to guide them, their managers, or funding agencies about what is involved following the training and the commitment needed to translate the PRPP-A into real-world contexts. Given the increased uptake of the PRPP-A training, there is a need to better understand the gaps in knowledge regarding PRPP-A implementation. Therefore, I designed a two-phase investigation; Phase One explored occupational therapists' experiences of applying the PRPP-A in Aotearoa New Zealand; and Phase Two sought insights into how using the PRPP-A shaped therapists' clinical reasoning through the assessment process. The intended outcomes of the study included obtaining practice-based understandings relevant to PRPP-A training, aiding knowledge translation, and improving post-course training support.

A constructivist approach with qualitative interpretive description methodology guided this exploratory study. Purposeful sampling was used to recruit 13 and 8 PRPP-A trained occupational therapists for Phase One and Phase Two respectively. Data collection occurred through a focus group with two Māori participants, written reflective logs, and semi-structured interviews. Inductive thematic data analysis was used to identify five themes in Phase One and four themes in Phase Two.

This study revealed that the PRPP-A is the type of assessment participants want to use, with the ecological and flexible nature of the assessment valued in practice. Participants reported that the PRPP-A enhanced the occupation-focus of their practice and had sufficient flexibility for use with clients with diverse cultural backgrounds, including tangata whenua (Māori-Indigenous people). Task flexibility was necessary for cultural applicability; however, the relevance of the PRPP-A depended on therapists' ability to

attend to cultural safety, humility, and their cultural competency. Selecting assessment tasks necessitated collaboration and honed questioning skills to find ‘just right’ assessment tasks.

Translating the PRPP-A to practice involved initially returning to being novice assessors which was experienced as a demanding process that required commitment, dedicated time and support from others. Participants had learnt to use occupation-focused, context specific, and dynamic clinical reasoning to design bespoke client-centred assessments which were influenced by their own values and beliefs. Specific clinical reasoning skills and strategies were developed, and occupational performance was automatically viewed through a ‘PRPP lens’ that enhanced reasoning. The identified knowledge translation and clinical reasoning strategies will inform future occupational therapists in advance of PRPP-A training and guide PRPP-A Instructors designing courses. Overall, findings of this study contribute to the profession’s growing understandings of practice realities and skills associated with translating occupation-based assessments, like the PRPP-A.

TABLE OF CONTENTS

CONTENTS

Abstract.....	i
Table of Contents	iii
List of Figures.....	viii
List of Tables	ix
Attestation of Authorship	x
Acknowledgements.....	xi
Dedication	xiii
Chapter 1: Introduction to the Study.....	1
Introduction	1
Research Questions	2
Study Aims.....	2
Why this Study?	3
Phase One.....	3
The Varying Use of the PRPP-A in Practice.....	3
Cultural Applicability of the PRPP-A.....	4
Understanding the Knowledge Translation Process.....	4
Phase Two	5
Clinical Reasoning and Occupation-based Assessments	6
Study Context.....	6
Occupational Therapy Practice in Aotearoa New Zealand	6
Legislative Requirements Influencing Occupational Therapy Assessment Practice	7
Cultural Context Influencing Occupational Therapy Assessment Practice	8
Occupational Therapy Assessment Practice and Development of the PRPP-A.....	9
My Background and Interest as a Researcher	10
Thesis Overview.....	12
Chapter 2: Review of the Literature	15
Introduction	15
An Historical Perspective of Occupational Therapy Assessment Practice	15
Assessment Practice: Beginnings.....	16
The Press of Science and Biomedicine on Assessment Practice.....	17
An Era of Change: The Impact of Occupational Renaissance, Quality Assurance, Client-Centred and Evidence-based Practice	19
The Shift Towards Occupation-focused Practice	20
Cultural Considerations of Assessment Practice.....	21

Calls for Different Assessments for Clients with Cognitive Challenges	23
Overview of the PRPP-A System	24
PRPP-A Development.....	24
Description of the PRPP-A	26
Validity.....	29
Reliability	31
Clinical Utility of the PRPP-A	32
Summary	34
Chapter 3: Translating knowledge to practice.....	36
Introduction	36
Section 1: Clinical Reasoning and Occupation-based Assessment Practice.....	37
Clinical Reasoning Terminology	37
Defining Clinical Reasoning Related to Occupational Therapy Assessment Practice.....	37
Clinical Reasoning and Assessment Practice.....	38
Section 2: Knowledge Translation	54
KT and Occupational Therapy Practice	55
KT Theories, Models, and Strategies.....	57
Stages of Learning Theories.....	61
Summary	64
Chapter 4: Methodology.....	66
Qualitative Interpretive Descriptive Design: Theoretical and Philosophical	
Perspectives.....	66
Positioning the Researcher	69
Introduction	71
Formulation of Research Questions	71
Research Purpose	72
Selection of the Research Approach	72
Summary	74
Chapter 5: Methods	75
Introduction	75
Ethical Approval	75
Ethical Considerations	75
Do No Harm and Avoid Deceit.....	75
Confidentially and Anonymity.....	77
Te Tiriti o Waitangi and Cultural Considerations	78
Recruitment	80

Phase One.....	80
Phase Two	81
Participant Selection.....	82
Participant Demographics	82
Data Collection.....	83
Phase One.....	83
Phase Two	85
Concluding Data Collection.....	89
Transcribing the Data	89
Summary	90
Chapter 6: Data Analysis	91
Introduction	91
Data Analysis	91
Introduction to Data Analysis	91
Phase One.....	92
Phase Two	101
Addressing Rigour	111
Summary	114
Chapter 7: Phase One Findings – Part 1.....	115
Training to Practice	115
Resonating with Practice as it Should Be	116
Translating to Practice.....	119
Assimilating Information from the Training.....	119
Initial Approaches to Translating the PRPP-A to Practice.....	122
Learning Together.....	125
Reporting Using an Occupational Performance Focus on Cognition	130
Shifting from Reporting on Cognitive Skills	131
Utilising the PRPP Descriptors	133
Documenting the PRPP-A Results.....	136
Summary	138
Chapter 8: Phase One Findings – Part 2.....	141
Using the PRPP-A in Practice.....	141
Validating the Practice Fit of the PRPP-A.....	141
Real-world Application.....	141
Client-centred Approach	143
Flexible Assessment System	144

Pertinent Assessment Results.....	147
Cultural Application.....	151
Diverse Applications.....	151
Actively Involving Clients	153
Changing the Power Dynamic.....	155
Cultural Competency	157
Summary	158
Chapter 9: Summary and Discussion of Phase One Findings	161
Introduction	161
Prelude.....	161
Full Publication Reference	161
Chapter Summary.....	178
Chapter 10: Configuring a PRPP-A for a Specific Client.....	179
Introduction	179
Configuring a PRPP-A Process.....	179
Forming an Assessment Plan	181
Configuring Assessment Task/s	189
Summary	202
Chapter 11: Reasoning and actions influencing the application of a PRPP-A.....	204
Introduction	204
Having an Assessment Intention.....	204
To Do a Pure Assessment.....	204
To Do a Fair Assessment	205
To Do a Dynamic Assessment	205
Thinking and Actions Influenced by Assessment Intentions.....	206
Setting Up and Starting an Assessment.....	206
Positioning Before and During the Assessment.....	208
Using Cues and Prompts	209
Taking Notes or Not During a PRPP-A	212
Drawing on Theory	214
Developing Skills and Strategies	215
Applying PRPP-A Stage One.....	215
Summary	230
Chapter 12: Discussion	232
Introduction	232
Revisiting the Purpose of Phase Two of the Study	232

Reflecting on the Findings	233
Learning and Translating the PRPP-A to Practice	233
Understanding Occupational Performance Through a PRPP Lens	235
Reasoning to Enact an Occupation-focused Assessment Process	238
Study Strengths and Limitations	245
Implications of the Study and Recommendations.....	248
For Occupational Therapists in Practice	248
For Occupational Therapists Considering PRPP-A Training and Associated Funding Agencies/Organisations.....	252
Recommendations for PRPP-A Instructors.....	252
Conclusion.....	253
References	256
Appendices	288
Appendix A: AUTECH Ethical Approval 2016	288
Appendix B: AUTECH Ethics Approval 2019.....	289
Appendix C: AUTECH Amendment Approval 2020	290
Appendix D: Phase 1 Participant Information Sheet	291
Appendix E: Phase 2 Information Sheet for Occupational Therapists	294
Appendix F: Participant Demographic Form.....	297
Appendix G: Transcriber Confidentiality Agreement.....	299
Appendix H: Recruitment Email to OTBNZ Phase One	300
Appendix I: OTBNZ Campaign Overview	301
Appendix J: Consent Form for Interviews and Focus Groups Phase One.....	302
Appendix K: Recruitment Email to OTBNZ Phase Two.....	303
Appendix L: Phase 1 Indicative Questions for Semi-Structured Interviews	304
Appendix M: Phase 1 Indicative Questions for the Focus Groups	305
Appendix N: Phase 2 Occupational Therapist Participant Consent Form	306
Appendix O: Phase 2 Information Sheet and Consent Form for Tangata Whaiora Clients	308
Appendix P: Phase 2 Information sheet for Parent /Legal Guardian.....	310
Appendix Q: Phase 2 Information Sheet and Assent Form for Children 4-10 Years.....	314
Appendix R: Phase 2 Information Sheet and Consent Form for Young Persons	316
Appendix S: Phase 2 Reflective Log	319
Appendix T: Phase 2 Interview Guide	321
Appendix U: Examples of Phase 1 Mind Maps	324

LIST OF FIGURES

Figure 1. <i>Occupational Performance Model (Australia) OPM(A) (2011)</i>	25
Figure 2. <i>The PRPP System of Task Analysis: Stage Two Model</i>	27
Figure 3. <i>PRPP-A Stage 2 Radar Graph</i>	28
Figure 4. <i>The Perceive, Recall, Plan and Perform (PRPP) System of Task Analysis Conceptual Model: Hypothesised Cognitive Strategies Used in Clinical Reasoning During Every Therapy Situation</i>	50
Figure 5. <i>Initial Coding: Main Actions Grouped Under Codes of Preparation, During the PRPP-A, and After the PRPP-A</i>	104
Figure 6. <i>Information and Questions Considered as Participants Formed an Assessment Plan</i>	180
Figure 7. <i>Elaboration of Background Client Information Section from Figure 6</i>	181
Figure 8. <i>Elaboration of a Section from Figure 6 of the Information Gathered and Considered When Determining Assessment Fit for Client and/or Whānau/Family</i>	183
Figure 9. <i>Elaboration of the Assessment Purpose and Outcomes Section from Figure 6</i>	186
Figure 10. <i>The Process of Configuring Assessment Task/s</i>	189

LIST OF TABLES

Table 1. <i>Summary of Systematic Reviews of Occupational Therapy Clinical Reasoning Literature</i>	40
Table 2. <i>Outlines the Frequent Modes of Reasoning Presented in the Occupational Therapy Literature</i>	43
Table 3. <i>Knowledge Translation Strategies</i>	60
Table 4. <i>Summary of the Stages of Learning Incorporated in the PRPP Task Analysis System Based on Chapparo and Ranka (2016).....</i>	64
Table 5. <i>Outline of the Naturalistic Inquiry Axioms Related to the Study Design.....</i>	67
Table 6. <i>Ethical Considerations and Actions Taken for Interviews and Focus Group..</i>	77
Table 7. <i>Summary of Phase Two Data Collection</i>	88
Table 8. <i>Initial Codes and Groupings</i>	94
Table 9. <i>Summary of Early Themes, Meanings, and Practical Implications</i>	96
Table 10. <i>Initial Codes Based on Modes of Clinical Reasoning Related to Choosing an Assessment</i>	102
Table 11. <i>Summary of Phase Two Broad Codes and Groupings</i>	105
Table 12. <i>Summary of Phase Two Early Themes, Description, and Practical Interpretation</i>	107
Table 13. <i>Overview of Themes</i>	116
Table 14. <i>Participant Demographics</i>	166
Table 15. <i>Examples of Questions and Prompts from the Semi-Structured Interviews and Focus Group</i>	167
Table 16. <i>Summary of the Skills and Strategies Related to Actions Participants Performed Before, During, and After a PRPP-A</i>	226

ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Wendy Burrows

2nd July 2025

Signature

Date

ACKNOWLEDGEMENTS

I have imagined writing this acknowledgement section for some time, even while many times on this learning journey I have been unsure if I would ever reach this point. Certainly, I would never have arrived here without the many people who have encouraged, nurtured, and supported me in so many ways.

I would like to first acknowledge my amazing supervisors Professor Clare Hocking and Associate Professor Chris Chapparo who I have been privileged to have guide me. The whakataukī (Māori proverb) “*Ko te pae tawhiti whāia kia tata, Ko te pae tata whakamaua kia tīna*” (Seek to bring distant horizons closer and sustain and maintain those that have been arrived at) represents the vision Clare and Chris had, the encouragement they gave, and the nurturing and strength provided as they recognised my accomplishments.

Chris, the idea to study the PRPP-A began with your sowing a seed and your enthusiasm. Thank you for your ongoing navigation and keeping me focused on the purpose of the research. Many times, your gems of wisdom were given just when I needed them most. You continually watered the seed and have inspired me to stretch and grow.

Clare, I would have been adrift without you as my primary supervisor. You had faith that I could do this *mahi* (work) and always set the bar high for that I am very appreciative. Thank you for your scholarly excellence and guidance that has always been calm, clear, steady, and unwavering. You have steered me through many choppy waters and your reassurance enabled me to stay on the journey.

Ngā mihi mō tō rangatiratanga (thanks to your leadership) Iris Pahau tikanga (cultural) adviser. *Ngā mihi* Iris for the *taonga* (treasure) you gave by partnering with me from the outset of this study. Your generosity and sharing of *mātauranga* (knowledge) greatly increased my cultural awareness and understandings of *Te Ao Māori* (Māori worldview) and ensured this study was *tika* (*right*) and culturally safe for all involved.

To the participants in both phases of the study *ngā mihi nui ki a koutou katoa* (thank you all very much). You gave so generously of your time, energy, and experiences that brought this study to life and which would not have been possible without you.

I am grateful to have received both an AUT Faculty of Health and Environmental Sciences Doctoral Fees scholarship and Occupational Therapy New Zealand – Whakaora Ngangahau Association scholarship, which significantly helped the financing of this study. I would also like to acknowledge Shoba Nayar for her fast professional transcribing

and proof-reading services. Thank you to the Auckland University of Technology Ethics Committee for your work related to the ethics procedures for both phases of this study (ref numbers: 1697_27042016 and Hocking 19441-11122019).

To all my AUT colleagues thank you for showing me the way, the great advice, and keeping me going.

To my whānau (family) in England who provided desks, technology, listening ears, and always gave encouragement, thank you. Special thanks to my dad, Ken Callum, for teaching me the value of hard work; and my sister, Gwen, and brother, Jerry, for your regular cheering from the sideline that boosted me along.

To my whānau of friends in Aotearoa, thank you for all your aroha. Although, there are too many people to mention, there are some without whom I would not have completed the study. Thank you to Carolyn Simmons for many years ago casually suggesting maybe the time had come for some postgrad study and being my study buddy, listening tirelessly to the ups and downs. Thank you to Margo Angland, Jackie Smalldridge, Andrew Jeffs, Janine Swail, Claire Fountaine, Ginny Hall-Cowley, Christina Patterson, and Stephanie Cox for the endless check-ins and enduring interest in what I was doing, even when you saw so little of me.

Lastly, I would like to recognise and thank my wonderful whānau in Aotearoa. My daughter, Jenna-Rose and partner, Lachy McCulloch; and my son, Mac, and fiancé, Eden Cairns. During my time as a student, you have grown to fabulous adults and have always been there for me. A huge thank you goes to my husband, Ian, whose love, care and patience has been never ending, you are the best.

DEDICATION

I dedicate this work to my mum, Ruth Callum, and brother, Paul Callum, both of whom began this journey with me. My mum always encouraged me to reach for the sky; and Paul frequently reminded me there was more to life than just study. Sadly, neither of them is here to celebrate the end which is definitely the part they would have enjoyed the most!

CHAPTER 1: INTRODUCTION TO THE STUDY

Introduction

This two-phase study explores the experiences of occupational therapists applying the Perceive, Recall, Plan and Perform System of Task Analysis assessment (PRPP-A) in Aotearoa New Zealand and how using this assessment influences occupational therapists' clinical reasoning. Developed in Australia in the late 1990s, the PRPP-A is an ecological standardised occupational performance based measure designed for occupational therapists to evaluate how well clients can perform necessary or desired routines or tasks in real-world contexts (Chapparo & Ranka, 2016). The first PRPP-A training course occurred in Aotearoa New Zealand in 2007. By the outset of this study in 2016, a further seven courses had been held and there were over 240 therapists who were PRPP-A trained in Aotearoa New Zealand.

Despite the growing numbers of PRPP-trained occupational therapists worldwide, relatively little is known about the PRPP-A's utility, the realities of applying it in practice, or how using it influences therapists' thinking and decision making. Growing research reports the psychometric properties of the PRPP-A and the assessment's validity for clients with different conditions/diagnoses with varied occupational performance issues (Fry & O'Brien, 2002; Lewis et al., 2016; Nott & Chapparo, 2008, 2012; Ranka & Chapparo, 2010; Voigt-Radloff, 2012). However, there is little information on how occupational therapists have found the practical application of the assessment, the clinical reasoning involved in using the PRPP-A or how it guides practice. There are some insights into knowledge translation processes involved in taking the learning from the course into practice which have been described as "complex" (Lu, 2014, p. 74). Yet, the nature of this complexity is mostly unknown. Questions remain as to what happens when occupational therapists initially try to apply the assessment with clients, particularly how relevant they find the PRPP-A and how it fits with practice demands. Knowing more about these aspects of the assessment is important for occupational therapy practice in Aotearoa New Zealand, where occupational therapists are required to practice with responsiveness to Te Tiriti o Waitangi¹ and apply knowledge for equitable outcomes for Māori' (Indigenous people of Aotearoa New Zealand) well-being and use appropriate assessment tools with all clients (OTBNZ, 2015b). Currently, the cultural applicability of using the PRPP-A with tangata whenua² and clients of other cultures is mostly unknown. It was these gaps in knowledge

¹ Te Tiriti o Waitangi is the 1840 foundational document in Aotearoa New Zealand

² Tangata whenua refers to people of the land, Māori as Indigenous people of Aotearoa New Zealand

concerning the practical and cultural application of the PRPP-A, and the complexity of translating it to practice, which first drew my interest to undertake this study. I was keen to understand more and, therefore, designed an initial research question to guide Phase One of the study.

It became apparent during Phase One data analysis that further investigation in another aspect of using the PRPP-A was important as it signalled a need for deeper exploration into how using the PRPP-A shaped occupational therapists' clinical reasoning. Accordingly, an additional question was formed to focus the design of Phase Two of the research.

Research Questions

Phase One question: *What are the experiences of occupational therapists in Aotearoa New Zealand applying the Perceive, Recall, Plan and Perform System of Task Analysis assessment (PRPP-A) into their practice?*

Phase Two question: *How does using the PRPP-A influence occupational therapists' clinical reasoning through the occupational therapy assessment process?*

I selected qualitative interpretive description (QID) methodology to answer both questions. In Phase One, data were collected through individual semi-structured interviews with 11 PRPP-trained occupational therapists and a focus group with two Māori occupational therapists. In Phase Two, data were gathered through individual semi-structured interviews and reflective logs completed by eight occupational therapists. QID methodology is well suited for exploring a discipline specific topic which seeks practical understandings (Thorne, 2016b; Thorne et al., 2004). This study pursues understandings of the PRPP-A that will have practical relevance for the occupational therapy profession in Aotearoa New Zealand and other countries where the PRPP-A is used. That includes occupational therapists presently using the PRPP-A in practice; occupational therapists considering training in the future and corresponding funding agencies; managers of occupational therapists and PRPP instructors who will teach future PRPP-A courses. The aims of the study are summarised below.

Study Aims

1. To generate practical understandings of applying the PRPP-A from occupational therapists working in a range of contexts across Aotearoa New Zealand.

2. To gain insights of the PRPP-A's cultural applicability from the worldview of Māori occupational therapists.
3. To describe some of the contextual realities of translating the PRPP-A to practice.
4. To understand ways in which using the PRPP-A influences occupational therapists' thinking and decision-making through the occupational therapy assessment process.
5. To identify strategies used by occupational therapists to assist their clinical reasoning and knowledge translation (KT) of the PRPP-A from training to practice.

Why this Study?

Phase One

The study initially arose from my own experiences of using the PRPP-A and those of other occupational therapists I had supported to integrate it into their practice. Those experiences had given rise to questions concerning aspects of applying the PRPP-A in practice. I wondered why the PRPP-A was used by occupational therapists to varying degrees in practice and why some occupational therapists struggled to implement it. In addition, how was the PRPP-A used across cultures in Aotearoa New Zealand and was it a suitable option for tangata whenua? What was involved in the KT process to take the learning from training to practice and were there KT strategies that might aid the process?

To begin to answer these questions I undertook an initial literature review and established that little was known about these areas. Thus, I was impelled to investigate further and design Phase One of the research. The reasons for exploring answers to these initial questions are outlined below.

The Varying Use of the PRPP-A in Practice

Attending the week-long PRPP-A training is a considerable investment of time and money for occupational therapists and work organisations alike. For such a training investment to be worthwhile, occupational therapists need to regularly use the new assessment in their practice and the training needs to result in changes that have positive outcomes for therapists, clients, and work organisations (Chard, 2000). Early indications, from one study, are that following training not all occupational therapists successfully use the assessment. Lu's (2014) study revealed varying patterns of use, with some occupational therapists regularly applying the full PRPP-A, others only parts, some intermittently, and a small minority never applying it in practice. The reasons for this varied use and why some therapists seem to readily implement the assessment while others struggle or chose

not to use it, remain unclear. Further investigation is needed as to what might influence this varied application and why occupational therapists use it differently in practice.

I also considered research was needed to understand how the PRPP-A might support occupational therapists' practice, together with the challenges of applying it in practice. I reasoned insights into practice realities were needed for future occupational therapists to be better informed and understand the experiences of other occupational therapists before they invested in training. Such information would help occupational therapists evaluate the likely relevance, or not, of having the PRPP-A in their practice and avert potential unnecessary investment in the PRPP-A training. In addition, existing PRPP-A trained occupational therapists could reflect on their use of the PRPP-A and consider other ways they might implement the assessment or overcome challenges they may encounter.

Cultural Applicability of the PRPP-A

In Aotearoa New Zealand the PRPP-A is currently being implemented by occupational therapists without any knowledge of its cultural applicability (i.e., specific to the Aotearoa New Zealand context). This is a concerning situation, since many of the profession's other standardised occupational therapy assessments have been criticised as culturally irrelevant (Nelson, 2007; Stanley, 1995), unfair, and/or even disadvantaging clients (Thorley & Lim, 2011). Presently, occupational therapists in Aotearoa New Zealand are forming their own evaluation of the cultural appropriateness of the PRPP-A and whether or not to use it with tangata whenua. There is little to inform or guide this evaluation, no indication of the cultural considerations required, or the cultural relevance or safety of using the PRPP-A in Aotearoa New Zealand. More information about the cultural application is needed to increase occupational therapists' awareness of the cultural relevance or otherwise and implications of using the assessment with ethnically diverse clients.

Understanding the Knowledge Translation Process

Application and integration of the PRPP-A involves occupational therapists transferring knowledge from the course and changing their previous existing assessment practices. Both these processes are recognised in the wider occupational therapy literature as presenting challenges for occupational therapists (Alotaibi et al., 2009; Chard, 2000; Lockyer et al., 2001). One study investigated the use of the PRPP-A in practice and found the integration process to be complex and influenced by many factors (Lu, 2014), including managing caseloads while therapists continued learning, time required to practice the assessment, fitting the PRPP-A to match the pace and demands of different work settings, the use of new language for the assessment, and therapists' level of

confidence to use a client-centred assessment process. Broad strategies that promoted the adoption of the PRPP-A included peer and/or group support, access to supervision, managerial support, and applying the PRPP-A soon after training (Lu, 2014). That said, Lu (2014) concluded more information on “a practical approach of implementation strategies to support therapists” (p. 72) was needed.

To date, little exists to understand the type of strategies that might assist occupational therapists translate the PRPP-A to practice. There would, however, be benefits prior to training for occupational therapists and work organisations in knowing the likely learning commitments required after the course as well as possible practice challenges and strategies that may assist to overcome these. Armed with such information, future occupational therapists could plan for challenges and identify and negotiate support systems before attending the training; thereby increasing the probability of integrating the PRPP-A in their practice. Furthermore, greater understandings of occupational therapists’ practice experiences would inform future PRPP-A education, providing opportunities for the training to be tailored to specifically address practical application challenges.

Phase Two

The need for a second phase of research became evident after the data collection and early data analysis in Phase One. The initial findings revealed links between occupational therapists’ clinical reasoning and use of the PRPP-A. Using it seemed to influence, challenge, alter, and enhance clinical reasoning. However, the data did not provide clear accounts for how the PRPP-A specifically informed clinical reasoning. For example, how or why occupational therapists chose to use the PRPP-A with certain clients, how clinical reasoning shapes different applications of the PRPP-A, and how clinical reasoning is used during the assessment process. This lack of detail was not surprising, given Phase One utilised open-ended questions which did not target clinical reasoning.

From my own experiences I was aware using the PRPP-A had changed my thinking and therapy focus with clients during both assessment and intervention phases. Hearing the participants in Phase One had experiences of changing their clinical reasoning sparked my interest to investigate further. I felt it was important to gain understandings of how the PRPP-A shaped occupational therapists’ thinking, decision making, and subsequent actions. Thus, I explored the literature associated with clinical reasoning, the PRPP-A, and other occupation-based assessments. The outcome of this initial review is outlined below and supported the need to extend my research.

Clinical Reasoning and Occupation-based Assessments

There is a scarcity of literature on clinical reasoning associated with using occupation-based assessments. No research was found concerning the PRPP-A and clinical reasoning. Two studies had explored utility of the Canadian Occupational Performance Measure (COPM) and identified occupational therapists needed to be able to share their clinical reasoning with clients (Parker & Sykes, 2006) and make good clinical judgements (Gustafsson et al., 2012). However, little information was provided to comprehend what occupational therapists thought about as they reasoned and made these judgements. Mew and Fossey's (1996) research more directly studied one occupational therapist's clinical reasoning when performing the COPM interview, although the findings related to client-centred reasoning processes rather than how clinical reasoning informed the assessment process and the therapist's actions.

Considerable gaps exist in understanding how occupational therapists use clinical reasoning as they apply standardised occupation-based assessments, how they think about results from these assessments, and what guides their decision making and therapy actions. This lack of knowledge is concerning, given clinical reasoning is an integral part of occupational therapists' assessment process (Carrier et al., 2010) and that therapists need sound clinical reasoning to perform effective assessments (Fawcett, 2007). The paucity of research, in addition to the preliminary findings in Phase One, justified the addition of a second phase in the current study.

Study Context

This section provides context to the study. Included is a brief overview of salient aspects of occupational therapy practice in Aotearoa New Zealand, including legislative requirements and cultural context which influence occupational therapists' assessment practice. A short synopsis is then provided of the background to occupational therapy assessment practice and the development of the PRPP-A.

Occupational Therapy Practice in Aotearoa New Zealand

The practice described here reflects the occupational therapy workforce in Aotearoa New Zealand when this investigation first started. At that time occupational therapists worked across diverse settings with 49% of the workforce in hospital and community services within government funded District Health Boards (DHBs) (Stokes & Dixon, 2018). A further 23% of occupational therapists worked in private practice contexts such as private clinics and contract work for Accident Compensation Corporation (ACC) (a government

insurance scheme for people with personal injuries). The remaining 28% were employed in a range of work contexts including non-government organisations (NGOs), Kaupapa Māori services (cultural services specifically for Māori), Ministry of Education, schools, corrective services, private hospitals, and rest homes (Stokes & Dixon, 2018). Occupational therapists in these settings work across the lifespan providing services for infants, children, adults, and older persons. Occupational therapists serve individual clients or tangata whenua and their whānau³/family, and/or groups or communities. The term ‘client’ is used generally in this study to cover all of these possibilities.

The Occupational Therapy Board of New Zealand (OTBNZ, 2015b) has defined occupational therapists’ role as “to increase and transform people’s participation in occupation. This helps to promote and improve wellbeing, health and social outcomes. You (an occupational therapist) aim to enhance tino rangatiratanga (self-determination), ensure equity, and enable occupational justice” (p. 2). Clients seen by occupational therapists can have physical or mental health conditions, long term disability, injuries, or have experienced social barriers which limit participation in occupation.

Legislative Requirements Influencing Occupational Therapy Assessment Practice

Under the Health Practitioners Competence Assurance Act 2003 (Ministry of Health [MOH], 2003) all practicing occupational therapists in Aotearoa New Zealand are required to be registered with the OTBNZ, abide by the Code of Ethics for Occupational Therapists (OTBNZ, 2015a), and hold a current annual practising certificate. They are also required to ensure their continued competency via five areas of competency for the annual recertification process (OTBNZ, 2015b), all of which have some bearing on the assessment practice of occupational therapists. Of significance to this study are the requirements that occupational therapists:

- Ensure practice has an evidence-base (OTBNZ, 2015b Competency 5).
- Select appropriate assessments (OTBNZ, 2015b Competency 1.6).
- Practice appropriately for bicultural Aotearoa New Zealand (OTBNZ, 2015b Competency 2).
- Use current theory and evidence, as well as sound clinical reasoning, to help make decisions and use the best processes in practice (OTBNZ, 2015b Competency 1.7).

³ Whānau is the Māori term for family

- Identify, express, document and justify the strategies chosen as appropriate for clients, based on the results of assessment (OTBNZ, 2015b Competency 1.13).

One well recognised way to base practice on evidence is to use a standardised occupational therapy assessment. Standardised assessments need robust psychometric properties that demonstrate an instrument's reliability and validity. It includes the assessment's inter-rater reliability (statistically similar results are produced across raters), intra-rater reliability (results are stable over time), and that it measures what it purports to measure (Classen & Velozo, 2014). When selecting an appropriate assessment, as part of evidence-based practice, occupational therapists need to evaluate the psychometric properties of the assessment and understand its utility, strengths, and limitations in practice; and, significantly, for practice in Aotearoa New Zealand, the assessment's cultural validity (OTBNZ, 2015b). Additionally, all decisions need to be comprehensively thought through and reasoned, with assessment results informing the actions occupational therapists take in practice.

Cultural Context Influencing Occupational Therapy Assessment Practice

Occupational therapists need to examine how valid an assessment is to apply across cultures. In Aotearoa New Zealand this includes evaluating the cultural relevance of assessments for use with tangata whenua and clients of all cultures, “taking into account Te Tiriti o Waitangi” (OTBNZ, 2015b, p. 5). Health service providers working with tangata whenua must honour Te Tiriti in practice and the principles derived from it: partnership, protection, and participation. All health practitioners are required to work towards improved outcomes for Māori and address the substantial health inequities that exist for Māori as a result of colonisation (MOH, 2014). To ensure that occupational therapists work towards improved health outcomes and enact Te Tiriti o Waitangi in their work with tangata whenua, a commitment to bicultural practice is woven into all five OTBNZ continuing competency areas for recertification (OTBNZ, 2015b). In relation to assessment practice, this means occupational therapists need to use an assessment practice that is culturally safe⁴ (OTBNZ, 2015b Competency 4.7), and select appropriate assessments (OTBNZ, 2015b Competency 1.6) relevant from the perspective of Māori, with outcomes that benefit tangata whenua. There is an expectation that assessment processes are collaborative and respectful of the uniqueness of individuals and

⁴ Cultural safety is an Aotearoa New Zealand concept that relates to health care practice which considers and addresses the historical socio-political context, impact of colonisation, and health disparities that exist for tangata whenua. Cultural safety can only be determined by the person receiving care feeling safe (Gray & McPherson, 2005).

communities, and beyond the tinana (physical) and hinengaro (mental and emotional well-being) to include their mana (status), wairua (spirit), (OTBNZ, 2015b Competency 1.9) and whānau (family) (Durie, 2011).

Occupational Therapy Assessment Practice and Development of the PRPP-A

Since the early 1990s there have been growing calls for occupational therapists to take an occupational perspective to practice, in keeping with current occupational therapy theory and models (Hocking, 2001; Molineux, 2004; Rodger, 2010). This type of practice has an occupation-focus, concentrating on occupation from the outset through all stages of the occupational therapy process. Occupational therapists in Aotearoa New Zealand are recognised to generally strive to keep occupation at the “absolute core” (Orton et al., 2015, p. 95) of practice. However, despite this intended occupation-focus, research has found occupational therapists continue to select assessments in practice which are entirely at odds with this focus (Alotaibi et al., 2009; Brangan & O'Neill, 1998; Piernik-Yoder & Beck, 2012). Much of today's occupational therapy assessment practice is still influenced by the profession's past and the biomedical mechanistic era of the 1950-60s (Hocking & Whalley Hammell, 2017; Kielhofner, 2009a). Consequently, the use of assessments that evaluate clients' level of impairments or performance components remains prevalent (Douglas et al., 2007; Pilegaard et al., 2014). This type of assessment practice continues despite growing acknowledgment that the results of component-based assessments are frequently meaningless for clients and bear little correlation to occupational performance (Sansonetti & Hoffmann, 2013). To combat these challenges the profession has gradually developed standardised occupation-based assessments (Alotaibi et al., 2009; Classen & Velozo, 2014; Hocking, 2001). Only a small selection of these are available to occupational therapists, and the uptake of occupation-based assessments in practice has been slow; the reasons for which are not well understood (Alotaibi et al., 2009; Pilegaard et al., 2014).

Questions have also been raised about the cultural relevance of many standardised occupation-based assessments with concerns related to the western bias of assessments. Assessment tasks are often unfamiliar and/or lack meaning to non-western cultures (Buchan, 2002), focus on occupational categories that are only important in western societies (Skawski, 1987), and the standardisation of assessments is typically based solely on western populations (Stanley, 1995). Presently, there is no research evidence to indicate that this situation has substantially changed in more recent times. Assessments

have, therefore, been criticised as having little or no relevance to people of diverse cultures or collective societies (Hammell, 2009; Iwama, 2007; Thorley & Lim, 2011).

The PRPP-A was developed to address some of the limitations of other perceptual and cognitive assessments. It was designed for use with clients with information processing difficulties, of any age or condition, performing any client-selected routine or task (Chapparo & Ranka, 2016). Given that the PRPP-A is a relatively new assessment, there is still much to understand about its practical application in real-world occupational therapy contexts. Early indications are that the PRPP-A is a flexible assessment; however, existing literature only reports assessment of western tasks. As outlined earlier, understanding the possible cultural application of the PRPP-A is important in the unique practice context of bicultural Aotearoa New Zealand.

My Background and Interest as a Researcher

In qualitative studies the researcher is always an integral part of the research process. Consequently, it is essential that my background and interest as a researcher is explained so that my approach and the ways I shape this study and thesis are clearly visible. It is with this intention that I share my background so that readers can gauge for themselves my influence on the research design and process.

I am of English Scottish descent and completed my occupational therapy training in the United Kingdom. I have lived in Aotearoa New Zealand for the last 35 years. I have practiced as an occupational therapist for 40 years and, more recently, held an educator role. I have worked in a wide range of practice settings with adults and children including acute hospitals, community services, private practice, special education, and mainstream schools. For the last 20 years, I have also been a partner in Chameleon Courses, a business partnership that has organised a range of courses and workshops predominantly for occupational therapists in Aotearoa New Zealand. Chameleon Courses has been, and continues to be, the only provider of PRPP-A courses in Aotearoa New Zealand.

It was through Chameleon Courses that I first attended the PRPP-A course in 2007 and began using the assessment in my practice. My own experience of the PRPP-A was that, following the initial training I was excited to have the opportunity to use a standardised occupation-based assessment. It took 6 months, however, before I felt competent applying all stages of the assessment with clients. In that time, I gradually learnt to use the assessment through practice, supervision, and discussion with peers, both individually and in groups. I was also encouraged to continue to use the PRPP-A from the positive feedback

I received from clients, whānau, and team members. Eventually the PRPP-A became a valuable part of my assessment kete⁵ and it has sharpened my occupational focus and clinical reasoning. I continued to use the PRPP-A in my practice for the following 2 years after first training; later taking opportunities to further build on these initial PRPP-A skills through subsequent PRPP-A courses (in my role as a Chameleon Courses partner, explained below) and by attending the PRPP Intervention (PRPP-I) course⁶ in 2011.

In addition to my own learning and experiences with the PRPP-A, I have several other roles associated with supporting and educating occupational therapists to learn and apply the PRPP-A. Through the Chameleon Courses partnership, I have attended all eight assessment courses held in Aotearoa New Zealand and first assisted with teaching on the 2013 PRPP-A course. I committed to on-going training as a PRPP instructor and assisted with teaching on the three subsequent courses in Aotearoa New Zealand. In addition, for the last 16 years I have run a private supervision service supervising other occupational therapists, some of whom are also PRPP-trained.

Through these different roles I have witnessed the enthusiasm other occupational therapists have experienced with the PRPP-A and realised how some occupational therapists face significant challenges applying the PRPP-A in practice. These challenges were particularly evident when I was asked to attend a PRPP-A support group of occupational therapists who were struggling to implement aspects of the assessment in their practice. Over four sessions I helped this group develop strategies to use and integrate the assessment. These roles gave me valuable insights into some of the challenges of integrating the PRPP-A and fuelled my curiosity to know more about the practice realities of applying the assessment. It was also evident that therapists grappled with different thinking and decision-making processes associated with using the PRPP-A; for some, this was confronting and disrupted their existing clinical reasoning. Consequently, I became increasingly interested in understanding the thinking and decision-making processes therapists need to use and what might better support the learning process for occupational therapists after their PRPP training.

Another aspect that personally interested me was the cultural application of the PRPP-A. In line with the continuing competency requirements for practice as an occupational therapist in Aotearoa New Zealand, I have focused for many years on improving my own

⁵ Kete is a flax bag, commonly used to denote toolbox

⁶ PRPP-I course is a training course that PRPP-A trained occupational therapists can attend to learn intervention strategies based on the PRPP system of task analysis

cultural understandings and culturally safe practice to better support the occupational well-being of tangata whenua. Prior to training in the PRPP-A, I was frustrated and challenged by not having suitable assessments to use with tangata whenua. I was all too aware the assessments I had access to were either designed for western populations and/or included culturally irrelevant tasks. As the PRPP-A has no fixed tasks, I considered the assessment had potential to be relevant. I tried using it with a few tangata whenua and found the assessment process allowed them to choose tasks that were important and culturally relevant for them. Although these were good experiences, questions remained for me as to whether the PRPP-A really was culturally appropriate to use in practice as a tau iwi⁷ occupational therapist. I viewed having a culturally relevant task as only one aspect of using a standardised assessment with tangata whenua and I became interested in knowing more; what else needed to be considered?

Ultimately these interests in the practical application and KT of the PRPP-A resulted in starting my postgraduate study and undertaking the current research. This study, therefore, forms my Doctor of Philosophy degree.

Thesis Overview

This chapter contained a synopsis of my study which is focused on the experiences and clinical reasoning of occupational therapists applying the PRPP-A in Aotearoa New Zealand. The study questions and aims have been explained, together with the context and influences on occupational therapy assessment practice in Aotearoa New Zealand. I have described my interest in knowing more, including why I consider it important for the profession to have greater understandings of the topic. The layout of the thesis is now presented.

In Chapters 2 and 3 the literature related to the study questions is explored. Chapter 2 begins with a historical discussion and considers how the past has shaped present day occupational therapy assessment practice and the influences which led to the development of the PRPP-A. The literature associated with what is already known about the PRPP-A is described, providing the context of the assessment for this study. The gaps in the current PRPP-A research are identified and related to the Phase One focus of the study. Chapter 3 has two sections which cover a review of the occupational therapy literature concerning applying and translating an occupation-based assessment like the PRPP-A to practice. Section one provides a summary of current perspectives of occupational therapists'

⁷ Tau iwi is an encompassing term for non-Māori

clinical reasoning associated with the assessment stage of practice and specifically considers clinical reasoning and applying occupation-based assessments. Section two concerns KT and seeks understandings of possible learning associated with translating a new assessment to practice. There is a brief overview of KT and occupational therapy practice, followed by an exploration of KT models, strategies, and stages of learning theories which may be applicable to translating the PRPP-A to practice in Aotearoa New Zealand. Chapter 3 concludes by linking the review findings from the clinical reasoning and KT literature to a justification for both Phases One and Two of this study.

The methodology is presented in Chapter 4. It outlines the reasons for selecting QID and the philosophical underpinnings of the study. Chapters 5 and 6 detail the methods employed for both Phases One and Two and include explanations of how rigour has been addressed throughout the research. Specifically, Chapter 5 is focused on the ethical considerations, recruitment, participant selection, and data collection. Data analysis is explained in Chapter 6.

Chapters 7 and 8 present the findings from Phase One; described under five themes across the two chapters. Chapter 7 covers participants' experiences of taking the PRPP-A from training to practice through the three themes 'resonating with practice as it should be', 'translating to practice', and 'reporting using an occupational performance focus on cognition'. Chapter 8 continues with two themes accounting for the actual use of the PRPP-A in practice, 'validating the practice fit' and 'cultural application'. Chapter 9 provides a summary and discussion of Phase One main findings in a manuscript published in a peer-reviewed occupational therapy journal.

Phase Two findings are explained in Chapters 10 and 11 through four themes. The first theme, 'configuring a PRPP-A process', is presented in Chapter 10 and pertains to clinical reasoning from the outset of assessment planning to the development of unique PRPP-A plans and selection of assessment tasks for specific clients. The three remaining themes 'having an assessment intention', 'drawing on theory', and 'developing skills and strategies' are covered in Chapter 11. All three themes relate to different aspects of clinical reasoning associated with applying the PRPP-A through to interpreting and scoring the assessment.

Finally, Chapter 12 provides a reflection of the central Phase Two findings along with a few relevant Phase One findings not discussed in Chapter 9. The findings are discussed and situated in relation to previous research and knowledge from the literature, followed

by an account of the study strengths and limitations. The chapter concludes by presenting the implications of the findings for occupational therapists considering PRPP-A training, future PRPP-A education, and further research. Recommendations for future research are made and a summary of the overall study provided.

CHAPTER 2: REVIEW OF THE LITERATURE

Introduction

This chapter contains a review of the available literature at the time that informed the initial study design. A critical evaluation of some of the key issues that generated the Phase One research question are provided with literature included up until 2020. Subsequent, more recent literature is integrated into the analysis of the findings in the discussion chapter (see Chapter 12). The chapter opens with a brief historical perspective of influences that have shaped current occupational therapy assessment practice, followed by an overview of the Perceive, Recall, Plan and Perform System of Task Analysis Assessment (PRPP-A) including its theoretical base, validity, and reliability. Understandings concerning the practical application of the PRPP-A are reviewed and compared to the clinical utility of other occupation-based assessments. The chapter ends by highlighting barriers that exist to occupational therapists' use of occupation-based assessments.

An Historical Perspective of Occupational Therapy Assessment Practice

Titiro whakamuri kohiri whakamau

Look back and reflect so you can move forward

The above whakataukī (Māori proverb) captures the overall purpose of reviewing the past to provide understanding of the present and guide the future. This section draws on salient historical points that have influenced the nature of occupational therapy assessment practice over time and shaped present day practice. The history of occupational therapy assessment practice prior to the development of the PRPP-A is reviewed to provide background to the types of assessment options available to occupational therapists before they trained in the PRPP-A.

At the time of writing this chapter, I found no specific literature that exclusively addressed the overall history of occupational therapy assessment practice. Consequently, the history is drawn from multiple sources, including accounts of the development of the occupational therapy profession, practice in the 20th century, and the assessments used in different periods up to current day practice. I have also placed attention on three specific areas that are pertinent to my research questions. First, the cultural application of assessments as this provides background for considering the cultural applicability of the PRPP-A. Second, literature containing reports of issues about assessment practice for clients with cognitive challenges which contributed to the development of the PRPP-A.

Finally, research associated with clinical reasoning and occupational therapy assessment practice.

Assessment Practice: Beginnings

Occupational therapy emerged early in the 20th century with a holistic view of health encompassing notions that good health came from “engaging body, mind and spirit” (Quiroga, 1995b, p. 13) and that health could be enhanced through a person being occupied (Reed, 2017). Early occupational therapy, developed with recuperating World War I soldiers, typically used work related or craft occupations which were diversional in nature to structure patients’ days (Townsend & Polatajko, 2007). An account of early occupational therapy in Aotearoa New Zealand (Wilson & Cheetham, 2008) describes practice centred on the “products” (p. 33) of craft activities, with leisure and social pursuits aiding rehabilitation of long stay patients.

From 1910 onwards, the use of occupations to enhance health grew. Eventually the practice reached a crossroads whereby, rather than remaining an adjunct to nursing, part of charitable organisations, or volunteer services, a profession in its own right was formed (Colman, 1992; Quiroga, 1995c). Despite the fledgling profession severing its original nursing ties, it continued to maintain strong alliance with medical practice and seek recognition as a valid health profession (Quiroga, 1995c). Yet even in those pioneering years, occupational therapy had a somewhat uneasy fit with medicine and was not seen as an “exact science” (Quiroga, 1995c, p. 81). To overcome this challenge, William Dunton, a psychiatrist and one of the American Occupational Therapy Association founders, proposed methods to measure the impact of therapy were needed “so that work could be brought into accordance with the contemporary scientific and systematic values of medicine” (Quiroga, 1995c, p. 81). Others argued differently, suggesting there was no requirement to prove practice, as observations alone were sufficient to demonstrate the profession’s worth, since the value was self-evident (Quiroga, 1995a, p. 131). It was, perhaps, this latter view that won over as there was an apparent lack of assessment tools developed.

Consequently, the literature of early practice has many references to activities, equipment, and tools needed for prescribed treatments rather than specific assessments to establish need for or outcome of intervention (Losada, 1936; Macdonald, 1949; Reed, 2017; Wilcock, 1998). Different occupations were seen as treatment options and evaluated for their relative efficiency to remedy specific types of disease and organs of the body (Wilcock, 1998). Generally, occupations were medically directed and based on patients’

diagnoses. Losada (1936) described this process as “activities are prescribed as a drug might be” (p. 285) and Macdonald (1949) noted that occupational therapists needed the “ability to carry out prescriptions” (p. 193).

In keeping with providing occupational therapy treatments, prescriptions were evaluated with medically based outcomes such as monitoring patients’ vital signs, bowel and bladder functions, sleep and eating patterns (Quiroga, 1995c). Early accounts do exist of “careful activity analysis” (Wilson & Cheetham, 2008, p. 34) to match an activity to a patient’s specific condition. Pioneering practice also incorporated concepts of grading activities by increasing time, demands, or complexity of activities, and the adaption and/or simplification of tasks (Reed, 2017). Furthermore, the study of craft analysis and adaptation of occupations were essential components of the first American minimum training standards set in 1924 (Quiroga, 1995d). It appears, therefore, the beginnings of an occupational therapy assessment practice which was fundamentally different from other health professionals’ evaluations, was based on activity analysis, grading activities, and identification of adaptations for increasing occupational performance.

The Press of Science and Biomedicine on Assessment Practice

During the first half of the 20th century, the occupational therapy profession continued to be strongly associated with medicine and the medical perspective of health. Occupational therapists pursued the development of therapeutic activities as treatments to cure people or certain conditions. This ongoing alliance with medicine, combined with the explosion of technological advancements and the wider pursuit for scientific evidence, eventually caused a major shift in theoretical thinking within the profession. As a result, by the 1950s, occupational therapy had entered, what later was termed, the mechanistic paradigm (Kielhofner, 2009a). The dominant scientific reductionist theories of the day greatly influenced the profession’s theoretical perspective resulting in considerable pressure for the profession to provide a scientific rationale for its practice. In the 1950s occupational therapists were focused on “underlying neurological, anatomical and intrapsychic mechanisms”, which they considered would reduce “client’s neurological, biomechanical and psychodynamic impairments” (Kielhofner, 2009a, p. 31) rather than on occupations and activities.

Accordingly, occupational therapists strove for objectivity and an emphasis on measurement and standardisation became important (Kielhofner, 2009a). With these changes came the need to develop or adopt standardised assessments to measure outcomes of occupational therapy treatment. Standardised tests, measures, and

assessments were considered robust scientific methods to demonstrate the credibility of occupational therapy practice. That perspective is clear in a 1970s occupational therapy textbook:

Occupational therapists who use locally devised tests [assessment tools] should attempt to standardise them. The test must have clear aims. It must be administered in exactly the same way to each patient and under the same conditions. A method of scoring must be devised which will eventually make it possible to relate individual scores to some well-defined reference groups. Records should be kept of patient's achievements so that a body of knowledge is built up about the test. (Macdonald et al., 1976, pp. 134-135)

Occupational therapists responded to pressure to justify and use scientific approaches to practice by developing standardised assessments congruent with the reductionist theories of the time. Such assessments specifically measured impairments, underlying bodily structures or inner mechanisms, and components or skills that therapists considered influenced functional outcome. They were subsequently termed “bottom-up assessments” as they focused on “the deficits of components of function” (Tromby, 1993, p. 253) assumed to be the prerequisites to improving a person's occupational performance or function.

In keeping with the scientific perspectives of the time, establishing the validity and reliability of these new assessments became important. For an assessment to be accepted as a valid measure it needed to demonstrate statistical reliability; that is, the measure produced the same results over time (intra-rater reliability) and across assessors (inter-rater reliability). From the late 1950s onwards, the development of component and impairment-based assessments flourished. Although too numerous to list the range of such assessments here, their use remains prevalent in today's occupational therapy practice (Alotaibi et al., 2009; Kramer et al., 2009). Research on recent assessment practices indicates that many occupational therapists considered these component-based assessments to be quick and easy to administer and important tools in their practice (Douglas et al., 2007). Moreover, some occupational therapists continued to argue that they are the most suitable assessments for evaluating clients' needs (Bagatell et al., 2013; Gutman et al., 2007; Weinstock-Zlotnick & Hinojosa, 2004).

Along with developing assessments specifically for occupational therapy, the profession also sought credibility from using other disciplines' tests. For example, in the 1960-70s

psychology psychometric, tests such as Raven's Standard Progressive Matrices (Macdonald et al., 1976); physiotherapy and orthopaedic range of motion tests (Heck et al., 1966); education tests, like the Frostig Developmental Test of Visual Perception (Maslow et al., 1964); and from medicine the Mini Mental State Examination to evaluate cognitive functioning (Folstein et al., 1975). These non-occupational therapy impairment-focused types of assessments remain key in some areas of practice today; valued particularly for their robust psychometric properties (Douglas et al., 2007; Koh et al., 2009). Consequently, some of these assessments have become associated with occupational therapy and other health professionals, particularly doctors, will refer clients to occupational therapists to administer these assessments (Stigen et al., 2017).

A further significant influence on assessment practice occurred with the advancement of the mechanistic era as the "therapeutic use of arts and crafts came under scrutiny" and in its place "a more practical approach was to focus on self-care and training in work skills for productivity in the home and out of it" (Ross, 2009, p. 37). Activities of daily living (ADL) checklists, functional charts, and tests to meet the assessment needs of this changing focus of practice were established. A multitude of standardised measurements for ADL were developed through the 1970s-80s (Law & Letts, 1989). However, their uptake in clinical practice varied and, despite the wide range of standardised ADL assessment options available, many therapists continued to report ongoing challenges to finding appropriate ADL assessments for their actual practice setting and/or client group (Law & Letts, 1989; Mulligan et al., 2014; Pilegaard et al., 2014; Robertson & Blaga, 2013). Subsequently, although occupational therapists have increasingly used standardised ADL assessments, the use of 'home grown' non-standardised ADL assessments since the 1960s seems to have continued into recent practice (Bagatell et al., 2013; Brangan & O'Neill, 1998; McGrath & O'Callaghan, 2014; Moulton, 1997; Robertson & Blaga, 2013; Rouleau et al., 2015).

An Era of Change: The Impact of Occupational Renaissance, Quality Assurance, Client-Centred and Evidence-based Practice

In the 1960-70s, some occupational therapists started to strongly challenge the direction the profession had taken (Reilly, 1962). In relation to assessment practices, questions were raised concerning the impairment-based focus, lack of meaningful occupations for clients, and loss of a holistic view of health. Over time these challenges saw the profession rethink its position, underpinning theories and its alignment with the medical model. By the late 1980s what became known as an "occupation renaissance" (Whiteford et al., 2000, p. 62),

or the contemporary paradigm (Kielhofner, 2009b), began to exert an influence on occupational therapy assessment practice.

In the 1980s, assessment practice was further shaped by demands for accountability in health and education sectors including fiscal responsibility and a press to provide effective quality services (de Clive-Lowe, 1996; Klein et al., 2008; Unsworth, 2000). Moyer (1984) described this as “today occupational therapists are eager to prove the effectiveness of their services by having good baseline data for treatment planning from which subsequent progress and improvement can be measured” (p. 34). Outcome measures in the form of standardised assessments were required across different practice settings (Fricke, 1993; Moyer, 1984). In the 1990s the need for outcome measures intensified, with evidenced-based practice endorsed as an essential component of occupational therapy practice (Alsop, 1997; Cusick & McCluskey, 2000; Klein et al., 2008). It became necessary to have outcome measures to provide evidence of quality services and demonstrate fiscal accountability of services (de Clive-Lowe, 1996; Fricke, 1993; Unsworth, 2000).

Alongside the demands from health care organisations and the profession for greater accountability and evidence, clients were also reported to have changing expectations of assessments provided by occupational therapists (Moyer, 1984). For example, clients sought evaluations that related “in a direct and obvious way to their problems” (p. 34) in everyday functioning. Thus, the profession as a whole was becoming increasingly cognisant that assessment practices based on biomedical perspectives focused on medical conditions and analysis of impairments did not fit these expectations (Hocking, 2001). Additionally, these assessments were increasingly viewed as disempowering clients and providing results that were more related to the clients’ condition rather than their occupational needs (Kielhofner, 1993).

The Shift Towards Occupation-focused Practice

By the late 1980s, the occupational therapy profession was emphasising the need for personalised care; recognising and articulating a client-centred approach was important to practice (Pollock et al., 1990; Wilson & Cheetham, 2008). The concept of client-centred practice had been evident throughout the history of occupational therapy; however, until this time the implications for practice were unclear and little was documented about how to actually apply it (Law et al., 1995).

The development of better understandings of client-centred practice within the occupational therapy profession raised the need for new types of assessments and outcome measures that aligned with occupation-centred theories and client-centred practice (Baum & Law, 1997; Hocking, 2001; Molineux, 2004; Pollock et al., 1990). In the 1990s, the profession responded by developing standardised occupation-based assessments often referred to as “top-down assessments” (Tromby, 1993, p. 253). Today, top-down assessments that typically focus on occupational performance have gradually become incorporated into many areas of occupational therapy practice. Early examples of such assessment include the COPM, which was designed to establish client-centred occupational performance goals and to evaluate performance following occupational therapy intervention (Law et al., 1990); and the Assessment of Motor and Process Skills (AMPS), an assessment of a person’s performance of personal or instrumental ADL (Fisher, 2006).

Cultural Considerations of Assessment Practice

During the 1990s, the profession continued to grapple with implementing client-centred practice (Law et al., 1995; Wilkins et al., 2001). One aspect that caused considerable concern was whether the profession was truly meeting the needs of its clients, especially the unique needs of clients from diverse cultures. This concern raised ethical dilemmas and ongoing criticism of the profession’s cultural practices (Castro et al., 2014; Dyck, 1991; Nelson, 2007). Furthermore, it exposed the profession’s underlying western cultural bias and predominant “white middle class” (Stanley, 1995, p. 155) value structure permeating professional theory and practice (Awaad, 2003; Dyck, 1989; Skawski, 1987; Stanley, 1995).

Consequently, specific concerns relating to assessment practice and cultural relevance surfaced. These included, but were not limited to, the following concerns: a) standardised assessments were typically targeted to the needs of western societies (Nelson, 2007); b) they focused on occupations that were not necessarily understood by people of non-western cultures (Skawski, 1987); c) they were norm-referenced on western populations and then routinely applied to clients of other cultures (Stanley, 1995); d) evaluations were at the individual level of performance and/or the person’s independence without any consideration to other culture’s collective ways of doing and lifestyles of interdependence (Dyck, 1991; Iwama, 2007); and e) outcome measures did not necessarily measure things “clients deem as important” (Nelson, 2007, p. 253). Furthermore, some assessment tasks were challenged as being culturally irrelevant and lacking any correlation to people’s

culturally-specific occupations (Stanley, 1995). Clients from diverse cultures may not have had previous experience of performing the set assessment tasks, in turn, jeopardising the likelihood of successful performance; the results of such assessments potentially disadvantaged the very clients that occupational therapists were trying to assist (Thorley & Lim, 2011).

Cultural concerns have also been raised with the more recent occupation-based assessments. Critics have highlighted the meaningless nature of predominantly western occupational categories of self-care, leisure, and productivity for some societies, and argued that notions of satisfaction are alien concepts for some cultures (Hammell, 2009). Others have attempted to create culturally specific assessments (Stanley, 1995) or adjust existing assessments to better accommodate clients' cultural needs. For example, tasks were added to the AMPS for clients of Japanese and Chinese descent (Fisher, 1992; Goto et al., 1996). Although this, too, is limited, given the endless number of culturally specific occupations that exist within cultures. Hence, occupational therapists continue to report a lack of culturally-relevant tasks on the AMPS for some clients (Buchan, 2002).

Over the last 3 decades, in addition to the profession gradually developing insights into the significant flaws in the cultural biases of available assessment tools, there has been growing acknowledgement of occupational therapists' own cultural competence impacting the application and interpretation of assessments (Fitzgerald et al., 1997; Stanley, 1995). Occupational therapists have been urged to better understand their own cultural values, beliefs, and assumptions, and to recognise how this impact their practice. In Aotearoa New Zealand the expectation of cultural competence and reflexivity overtly extended to registered occupational therapists in 2004, with members of the profession being required to demonstrate culturally safe practice as part of their ongoing competency for recertification (OTBNZ, 2004). This requirement was strengthened in 2015 in the revised OTBNZ competencies for registration and continuing practice with Competency Two requiring all practicing occupational therapists demonstrate they are "practicing appropriately for bicultural Aotearoa New Zealand" (OTBNZ, 2015b, p. 5). This revision of the OTBNZ competencies unequivocally aimed to bring practice in line with the profession's commitment to Te Tiriti o Waitangi and address the inequitable health statistics of Māori. Competency One (OTBNZ, 2015b) stipulated that occupational therapists must demonstrate they select appropriate assessments, evaluate practice with appropriate measures, and seek feedback from clients on assessment processes. These

competencies have started, and will continue, to shape assessment practice in Aotearoa New Zealand.

Calls for Different Assessments for Clients with Cognitive Challenges

Alongside concerns associated with the cultural application of assessments, occupational therapists have identified ongoing gaps in the range of available assessments for the evaluation of clients with cognitive issues (Douglas et al., 2007). For these clients, existing occupation-based assessments were often difficult to apply, since clients needed to comprehend the instructions and questions to complete the assessment. This, in itself, required clients to have adequate language and/or cognitive skills, the very performance skills that were challenging for them (McColl et al., 2005).

Another limitation which has been identified for clients who lack initiation and/or motivation is that many assessments focus on clients' capacity to perform an occupation; however, do not evaluate the clients' real-life performance; that is, their ability to perform occupations as and when the occupation needs to be done (Stigen et al., 2018). Furthermore, some assessments have prerequisite skills that exclude clients with low motivation or cognitive challenges, such as the Dynamic Performance Analysis (DPA) where clients need to be motivated to do a task and know what to do in order to be assessed (Polatajko et al., 2000). In contrast, component-based assessments (bottom up) are often designed to be applied with clients with low motivation or cognitive changes to identify underlying cognitive deficits. However, occupational therapists report the assessment results do not readily relate to clients' real-world occupational performance (i.e., the assessments lack ecological validity) (Sansonetti & Hoffmann, 2013; Stigen et al., 2018).

In recent years, to overcome the many assessment practice challenges highlighted above, occupational therapists have used a collection of assessments to evaluate client needs. These include standardised component-based assessments and occupation-based assessments, some of which are standardised although more typically are non-standardised home-grown assessments (i.e., assessments developed locally by occupational therapists in their practice contexts, c.f. Douglas et al., 2007; Pilegaard et al., 2014; Sansonetti & Hoffmann, 2013). In some instances, home-grown assessments have been combined with a different standardised tool, often from another discipline, to evaluate clients' progress (i.e., an outcome measure) (Douglas et al., 2007). Consequently, there have been calls for other assessment options for clients with cognitive challenges, which are neither top-down nor bottom-up in nature, but are capable of providing

information on a person's occupational performance and associated cognitive capacity (Douglas et al., 2007) and which can measure "the consequences of the cognitive impairments on everyday occupations" (Stigen et al., 2018, p. 6) and evaluate the outcome of intervention.

It is from this historical backdrop that the conceptual foundations for the Perceive, Recall, Plan and Perform System of Task Analysis (PRPP) were formed and the PRPP Assessment (PRPP-A) developed in 1996. The PRPP-A has been described as a "contemporary assessment" (Nott & Chapparo, 2012) capable of measuring occupational performance related to both the level of activity and participation and the level of body structure and function of the International Classification of Functioning Disability and Health (World Health Organization, 2001).

Overview of the PRPP-A System

Guiding the literature review for this section, the search words 'Perceive, Recall, Plan and Perform' or 'PRPP' or 'Perceive, Recall, Plan and Perform system of task analysis' or 'PRPP system of task analysis' were initially searched and then combined with 'occupational therap*' and 'assessment'. The databases Scopus, Sage, EBSCO Health (AUT collective database which includes CINAHL, Psychology and Behavioural science collections and Medline) were primarily used; and, as a final check, Google Scholar. The search had no year limit. A hand search of the PRPP training manual (Chapparo & Ranka, 2016) reference list was included. The search located 18 research articles, 3 chapters in books, Masters and PhD dissertations. In September 2018, at the outset of Phase Two of the study, the search was repeated to ensure all available literature was included and yielded a further two research articles.

PRPP-A Development

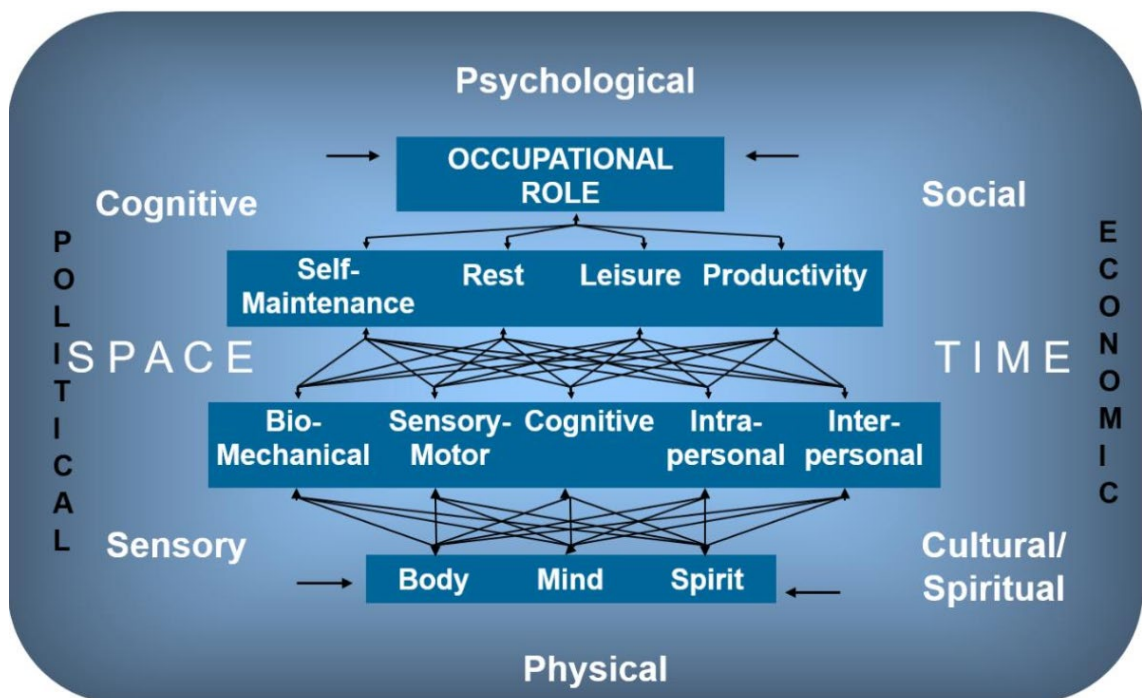
The development of the PRPP-A was in response to occupational therapists identifying a need for standardised, ecologically valid assessments capable of evaluating clients' occupational performance (Chapparo & Ranka, 2016; Douglas et al., 2007; Hocking, 2001; Klein et al., 2008; Law, 1993). Occupational therapists were concerned that many traditional tests of cognition and perception bore little correlation to clients' actual occupational performance and that findings from such assessments often did not assist with forming intervention strategies to improve clients' actual occupational performance (Sansonetti & Hoffmann, 2013). As reported by Chapparo and Ranka (2016), a decision was made to research other assessment options and develop a tool that could be used in

natural contexts and would provide relevant information for guiding occupational therapy interventions.

The Occupational Performance Model (Australia) (OPM(A)) was developed first and became the theoretical framework for the PRPP system and PRPP-A (Fig. 1). The OPM(A) has been described as “a conceptual illustration of factors impacting on occupational performance and representative of the domains of concern of occupational therapy” (Ranka & Chapparo, 2010, p. 197). It is a recognised and a well-accepted occupational therapy model used by occupational therapists to explain occupational performance (Chapparo et al., 2017a; Stamm et al., 2006).

Figure 1.

Occupational Performance Model (Australia) OPM(A) (2011)



Note. From Occupational Performance Model Australia website <http://www.occupationalperformance.com> by Chapparo, C., & Ranka, J. (2011). Reprinted with permission.

Subsequent to the OPM(A), the PRPP-A was developed through multiple research phases with small clinical studies of adults with and without brain impairments (Chapparo & Ranka, 2016). The two-stage assessment process within the PRPP-A was established. Since 1996, as the result of further research, the PRPP-A has been refined to its present-day format.

Description of the PRPP-A

The PRPP-A is a standardised criterion referenced, ecological, client-centred assessment of occupational performance (Ranka, 2014). It is suitable for use with a person of any age, gender, culture, or disability, performing any relevant tasks in real-world contexts (Ranka & Chapparo, 2010). The assessment involves observations of a person performing between two to four chosen tasks based on the person's and/or significant others' occupational needs and desires. There are two stages to the assessment process and occupational therapists can choose whether to assess using just Stage One or both Stages One and Two depending on the needs of the client, the practice setting, and the nature of the assessment information required. Both Stages One and Two can be used as either quantitative and/or qualitative assessment tools (Chapparo & Ranka, 2016).

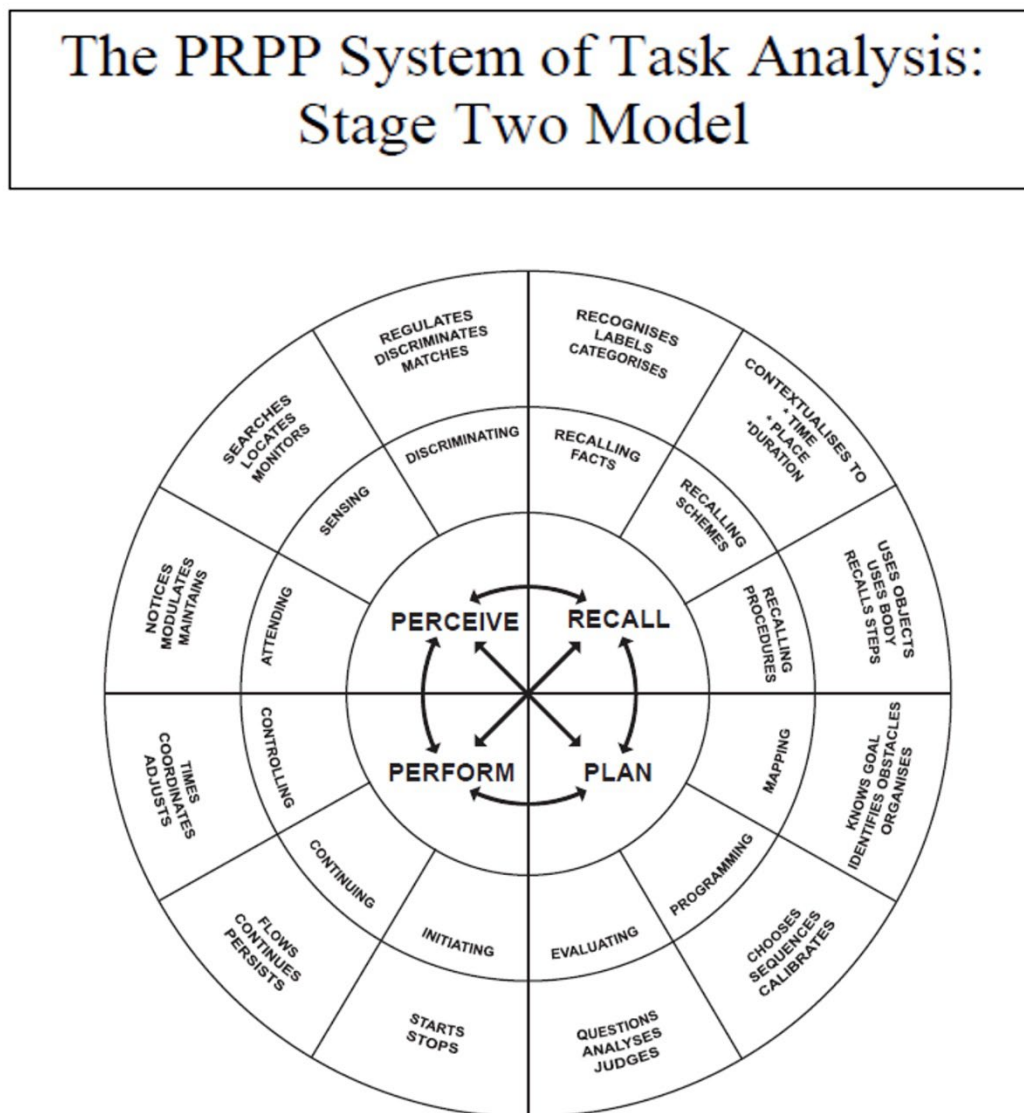
Stage One of the PRPP-A is based on a standardised method of procedural task analysis from which the steps of the task/routine/role are established, and the performance criterion set. A person's occupational performance is assessed through observation and their performance mastery (skill) evaluated. Occupational performance errors are identified and errors of accuracy, omission, repetition, or timing can be scored along with a total score of task mastery calculated (Chapparo & Ranka, 2016). The findings from a Stage One PRPP-A can be used in several ways, including as an outcome measure to record the level of a person's occupational performance pre-and post-occupational therapy intervention (Mills et al., 2016); to set goals for intervention, such as a specific step which needs to be learnt (Chapparo & Ranka, 2016); or to identify the level of assistance a person needs to be able to do the task (Fry & O'Brien, 2002; Ranka & Chapparo, 2010).

The PRPP-A Stage Two incorporates cognitive task analysis, a recognised group of analytical methods for describing underlying cognitive processes and cognitive strategies used during complex task accomplishment (Aubin, Chapparo, et al., 2009). Cognition is viewed within the PRPP system from an information processing perspective related to occupational performance (i.e., the application of cognitive strategies needed to efficiently process information for a person to perform an occupation). The PRPP-A Stage Two conceptual model (Fig. 2) was developed to explain information processing behaviours. It was founded on the Skill Wheel, a psychology model which coined the terms Perceive, Recall, Plan, and Perform, to explain the cognitive information processing operations used for learning in workplaces. Early research adapted and

validated the Skill Wheel to form the conceptual basis for the Stage Two PRPP-A (Chapparo & Ranka, 2016).

Figure 2.

The PRPP System of Task Analysis: Stage Two Model



Note. From The Perceive, Recall, Plan and Perform System of Task Analysis Manual Assessment Course Manual by Chapparo, C. & Ranka, J. (2016). Reprinted with permission.

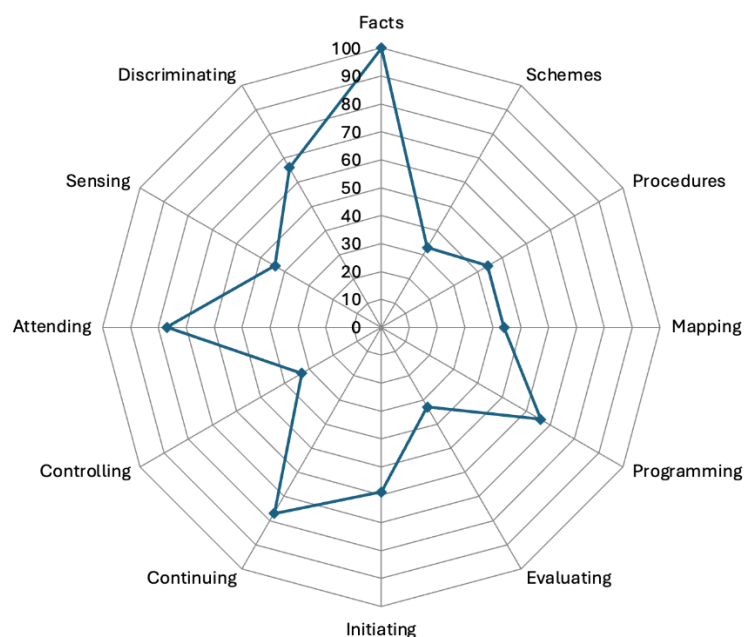
The PRPP-A Stage Two model is portrayed as a wheel with a series of rings categorising information processing cognitive strategies. The central ring is divided into four quadrants. The Perceive quadrant (cognitive strategies needed for attention and sensory gathering of information); the Recall quadrant (cognitive strategies for remembering, recognition, retrieval and storage of information); the Plan quadrant (cognitive strategies

for planning, evaluating and judgment of information); and the Perform quadrant (cognitive strategies needed for performance monitoring and the actual ‘doing’). The middle ring further defines the cognitive processing strategies into sub quadrants, with the outer wheel having 35 information processing cognitive strategies referred to as ‘descriptors’ (Chapparo & Ranka, 2016). These descriptors have been identified through research as being observable behaviours which are consistently needed for the successful performance of tasks, routines, and roles and can, therefore, be evaluated (Chapparo & Ranka, 2016). In the design stage of the descriptors, everyday terminology was used to ensure the descriptors would easily be understood by clients and their families (Chapparo & Ranka, 2016).

Using the descriptors, a person’s ability to process the information needed for completion of a task can be assessed and measured. Stage Two assessment can be used as a quantitative measure with a rating given to each of the 35 information processing descriptors on a 3-point scale. The score indicates whether a person’s performance of the descriptor is effective, questionable, or not effective (Lewis et al., 2016). An overall percentage score of a person’s ability to process the information required for the task and/or percentage scores for each quadrant or sub quadrant can then be calculated. Scores can be plotted onto a radar graph, providing a visual representation of the person’s performance (Nott & Chapparo, 2008) (see Fig. 3).

Figure 3.

PRPP-A Stage 2 Radar Graph



Note. From The Perceive, Recall, Plan and Perform System of Task Analysis Manual Assessment Course Manual by Chapparo, C. & Ranka, J. (2016). Reprinted with permission.

Stage Two can also be applied as qualitative assessment through an interview or questionnaire (Chapparo & Ranka, 2016; Lowe & Chapparo, 2010). The information gained from Stage Two PRPP-A can be used to identify a person's strengths and challenges, set strategy application goals for intervention, and as an outcome measure following intervention (Aubin et al., 2018; Aubin, Chapparo, et al., 2009; Ranka & Chapparo, 2010).

Validity

The validity of an assessment provides insights into whether an assessment truly evaluates what is intended to be measured and the degree to which it does so (Law, 1987). The construct validity of the PRPP-A has been examined in several research studies. These studies have evaluated whether the PRPP-A could be used to identify the difference between the occupational performance of either adults or children with impairments and that of typical populations. The early test development research confirmed the PRPP-A could effectively differentiate between the occupational performance of healthy individuals (n=25) and those with traumatic brain injury (TBI) (n=20) doing the same daily living tasks (Chapparo & Ranka, 2016). Similarly, Aubin et al. (2014) compared the occupational performance of adults with schizophrenia with adults without mental health conditions making a meal and tidying the kitchen. They found that the former group made significantly more errors during the steps of the task and had more difficulty processing the information required for the task.

Nott and Chapparo (2012) also studied adults with brain injury using a multifaceted Rasch analysis to explore the hierarchy of the test items, raters, patients, and tasks. They concluded the "construct validity was well supported by strong parallels between the Rasch generated hierarchy of the PRPP items and conceptual models of information processing and occupational performance" (Nott & Chapparo, 2012, p. 256) and the PRPP-A was "a valid measure of cognitive strategy use during occupational performance of adults with brain injury" (Nott & Chapparo, 2012, p. 256). These studies, although small in number, show evidence that supports the construct validity and internal consistency of the PRPP-A.

An instrument's criterion (or concurrent) validity is determined by comparing the findings of the newer tool with the results from another well-known instrument. Two studies were

found that have explored the criterion validity of the PRPP-A. First, Aubin et al.(2009) found a statistical correlation ($p=0.032$) existed between the scores generated from a PRPP-A and those from the Independent Living Skills Survey (an established assessment of community independence) used with the same group of people with schizophrenia. The authors (Aubin et al. 2009) concluded the PRPP-A could be considered as a possible tool to predict a person's potential independence in a community living situation. Second, Stewart and Chapparo (2011) who used the PRPP-A to evaluate preschool children performing tasks typically associated with school readiness (e.g., drawing, cutting, and pasting) and compared the results with an independent teacher's perspective of each student's level for school readiness. The findings showed a direct correlation between the teacher's evaluation and the PRPP-A results and concluded that the PRPP-A was capable of distinguishing between those children who had skills ready for school and those who did not. These two studies establish preliminary criterion validity; however, the sample size in the first study was small ($n=10$) and further research is warranted for greater assurance of the criterion validity with other client groups and different instruments.

In recent years, there has been a growing number of published research articles which describe the face and content validity of the PRPP-A with different population groups. These have included adults with TBI (Fry & O'Brien, 2002) and schizophrenia (Aubin, Chapparo, et al., 2009), women with cognitive difficulties following breast cancer (Lewis et al., 2016), men with HIV associated neurocognitive disorder (Ranka & Chapparo, 2010), older adults with dementia (Voigt-Radloff et al., 2009), children with autism (Lowe & Chapparo, 2010), and children with learning difficulties (Juntorn et al., 2016). These studies indicate the PRPP-A can be used as an assessment option for a wide range of adults and children experiencing occupational performance challenges with cognitive impairments or information processing difficulties. Clients who are non-verbal or have low cognitive capacity can also be assessed since there are no set instructions for the assessment which need to be followed (Chapparo & Ranka, 2016).

Another aspect of validity for occupation-based assessments is whether the assessment can be used to evaluate and/or measure a wide range of tasks being performed in different contexts. The PRPP-A was designed so that a client and/or their significant other decide the task, routine, or role to be assessed; where and when it is performed; and how it would typically be performed in their context (Chapparo & Ranka, 2016). The PRPP manual describes that no limitations are placed on the types of tasks which could be assessed using the PRPP-A (Chapparo & Ranka, 2016). The literature supports this assertion since

a wide array of tasks have been assessed by occupational therapists including grocery shopping (Ranka & Chapparo, 2010); virtual shopping activity (Aubin et al., 2018); work place assessment for a person working in the role of information technology support worker (Bootes & Chapparo, 2010); a child writing a creative story (Chapparo, 2010); leisure and self-care occupations of playing cards, gardening, grooming, washing face, teeth and hair brushing (Nott et al., 2009), putting on a shirt (Fry & O'Brien, 2002); kitchen tasks of making sandwiches and coffee (Nott & Chapparo, 2008), meal preparation with meat, potatoes; a premix cake; and doing the dishes (Aubin, Stip, et al., 2009); breakfast of coffee, toast, and fried eggs (Aubin, Chapparo, et al., 2009); and making jam (Wright et al., 2014).

These studies provide extensive evidence that the PRPP-A can be used to evaluate a wide range of tasks that people might need or want to do and confirms the selection of the task is not constrained by the assessment procedures. As such, the PRPP-A has the potential to be used with people from diverse ethnic backgrounds. In this review, however, no literature exploring cultural validity or describing the use of the PRPP-A with non-western tasks was found. Research using the PRPP system has, however, been carried out in different countries including Holland, Thailand, Germany, Norway, Sweden, and French Canada (Chapparo & Ranka, 2016) but, with the exception of Thailand, these are all still predominantly western cultures. Furthermore, the tasks described in these studies all have western cultural origins including the Thai study which looked at play occupations of children like puzzles, bingo, ball games, treasure hunts, and mazes (Juntorn et al., 2016). There remains a considerable gap in current knowledge concerning the cultural validity of the PRPP-A including whether the PRPP-A fits with bicultural practice in Aotearoa New Zealand.

Reliability

A recognised flaw of criterion referenced assessments is that scoring between raters can be inconsistent. Consequently, confirming inter-rater reliability and intra-rater reliability is important to establish, as this indicates whether a measure is stable and if the results can be relied upon or not.

Consistent with latent trait criterion referenced assessments (Griffin, 1995), the PRPP-A has a set of rules and scoring criteria with definitions, which make up a scoring rubric. Occupational therapists learn how to set, apply and score against the criteria through a 5 day intensive training course (Chapparo & Ranka, 2016). Seven studies were found at the time of this review, that have examined the inter-rater reliability of the PRPP-A (Aubin,

Chapparo, et al., 2009; Nott & Chapparo, 2008; Nott et al., 2009; Steultjens et al., 2012; Van Keulen-Rouweler et al., 2016; Voigt-Radloff, 2012; Voigt-Radloff et al., 2009).

Six of these studies found therapists assessing a range of patients with different diagnoses including schizophrenia, TBI, and dementia had inter-rater reliability within statistical ranges of fair to excellent (Intra class correlation [ICC] 0.46-0.90). The exception was the findings by Van Keulen-Rouweler et al. (2016) which evaluated inter-rater reliability across 38 PRPP-trained occupational therapists and only found slight to moderate inter-rater reliability (ICC 0.06-0.46). Their research presented many factors in the study design which could have influenced the lower result, such as the inconsistent interpretation by raters of the procedural task analysis for Stage One and that over half the raters lacked experience of working with the type of clients included in the sample population. Thus, the researchers recommended that further investigations were warranted.

In contrast, the other studies all used methods which preset the steps for the Stage One task analysis, ensuring that the raters were all scoring the same steps, and involved a smaller number of raters (n=2-25). The results indicated that the overall total score of the PRPP-A had the highest inter-rater reliability correlation with lower levels of correlation evident within the quadrant and sub quadrant scores. Inter-rater reliability is recognised to be challenging with criterion referenced assessments and the findings from six out of seven preliminary research studies support that the PRPP-A has acceptable levels of inter-rater reliability; although there is clear need for further research in this area.

Only two studies also researched intra-rater reliability. Nott et al. (2009) found that occupational therapists generally scored lower on a second assessment after a 1 month time interval. The differing methods therapists employed at the two time points were considered to have probably influenced the severity of scoring at the later assessment (Nott et al., 2009). In contrast, Van Keulen-Rouweler et al.'s (2016) study demonstrated moderate to near perfect correlation between scores taken at 6 week intervals (ICC 0.60 -0.88). In summary, to date only a small amount of information is available on the intra-rater reliability of the PRPP-A and further research is needed for assurance of this aspect of its reliability.

Clinical Utility of the PRPP-A

Research has shown that typically it is the factors that contribute to the clinical utility of an assessment which dictate if an assessment is actually used in practice or merely discounted by therapists (James & Mackenzie, 2009). Clinical utility refers to the degree

of usefulness of an assessment in practice. It is commonly governed by practical features of a tool such as administration procedures, financial implications, and time requirements; along with the degree of the assessment's flexibility; the clinical relevance for the client group being evaluated; and if the assessment results actually guide therapy interventions (i.e., the overall value of the assessment to inform a therapist's practice) (Alotaibi et al., 2009; Donnelly & Carswell, 2002; James & Mackenzie, 2009).

In this review only one study was found which had explored the clinical utility of the PRPP-A. Lu (2014) investigated the use of the PRPP-A by occupational therapists in Aotearoa New Zealand and identified factors which influenced its adoption and implementation to practice. Data was gathered from web-based surveys (n=43) and analysis was predominantly statistical with some qualitative data in the form of short written responses to questions. Findings indicated that most occupational therapists who had trained in the PRPP-A (95%, n=41) were using the PRPP-A in their practice. The majority (95%) reported that it helped to frame their observations of client's occupational performance; 65% scored both Stages One and Two of the assessment; and 83% considered the PRPP system to be flexible and able "to be used with clients regardless of their performance level, disability/medical condition, age or cultural background" (Lu, 2014, p. 147). Therapists working in schools and rehabilitation services conveyed that the tool was highly valuable, while therapists who were practicing in faster paced acute environments or slower paced community settings suggested that it was less likely to be useful in their practice. Although Lu suggested factors to account for this reduced utility, the research did not capture the detail of therapists' experiences or explain these different views between the various work settings.

The two most common factors that limited the therapists' implementation of the PRPP-A in Lu's study (2014) were time and therapists' lack of confidence with aspects of the assessment. In addition, some therapists identified limited managerial support or peer support, and only a few described receiving ongoing supports from their managers to help them transfer their new skills to practice. Research investigating another occupation-based assessment, the AMPS, similarly found time limitations and lack of managerial support as significant factors affecting its clinical application (Chard, 2000, 2006). Chard (2000) recommended it was beneficial for clinicians to have time released from caseloads following the AMPS training and managerial support to help consolidate their new learning. Time for learning was also recognised as necessary in Lu's study with therapists

reporting an intense learning process during the initial implementation of the PRPP-A which gradually reduced over time.

Lu (2014) reported uncertainty was experienced by therapists when they tried to use and define the PRPP descriptors to communicate the assessment to others, and suggested repeated practice and peer support seemed to assist. No other strategies or KT processes were explored and there remains a lack of information on how to specifically support occupational therapists using the PRPP-A. Issues of confidence and difficulties explaining the results of other occupation-based assessments to both clients and other health professionals have also been significant barriers for occupational therapists using occupation-based assessments in the USA. Piernik-Yoder and Beck (2012) suggested more research was required for these barriers to be better understood and to identify what needed to change at the level of the therapists, the educational faculties responsible for preparing students to use occupation-based assessments, and at policy/regulatory levels that influence and govern practice.

A further challenge for some therapists using the PRPP-A was the process of clients selecting the assessment task/s, which Lu (2014) considered might be therapists' overall inexperience, lack of client-centred skills, or that they had not formed adequate client-therapist relationships. Interestingly, comparable issues have been found to affect the application of COPM, a well-established occupation-based assessment. Studies have shown therapists were better able to implement the COPM when they were able to develop good rapport, use high levels of interview and communication skills, and make sound clinical judgements (Gustafsson et al., 2012; Law et al., 1994; Sewell & Singh, 2001). Currently, little is known about the types of skills required for applying occupation-based assessments or what supports occupational therapists to transfer them to practice.

Summary

In this chapter the development of the occupational therapy profession's assessment practice over time has been reviewed to reveal key historical influences that have shaped today's assessment practices as relevant to the research question: "What are the experiences of occupational therapists in Aotearoa New Zealand applying the Perceive, Recall, Plan and Perform System of Task Analysis (PRPP) Assessment into their practice?". The occupational therapy assessment history has been tracked from the origins of health-enhancing occupations, grown out of the impact of war, the profession's initial assessment focus of task analysis, through the scientific impairment-focused era and

reductionist component-based assessments; to the impact of client-centred and evidence-based practice and the profession's reconnection with occupation and the establishment of occupation-based assessments.

Reviewing past assessment practice has shown that remnants of previous practice are still very much part of present occupational therapy assessment practice. These past influences are particularly evident in relation to assessment practice with clients who have cognitive impairments where, despite the multitude of assessments that have been developed, there has remained a lack of suitable occupation-based assessments. The literature review also highlighted considerable concerns related to the cultural application of many of the profession's existing standardised assessments. It was from these challenges and concerns that the original rationale for developing the PRPP-A emerged.

The development of PRPP-A has been described from the available literature, including the research which has investigated the PRPP-A validity and reliability. Of relevance to this current study, the review uncovered a considerable gap in the knowledge concerning the clinical utility of the PRPP-A; particularly the lack of research into cultural application, which is a salient point for occupational therapists in Aotearoa New Zealand, where professional regulatory requirements stipulate therapists have appropriate bicultural practice, cultural competency, and use appropriate assessments with clients. This research is, therefore, necessary to gain insights into the application of the PRPP-A specifically in Aotearoa New Zealand.

Lastly, the occupational therapy profession has acknowledged the need to have better understandings of how occupational therapists translate occupation-based assessments into practice; particularly the skills, supports, and strategies required to use occupation-based assessments. Accordingly, Phase One aims to develop understandings of how occupational therapists translate the PRPP-A to practice.

In the next chapter I review two further aspects of the literature. First the literature related to clinical reasoning and decision-making which informed the focus of Phase Two of this study. Second, the literature which explores concepts of KT relevant to translating an occupation-based assessment such as the PRPP-A to practice.

CHAPTER 3: TRANSLATING KNOWLEDGE TO PRACTICE

Introduction

In Chapter 3, I have brought together two important bodies of literature pertaining to applying and translating an occupation-based assessment, like the PRPP-A, to practice. First, to understand the thinking processes involved when applying the PRPP-A in practice, I reviewed the clinical reasoning literature concerning thinking and decision-making processes occupational therapists use during the assessment stage of practice. Second, the knowledge translation (KT) literature was reviewed as it related to translating information from a training course, such as the PRPP-A training, to application in practice. It included identifying KT models, strategies and learning theories that may support the translation process. As in Chapter 2, the KT literature discussed in this chapter is contextualised to the period up to 2018, when the KT question guided Phase One of the study and to 2020 when I engaged with clinical reasoning literature to inform the development of Phase Two research questions. The more recent literature is considered in the discussion chapter to inform the contribution the study findings make to knowledge.

The chapter is presented in two sections. The first section begins with an explanation of clinical reasoning terminology and why the term clinical reasoning was used in this study. Practical definitions of what is meant by clinical reasoning in relation to occupational therapy assessment practice are then considered, followed by a brief overview of the occupational therapy clinical reasoning literature current at the time, including different modes of reasoning. Next, an appraisal of the knowledge associated with information processing and clinical reasoning is provided. Finally, gaps in the available clinical reasoning knowledge associated with occupation-based assessments that evaluate occupation in relation to cognition, like the PRPP-A, are examined.

The second section contains an initial synopsis of the literature concerning KT and occupational therapy practice. Three KT models recommended for use by occupational therapists are evaluated, followed by an exploration of KT strategies commonly presented in the literature as possible options for occupational therapy practice. Stages of learning theories are considered, particularly their relevance for assisting KT. The chapter concludes with an overall summary of the literature review.

Section 1: Clinical Reasoning and Occupation-based Assessment Practice

Clinical Reasoning Terminology

The term clinical reasoning was first associated with occupational therapy practice by Rogers (1983) over 30 years ago to describe thinking processes used by occupational therapists in their practice with clients. Since Roger's pioneering work, the term clinical reasoning has continued to be frequently used both in research and by practitioners. More recently, the phrase professional reasoning has been proposed as a broader term to encompass practice that occurs outside of clinical and medical contexts and includes the reasoning managers, educators, and supervisors use to "conceptualise occupational therapy practice" (Schell & Schell, 2018a, p. 6); that is, reasoning not directly associated with client/therapy interactions. In the current literature both terms are used, although in Aotearoa New Zealand the term professional reasoning is yet to be widely adopted, with the OTBNZ describing the reasoning processes associated with occupational therapy practice as clinical reasoning. For instance, in the OTBNZ (2015b) competencies requirements for registration and continuing practice, competency 1.7 states "You [an occupational therapist] use current theory and evidence, as well as sound clinical reasoning, to help you make decisions and use best processes in your practice" (p. 3).

In this study, therefore, clinical reasoning is the chosen term as it is associated with thinking processes used during occupational therapy practice with clients and their families, and it is the terminology used in Aotearoa New Zealand. However, given professional reasoning and clinical reasoning are both used within the occupational therapy literature, this literature review will also include professional reasoning literature where it pertains to client care.

Defining Clinical Reasoning Related to Occupational Therapy Assessment Practice

Within health professional and occupational therapy literature no definitive definition of clinical reasoning exists; rather, a multitude of definitions explain what is recognised to be a "complex construct" (Unsworth, 2013, p. 210). Given this complexity, together with the vast array of definitions, an in-depth investigation of clinical reasoning definitions is not intended here. Instead, aligned with the study's aims, clinical reasoning is briefly defined as it relates to occupational therapists applying an assessment like the PRPP-A.

Simply stated, clinical reasoning is thinking used when occupational therapists "are trying to understand people's needs and what to do about them" (Cole & Creek, 2016, p. 19), or the thought processes therapists use during all stages of the occupational therapy process (Leicht & Dickerson, 2002) "to plan, direct, perform and reflect on client care" (Schell,

2014, p. 384). Mattingly (1991b), a forerunner in clinical reasoning research, considered clinical reasoning as a form of “practical reasoning” which directs the best course of action to take in a “particular” situation (p. 981). This perspective of clinical reasoning used to guide actions is recognised as an essential component of occupational therapists’ assessment practice (Fawcett, 2007), since occupational therapists need to apply theory and use their experience when they assess clients. However, knowledge and experience are insufficient to meet the demands and complexities of assessing clients’ unique needs, which occur in their “particular” (Fawcett, 2007, p. 283) contexts. Consequently, “each assessment requires the therapist to engage in “original thinking” (Fawcett, 2007, p. 283) which involves multidimensional thinking processes (Higgs et al., 2019). Chapparo and Ranka (2019) provided a useful explanation of clinical reasoning from an information processing perspective, defining it as:

A nonlinear, recursive style of thinking that involves gathering and analysing client information and deciding on therapeutic actions specific to a client’s circumstances. It combines cognitive and metacognitive strategies such as analysis, problem solving and evaluation together with precognitive intuition. Finally, information is synthesised with visualization of the client’s future needs in his or her unique physical, social and cultural context. (p. 272)

This definition has relevance to assessment practice where therapists are required to process and synthesise multiple sources of information (Carr & Shotwell, 2018; Leicht & Dickerson, 2002). Specific to assessment practice, occupational therapists process information and use clinical reasoning as they consider individual needs, select assessments, observe clients, make situational judgements, interpret assessment results, analyse problems, make decisions, develop strategies, and plan interventions (Creek, 2003; Fawcett, 2007). Success, or otherwise, of an assessment is determined by the degree to which sound and effective clinical reasoning is employed (Gustafsson et al., 2012; Parker & Sykes, 2006). How therapists develop effective clinical reasoning, along with understanding different types of reasoning and what constitutes the processes and content of clinical reasoning, has been the focus of considerable research.

Clinical Reasoning and Assessment Practice

To review the clinical reasoning literature associated with assessment practice I have divided this section into subsections. I begin by briefly overviewing the occupational therapy clinical reasoning literature, followed by a synopsis of theoretical aspects of clinical reasoning including a focus on information processing theories. In the final

subsection I consider the clinical reasoning literature specifically related to occupation-based assessment practice.

Brief Overview of the Clinical Reasoning Literature in Occupational Therapy

Research into clinical reasoning and occupational therapy emerged in the early 1980s. Professional interest in the field gathered momentum through the 1990s and has continued to the present day with extensive studies, articles, books, and book chapters published (Chapparo & Ranka, 2019; Schell & Schell, 2018b). Despite the quantity of literature, at the time of writing this review only one systematic review (Unsworth & Baker, 2016) and one scoping review (Márquez-Álvarez et al., 2019) of the occupational therapy professional/clinical reasoning literature were found from studies in the last decade. Key findings from the two reviews are discussed and provide a brief overview of the existing clinical reasoning literature as it relates to the focus of this study on assessment practice.

The two reviews differed in their inclusion and exclusion criteria, the number of articles reviewed, and how the topics of the articles were categorised however, overall, they presented similar patterns of evidence and topics within clinical reasoning (see Table 1). Both reviews confirmed a pattern of research evidence predominantly based on empirical data with two thirds of existing studies of this type, while the remaining third were theoretical, non-empirical, and descriptive in nature. Qualitative studies made up more of the empirical research and, in keeping with early research trends, studies founded on phenomenology or ethnography were prevalent. Typical of qualitative research, the studies involved small numbers of participants, several of which were single case study design. The phenomenological studies explored therapists' experiences and identified different modes of reasoning applied in practice. These qualitative studies are described as building understandings of therapists' tacit knowledge including uncovering practical insights to "know how to practice" (Unsworth & Baker, 2016, p. 79) in specific contexts. Ethnographic studies revealed ways therapists' beliefs, values, and cultural practices influence their reasoning processes.

Table 1.*Summary of Systematic Reviews of Occupational Therapy Clinical Reasoning Literature*

Title and Type of Review	Criteria	Topics Identified	Type of Studies
Systematic review of professional reasoning literature in occupational therapy (Unsworth & Baker, 2016)	Included Peer review articles between 1982 and 2014 Articles describing occupational therapists reasoning in multidisciplinary research Written in English Excluded Practice papers, theses, book chapters Papers where professional reasoning was not the focus Papers focused on professional decision making	Six main topics identified from 140 peer reviewed articles • Developing reasoning in students 45% (n=63) • What is professional reasoning? 30% (n=42) • Advancing a specific field of clinical reasoning 22% (n=35) • Ethics and moral reasoning 7.6% (n=12) • Methods for studying professional reasoning 1.9% (n=3) • Professional reasoning of occupational therapist assistants 1.3% (n=2) (From 157 topic instances with some articles counted more than once)	Empirical studies 69% (n=97) Qualitative studies 42% (n=59) of which 8.5% (n=12) were single subject Quantitative studies 14.8% (n=20) Mixed methods 12.8% (n=18) Non-empirical studies 31% (n=43)
Professional reasoning in occupational therapy: A scoping review (Márquez-Álvarez et al., 2019)	Included Any article, book chapter or doctoral thesis with keywords (reasoning, allied health personnel, clinical reasoning, professional reasoning) in title, keyword list, abstract or heading between 1982 and 2017 Written in any language Excluded Documents not containing keywords or not focused on professional reasoning or occupational therapists	Three main topics identified from 208 articles indexed journals • Professional reasoning in a specific field 27.9% (n=58) • Undergraduate student reasoning 20.2% (n=42) • Theoretical aspects of professional reasoning 16.8% (n=35) Other topics • Information processing • Novice/expert • Modalities of reasoning • Assistants • Research methodology • Cultural aspects and contexts	Empirical studies 71.6% (n=149) Qualitative studies 48.3% (n=72) Quantitative studies 24.03% (n=50) Mixed methods 6.25% (n=13) Non empirical studies 28.4% (n=59)

While research into clinical reasoning has been approached from different theoretical perspectives, there is no agreement within the profession as to which methodologies are most suited. The contribution to knowledge of clinical reasoning from the quantitative and mixed methods studies was less clear in the reviews, although Unsworth and Baker (2016) cited several quantitative studies investigating the novice to expert continuum by measuring the use of different modes of reasoning by therapists. An increase in quantitative studies with experimental designs between 2004 and 2014 was also recorded by Márquez-Álvarez et al. (2019), which they concluded indicated a progression in the profession's development of higher levels of scientific evidence. Others contest such a view, cautioning a traditional hierarchy of evidence approach that prioritises randomised control trials and statistical measurement constrains investigations and risks overlooking core tenants of occupational therapists' reasoning including the influence of clients' involvement and their unique contexts (Chapparo & Ranka, 2019). The overall quality of the existing research is not apparent, since neither review included any critical analysis of this aspect. What is evident is the need for more empirical studies, with a third of current clinical reasoning studies unsupported by empirical data and many small-scale studies.

From the two literature reviews, the three most commonly studied topics were developing reasoning in undergraduate students, theoretical aspects of reasoning which address what professional reasoning is and/or different modalities or types of reasoning, and professional reasoning related to specific fields of practice. Of these topics, the latter two have most relevance to this study and a short summary of literature associated with clinical reasoning and assessment practice from each of these topics is now presented.

Theoretical Aspects of Clinical Reasoning.

Fleming's (1991) seminal research investigated the types of clinical reasoning used by occupational therapists. Based on a small scale (n=7) ethnographic study, Fleming hypothesised occupational therapists used three types of reasoning, termed "tracks" (p. 1007) procedural, interactive, and conditional. These types of reasoning were considered "different operations that interacted with each other in the therapist mind" (Fleming, 1991, p. 1008). The notion of the "therapist with the three-track mind" (Fleming, 1991, p. 1007) quickly gained popularity and shapes the profession's understandings of clinical reasoning to the present day. Later research has confirmed therapists across different settings apply the three tracks of reasoning in practice (Case-Smith, 1997; Gitlin & Burgh, 1995; Mitchell & Unsworth, 2005; Munroe, 1996; Unsworth, 2005, 2011; Ward, 2003)

and has identified other types of reasoning that are used such as pragmatic (Mitchell & Unsworth, 2005; Schell, 2018; Ward, 2003) and embodied reasoning (Arntzen, 2017; Kinsella, 2018) (see Table 2).

As the research has grown, so too have the range of terms to describe what Fleming (1991) first called “types”, “tracks” (Fleming, 1991, p. 1007), and “modes” (Mattingly & Fleming, 1994, p. 17) of reasoning. Other terms now include “aspects” (Boyt Schell & Benfield, 2018, p. 127), “lines” (Chapparo & Ranka, 2019, p. 275), “dimensions” (Carrier et al., 2010, p. 358), “forms” (Chapparo & Ranka, 2019, p. 277), and “modalities” (Márquez-Álvarez et al., 2019, p. 6) of reasoning. Currently, within the profession there is no consistent terminology and in this study the term ‘modes’ is used as an umbrella term to capture all the different terms.

The modes of reasoning frequently discussed in the occupational therapy literature are scientific (including diagnostic and procedural reasoning), narrative, interactive, conditional, pragmatic, ethical, and embodied. An outline of the modes of reasoning is presented in Table 2 with the underpinning theory and/or research base and a description of the reasoning process associated with each mode.

From this review of the modes, it is evident much of the understanding of these reasoning processes stems from the original American Occupational Therapy Association (AOTA) studies (Fleming, 1991; Gillette & Mattingly, 1987; Mattingly & Gillette, 1991) or are theory based. Subsequent research has focused predominantly on identifying the use of the modes in practice rather than necessarily developing deeper understandings of the modes or how they are specifically applied in practice. Furthermore, what is and is not considered a mode of reasoning has been questioned within the profession (Boyt Schell & Benfield, 2018), with some suggesting the different modes may represent scholars’ differing epistemologies rather than separate reasoning processes (Robertson, 2012). It seems greater clarity is required, along with further investigation of “the unique and distinctive characteristics” (Márquez-Álvarez et al., 2019, p. 6) of occupational therapists’ modes of reasoning.

In Aotearoa New Zealand, modes of reasoning remain popular constructs and shape undergraduate training in clinical reasoning. Modes of reasoning have been used to generate questions to guide the development of clinical reasoning; for example, the Clinical Reasoning Framework (Reason, 2012, p. 63) which was developed to assist

Table 2.

Outlines the Frequent Modes of Reasoning Presented in the Occupational Therapy Literature

Mode of reasoning	Theoretical base and/or research base of mode of reasoning	Description of the reasoning
Diagnostic reasoning (Arntzen, 2017; Rogers & Holm, 1991)	• Based on psychosocial paradigms of information processing, judgement and decision making. • Uses a rational model of cognitive processing involving cognitive strategy application. • Was developed from clinical studies in medicine which were applied to occupational therapy.	• Hypothetico deductive reasoning using a problem-solving process. Problem sensing leads to problem definition, creation of a clinical image, and identification of an intervention/s. • The assessment reasoning process includes cue acquisition, multiple hypothesis generation, cue interpretation, and hypothesis evaluation to establish an occupational therapy diagnosis. A problem statement helps understand the cause or nature of a person's occupational role performance, occupational performance, or underlying impairments to then develop an intervention to address the problem.
Procedural reasoning (Fleming, 1991)	• Original research part of a 2-year ethnographic study conducted by the AOTA (Gillette & Mattingly, 1987). • Data gathered in physical health settings from participant observation, video analysis of practice and in-depth individual interviews (n=7) (Fleming, 1991). • Subsequent research identified and confirmed occupational therapist in a range of contexts use procedural reasoning (Case-Smith, 1997; Gitlin & Burgh, 1995; Mitchell & Unsworth, 2005; Munroe, 1996; Unsworth, 2011; Unsworth, 2005; Ward, 2003)	• A logical thinking process focused on diagnosis, disease, condition, or disability and probable outcomes of interventions. • Competing hypotheses are generated related to cause and nature of the problem. • An occupational therapy clinical problem-solving process is applied through problem identification, pattern recognition, goal setting, and intervention planning.

Continued over...

Mode of reasoning	Theoretical base and/or research base of mode of reasoning	Description of the reasoning
Narrative reasoning (Mattingly, 1991a)	• Originated from social sciences and anthropology. • First described in the ethnographic action research of the AOTA study (Mattingly, 1991a; Mattingly & Gillette, 1991).	• Narrative reasoning is a client-centred inductive process where occupational therapists use cognitive strategies of telling and interpreting stories. • Story telling - A retrospective process involving listening and telling stories to understand/make sense of a situation and/or experience. • Story making - A prospective process where stories are formed with clients to connect the present with an imagined future. • Intervention plans are developed where therapists and clients envisage the same story ending (Hamilton, 2018).
Interactive reasoning (Fleming, 1991)	• Based on a phenomenological approach from the AOTA studies (Fleming, 1991). (described above)	• Intuitive form of reasoning used in interactions between therapists and client/s. • Applied when a therapist consciously and unconsciously uses a range of strategies to establish trust and understand a problem/situation/ diagnosis/ disability from the client's perspective. • Collaborative reciprocal process is used to develop and tailor intervention plans with the client (Unsworth, 2013).

Continued over...

Mode of reasoning	Theoretical base and/or research base of mode of reasoning	Description of the reasoning
Conditional reasoning (Fleming, 1991)	Based on the AOTA studies (Fleming, 1991). (described above)	- Multidimensional complex social reasoning process where therapists “project an imagined future condition or situation for a person” (Fleming, 1991, p. 1007). - Stories or narratives are developed from the client’s past, present, and future situation and the client’s condition considered is in three ways: - Interpretation of the whole of the client’s condition - How the present condition could change - Client’s level of participation and likely outcomes of therapy, success or otherwise - This type of reasoning is recognised to be greatly reliant on therapist’s own level of experience and is used by expert practitioners (Mattingly & Fleming, 1994)

Continued over...

Mode of reasoning	Theoretical base and/or research base of mode of reasoning	Description of the reasoning
Pragmatic Reasoning (Schell & Cervero, 1993)	• Informed by cognitive psychology and theory of situated cognition with “cognitive processes embedded in contextual situations” (Schell & Cervero, 1993, p. 607) • Pragmatic reasoning is a theory based reasoning developed to account for occupational therapists’ thinking about contextual factors not included in scientific, procedural, interactive, and conditional reasoning processes (Schell, 2018). • Later research has supported the concept of pragmatic reasoning theory and identified this type of reasoning in therapists’ practice (Munroe, 1996; Unsworth, 2004).	• Thinking on contextual factors that support or hinder practice attending to realities of providing therapy service. • Reasoning considers practice possibilities influenced by: • Practice context - External factors (e.g., organisational constraints; availability resources such as funding, time, and physical resources) • Personal context – Therapists’ own repertoire of skills, level of competency/expertise, worldview (Unsworth, 2004), and personal characteristics (e.g., physical body structure/function, sensory preferences) (Schell, 2018)
Ethical reasoning/ Moral reasoning	• Based on philosophy, psychology, and moral theories. • Originally presented by Rogers (1983) as one “strand” of an “inextricably intertwined” (p. 616) clinical reasoning process used for all clients to answer the ethical question “what, among the many things that could be done for this patient, ought to be done?” (p. 602). • Early research was theoretical in nature and drew both on occupational therapy theory and theory from other disciplines. • More recent studies have provided evidence of therapists’ use of moral or ethical reasoning specific to ethical dilemmas or practice contexts (Delany & Galvin, 2014; VanderKaay et al., 2019).	• Reasoning process linked to ethical decision-making. • Involves reflecting, thinking, and critical analysis of an ethical dilemma, conflict, or competing set of values to generate possible solutions and, ultimately, evaluate the best course of action to take (or not). • A range of ethical decision-making models exist to assist therapists through ethical reasoning processes (Doherty & Purtilo, 2016; Seedhouse, 2009; VanderKaay et al., 2020).

Continued over...

Mode of reasoning	Theoretical base and/or research base of mode of reasoning	Description of the reasoning
Embodied reasoning	• Over the last 2 decades growing understandings of embodied reasoning have emerged across many disciplines (e.g., education, philosophy, anthropology, sociology, psychology [Kinsella, 2018] and physiotherapy [Øberg et al., 2015]). • Neuroscience providing evidence of links between a person's interoception and interpretation of internal bodily sensations, cognition, and intuitive decision making (Herbert & Pollatos, 2012). • Within occupational therapy Kinsella (2018) developed theoretical understandings of embodied reasoning and Arntzen (2017) described practical applications of embodied reasoning from studies investigating the interplay between occupational therapists and clients with strokes.	• Reasoning process recognises influence of “bodily responses and bodily perceptions”(Kinsella, 2018, p. 119) and the intertwined relationship between the body and the mind. The lived experience of the body in reasoning. • Embodied reasoning may involve: • Embodied perception - interpreting a situation with one's entire body (e.g., an overall feeling, a gut feeling) • Embodied sensing - akin to the notion of tacit knowledge. A sense of knowing which is sensed, difficult to express, develops through ‘doing’ therapy and experience. A sense of what is occupationally possible gathered through practice. • Embodied responses - bodily responses (e.g., hair standing on end, butterflies in the stomach, gagging, and heart pounding) • Embodied reflection - A form of “reflection in action” bodily knowing used in “spontaneous performance” (Schön, 1995, p. 30) and reflection on doing • Embodied relational understanding - shaping of therapeutic relationship through bodily behaviours particularly gestures (Kinsella, 2018)

community occupational therapists' clinical reasoning, and broad questions posed by Chapparo and Ranka (2019) to direct a line of thinking. The latter has presented a question for each mode, including scientific reasoning, "What is the presenting problem?" (p. 275); narrative and interactive reasoning, "What does it mean to the person?" (p. 275); ethical reasoning, "What should happen?" (p. 275); conditional reasoning, "What will be the outcome? (p. 276)"; and pragmatic reasoning, "What can be done?" (p. 277). Such lines of questioning may be relevant for understanding clinical reasoning and occupation-based assessment practice, although no evidence was found in this review and research is needed to further explore this idea.

Alongside the need for further research on the well-established modes of reasoning, lines of questioning, and assessment practice, others purport investigations into the "basic process of information processing" (Márquez-Álvarez et al., 2019, p. 8) used by occupational therapists are required. That view is shared by Chapparo and Ranka (2019), who asserted the profession's perspective of clinical reasoning does not reflect advances cognitive psychologists have made in understanding information processing. Given those views, the profession's current understandings of information processing are briefly outlined below and viewed in relation to therapists' assessment practice.

Information Processing and Occupational Therapists' Clinical Reasoning

Consistent with the calls for further research, only a small quantity of literature concerning information processing and occupational therapists' clinical reasoning was found in this review. Most of the available literature was of less relevance to the current study, since it focused on information processing theories and the novice to expert development of clinical reasoning (Carr & Shotwell, 2018; Carrier et al., 2010; Robertson, 1996a, 1996b). More pertinent to this investigation on assessment practice was literature concerning information processing and Dual-Process Theory (Kahneman, 2011), as they are directly related to occupational therapy practice.

In the 1990s, during the period of early investigations into occupational therapy clinical reasoning, Roberts (1996) analysed both the content and process of occupational therapists' (n=38) thoughts as each participant reviewed two written referrals. Therapists' thinking about actions to take upon the receipt of a referral is part of a usual occupational therapy process and relates to the current study as it is frequently the point at which therapists select an assessment process to use. Robert's study found that in relation to content, therapists' reasoning was "framed by the components of occupational therapy practice", although their thinking was "not necessarily used in a sequential fashion" (p.

376). That is, not ordered in an anticipated sequence presented in theoretical representations of the occupational therapy process. Additionally, the process of reasoning involved two types of information processing reasoning strategies: rapid formation involving intuitive and pattern recognition processes, and hypothetico-deductive reasoning where information was used to formulate a problem and an approach to manage the problem, and further information sought to either support or refute the hypothetical problem or solution. Robert's findings identified two information processing processes which are akin to the two thinking systems presented in Dual-Process Theory (Kahneman, 2011) and which, for simplicity, are known as System 1 and System 2.

System 1 has been described as an automatic, unconscious, rapid, intuitive system which is highly influenced by a person's affect. In contrast, System 2 is conscious, slow, deliberate, analytic thinking where rules are applied involving higher cognitive demands. Studies from medicine (Pelaccia et al., 2011) found System 1 to be used when time is limited, in routine situations, or where there is reasonable certainty. In contrast, System 2 is applied for complex and/or ill-defined circumstances, where risks and/or outcomes are of higher concern, or when time allows for deeper thinking to occur. Preliminary research with clinical psychologists (Nieto & Villarejo, 2020) has shown that while both systems are used, psychologists demonstrate a preference for System 2. This preference has been attributed to the unique, individual nature of psychology practice and need for deep analytical and reflective thinking to formulate intervention plans (Nieto & Villarejo, 2020). As yet, since Robert's (1996) study, there has been no specific research into how and when occupational therapists use System 1 and 2 thinking. However, there is some literature which has explored the use of intuition by occupational therapists (Chaffey et al., 2010, 2012; Robertson, 2012) and is likely to be describing the use of System 1 thinking in practice.

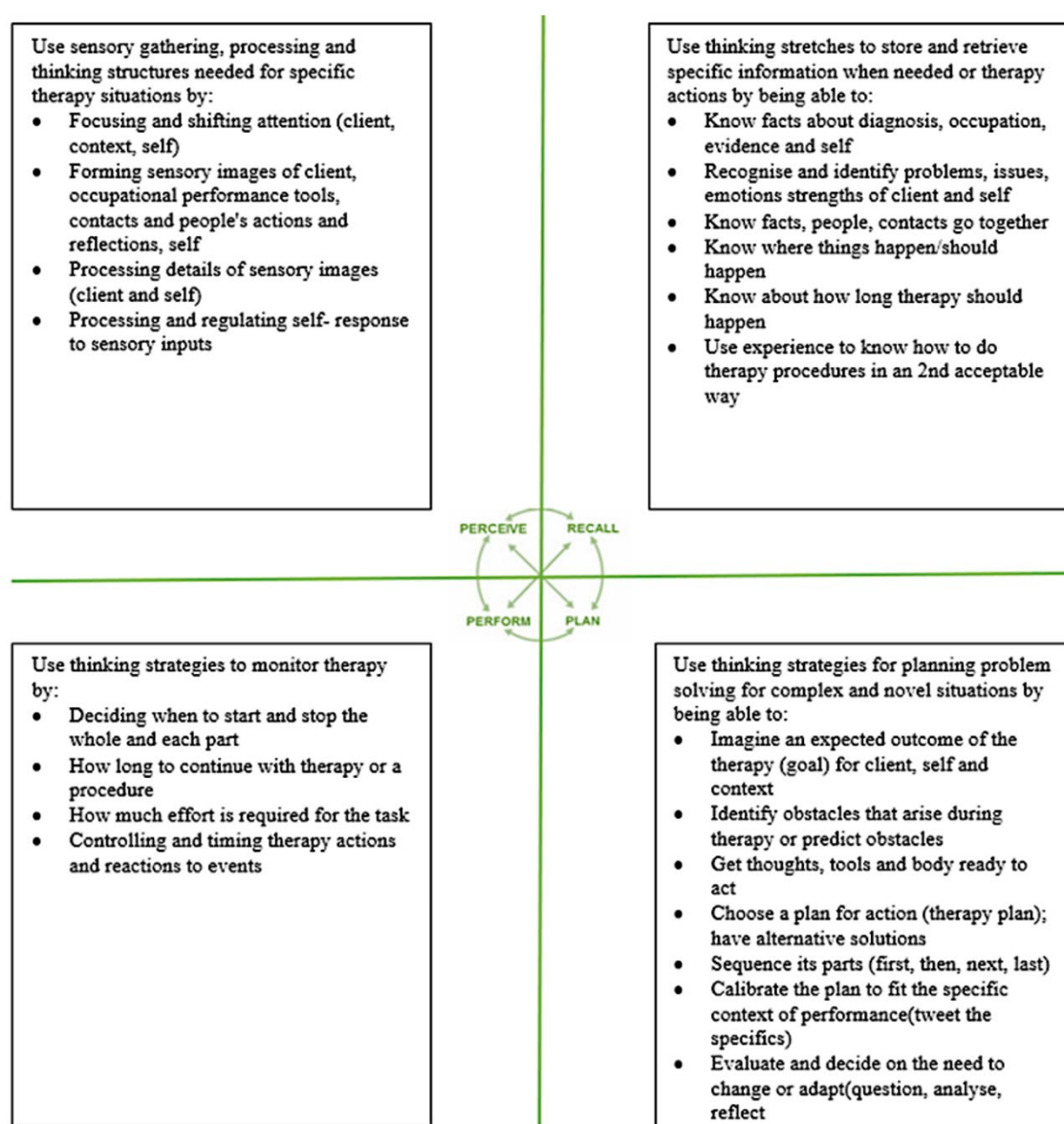
Chapparo and Ranka (2019) hypothesised occupational therapists' reasoning involves both System 1 (automatic thinking) and System 2 (deliberate thinking) to process information and use cognitive strategies⁸ to meet the demands of any given therapy situation. Furthermore, they developed the model, the Perceive, Recall, Plan and Perform System of Task Analysis Conceptual Model (PRPP-CM) (Chapparo & Ranka, 2019) (see Fig. 4) to explain the process. The PRPP-CM is based on the PRPP system described in

⁸ Cognitive strategies are 'mental thinking tactics'. See Chapparo, C., & Ranka, J. (2019). Clinical reasoning in occupational therapy. In J. Higgs, G. Jenson, S. Loftus, & N. Christensen (Eds.), *Clinical reasoning in the health professions* (4th ed., pp. 271-284). Elsevier.

Chapter 2, an information processing theoretical model where information across four quadrants Perceive, Recall, Plan, Perform is processed in multiple directions and cognitive strategies are applied to effectively think through any routine and task. The PRPP-CM includes cognitive strategies occupational therapists are thought to use as they process information for clinical reasoning during therapy. A full explanation of the application of PRPP-CM is available in a chapter in “Clinical Reasoning in the Health Professions” (Chapparo & Ranka, 2019).

Figure 4.

The Perceive, Recall, Plan and Perform (PRPP) System of Task Analysis Conceptual Model: Hypothesised Cognitive Strategies Used in Clinical Reasoning During Every Therapy Situation



Note. From Chapparo, C., & Ranka, J. (2019). Clinical reasoning in occupational therapy. In J. Higgs, G. Jenson, S. Loftus, & N. Christensen (Eds.), *Clinical reasoning in the health professions* (4th ed., pp. 271-284). Elsevier. Reprinted with permission.

At the time of this review, no research was evident that had investigated the application of the PRPP-CM to occupational therapy practice. The model may, however, be of relevance to this study as it is purported that it can be applied to clinical reasoning associated with any aspect of occupational therapy practice. Chapparo and Ranka (2019) explained how “each occupational therapy session demands particular client information to be chosen, constructed, processed, stored, recalled and used for a particular purpose” (p. 278) and the PRPP-CM may provide a way to potentially understand specific cognitive strategies used by occupational therapists performing a PRPP-A.

Cognitive strategies are known to manifest as observable behaviours and studies have shown PRPP system analysis can explain complex thinking involved in work routines and tasks (Bootes & Chapparo, 2010; Lewis et al., 2016). Given complex thinking is known to be required for occupational therapy practice (Higgs et al., 2019), the PRPP-CM may provide a means to better understand occupational therapists’ clinical reasoning. With the profession having identified that gaining more understandings of information processing is a direction for future research in clinical reasoning, further investigation to ascertain if there is merit to using the PRPP-CM to view clinical reasoning as it is applied in practice seems warranted.

The focus on clinical reasoning now shifts to what is currently known about kaiwhakaora ngangahau Māori occupational therapists’ clinical reasoning, an essential area to explore when considering practice in Aotearoa New Zealand. The final section then addresses clinical reasoning and occupation-based assessment practices and practice contexts.

Kaiwhakaora Ngangahau Māori Occupational Therapists’ Clinical Reasoning

At the time of this review, using databases commonly associated with traditional Western academic methods, only two sources were found relating to kaiwhakaora ngangahau Māori occupational therapists’ clinical/ professional reasoning. The first, a book chapter by Gilsenan, Hopkirk, and Emery-Whittington (2012), directly addresses collective reasoning within whakaora ngangahau occupational therapy practice. The second, a study by Hopkirk and Wilson (2014), has a broader focus on Te Ao Māori⁹ health perspectives and occupational therapy. Although clinical reasoning was not its primary focus, the study offers valuable insights into key aspects of practice that kaiwhakaora ngangahau Māori occupational therapists consider integral to their

⁹ Te Ao Māori - A holistic worldview encompassing Māori language, culture, traditions and values.

professional approach. The central influences on clinical reasoning as identified in both sources are briefly presented below. Direct quotes from the original texts are used throughout to preserve the integrity of Indigenous perspectives and endeavour to limit the influence of my own Western interpretation.

For kaiwhakaora ngangahau Māori occupational therapists, culture is central to “effective practice” with “traditions and Māori worldview paramount” (Hopkirk & Wilson, p.160, 2014). One participant in Gilsenan and colleagues’ study expressed this as “cultural perspectives are the lens through which I view my practice” (p.160). This viewpoint stands in stark contrast to dominant Western occupational therapy thinking where occupation is central. For kaiwhakaora ngangahau who are Indigenous to Aotearoa New Zealand, occupational therapy perspectives are considered secondary to Te Ao Māori. This process of clinical reasoning is explained as “to strive for the meaning in each encounter with clients: where did they come from, who are they, I strive to be open to do what I don't know and I feel comfortable when I am able to discuss and confer with others, including Whānau /extended family, in a collective process to support an integrated approach” (Gilsenan, Hopkirk & Emery-Whittington 2012, p.135). The authors refer to this reasoning process as “collective reasoning” involving thinking about te Tiriti o Waitangi and colonisation, “tikanga¹⁰”, “kawa¹¹” “whakawhanaungatanga¹²”, “knowledge in Te Ao Māori... which considers what has gone before”, “intergeneration knowledge”, “occupation as a connector of wairua¹³ and tangata¹⁴”, “working with whānau¹⁵”, and “discussions with a number of people” (pp.136-149). Hopkirk and Wilson (2014) further emphasised that “understanding [the] holistic care context”, “relationship between the environment and health” and “whānau and whānau ora¹⁶ (pp.161-162) are also key tenets needing consideration.

Each of the facets of clinical reasoning presented in the overview above is explored in detail by the respective authors and warrants greater consideration than is possible here. What becomes evident, however is the richness and complexity of collective reasoning within kaiwhakaora ngangahau practice. Further investigation is needed to enhance understanding of the practical applications of collective reasoning and the influences

¹⁰ Tikanga- Customary practice

¹¹ Kawa- Process

¹² Whakawhanaungatanga - Relating with one another and building trust

¹³ Wairua – Spirit

¹⁴ Tangata – person/people

¹⁵ Whānau- Extended family

¹⁶ Whānau ora- well communities

shaping the thinking, decision-making, and practice of kaiwhakaora ngangahau Māori occupational therapists.

Clinical Reasoning Specific to Occupation-based Assessment Practice

In recent years the profession has begun to explore clinical reasoning as it is used by occupational therapists in different areas of practice. Currently, this type of research is limited. Examples include investigations into clinical reasoning in community practice (Munroe, 1996; Reason, 2012), dementia care (Toth-Cohen, 2008), and brain injury (Kuipers et al., 2006). These studies reveal factors and content of clinical reasoning used by occupational therapists during different stages of the occupational therapy process, although they do not cover reasoning pertaining to administration of an assessment. In this literature review only one study with such a focus was found (Unsworth, 2011).

Unsworth's (2011) study involved a video recording of an experienced occupational therapist performing a driving assessment with a "straightforward" (p. 99) client with physical limitations. Following the assessment, the therapist watched the video and described her clinical reasoning to the researcher. Priori categories of well-established modes of reasonings were used in the data analysis, as well as new modes being sought, although none were identified. Overall, Unsworth found the therapist applied established modes of reasoning during the assessment process through a blended form of reasoning with procedural reasoning interwoven with interactive reasoning. The therapist's reasoning was also influenced by her beliefs about what should happen (i.e., her worldview). Unsworth's findings provide useful preliminary insights and practical evidence of modes of reasoning applied during an assessment process; however, with the study based on a single case and only the application of a non-standardised assessment with a client without cognitive impairments, many unanswered questions remain. For instance, what is the nature of reasoning used: with more complex clients? with standardised occupation-based assessments? in other areas of practice? or by less experienced therapists? These are important questions which the profession needs to address, highlighting a need for further research in this area.

The only other sources of information on occupational therapists' clinical reasoning and assessment practice appear in book chapters. An edited book chapter of particular relevance to the focus of this current study tracked an occupational therapist's clinical reasoning and application of the AMPS with a client with executive function impairment (Duran & Fisher, 1999). Detailed descriptions of the therapist's reasoning, founded on clinical experience, are provided for each stage of the assessment process. The decisions

the therapist made are included, together with an analysis related to modes of reasoning the therapist applied. Consequently, the information in this chapter is limited to anecdotal practical descriptions of clinical reasoning and assessment practice related to well understood modes of reasoning rather than research evidence. The use of non-empirical sources of evidence concerning clinical reasoning and assessment practice is, however, consistent with knowledge on the topic as presented in other occupational therapy professional book chapters (Curtin et al., 2017; Schell & Schell, 2018a).

Professional book chapters typically portray assessment practice and associated clinical reasoning for clients with certain conditions (Egan & Zakutney, 2017; Stamm et al., 2017) or for practice within specific contexts (Allison & Shotwell, 2018; Swinth, 2018). Practice-based case studies generally illustrate clinical reasoning associated with different assessments options including standardised occupation-based assessments. These case studies have an important role in guiding practice; although, since they are based on authors' expert opinions and practitioners' clinical experience, they reveal a lack of research into occupational therapists' actual thinking and reasoning for assessment practice. There is a significant gap in knowledge, which has also been raised in studies exploring the utility of the COPM (Mew & Fossey, 1996; Parker & Sykes, 2006). These studies concluded sound clinical reasoning was important for the successful outcome of the COPM and stressed further investigations into clinical reasoning skills, training of reasoning skills, and client-centre practice for using occupation-based assessments, like the COPM, was required. That finding is supported by this current literature review, which has revealed an overall scarcity of research associated with clinical reasoning and occupation-based assessment practice, thus affirming a need for more research in this area.

Alongside a therapist having clinical reasoning skills to use an occupation-based assessment, another important aspect for an assessment being used in practice is how the assessment is transferred to a therapist's context. In recent years, the growing field of KT has offered processes to assist such a transfer. KT literature associated with occupational therapy practice is examined in the following section.

Section 2: Knowledge Translation

A brief review of the literature available at the time of Phase One of this study concerning KT and occupational therapy practice is offered. Three KT models that have been suggested for use by occupational therapists are critiqued, followed by an exploration of KT strategies commonly presented in the literature as possible options for occupational

therapy practice. Finally, stages of learning theories are explored and the relevance of these theories for assisting KT considered.

KT and Occupational Therapy Practice

Over the last decade there has been growing recognition of the importance of building stronger connections between the development of theories, research, and the implementation of these in clinical practice. It is widely acknowledged that new knowledge is often not integrated into practice and that there is frequently a disconnect between the creation of knowledge and its actual use (Menon et al., 2009; Straus et al., 2011). Furthermore, it has been recognised that the processes which are involved in applying knowledge to practice are highly complex (Cramm et al., 2013). To assist these processes, KT and implementation science (a term used in the northern hemisphere countries) (Straus et al., 2011) have evolved, becoming specialised multidisciplinary fields in their own rights. The research from these fields is extensive and, as such, full investigation is outside the scope of this study which only aims to gain preliminary insights as to how KT relates to occupational therapy and, specifically, whether there is potential for it to assist with the application of the PRPP-A.

Over 90 terms may exist to describe the process of applying knowledge to practice, each with different definitions of the process (Straus et al., 2011). The more frequently used terms include knowledge transfer, knowledge exchange, research utilisation, implementation, dissemination, diffusion, continuing education, and continuing professional development. The most commonly used term is KT (Graham et al., 2006), which is also most frequently referenced in the occupational therapy literature (Cramm & White, 2007; Law et al., 2008; Metzler & Metz, 2010a). For this reason, KT will be used to describe the knowledge to action processes in this study. In many health-related articles, including those for occupational therapy, KT is typically defined using the Canadian Institutes of Health Research website definition:

As a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system. This process takes place within a complex system of interactions between researchers and knowledge users which may vary in intensity, complexity and level of engagement depending on the nature of the

research and the findings as well as the needs of the particular knowledge user.
(Graham, 2010)

This definition provides a useful basis to understand the broad tenets of KT. Colquhoun et al. (2010) have related KT more specifically to occupational therapy practice, describing it as an overarching term which encompasses evidenced-based practice along with “any tasks that might bridge the gap between what we know and how we use this knowledge to improve care” (p. 271). That includes “how we make the necessary changes in practice to utilize a new intervention” (Colquhoun, p. 271). This latter description reveals the potential relevance of KT for practitioners implementing a new assessment to practice.

The KT literature within health sectors is prolific but most has focused on medicine and nursing, with very few studies investigating KT in rehabilitation (Scott et al., 2012) and even less specific to occupational therapy (Cramm et al., 2013; Menon et al., 2009). At the time of this review in 2018, literature concerning Indigenous perspectives on KT was notably scarce within traditional Western academic databases, and no sources were identified that specifically addressed KT in the context of Indigenous practice and occupational therapy. This significant gap in the literature reflects what is recognised as the impact of colonisation, which continues to shape dominant understandings of KT that are largely informed by Western epistemologies and research conventions (Oy & Campbell, 2015). The absence of Indigenous perspectives of KT in occupational therapy is concerning for practice in Aotearoa New Zealand where culturally responsive approaches are essential. This gap highlights the need for targeted research in this area. Currently, KT remains an emerging field within occupational therapy and existing literature offers no clear evidence as to which KT theories/models or strategies might best fit the unique needs of occupational therapists (Colquhoun et al., 2010; Cramm & White, 2007) including kaiwhakaora ngangahau Māori occupational therapists. Available research suggests occupational therapists typically develop their knowledge and practice through combinations of clinical experience, colleagues, peers, continuing education courses and workshops (Cramm et al., 2013; Lencucha et al., 2007; Rappolt & Tassone, 2002). It has, therefore, been argued that practically based strategies may hold more relevance than theories and “theory-driven strategies” (Bhattacharyya et al., 2006; Colquhoun et al., 2010, p. 277). Furthermore, occupational therapists have been described as “pragmatists whose practice is driven by practicality” (Menon et al., 2009, p. 1030), who do not necessarily actively seek evidence or new ways of doing (Menon et al., 2009),

and typically prefer to rely on traditional modes of practice (Cramm et al., 2013; Robertson et al., 2013). Given these practice patterns it is, perhaps, hardly surprising that the occupational therapy literature reports only very limited uptake of KT theories/models or strategies by occupational therapists.

Yet, there is growing evidence and debate indicating that KT may benefit the profession (Cramm & White, 2007; Kerner, 2006); although exactly what would support occupational therapists remains unclear. Some propose that occupational therapists and their organisations need guidelines as to how KT theory might support occupational therapy practice (Colquhoun et al., 2010) and that discipline specific KT models and strategies need to be developed (Donnelly & Cramm, 2016; Metzler & Metz, 2010a; Scott et al., 2012). Others argue that continuing education courses need to design and incorporate KT strategies from the outset to facilitate intentional learning and help course participants organise, synthesise, reflect, evaluate, and adapt learning to their practice context (Cramm & White, 2007; Moon, 2004). This has potential relevance for the PRPP-A training and the possible need to include KT strategies within the course. It is uncertain, however, given the dearth of specific occupational therapy KT theory/models or strategies what would need to be included. To identify possible options, three of the most widely used health related KT theories / models which had also been referred to in the occupational therapy literature were reviewed for their possible value in supporting occupational therapists implementing a new assessment. In addition, a range of KT strategies identified in the broader literature as effective for rehabilitation professionals, including occupational therapists, were explored. The intent of exploring these strategies was not to compile an exhaustive list of all the existing KT strategies but rather to help me recognise KT terminology or strategies that participants might refer to during the subsequent data collection phase.

KT Theories, Models, and Strategies

The diffusion of innovations (DOI) (Rogers, 1995) is a well-established theory that evaluates the likelihood of an innovation being adopted and is recognised to guide the translation of research innovations (Sudsawad, 2005). The DOI is an extensive theory which, simplistically described, is based on an innovation-decision process that aids the identification and analysis of factors that facilitate or hinder the uptake of a new idea. Five steps form the innovation-decision process which can be evaluated and include the *knowledge* to develop an understanding of the innovation, its advantage, compatibility, complexity, and visible benefit; *persuasion* factors that establish a positive or negative

attitude towards the innovation; *decision* to adopt or reject the innovation; *implementation* actually putting the innovation into practice; and *confirmation* factors that influence whether or not an innovation is kept or adopted in the long term (Haider & Kreps, 2004). For practising occupational therapists, one criticism of the DOI theory is that its practical application still remains unclear (Colquhoun et al., 2010). Consequently, the theory has been extended, based on an extensive systematic review, to develop a conceptual model for health service organisations which provides comprehensive information of multiple factors that influence and determine the uptake of innovations (Greenhalgh et al., 2004). Within the occupational therapy literature, the extended DOI model has been proposed as suitable to explore questions such as “what affects the integration of occupation-based measures” (Warner & Townsend, 2012, p. 20), although, in the current review no studies of the model being used for such a purpose were found.

The Promoting Action on Research Implementation in Health Services (PARiHs) Framework (Kitson et al., 1998) offers a method to evaluate the probability of success when making a change in practice. The framework can be used to examine the interplay between three elements; the quality of evidence, the practice context, and facilitation of the implementation. Analysing a possible practice change with the PARiHs framework guides the areas which need addressing and the development of appropriate KT strategies (Kitson et al., 2008). Potential strengths of this framework lie in the formation of facilitation strategies that support the change within the actual practice setting and that it was designed to be easily used in clinical practice (Colquhoun et al., 2010; Warner & Townsend, 2012).

Finally, the Knowledge to Action Cycle (KTA) (Graham, 2010) is reported to be the most widely recognised KT model and has been used in many health settings (Cramm et al., 2013; Cramm & White, 2007; Metzler & Metz, 2010b). The KTA uses a systems approach and consists of two interconnected phases involved in the KT process, a knowledge creation phase and an action cycle phase. The knowledge creation phase is represented as a funnel where knowledge is tailored, synthesised, refined, and shaped into a meaningful format ready for application to a specific practice context. The action cycle phase provides steps to facilitate the actual application of the knowledge in practice. Steps include selecting, tailoring, and adapting the knowledge to the local context; assessing barriers to the knowledge use; the implementation of interventions; monitoring the knowledge use; evaluating the outcome; and, last, sustaining the use of the knowledge.

The knowledge creation phase of the KTA may have potential benefit before an occupational therapist selects a new assessment (i.e., at the outset when they were reviewing their assessment practice). However, significant restrictions to this process within occupational therapy are the profession's lack of extensive research and/or systematic reviews to inform this phase. In addition, only evidence from research is considered in the model, which omits important evidence from clients' and therapists' tacit knowledge (Cramm et al., 2013; Lencucha et al., 2007). That said, the knowledge to action phase of the KTA may have some applicability, especially if occupational therapists combine the Person-Environment-Occupation (PEO) model with this phase to aid the analysis of barriers and supports (Metzler & Metz, 2010a).

The PEO is a well-established occupation-centred practice model (Strong et al., 1999) and Metzler and Metz (2010a) have outlined how the core constructs of the PEO could be applied to the KTA. Applying these constructs has potential to promote a deeper analysis of factors related to the practitioner, practice context, and the KT activity, which may assist the development of suitable KT strategies for the integration of the knowledge to a specific practice context. Despite this apparent utility, when writing the current review, no practice studies were found to support the combined application of the PEO and KTA. However, given that occupational therapists' practice is based on such occupational analysis, there may be value in these two models guiding therapists to relevant KT strategies for their practice context.

The three theories/models presented may have relevance for occupational therapists implementing the PRPP-A, although they do not specifically indicate which KT strategies should be used; highlighting instead areas and/or potential barriers that would benefit from the development of KT strategies. When considering KT interventions, the KT literature supports that for knowledge to be implemented in practice, numerous strategies need to be actioned (Scott et al., 2012). Menon et al. (2009), in an extensive review of KT strategies used in rehabilitation, including occupational therapy, reported that in changing clinicians' practice "active multi component strategies were found to be more effective than passive dissemination or single KT interventions" (p. 1030). Some of the main KT strategies purported to support rehabilitation practitioners to implement new knowledge to practice are outlined in Table 3, alongside the recognised benefit of each of these strategies.

Table 3.*Knowledge Translation Strategies*

KT strategy	Recognised benefits
Support from managers/workplace/organisation (King, 2009; Rappolt & Tassone, 2002; Robertson et al., 2013)	Promotes an environment for learning and implementing change Can assist with caseload demands
Specific time allocated for learning (Robertson et al., 2013)	Provides a designated time for learning
Reflective practice (Kinsella, 2001)	Enhances professional reasoning Helps navigate change in messy practice environments Develops clinical expertise and practice wisdom Promotes strategic planning Critical review of experiences
Engage in experimental learning through a cycle of deliberate practice, active feedback and reflection on experiences (King, 2009)	Develops mindful practice, openness to learn, and willingness to learn from experience
Coaching and mentoring with more experienced therapists supporting less experienced (King, 2009)	Provides role model, develops competency and clinical skills
Develop a culture of inquiring (Reagon et al., 2010)	Promotes questioning, challenging of ideas, and exploration of uncertainty
Communities of practice (Wilding et al., 2012)	Facilitates shared learning and learning from others Nurtures and develops practitioners Increases confidence and satisfaction
Online communities of practice (White et al., 2008)	Connects geographically isolated practitioners with limited time
Local champions/leaders of change. These are often the earlier adopters of the change and/or respected colleagues/peers in a team (Rappolt & Tassone, 2002; Rouleau et al., 2015)	Assist others to acquire and integrate skills They back the change Foster an environment that supports change
Use of the stages of readiness for change (McCluskey & Cusick, 2002)	Identifies the readiness of an individual to change and shows the next step needed for changing a specific practice area

One KT strategy presented in Table 3 which is gaining increasing recognition for the support it affords healthcare professionals, is communities of practice (CoP) (Bezyak et

al., 2013). CoP are based on situated learning theory with the underlying premise that learning is a social phenomenon (Wenger-Trayner & Wenger-Trayner, 2012) fostered through relationships and social interactions (Wenger, 1998) that take place in the setting where knowledge needs to be applied (Cope et al., 2000). Studies exploring the use of CoP by occupational therapists are limited (Barry et al., 2017); however, there are a few that have relevance to the focus of this study. These include that CoP have been the central support for occupational therapists learning to implement the Model of Human Occupation (MOHO) and the MOHO assessment tools (Wimpenny et al., 2010), have assisted occupational therapists to develop evidence-based practice (Kilbride et al., 2011), and have enhanced critical reasoning and facilitated “skill acquisition” (Wilding et al., 2012, p. 7).

In addition, a practical example of a CoP used to translate the AMPS to practice was found (Moore & Lewis, 2008) and provides insights into the possible steps required to support the translation of occupation-based assessments to practice. The steps taken for the AMPS CoP included: developing a clear purpose for the group from the outset, establishing common ground, forming a plan to address the group’s learning, having an efficient organiser, using an agenda, and identifying strategies to assist the process of transferring the learning. The strategies included reading and discussing the manual; critically reflecting on group members’ assessments, interpretations, and reports; and linking with the AMPS international centre when they needed expert advice. Founding the CoP in this way increased members’ confidence and ultimately developed knowledge in the group that was shared with the wider profession at conferences (Moore & Lewis, 2008). This example may have relevance for translating the PRPP-A into practice since the PRPP-A training has some similarities with AMPS.

Exploring these KT models and strategies has provided potentially useful insights for translating the PRPP-A; however, although the likely value of each KT model/strategy has been described in the literature, it remains unclear which combination of models and/or strategies is most applicable or useful for occupational therapists. This current study aims to uncover if participants used any KT models and/or strategies to help them translate the PRPP-A to practice.

Stages of Learning Theories

A final aspect of translating knowledge is the literature related to the stages of learning new skills. This body of knowledge indicates that the stage of a person’s learning influences their performance, readiness, and ability to translate skills to different contexts

(Benner, 2004; Dreyfus, 2004; Shuell, 1990). Considering these stages may, therefore, be useful for occupational therapists' learning and translating a new assessment to practice. Both the terms 'stages' or 'phases' of learning have been used interchangeably in the literature to describe a progression or continuum of learning. In this review the term stage will be used, consistent with the terminology described by the authors of the PRPP system (Chapparo & Ranka, 2016).

At the time of reviewing the literature concerning the stages of learning, only one study (Shuell, 1990) was found which questioned the evidence that supported the notion that learning occurs through recognisable stages. This study compared and evaluated theories, concluding that although more empirical studies were required, there was "reasonable agreement ...that a learner passes through a series of phases as their knowledge about something evolves. During these phases, the learning process and the variables influencing it, change in systematic ways" (Shuell, 1990, p. 540). The number of stages of learning proposed by different theorists ranged between three to five stages, with three stages the most common. Despite the obvious difference in the number of stages, Shuell (1990) considered the theories were describing a similar progression of learning, which they summarised as an initial acquisition stage, an intermediate stage, and a terminal stage. Shuell postulated that generating further understandings of these stages would improve teaching methods and support learning by pairing the demands of learning with progression through the learning stages.

According to Shuell (1990), the acquisition stage involves learning the facts, where concrete knowledge is learned and associated with a person's pre-existing knowledge and schemas to provide meaning and interpretation. At this stage, information is generally memorised, and the application of the knowledge is context dependant. Next, the intermediate stage is when the learner develops procedural learning, reasoning, and a deeper understanding of the knowledge. This allows the knowledge to be applied to new situations with the learning occurring through using the knowledge and reflecting on its application. The knowledge is gradually applied in ways that are more abstract and eventually generalised to different contexts. During this stage there is often an associated short-term reduction in competency as the learner meets the challenges of adjusting the knowledge to different situations. In the terminal stage of learning, performance becomes automatic, and the knowledge is applied without effort or mental exertion and is easily generalised to different contexts.

Of significance for occupational therapists is that Shuell's (1990) overview of the stages of learning has consistent features with the stages of learning used in many rehabilitation approaches that are familiar to occupational therapists, including the skill acquisition approach (Gentile, 1972), motor learning theory (Carr & Shepherd, 2000; Tse & Spaulding, 1998), and task orientated learning (Hubbard et al., 2009). The PRPP system also incorporates stages of learning theories within the intervention approach (Chapparo & Ranka, 2016); however, it differs in some respects from the overview, in that five stages of learning are represented in a learning progression of acquisition, maintenance, fluency, generalisation, and transfer of learning.

I have summarised the stages of learning used in the PRPP system in Table 4, together with the performance associated with each stage and the supports which Chapparo and Ranka (2016) purport to promote learning at each of these stages. This representation of learning stages has the addition of the fluency stage of learning. In the fluency stage, a person learns to smoothly and efficiently perform the task/s within the time requirements of real-world contexts with a "fluid combination of accuracy plus speed that characterises competent performance" (Binder, 1996, p. 164).

Transfer of learning is the final stage and describes aspects of learning beyond that of generalisation outlined in Shuell's terminal stage of learning. This learning concerns the transfer of relevant parts of the knowledge or skill/s which are applied in different ways and within varying contexts. A similar type of learning has been portrayed by Dreyfus (2004) in the final stage of a five stage model of adult skill acquisition that follows the progression of novice to expert learners. In Dreyfus' model, at the expert stage aspects of the learning are intuitively and seamlessly applied in an expert manner to different situations.

Interestingly, despite occupational therapists using stages of learning theories within intervention approaches with clients, and a few researchers applying the theories to understand the development of expertise in occupational therapists (Feaver & Creek, 1993; Paterson et al., 2006), there is a lack of reference to these theories in the occupational therapy KT literature. Clearly more research is needed in this area. However, with the increasing evidence that learners do transition through stages of learning, it appears that relating a person's stage of learning to the support suggested for that stage (see Table 4), and scaffolding learning accordingly, may aid their progress to the next stage of learning, leading eventually to the transfer of the learning and development of expertise in practice (Dreyfus, 2004).

Table 4.

*Summary of the Stages of Learning Incorporated in the PRPP Task Analysis System
Based on Chapparo and Ranka (2016)*

Stages of learning	Learning involved	Performance associated with stage	Support for stage
1. Acquisition	Person is learning the basic facts of the task/s Reflecting on early learning	Slow performance Performance is context dependant	Explain facts and steps needed for performance of task/s Promote reflection on performance
2. Maintenance	Person has learnt to do the task/s without making errors	Performs task slowly in familiar context without errors. Errors return if task/s is changed, or novelty introduced	Use cues and prompts to support performance
3. Fluency	Person is learning to do task/s more quickly and efficiently	Performs task/s competently and smoothly within required real-world time frames	Opportunity to practice
4. Generalisation	Person is learning to do the task/s in different contexts	Can perform task/s automatically across different contexts	Practice in different contexts and or / with different cues and prompts
5. Transfer of learning	Person learns to use parts of the task/s to do a similar but different task/s	Performs different aspects of task/s in different contexts	Promote reflection Opportunities to think through creative use of skill/s

Summary

The clinical reasoning and KT literature has been explored as it pertains to occupational therapists' assessment practice. The growing research on different aspects of occupational therapists' clinical reasoning has been considered, including the well-established perspectives of modes of reasoning as well as lesser studied kaiwhakaora ngangahau Māori occupational therapists' collective reasoning, and metacognition and information processing theories. The existing literature provided insights into possible thinking and

decision-making processes that might be relevant to assessment practice, although overall a considerable gap in the literature specifically related to clinical reasoning and occupation-based assessment practice was identified. Most information on this topic was found in professional book chapters based on expert opinions rather than research. This review of the clinical reasoning literature supports the intent of the Phase Two study aims, since it was found that further investigations into occupational therapists' thinking and decision making when applying occupation-based assessments, such as the PRPP-A, are needed.

In relation to KT, the review established that there is still much to understand about what best supports KT for occupational therapists in practice. KT theories may hold some relevance, although it seems that often the existing theories do not naturally fit with the type of knowledge and learning that occupational therapists need to translate. To combat the limitations with KT theories from other professions, it has been proposed that specific KT theories may need to be developed by occupational therapists. An alternate view was that given the pragmatic nature of most occupational therapists, applying multiple KT strategies may be more useful than utilising KT theories. Currently, however, no consensus was evident in the literature as to which KT strategies are most effective for occupational therapists to use. A final aspect of KT reviewed was the stages of learning theories as a potential option for supporting occupational therapists' transferring new learning to practice.

Overall, reviewing the KT literature revealed there is no definitive process that assists the translation of knowledge to occupational therapy practice, including understandings of Indigenous perspectives of KT and further research is required. However, it appears that increasing occupational therapists' awareness of existing KT theories, KT strategies, and stages of learning holds potential for directing and supporting their learning and may help them to better utilise new knowledge in practice. Phase One of the current study aims to explore ways occupational therapists have translated the PRPP-A to practice and describe the KT processes they used to assist future occupational therapists when translating the PRPP-A to their practice. The following chapters cover the methodology and methods used to guide both phases of the study.

CHAPTER 4: METHODOLOGY

Qualitative Interpretive Descriptive Design: Theoretical and Philosophical Perspectives

Epistemology has been defined as “understanding what it means to know” (Crotty, 1998, p. 10) and includes theories of knowledge. Unlike more traditional qualitative methodologies, QID does not originate from a single philosophical stance or way of knowing (Thorne et al., 1997). Instead, it aligns with theoretical underpinnings of constructivism, naturalistic inquiry, and pragmatism (Colorafi & Evans, 2016; Hunt, 2009; Thorne, 2016b), with a discipline-specific orientation, which in this study is occupational therapy.

QID is based on constructivist understandings of knowledge wherein knowledge is viewed as constructed by human beings through interactions with each other and the world around them, with socially built meanings that do not exist separately from humans (Carpenter & Suto, 2008b; Crotty, 1998). From this viewpoint, no singular universal ‘truth’ exists, only ‘truth claims’ with interpretations formed in different ways by different people (Carpenter & Suto, 2008b). Varied meanings of the same thing are seen to exist, a perspective which is consistent with an ontological stance of relativism. Ontology is an understanding of “what is” (Crotty, 1998, p. 10) and what constitutes reality. From a relativist standpoint, the meaning of things come from “the sense we make of them” (Crotty, 1998, p. 64) and such ‘sense making’ is inextricably linked to the social, historical, and cultural contexts of the time. These constructivist and relativist views of knowledge and reality have a good fit for this current study since occupational therapists’ experiences of practice are all different and it would not be possible to find an absolute understanding of these experiences. Multiple realities associated with these practice experiences are acknowledged to exist which are context-bound to specific environments, points in time, and individual interpretation.

Recognition of complex multiple realities is also one of the five axioms that form the base of naturalistic inquiry (Guba & Lincoln, 1982) and which are inherent in the theoretical foundations of QID (Thorne et al., 2004). A description of these axioms is provided in Table 5, along with my analysis of the relationship of each axiom to the present study design. As shown in Table 5, the naturalistic inquiry axioms have a good fit with the study purpose and show congruency between underlying theoretical constructs and the research design.

Table 5.*Outline of the Naturalistic Inquiry Axioms Related to the Study Design*

Naturalistic inquiry axiom	Application to the study
Multiple realities exist that are subjective, complex, contextual, and only studied holistically.	Occupational therapists' assessment practice experiences and their associated clinical reasoning are unique, varied, intertwined with and inseparable from the complex multifaceted practice contexts where they occur. Only gaining partial understandings of these complex experiences and reasoning was possible.
The inquiry takes place where the phenomenon occurs (i.e., within the natural environment).	The inquiry focused on occupational therapists' experiences and clinical reasoning of therapeutic practice that had occurred in their natural work settings or the client's natural setting.
There will always be some influence between an inquirer and the object of inquiry, which is inseparable.	The knowledge generated was co-constructed by the participants and myself as a researcher (Carpenter & Suto, 2008b). Influences were recognised in the research and "safeguards" (Guba & Lincoln, 1982, p. 238) included to minimise the impact.
Research is value bound, and values and beliefs always influence the study content, design and interpretations of data.	I declare my position in relation to the research below, including acknowledging my values, beliefs, and experiences associated with applying the PRPP-A in practice and my role as an education provider of the tool.
Generalisation is not possible; however, research findings should be transferable.	Detailed descriptions of research findings and contextual information has been provided to assist others to compare between their experiences and this study's findings, thus allowing the transferability of the findings to be considered (Curtin & Fossey, 2007).

Since my study aims to gain insights into the complexity of occupational therapists' contextual experiences and their clinical reasoning, an inductive approach was taken. An inductive approach commences with open exploration of specific phenomena and builds knowledge through the gradual construction and recognition of patterns and themes (Thorne, 2016a). The gathering of data in this study occurred in the context of social interactions between myself, as the researcher, and participants through semi-structured interviews and a focus group for Phase One; and reflective logs and individual semi-structured interviews for Phase Two. Thematic analysis was then applied to allow

patterns, themes, and understandings to emerge that were “grounded in the data” (Thorne et al., 2004, p. 3).

Pragmatism is recognised as a philosophical foundation of occupational therapy practice (Ikiugu & Schultz, 2006) and has a natural fit for this discipline-oriented study. Consequently, pragmatism was chosen to underpin the research design where “the meaning of an idea or a concept is the practical consequences of the idea/concept” (Goldkuhl, 2012, p. 7) and research outcomes inform practice (Thorne et al., 1997). A key concept of pragmatism is knowledge being created “in the interest of change and improvement” (Goldkuhl, 2012, p. 9); that is, to make a practical difference. An inquiry viewed from a pragmatic viewpoint is driven from “doubt” and “what does not fit” (Kuzel & Engel, 2001, p. 5) and seeks multiple options that can be considered in future practice. My curiosity for undertaking this study came from uncertainty about how occupational therapists experienced the PRPP-A. As an occupational therapist, I value occupation and believe clients should receive a quality, occupation-focused service that addresses their unique occupational needs. I consider the PRPP-A has potential to offer an assessment process consistent with this professional viewpoint. Therefore, I became interested in creating practical understandings that might assist future occupational therapists to learn and use the assessment, as well as gaining some understandings of thinking and decision making involved in applying a PRPP-A to inform forthcoming training courses. A research design was developed that would generate practical outcomes specific to occupational therapy practice and the methods supported the pragmatic aspects of this inquiry (Thorne et al., 2016).

Occupational therapists are recognised to use reflective practice as an “integral part of professional thinking” (Bannigan & Moores, 2009, p. 342). They construct knowledge through a process of reflection and critical analysis of experiences that integrates new understandings with existing knowledge (Mann et al., 2007). Furthermore, in Aotearoa New Zealand the occupational therapy profession is committed to reflective practice, which is a regulatory part of the ongoing competency for practice (OTBNZ, 2015b, 2022). It is in line with occupational therapy practice that I have incorporated reflection throughout this research design. It formed a key component of my academic supervision and an essential aspect of the data gathering and analysis stages as described in Chapter 5 and 6.

Positioning the Researcher

In qualitative research it is important to introduce myself as the researcher as I am directly involved in the study and, as such, “an integral part of the research process” (Hammell et al., 2000, p. 7). With such close involvement in the research, it is impossible to eliminate my influence. By explaining, my experiences, values and assumptions, I aim to make transparent both my motivation for this research and the worldview that I bring. In Chapter 1 I provided background to my cultural affiliation; experience as an occupational therapist; and my ongoing roles as a partner of Chameleon Courses, supervisor, and educator. I will now restate my role with Chameleon Courses and explain in greater detail my own experience of learning and using the PRPP-A, my connections with teaching the assessment, and the assumptions I held prior to commencing this study.

For the last 22 years, I have been a partner in Chameleon Courses, a business partnership that has organised a range of courses and workshops predominantly for occupational therapists in Aotearoa New Zealand. Chameleon Courses has been, and continues to be, the only provider of PRPP-A courses in Aotearoa New Zealand. It was through Chameleon Courses that I first attended the PRPP-A course in 2007 and began using the assessment in my own practice. Since that time, I have attended seven courses held in Aotearoa New Zealand and two in the UK. In 2011, I participated in a PRPP Intervention (PRPP-I) course and subsequently assisted with teaching on the PRPP-A course in 2013 in Aotearoa New Zealand. Following that experience, I committed to training as a PRPP instructor and have taught on the last three courses in Aotearoa New Zealand. For the last 17 years I have also run a small private supervision practice through which some occupational therapists trained in the PRPP-A have sought support to use the assessment in their practice. In addition, I was asked in 2015 to attend four meetings to support a group of occupational therapists to develop strategies to implement the PRPP-A in their practice. It is through my involvement with supervisees, the support group, and Chameleon Courses that I became aware of challenges experienced by occupational therapists with the process of learning and fitting the PRPP-A into practice.

My own experience of using the PRPP-A was that I could use Stage One with clients after completing the first course, but that Stage Two required more practice and challenged my clinical reasoning. I used supervision and a community of occupational therapists, who had completed PRPP-A training with me, to discuss experiences and develop my skills and competency. Once I had mastered the assessment process, my greatest challenge was finding a relevant and time efficient way to document the assessment. This required

persistence and trialling of different methods while seeking feedback from others. My enthusiasm to continue to use the assessment came from the positive feedback that I received from clients, families, and team members. Within 6 months after the initial training, the PRPP-A had become an essential and, usually, my first assessment to use in practice.

Prior to training in the PRPP-A, I experienced not having suitable assessments to use with many clients I saw. As discussed in Chapter 1, I considered the standardised assessments I had prior to the PRPP-A were not culturally appropriate for my practice in Aotearoa New Zealand, since these assessments were either designed for western populations and/or included irrelevant tasks for many clients. In contrast, using the PRPP-A I found tasks could be selected that were relevant for children and adults from a range of cultures. I began using the assessment across cultures and received positive feedback on the assessment process from clients. These experiences encouraged and drove me to want to understand more. I considered having culturally relevant assessment tasks was only one facet to the cultural applicability of an assessment. I became interested in gaining other perspectives concerning the PRPP-A application with clients of various cultures, particularly with Māori. In addition, I was aware that using the PRPP-A involved complex clinical reasoning and I was keen to understand the ways other therapists reasoned their assessment applications.

As a result of my experiences and witnessing the challenges of other occupational therapists I began my postgraduate studies. I wanted to understand how occupational therapists perceived and experienced using the PRPP-A. I was interested in knowing whether others thought it was a suitable assessment for using with clients in Aotearoa New Zealand and particularly whether it had any fit for Māori clients. I was motivated to seek practical findings that may progress occupational therapists' use of occupation-based assessments, especially the PRPP-A. Furthermore, in my PRPP-A instructor role, I wanted to understand the clinical reasoning associated with the assessment, as well as type of supports occupational therapists used to learn and translate the assessment into their practice. I felt it was also important to know if there were settings or situations where the PRPP-A did not fit or was unsuitable, and how clinical reasoning influenced therapists' application of the assessment.

I have outlined the underlying assumptions that I brought to this research below. It is my intention that emphasising these presuppositions will reduce the impact of potential bias within the research.

Assumptions

- Occupational therapists need to bring an occupation-focus to their practice
- The PRPP-A is a useful assessment that has the potential to support the implementation of occupation-focused practice
- To apply the PRPP-A in practice requires practice and commitment
- Occupational therapists that attend a PRPP-A course are committed to evaluating their learning and translating relevant aspects of the learning to their practice
- PRPP-A training changes occupational therapists' thinking and their informal/formal occupational performance analysis
- Clinical reasoning associated with applying the PRPP-A can be complex and nuanced

Implications of My Position for the Research

- In recruiting, many prospective participants already knew me from one of my various roles outlined above. The steps I took to manage recruitment are described in the next chapter.
- In the data collection stage I needed to separate my views and thoughts about the assessment and be open and actively listening to participants. I was particularly mindful of the need to suppress my urge to make suggestions or solve any problems that arose.
- When analysing the data I tried not to jump to obvious conclusions based on my own experiences. When these thoughts did occur, I reflected on why I initially believed something to be so and then took a deeper look at the data and considered other options and ideas. I used regular academic supervision to discuss the influence of my assumptions, check my thinking, and identify blind spots.

Introduction

In this chapter, I explain the methodological approach used to guide the research. The chapter begins with the research questions and purpose, followed by my reasoning for selecting a qualitative interpretative description (QID) research approach and its fit with the research questions. Finally, I discuss the philosophical underpinnings of the approach, present the study design, and position myself as a researcher.

Formulation of Research Questions

The research question sets the focus of an investigation and, together with the study purpose, forms the basis for deciding the methodology and methods for the inquiry

(Carpenter & Suto, 2008a; Nicholls, 2009; Thorne et al., 2004). In this study the following two questions were posed:

- 1) What are the experiences of occupational therapists in Aotearoa New Zealand applying the Perceive, Recall, Plan and Perform System of Task Analysis Assessment (PRPP-A) into their practice?
- 2) How does using the PRPP-A influence occupational therapists' clinical reasoning throughout their assessment process?

In designing these questions, I considered they needed to be broad and open-ended to invite exploration (DePoy & Gitlin, 2005), but specific enough to reflect the disciplinary focus. The questions specifically identified the assessment being studied, the practice context, and focus of the investigation. Both questions portrayed the study intentions in a way in which the projected audience (i.e., occupational therapists) would understand.

Research Purpose

The purpose of this research was twofold. First, to gain understandings of occupational therapists' PRPP-A practice experiences. This included exploring some of the realities of translating the assessment to practice and describing practical strategies therapists used in their translating process. This purpose was addressed through question one above. The second purpose related to question two and was to seek insights into how using the PRPP-A shaped therapists' thinking and decision making throughout the occupational therapy assessment process.

Selection of the Research Approach

In selecting a methodology to address the questions and research purpose, I determined a qualitative methodology to be the best match given its focus on human phenomena and human experiences (Polit & Beck, 2006). There are many established methodologies within qualitative research founded on different professional viewpoints such as, ethnography from anthropology, grounded theory from sociology, and phenomenology from philosophy (Carpenter & Suto, 2008b). While valuable research exists based on these methodologies, the suitability of these approaches to answer questions from health-related fields has been increasingly challenged (Brewer et al., 2014; Morse, 1991; Sandelowski, 2000). Likewise, as I investigated which methodology to use, I found these traditional approaches did not readily match the study purpose. For example, ethnography involves the investigation of cultural patterns and cultural meanings across groups, which was not an aspect of the current study. Similarly, grounded theory served a different aim,

with research on social structures and processes, and a central focus of theory generation. Finally, phenomenological research seeks deep meanings of what life experiences are like, the ‘essence’ of phenomena, with the research typically involving only a few participants or an individual (DePoy & Gitlin, 2005). In contrast, the interest in the present study is on both shared and individual experiences with the nature and depth of interpretation differing from phenomenology (Thorne, 2016b). The current research aims to develop practical understandings and meanings relevant to therapists’ practice, rather than deeper meanings or essence of lived experiences.

In line with this practical purpose I investigated qualitative interpretative descriptive (QID) (Thorne et al., 1997) methodology further. QID was developed to address the needs of applied health research and offers “an approach to knowledge generation that straddles the chasm between objective neutrality and abject theorizing, extending a form of understanding that is of practical importance” (Thorne, 2016b, p. 26). It is a pragmatic methodology suited for discipline-specific studies (Thorne, 2016b) with the overall purpose of creating “clinically relevant and clinically applicable findings” (Brewer et al., 2014, p. 1290). It is a methodology that can be used to explore aspects of practice realities and develop ‘rich descriptions’ (Sandelowski, 2000), interpreting findings so they make practical sense to inform professional reasoning and future practice (Thorne et al., 2004). Interpretive description is particularly suitable for preliminary research where there is little known about a topic (Kielhofner, 2006; Sandelowski, 2000). I viewed the exploratory and practically oriented focus of QID to have a good fit with the purpose of my research.

I conducted a literature review to establish the existing knowledge and more deeply explore gaps in the literature concerning occupational therapists applying the PRPP-A to practice and influences on clinical reasoning. At the time of the literature review I found only one study (Lu, 2014) had previously investigated the clinical utility of the PRPP-A and no studies were sourced exploring clinical reasoning associated with the PRPP-A. Lu’s (2014) study predominantly used statistical methods to analyse information gathered from a questionnaire and some qualitative short answer questions. Findings reported the percentage uptake of the PRPP-A and factors that supported or hindered its application in practice. Lu’s research identified occupational therapists needed to find ways to integrate the PRPP-A with existing practice and that supervision, peer, and group supports assisted this process. No information was given on how supervision, peer, and group learning was set up, or specifically how they helped, or any KT strategies used. In

addition, Lu reported occupational therapists (n=43) considered the PRPP-A was “a relevant tool within a multicultural context” (p. 49), although the study lacked support for why they held this view. Lu provided only one description of the PRPP-A having been used to assess a culturally specific task and two participant quotes which explained assessing therapists’ need to understand the culturally specific task being assessed. No studies were found that addressed the cultural applicability or captured occupational therapists’ experiences of applying the PRPP-A, how it was transferred into practice or clinical reasoning and the assessment.

Consequently, the exploratory nature of my study was further endorsed by the limited literature available about the application of the PRPP-A and related clinical reasoning. Given how little was known about these topics, I deemed QID was the most suited methodology to gain initial understandings. Additionally, this methodology aligned with my interests, since having worked as a clinician for many years, I value practically orientated research that has direct relevance for professional practice.

Summary

In this chapter I have addressed the philosophical and theoretical perspective of the study and provided the study design and methodology that have informed the research findings. I have aimed to clearly provide information about myself as a researcher which, together with the content of the subsequent two chapters on methods, is intended to aid the independent evaluation of trustworthiness of the study.

CHAPTER 5: METHODS

Introduction

I present the research methods for both Phases One and Two of the study across two chapters. I begin this chapter with the ethical approvals and considerations which underpinned the methods I used. I then describe the reasons I selected the methods related to the recruitment process, participant selection, and data collection. Data analysis and how I addressed the overall ‘rigour’ of the research are explained in Chapter 6. Throughout both Chapters 5 and 6, I have aimed to share information so the ‘trustworthiness’ (Lincoln & Guba, 1986) of the study can be evaluated by the reader.

Ethical Approval

Ethical approval for Phase One was granted on 27th April 2016 and Phase Two on 11th December 2019 by the Auckland University of Technology Ethics Committee (AUTC) (Appendices A and B). A further amendment to the recruitment process was approved by AUTC on 18th March 2020 (Appendix C).

Ethical Considerations

The ethical principles do no harm and avoid deceit, and confidentiality and anonymity guided the study methods and are discussed below.

Do No Harm and Avoid Deceit

From the beginning of this study, there was a need to be open and transparent about the various roles (presented in Chapter 1) I hold as the primary researcher. Any potential impact or conflict of interest that these roles might have on conducting the study were addressed in the AUTC application and are outlined in the study design along with the actions taken to manage them.

As a partner of Chameleon Courses and a PRPP instructor, any prospective participant who had completed their PRPP-A training in Aotearoa New Zealand would already be familiar with me. In addition, Dr Christine Chapparo, the second supervisor to this study, is one of the authors of the PRPP-A and has taught all the courses in Aotearoa New Zealand. Consequently, she, too, was familiar to prospective participants who had completed their PRPP-A training in Aotearoa New Zealand. Familiarity with prospective participants has the potential of introducing coercion, with prospective participants feeling pressured or obliged to volunteer. To avoid this issue, neither Dr Chapparo nor I contacted prospective participants to advertise the research. I also undertook not to initiate discussion of recruitment in any formal or informal contacts with New Zealand-based occupational

therapists over the recruitment periods. Instead, OTBNZ, as an independent organisation, sent out advertising emails (see recruitment process section). In addition, I arranged the placement of adverts on OTBNZ website (including the OTBNZ Facebook page), Chameleon Courses website, and through occupational therapy and PRPP instructor networks, and in Occupational Therapy New Zealand – Whakaora Ngangahau Aotearoa's (OTNZ-WNA) *Insight* magazine. Prospective participants then had a choice as to whether or not to respond to the emails and adverts.

To be transparent and adequately inform prospective participants, both Dr Chapparo and I declared our roles related to the PRPP-A training in the participant information sheet for occupational therapists (see Appendices D & E). Potential volunteers were informed that if they had completed a PRPP-A course in Aotearoa New Zealand they would be familiar with us. The purpose of this open declaration was to allow prospective participants to make an informed decision about volunteering.

Benefitting financially from research can create a conflict of interest for researchers. It was important to explain within the participant information sheets that there was no direct financial gain from the research for either Dr Chapparo or I, since all prospective participants had already completed their training.

At the time of both recruitment periods, I practiced alongside other occupational therapists, had a guest lecturer contract with Auckland University of Technology, and ran a private supervision practice. To protect these supervisory relationships and avoid existing power dynamics influencing the data collection (i.e., where a participant could not freely express their views for fear of future consequences), the recruitment process had exclusion criterion meaning prospective participants could not volunteer if they had ongoing connections with me from either my workplace or supervision practice (see the recruitment process section).

Further ethical considerations and actions to do no harm were taken with respect to interviews/focus group and are outlined in Table 6 below. In addition, as Phase Two provided a data collection option that could involve occupational therapist participants videoing themselves performing a PRPP-A with a tangata whaiora/client (explained below under Data Collection, Phase Two and Video Recordings) further considerations and actions were taken to minimise potential discomforts and risks associated with being videoed. These included that being filmed had the potential to cause stress to tangata whaiora/clients and/or occupational therapist participants, particularly if they said or did things they preferred were not recorded. To minimise these risks tangata whaiora/client

participants were informed in the information sheet and at the start of the occupational therapy session that filming could be stopped at any time and would only continue if they agreed. Both tangata whaiora/clients and occupational therapist participants were also provided the option to withdraw the video and it be deleted (up to 2 days post filming).

Table 6.

Ethical Considerations and Actions Taken for Interviews and Focus Group

Ethical consideration	Action taken
Minimise risks to occupational therapist participants	The research involved occupational therapists sharing their experiences, views, thoughts, and decision-making related to applying an assessment in their practice. Discussing this topic was unlikely to cause distress, discomfort, or embarrassment for participants who were all registered professionals.
Manage any discomfort during the interviews/focus group	At the start of each interview/focus group I reminded participants that they could stop the discussion at any point without having to provide explanation, and they could say as little or as much as they chose.
Minimise risk for researcher	As all the interviews took place in participants' work contexts, at the university, or virtually, there were no identified risks for the researcher.

Confidentially and Anonymity

The information sheet informed occupational therapist participants that they would remain anonymous in all reporting of the study, with pseudonyms used in the research thesis and any future publications (Appendix D). To protect confidentiality and provide anonymity to participants who were volunteering to be videoed it was agreed none of their personal information or medical records would be shared with the research team. In addition, no identifiable information would be contained within the PhD thesis or related future publications. Both tangata whaiora/client and occupational therapist participants were informed that following filming they would be asked if they agreed for the video to be sent to Wendy Burrows (primary researcher). If participants chose to send a video to me, the information sheet informed them the video would be stored in a secure office at AUT for 6 years and then deleted. A further option to grant permission for the video to be used for future education purposes with occupational therapy students and/or qualified occupational therapists was provided. To avoid coercion and a sense participants might feel they should

give consent for wider educational use of the video, they were informed that consent was a free choice and there would be no consequences regardless of their decision.

All occupational therapist participants were assured that only myself, my supervisors, and the transcriber would have access to audio recordings and transcripts, and that the transcriber had signed a confidentiality agreement (Appendix G). All computers and email addresses used were password protected. Transcripts were only identifiable by numbers without any names used. A spreadsheet with names and phone numbers was stored separately from transcripts on my password-protected computer. The consent forms and transcripts were secured in a cabinet in the office area of my home until completion of the research, following which they are now stored in a locked cabinet at AUT for 6 years before being shredded and disposed of.

Te Tiriti o Waitangi and Cultural Considerations

Nā tō rourou, nā taku rourou kia ora ai te iwi.

With your food basket and my food basket, the people will thrive.

As symbolised by the above whakataukī, when conducting health research in Aotearoa New Zealand there is an obligation to consider the research in relation to Māori as tangata whenua and partners of Te Tiriti o Waitangi. At the time of designing Phases One and Two of the study, I followed AUTECH's recommended practice for cultural responsiveness and used the Te Ara Tika guidelines for Māori research ethics developed by Health Research Council of New Zealand (Hudson et al., 2009). As part of my research, I particularly wanted to capture the perspectives of Māori occupational therapists, and Te Ara Tika set out a framework based on principles derived from Te Tiriti o Waitangi of partnership, participation, and protection. I now explain the actions taken to nurture aroha (care), mana tangata (dignity), and manaaki (respect) using the Te Ara Tika framework.

The first step to developing partnership, participation, and protection was engaging in a consultation process, established from the outset and continued throughout all stages of the study. Before developing the research question or study design I contacted Iris Pahau, the Tikanga¹⁷ advisor (cultural advisor) to Occupational Therapy New Zealand-Whakaora Ngangahau (OTNZ-WNA) and arranged a consultative hui (meeting) with her and Professor Clare Hocking (supervisor). We met at a time and venue of Iris' choice at the Asian Pacific Occupational Therapy Congress in September 2015. This hui was the start of building partnership through whanaungatanga (relationship built through shared

¹⁷ Tikanga is the term for Māori protocol and practices

experiences, working together, and providing people with a sense of belonging). Initial kōrero (discussions) included sharing the background to the research idea, reasons for my interest in studying the PRPP-A, and what I knew about the PRPP-A and its use with tangata whaiora and Māori practitioners. Through shared kōrero, ideas for the research question were formed which eventually led to the development of an open-ended flexible question that invited participants to freely share their perspectives without any pre-determined restrictions. Kōrero included considering how to engage Māori participants in the study. As a result, for Phase One an option of a focus group with Māori participants and the open invitation to bring a support person were incorporated into the study design. A focus group afforded greater protection for Māori participants, as it is an inherent and culturally safe/appropriate way to meet which is in line with tikanga. From the initial hui, Iris kindly agreed to be an ongoing tikanga advisor for the research.

Two further telephone conversations took place between Iris, Clare, and me in the design stages of Phase One. These were invaluable consultations that helped establish the focus group, address tikanga, and develop the types of questions to ask. Following these consultations, I had a series of conversations by phone and email with Aroha and Peter, the two Māori participants, to arrange the focus group at a time and place of their choosing. This included a suggestion that Iris attend the focus group to ensure tikanga and cultural safety for all involved. In discussion with Peter, however, he offered to host and attend to the tikanga for the hui; therefore, Iris attending was not required. In keeping with tikanga, I took kai (food) to share and a koha (gift). Peter opened and closed the hui with karakia (prayer).

To provide protection and safeguard Aroha and Peter's perspectives, ensuring they were accurately represented, they were each sent the entire draft Phase One findings (Chapters 7 and 8) and the draft summary of the findings. They checked the content and were asked to make any changes or recommendations; subsequently, two minor changes were made. They also read the draft manuscript for the article later published in the *British Journal of Occupational Therapy* (BJOT) (See Chapter 9) and recommended changes which were made before the manuscript was submitted. In addition, they elected for pseudonyms to be used in the BJOT article. After completion of this research, there is agreement that there will be further participation, with Aroha and Peter having the opportunity to check future manuscripts prior to submission for publication.

When planning Phase Two, a further hui was held with Iris on 24th October 2019 via Zoom. The kōrero focused on an update of Phase One and the plan to extend the research with a

second question focused on clinical reasoning. We discussed the nature of the second question/s, cultural considerations, and implications for any Māori participants. We agreed, given the nature of the second investigation centred on individual occupational therapists' thinking and decision making in relation to doing a PRPP-A, it was not relevant to offer a focus group for Māori. Iris confirmed individual interviews would be a suitable method with the option to bring a support person provided and tikanga attended to during the interview. The Phase Two research question and recruitment process was also agreed. During this hui, Iris kindly agreed to continue as a tikanga advisor for Phase Two.

Recruitment

Before starting recruitment, an email address specifically for recruitment correspondence was set up.

Phase One

Advertising for participants occurred through two methods. First was a request to the OTBNZ for an email to be sent to all registered occupational therapists who had previously consented (by selecting a tick box at the time of annual recertification) to being contacted by OTBNZ for research purposes. The OTBNZ email briefly stated the purpose of the study, expectations of participants, and provided the contact email address to receive more information, ask questions, and express interest (Appendix H). OTBNZ provided me with an email summary of the number of emails sent and opened by therapists (Appendix I). OTBNZ also posted the email on their Facebook page.

Another advert with the same information was placed on the Chameleon Courses website's research page (dedicated to informing therapists about Aotearoa New Zealand research). This page had an electronic form embedded which therapists could complete to express interest, with the form then electronically sent to the recruitment email address. No inquiries were received through the Chameleon Courses website.

Once a therapist responded for more information, I replied by email and attached a participant information sheet, demographic information form, and consent form (Appendices D, F, & J).

Inclusion criteria were:

- Aotearoa New Zealand registered occupational therapist with OTBNZ
- Occupational therapist who had completed the PRPP-A training, including members of the support group of occupational therapists I had met with in 2015 (at the time of commencing the research I had no ongoing involvement with this group).

Exclusion criteria were:

- Occupational therapists that were supervised by myself or who provided my supervision
- Occupational therapists who worked in the same work setting as myself at the time of recruitment

The selection process was designed to establish a maximum variation sample based on:

- Geographic spread
- Diverse practice area (i.e., paediatric, adults, elderly, physical or mental health)
- Length of time since completing the PRPP training
- Occupational therapists working in a team or in isolation.

Occupational therapists who decided to volunteer responded by email and attached the consent form and demographic form. As only 15 responses were received, all those who responded were considered for the study.

Phase Two

Multiple methods for advertising for volunteers occurred between March 2020 and September 2022 and included:

1. Using the same methods as Phase One recruitment, a request to OTBNZ for an email to be sent to all registered occupational therapists who had previously consented to being contacted by OTBNZ for research purposes. The OTBNZ first sent an email on the 14th of March 2020 (Appendix K) 10 days before COVID-19 restrictions were imposed in Aotearoa New Zealand. A subsequent email was sent by OTBNZ on 27th of July 2020, 15 days before the second COVID-19 restrictions occurred on 11th August 2020.
2. Information was sent to PRPP instructors, New Zealand Special Interest Groups, and New Zealand Occupational Therapy networks (as per the ethics amendment – Appendix C) including:
 - Auckland Neurological Special Interest Group who emailed information to members on 28th August 2020
 - Auckland District Health Board Occupational Therapy Professional Leaders
 - Dr Judy Ranka International Instructor on 21st July 2021 who provided information about the study to PRPP-A Australia course participants (including OTBNZ registered participants attending) on 22nd July 2021

3. Advertisement fliers were left at the back of room for occupational therapists attending Chameleon Courses training courses held in October 2020 and August 2021
 4. As agreed in the consent process for Phase One, an email was sent to all participants updating them on the Phase One findings and giving information on Phase Two of the study
 5. An opportunity to volunteer for Phase Two was included within an article on PRPP-A research published by OTNZ-WNA in the September 2021 *Insight* magazine
 6. Snowball recruitment occurred throughout the recruitment period, with occupational therapists who had participated asked to share information with colleagues and peers.
- The same inclusion criteria applied in Phase One were used for Phase Two.

Participant Selection

At the outset of the research, the plan was for a sample size of between 10 and 15 participants for Phase One and 6 and 12 participants for Phase Two, using a purposeful method of sample selection to achieve maximum variation (Sandelowski, 2000). For Phase One, 15 therapists volunteered. In applying the inclusion and exclusion criteria, two volunteers were declined and informed by email; one had a supervision relationship with me and the other worked closely with me. Thirteen occupational therapists met the criteria for inclusion and made up the final sample with no selection process required. Similarly, for Phase Two, 11 therapists volunteered; two subsequently withdrew after COVID-19 restrictions were imposed and one withdrew after reading all the information. The remaining eight volunteers met the inclusion criteria. There were no exclusions, and no selection process was needed.

Participant Demographics

Phase One

All 13 participants were PRPP-A trained and had attended different courses in Aotearoa New Zealand in 2009, 2011, 2013, 2014, and 2016. Three participants had also completed a PRPP-I course. Most participants worked in the Auckland region, with two participants working in other cities in the North Island of Aotearoa New Zealand. Participants identified as New Zealand European (n=8), Māori, New Zealand European and Māori, Cook Island Māori, Filipino, and Chinese (n=1 each). Twelve identified as female and one as male. Nine participants worked for DHBs, one had recently worked for a DHB and was an occupational therapy supervisor at the time of the research, two worked in private practice, and one for the Ministry of Education. Participants worked across a range of settings including six in mental health for adults or older adults across acute, community, and vocational settings;

six in physical health settings for adults or older adults in acute wards, rehabilitation in-patients and community settings; two worked with children, of which one provided services for main stream schools and the other worked in the community and contracted to Accident Compensation Corporation (ACC) along with another participant who contracted to ACC and provided services for adults in the community. Only one participant worked in isolation away from any occupational therapy peers and three other participants had occupational therapy peers but no PRPP-trained peers in their immediate workplace.

Phase Two

All participants were PRPP-A trained and two had also attended a PRPP-I course in 2013 and 2016. Seven participants trained in Auckland New Zealand in 2007, 2009, 2011, 2013, and 2016, one attended an Introduction to PRPP-A Workshop in 2017 and subsequently the 2020 PRPP-A course in Sydney, Australia. All eight participants identified as female. Participants' cultural identity included New Zealand European (n=6), Māori/New Zealand European (n=1), and Fijian Indian (n=1).

Six participants worked in the Auckland region, one in Hamilton (North Island) and one in Christchurch (South Island). All participants worked in city locations, with one participant also covering a rural area. Four participants worked in private practice, with three in community services contracted to ACC and one in a private clinic setting for children. Of the participants in private practice three worked with children and young people, and one with adults. Three other participants practiced in DHB mental health adult services (acute and rehabilitation), and one was employed in a special school with children aged 5-21 years old.

Participants used the PRPP-A with different frequency. Five participants applied the PRPP-A at least monthly, one participant weekly, and two reported daily use.

Data Collection

Phase One

Two forms of data collection were used. Face-to-face semi-structured interviews started in August 2016 and finished in January 2017, and a focus group was held in December 2016.

Semi-structured Interviews

Semi-structured interviews are known to be suitable for in-depth explorations of a topic and use a flexible interview approach (Nicholls, 2009). In line with this type of interview, an interview guide using open-ended questions was developed with my supervisors (Elliott & Timulak, 2006) (Appendix L). Open-ended questions allow for "richer and fuller

information” (Polit & Beck, 2006, p. 294) and were developed so that participants had an opportunity to express in their own way their experiences, thoughts, and emotions without any set answers being anticipated. In developing the questions, I considered the “logical sense” (Thorne, 2016a, p. 58) for occupational therapists answering them and designed them to elicit responses that would align with the practical and discipline-specific intent of the research. Examples of questions were:

- Tell me about a client that you used the PRPP-A with after you completed your training?
- Can you tell me about a time when using the PRPP-A did not work out in your practice?
- Have you used the PRPP-A with clients of cultural affiliations other than your own? Can you give some examples?

To arrange the interviews, I contacted each participant by email and had phone conversations to find a date, time, and location that best suited them. It was important that participants selected the location so that they were in a comfortable and familiar space. I offered to travel to participants to reduce their time commitment. When a participant selected a work location, they took responsibility for arranging that the time was separate from their work commitments and for booking a suitable quiet private space that ensured the interview was confidential. Prior to meeting, participants received the consent form (Appendix J) and information sheet (Appendix D). The information sheet outlined what to expect, how long the interview would take, the option to invite a support person (although no one chose to do so) and broadly described the research focus and topics for discussion.

Each interview commenced with an explanation of the interview process, including revisiting the consent, recording of the interview, and answering any questions participants might have before commencing. Most participants had previously signed the consent form and sent a scanned copy to me prior to the interview; however, some opted to sign it at the interview. To put participants at ease, a warm-up conversation took place before the digital recording started. Following that, I loosely used the interview plan (Nicholls, 2009), engaging in a natural conversation where I was mindful the main purpose was to pose open questions and actively listen. At times during the interviews I used probes, a follow up question, or statement to prompt for responses and more detail or to provide greater explanation (DePoy & Gitlin, 2005); for example, “And how’s that gone for you?” or “Tell me a bit more about that, how’s that been?” After the first three interviews, I reflected on the questions and discussed the content of the interviews with my supervisors. We realised

that the participants seemed concerned that maybe they were not using the PRPP-A in the 'right' way and were looking for reassurance. To address the issue, I changed the introduction to subsequent interviews and explained I was interested in hearing whatever their experiences of applying the assessment were, there were no right or wrong experiences, and that I was not evaluating the way in which they used the PRPP-A. Including this introduction appeared to help relax the participants in the later interviews. Following the early interviews and feedback from my supervisors, I tweaked the approach to my questions and used guidance on how to probe for more information.

Focus Group

The use of a focus group was primarily to provide a culturally safe and appropriate meeting for Māori participants. Two participants who identified as Māori were given the option to meet in a focus group and/or have an individual interview. They selected to attend just the focus group for which they chose and arranged the venue. Two participants are a small number for a focus group as the literature indicates typically anything from 4-12 participants are needed to develop meaningful group interactions and discussions (DePoy & Gitlin, 2005; Nicholls, 2009). That said, the nature of the focus group in this research was that everyone was familiar with each other. Consequently, I observed there was a high level of trust, which quickly established frank open discussion with sharing and questioning between the participants that led, in many instances, to my being able to take an active listening role. Similar to the interviews, previously constructed open-ended questions had been developed with input from the Tikanga advisor and were designed to elicit experiences associated with Māori perspectives and worldviews (see Appendix M). For example:

- The PRPP-A was developed from a western worldview which is different from a Māori worldview. Given these differences, how does it fit for you? For your clients?

I found that as the focus group progressed and participants actively engaged with the topic, I had less of a questioning role and used the occasional probe for clarification or detail.

Phase Two

Data collection commenced in October 2020 and finished in January 2022. Two options were provided to volunteers for participating in the Phase Two study (Appendix E). Option one was to complete a written, typed, or digitally recorded reflective log and an interview with me. Option two was to video an assessment, complete a reflective log, and have an interview with me. Participants selected their preferred option and ticked appropriate sections of the participant consent form to indicate their preference

(Appendix N) and provided tangata whaiora/clients with an information sheet and consent form (Appendix O). For Option two, additional information and consent forms were available for clients, parents/guardians (Appendix P), and information and an assent form for children 4-10 years (Appendix Q) and young people 10-16 years old (Appendix R). A further option of either a face-to-face or virtual interview was provided to occupational therapist volunteers and discussed in a telephone conversation with them after they had received all the study information. Participants then chose how they would like to partake in the interview and considerations and arrangements for an interview were made as per Phase One.

Reflective Logs

Participants could choose to keep a reflective log as they progressed through a PRPP-A with a client. The reflective log was designed to assist participants to recall their thoughts, ideas, feelings, and decisions immediately after doing an assessment. Reflective logs alongside semi-structured interviews were used as methods to prompt awareness and recall of clinical reasoning, which is known to be tacit and can be hidden (Carrier et al., 2010), so that participants themselves may not be fully aware of their thinking and decision-making (Hooper, 2018). Written questions were provided to guide reflective log entries and help participants recall the details (see Appendix S). The questions related to the outset of the assessment process, when they considered using the PRPP-A with a client, through to stages of performing the assessment, scoring, interpreting, sharing results, and establishing an intervention plan and/or providing intervention based on the assessment results.

Six participants completed a written reflective log in relation to applying a PRPP-A with a specific client, one participant partially completed the reflective log, and one participant who alternatively watched a video of her assessment (see explanation of this method in the section below) did not use a reflective log. Reflective logs were emailed to me in advance of interviews and were read to gather information that then shaped open-ended follow-up questions to build on answers given in the log and extend insights during the interviews.

Video Recordings

The use of video was provided as a recognised method to investigate clinical reasoning (Pierce, 2005; Unsworth, 2011) and draw out thinking processes that are often implicit (Mattingly, 1991b; Unsworth & Baker, 2016). Watching a video recording of practice can assist a participant to recognise and recall ‘in the moment’ thoughts and decisions taken.

Two participants selected to video a PRPP-A session, and I discussed with them the need for consent from their workplaces to do this. One participant worked as an independent contractor and asked the manager of the service which she contracted to about participating in the research and videoing an assessment session. The participant subsequently confirmed consent by email from the service for both a video and for me to attend the assessment session provided the client was in full agreement and consented. I sent the parent/guardian information and consent form and young person assent form and study information to the participant to share with the client. The participant gained written consent from the parent/guardian and assent from the young person for the session to be videoed. I then attended the assessment session to film it and watched the video recording with the participant immediately following the assessment and just before the interview. I did not keep a copy of the video. The participant did not complete a reflective log as the interview was completed immediately after watching the video. The other participant was the owner and manager of a private practice and, as such, able to directly give workplace consent. I sent the parent/guardian information and consent forms to her. The participant gained the written consent from a parent/guardian (the child was under 4 years old and so the assent process was not appropriate) and arranged for the assessment session to be recorded on Zoom and for me to join virtually. I did not keep a copy of the Zoom recording and only observed the session virtually. The participant later watched the recording and was interviewed 3 days later. Both participants kept the recordings as part of their own assessment processes and offered copies of these recordings to the clients. For both participants, consent to keep the videos for educational purposes was not granted.

Semi-structured Interviews

The reasons for using semi-structured interviews in Phase Two were the same as for Phase One. The interviews included an interview guide developed for Phase Two (Appendix T). The focus of the questions varied from Phase One and related to practical aspects of clinical reasoning and decisions taken as a participant applied a PRPP-A with a specific client. Examples of questions and follow-up probes were:

- Tell me about choosing to do the PRPP-A with this client/tangata whaiora?
 - What did you consider?
 - What influenced your choice to use the PRPP-A with this person?
- What was going on in your mind when you set up the PRPP-A with this tangata whaiora/client?
 - Did you have any doubts or concerns?
 - How confident were you using the assessment for this person?

- Did anything hinder the assessment process with this tangata whaiora/client?
 - What happened?
 - What were the challenges?
- On completion of the PRPP-A, what were the next steps you took?

The interviews were conducted as per Phase One with a warmup conversation, reassurance during the introduction of there being no correct or incorrect experience, and probes used. Following the first few interviews, there were modifications to the interview guide to explore topics that had been identified as I familiarised myself with the initial data.

Of the eight semi-structured interviews, four participants elected to have face-to-face interviews, and the others chose virtual interviews using Zoom. Table 7 summarises how the data were collected and when the interviews occurred in relation to when the participants had applied a PRPP-A with a client. Due to a technical recording error with one interview, one participant repeated a Zoom interview.

Table 7.

Summary of Phase Two Data Collection

Number of participants	Method of data collection	Time between applying a PRPP-A and Interview
1	Observations on home visit and face-to-face interview	Same day
3	Reflective log and face-to-face interview	1 week after
1	Observed on Zoom on the day, partially completed reflective log and face-to-face interview	3 days after
1	Reflective log and virtual interview	2 weeks after
1	Reflective log and virtual interview	Same day
1	Reflective log and two virtual interviews (technical error with first)	Same day and 1 week later

In both Phases One and Two, after completing initial interviews I began familiarisation with the data and continued data collection (Terry, 2021). This process helped to shape the content of later interviews by enabling me to follow up on aspects that were surfacing in the familiarisation stage of the analysis. For example, an early interview in Phase One raised issues around the impact of isolation and challenges related to not having peer support. I was then able to enquire about this issue in later interviews.

Concluding Data Collection

Phase One data collection concluded when all 13 participants had either had an individual interview (n=11) or attended the focus group (n=2). Phase Two data collection concluded after the eight participants had been interviewed.

In Phases One and Two, the decision to finish data collection was made through a reflective questioning process and in consultation with both supervisors. It included, for both phases, evaluating the quality of the findings (Cleary et al., 2014) and whether there was sufficient data to meet the study intent (Thorne et al., 2016); that is, to generate pragmatic understandings of experiences from a diverse group of occupational therapists. Using this method to conclude data collection was in keeping with recommendations for interpretive description where it is more relevant to check that the data represent the study intent and provide practical understanding for the intended audience, rather than seek the traditional concept of data saturation (Thorne, 2016b). This method of data conclusion acknowledges that, realistically, saturation would never fully be possible, as in the messy area of health practice there will always be more unique individual experiences worthy of investigation that potentially hold further valuable insights.

Transcribing the Data

Phase One

I recorded the interviews and focus group using a digital recording app on a mobile phone, with the phone set to flight mode so that no interruptions occurred. I downloaded each recording to the computer as soon as practically possible after the interviews and deleted the phone recording. I protected access to the mobile phone and computer with passwords. I transcribed the first two interviews and then, for time efficiency, used a typist to transcribe the remaining interviews and focus group. The typist completed a confidentiality agreement (Appendix G). On receipt of the transcripts, I listened to each recording and checked the content against the transcript, making the occasional alteration as needed for accuracy. I then returned each transcript to the participant to check that their views were accurately captured and to allow them to withdraw any information that they wished. Most participants emailed to confirm they had read the transcripts, and no one requested any information to be changed or withdrawn. I gave each transcript a number without any names referenced. I kept printed copies of the transcripts secure in a cabinet in the office of my home. The digital recordings were deleted on completion of this thesis.

Phase Two

Face-to-face interviews were recorded as per Phase One methods above. The four virtual interviews were recorded through the recording function on Zoom and on a mobile phone app (as per Phase One). Only the audio phone recording was sent to the transcriber and the Zoom recordings subsequently deleted. All eight recordings were transcribed by the same typist and the same methods taken to protect the transcripts and digital recordings. The digital recordings were deleted on completion of this thesis.

Summary

The methods which guided the generation of research data have been outlined, including my actions and obligations under Te Tiriti o Waitangi as tangata tiriti (a Treaty partner) to work collaboratively with Māori to design and undertake culturally safe research. The ethical considerations within the study design to reduce potential harm and risks associated with the research, and to maintain confidentiality and anonymity for participants, have also been discussed.

In writing the chapter, I have aimed to clearly provide an audit trail of information about the decisions made in relation to participant recruitment, selection, and data collection. The inclusion of this information is to ensure my decisions and subsequent actions as a researcher remain open and transparent, methods deliberately employed for overall trustworthiness of the study to be independently considered (Curtin & Fossey, 2007). Chapter 6 builds on the audit trail begun in this chapter and addresses the data analysis stages.

CHAPTER 6: DATA ANALYSIS

Introduction

The research methods presented in this chapter are focused on the data analysis methods and overall rigour of the study. I begin by explaining why an inductive data analysis method was chosen for both Phases One and Two. That is followed by an explanation of how data analysis was conducted, including the generation of codes and themes for both phases. In writing the data analysis methods, I have striven to make transparent the decisions taken at each stage of the analysis. I have also drawn together an account of how I addressed rigour throughout the research process. The inclusion of my decision-making processes in both this chapter and Chapter 5, along with the rationale for actions I have taken, are provided to assist the reader's evaluation of trustworthiness of the whole study.

Data Analysis

Introduction to Data Analysis

In this introduction, I discuss the overall inductive data analysis methods which I ultimately selected for both Phases One and Two, and provide a justification for my choices. Ahead of this, however, I want to note that for Phase Two, before settling on only an inductive method, I first tried a deductive approach which I explain in the Phase Two generating initial codes section. I also offer rationale for why I did not continue with the deductive method and instead selected only inductive approaches for both phases of the data analysis.

The nature of the study for both phases was exploratory. As such, I decided a method of data analysis that involved an inductive process was best suited; that is, one that allowed for the development of themes direct from the data without predetermined codes or categories (Vaismoradi et al., 2013). Thematic analysis is recognised to be a flexible “data driven” (Braun & Clarke, 2006, p. 83) method. In selecting this method, I used a latent approach to the thematic analyses which goes beyond mere description and organisation of content (Braun & Clarke, 2006). Consistent with the aims of this study, latent thematic analysis involves interpretation and the development of meaning from the data which, in this research, was to create pragmatic, discipline-specific understanding of the phenomenon (Thorne, 2016b). Braun and Clark (2006) developed six stages of thematic analysis that I used to guide data analysis:

- Familiarising oneself with the data
- Generating initial codes
- Searching for themes

- Reviewing themes
- Defining and naming themes
- Producing a report.

While this account depicts a linear organisation of stages, in reality the process bore more resemblance to an interconnected web as I moved in different directions, forwards and backwards through the stages. Braun and Clark (2006) recognised this form of data analysis is a “more recursive process” (p. 86) rather than simply moving from one stage to the next. In the following paragraphs, I describe the process and provide explanations of key analytical decisions I made along the way to organise and interpret the data. In discussing the analytical decisions, I have endeavoured to clearly explain the process used and how the final themes and interpretations were formed, and, in doing so, add “analytic credibility” (Thorne et al., 2004, p. 7) where the data analysis process is visible for others to understand (Dickie, 2003).

In the next section, I first discuss Phase One data analysis through the six stages, then the Phase Two analysis. Only actions that differed from Phase One or that were specific to the Phase Two data are described in the second analysis. I provide justification for Phase Two decisions only where they vary from those presented in Phase One. Otherwise, I performed actions for the same reasons given in Phase One data analysis.

Phase One

Familiarisation with the Data

This first step began as I transcribed the first two interviews. The process of transcribing directly connected me with the content of the interviews and allowed me to note initial insights. I jotted points that the participants had emphasised, and emotions that arose as they discussed certain topics. Researchers doing their own transcribing is a recognised method for focusing attention on the data to a deep level (Thorne, 2016b). Although I found this process useful, my own transcribing proved too slow and for subsequent interviews I used a transcriber. So, rather than making notes when I transcribed, I wrote notes when I listened to the digital recordings to check the transcriptions. By writing these notes on the side of the transcription, I could consider them alongside the text later in the data analysis.

I then spent time reading and re-reading each transcript in order to become familiar with the content and to get a feel for the data as a whole. Allowing time to be immersed in the data helps a researcher gain a more accurate sense of the content and facilitates thinking beyond just initial thoughts, reactions, and expectations of the data (Thorne, 2016b). Using

this process gave me an overall feel for the information and ideas to begin the process of sorting and organising the data (Braun & Clarke, 2006).

Generating Initial Codes

From the initial ideas, I generated three, broad preliminary codes: adding value, challenges, and strategies participants used to aid the application of the assessment (i.e., KT strategies). I selected these as they frequently arose, described pragmatic aspects of the PRPP-A, and provided insights that were practical in nature, in keeping with the purpose of this study. These initial codes were developed as an early stage of data analysis, where generalised groupings are formed that are consistent with the aims of the evaluation (Thomas, 2006). Following the formation of these codes, I read the transcripts specifically for related text and highlighted text with a different colour allocated for each code. Multiple copies of the transcripts were made to allow for overlapping coding (Thomas, 2006) wherein the same text sections could be highlighted in different colours and linked with two or more codes. Along with highlighting the text, I made notes in the margin to indicate the type and nature of the idea or action, with initial insights related to the text. For example, text discussing a challenge was highlighted green and a note was made in the margin about the type of challenge such as time; the nature of this being insufficient time for looking up information in the manual when also managing a busy caseload.

I cut and pasted sections of highlighted text onto either a fresh page for a new grouping within the code (e.g., a page for “time related challenges”) or, when the text represented an idea that had already been identified, I pasted it onto an existing page. I labelled each highlighted section with a participant number and page number, thereby creating a system where text could easily be located within a transcript when required during the later stages of analysis. The highlighted paper groupings were a clear visual reference for further analysis and later development of themes. In addition to the paper version of codes, three excel spreadsheets were set up and the highlighted data from each transcript organised onto each. I developed one spreadsheet for each of the codes, with columns for the groupings within each code. I allocated each participant a row with information related to years of occupational therapy experience, the year they completed their PRPP training, nature of their work, type of assessments that they were typically required to perform, and the support systems they had in place at work. The spreadsheets provided a method to organise the data within each code and grouping, which allowed for cross-referencing text to each of the participants’ context. Table 8 outlines three of the preliminary codes and initial groupings.

Table 8.*Initial Codes and Groupings*

Broad codes	Groupings
Challenges associated with:	PRPP descriptors PRPP language Time Documentation Amount of information Need for support and keeping current Fitting PRPP-A to work context Scoring Cultural awareness Power dynamics
Adding value	Attending the PRPP course Having the PRPP manual Using the PRPP as a clinical reasoning framework Using PRPP system to guide clinical observations As an occupational therapist From the PRPP system to guide intervention/planning Working ecologically Using the PRPP as an outcome measure Assessing with Stage 1 PRPP Assessing with Stage 2 PRPP Using the whole PRPP system Client-centred practice Using the PRPP to evaluate the client's safety With clients of different cultures Using culturally specific tasks Communicating the PRPP-A findings Sharing PRPP-A findings with PRPP colleagues
Strategies used	Liaising and working together with other PRPP-trained occupational therapists For starting to use PRPP system Support group Setting goals Using templates and developing systems For documenting PRPP-A findings For managing the time and demands of caseload Practical tips for translation

Searching for Themes

To begin forming themes and interpretations, the interactions between groupings, within and across each of the codes, were then considered in relation to participants' contexts to look for "meaningful connections for practice" (Thorne, 2016b, p. 156). I used a process of re-reading and constant questioning of the connections to organise them in a way that would make practical sense of them. Throughout this process of forming connections and questioning, I jotted ongoing notes of my questions, brainstormed ideas, and drew diagrams to link ideas as a way to "capture analytic insights" (Thorne, 2016b, p. 170). As these ideas grew, I created mind maps (see Appendix U for examples) on the computer, a type of "thematic map" (Braun & Clarke, 2006, p. 89), to visually represent the emerging themes with associated quotes and notes that helped me to view the relationships between different themes. Five early themes were developed with associated descriptions, with meanings and practical implications (see Table 9). Consistent with using inductive coding, the naming of two themes, 'resonating' and 'validating,' came from words participants had used in their descriptions (Thomas, 2006).

Table 9.*Summary of Early Themes, Meanings, and Practical Implications*

Early themes	Descriptions	Meanings/Practical implications
Resonating with positive accord	Confirmed the course Feeling positive about the assessment Clarified occupational therapy identity Fitted perception of how they wanted to assess clients Assessment provided viable options for practice Complemented existing practice Felt good to practice in this way	Excited, good, enjoyed Enthusiastic about possibilities Positive, clearer vision/purpose Congruent direction, aligning theory and practice Created relevant opportunities, exciting, satisfying practice Complemented existing practice Confirming the assessment
Validating occupation-centred practice	Assessment was natural way to practice Less intrusive Confirmed the use of assessment with everyday occupations Ecologically valid could be used across institutional and community settings Provided evidence for teams Useful scoring system and valid measure Results based on occupations in real world settings Team members understood results Therapists appreciated different ways it fitted client needs Assessment was worthwhile for clients of different cultures Hones occupational observational skills	Less set up/things that clients already were doing Less disruptive process than previous assessments Fitted with the occupations clients were doing Fitted across contexts Relevant valid results Practical clear application Self-evident results Flexible nature of the assessment valued Culturally appropriate Develops core occupational therapy skills
Continued over...		

Early themes	Descriptions	Meanings/Practical implications
Embedding to practice	Challenge of all the new information Difficulty keeping up within the course Different approaches first taken to help fit to practice Application in different settings acute, rehab, community, private practice Time to do the assessment Matching with organisational requirements Documentation systems Finding ways to present a different assessment to team members Strategies for KT	Overwhelmed, cognitive overload and uncertainty Challenge processing the volume of information and manual layout added to difficulty Different approaches resulted in differing outcomes Challenges and benefits in different settings impact use of assessment Need to make time, practice needed to increase speed Process to the fit with existing organisation requirements Multiple challenges/benefits - need to develop systems Need to educate others - manage team expectations Multiple strategies used: supervision, support groups, peer support, peer review, goal setting – challenges and benefits of these strategies existed
Cultural fit	Diverse applications Practical challenges assessing some culturally specific occupations Challenges of clients choosing assessment tasks Organisational constraints Clarifying cultural expectations Cultural awareness	Use with people of different ethnicity - culturally specific Adds complexity and resources required Therapists needed to actively listen and respond to client's choices Need to advocate for resources Challenges therapists to examine their underlying assumptions
Continued over...		

Early themes	Descriptions	Meanings/Practical implications
Communicating	Using new PRPP descriptors Writing reports centred on occupation Time to document Explaining new assessment to teams Sharing power with clients Actively engaging clients Cultural competency of therapist to develop relationship	Influenced by prior knowledge of cognitive terms Shift from communicating directly on cognition required Confident occupation-focus and practice needed Occupation-focus to documenting - challenges/benefits to this process Need to understand power dynamics - adapt approach and communication with clients Clients need active input in the process Influenced by the therapist's cultural competence

Reviewing, Defining, and Naming Themes

At this stage, I decided to begin a written draft of early themes and used the writing and re-writing process to review the themes. I continually reflected, critically questioned themes and interpretations, and constantly evaluated the practical meanings of these. Throughout this process, I returned to adding to and altering the mind maps, re-reading both text excerpts and, at times, whole transcripts. In writing draft themes, I realised there were places some of the data were not fitting and other areas where the data did not completely support the direction I had taken. This point of the analysis bore similarities to what has been described as having “pet ideas that have seemed so ‘perfect’ and discover they don’t work” (Dickie, 2003, p. 54). Some aspects needed to be completely discounted, others analysed further. The decision process for each theme and the final naming of each theme is outlined next.

When writing the early theme of ‘validating occupation-centred practice’, it quickly became evident more scrutiny was needed. Further exploration and analysis revealed that the participants were indeed confirming aspects of the PRPP-A, but this was not only about occupation-centred practice. I realised through discussions in supervision that this theme had subconsciously been affected by my own experiences and that the participants were validating more aspects of practice than I had been seeing. I revised this theme to include other parts of the data which I had previously categorised in other groupings. This gradually established a final theme of ‘*validating the practice fit of the PRPP-A*’.

Likewise, the theme ‘resonating’ was more extensive than I first perceived; it was not just the general sense of ‘positive accord’ or feeling good as I had originally considered. When I reflected on what these positive feelings meant and particularly why they were important to practice, it was more specific and had deeper meaning than had first appeared. It was more about the direction in which therapists wanted to take their practice and so the theme gradually evolved to ‘*resonating with practice as it should be*’.

The theme ‘embedding to practice’ was where I first placed data related to experiences that had been either positive or challenging when learning and implementing the PRPP-A in practice. The KT strategies that therapists had used were also captured in this theme. During the writing phase, it became evident that I was trying to cover too much in one theme, and I had created a dichotomy between beneficial and challenging experiences. Not all the data fitted into the polarising view I had formed. Furthermore, considering the meaning of these experiences from this dichotomy was limiting me from seeing other meanings of the experiences. On re-reading and re-thinking this theme, I realised I had represented it as a

series of disconnected snippets of practice and strategies rather than patterns and unique descriptions. Consequently, I returned to the whole data set, my notes, the mind maps, and spreadsheets to re-question the practice implications and consider other ways to connect the data. Subsequently, when the ideas from this further analysis were discussed with my supervisors, a different way of grouping the information began to emerge, one that tracked the natural progression of what the therapists had experienced. That experience started from when they had learnt the new assessment, then applied it in practice, and received feedback from others. Considering the data from this different angle further allowed the supports and strategies that therapists had used to be linked to the progression of their experiences of translating the assessment. Grouping the information in this manner shed different light on the meaning of some of the data and two themes started to emerge which ultimately were named '*translating to practice*' and '*reporting using an occupational performance focus on cognition*'.

In the process of reorganising the latter themes, I realised that much of the data within the tentative theme of 'communicating' was also better placed within the two new themes. Some of what had first been seen as communicating included descriptions that formed part of the therapists' processes of developing communication skills in order to translate the PRPP-A to practice. Other data were concerned with communicating from an occupational performance perspective and this eventually became a theme in its own right. On further review, the final grouping in the original theme 'communicating' aligned better with the theme 'cultural fit' since this data encompassed meanings associated with power dynamics and the formation of relationships that shared power to develop partnerships.

The early theme of 'cultural fit' had originally portrayed the use of the PRPP-A with clients of varied cultures, the diversity of occupations assessed, the avoidance of cultural assumptions, and giving clients a voice in this process. Through further analysis of data related to power dynamics, and from discussions in supervision, it became apparent that the previous meaning of giving clients a voice was in itself not representing power sharing. Within the idea of giving a voice was the perspective that one party held power to give to the other rather than meaning a partnership was formed with clients having equal power. From this new insight, the data were again reviewed and it became apparent a more useful interpretation was that therapists were emphasising clients' active involvement and the need to change power dynamics. To reflect the changes and additions to this theme, and more aptly describe its content, the theme was renamed '*cultural application*', to represent both

how therapists had used the assessment and the practical considerations for others using it in the future.

In the review of the names for themes and subthemes, I checked that the titles were both clear and practical, so that the intended future audience (i.e., occupational therapists) would readily understand what the themes addressed and easily recognise the practical relevance. The final step in this stage was to review all the themes, re-read the transcripts and notes, and compare and consider the fit of the raw data to the final themes. This step ensured no significant data had been missed in the data analysis process.

Producing the Report

Since, I had simultaneously used a writing process of developing multiple drafts of themes in the stages of searching and reviewing of themes, the last stage was to review the overall written account of the analysis. I questioned and reflected on the content to challenge whether I had written a coherent narrative (Hunt, 2009) with rich descriptions (Sandelowski, 2000). I checked if interpretations were clearly explained and if they would hold likely meaning for the intended audience (Thorne et al., 2004).

Phase Two

Familiarisation with the Data

I began to first familiarise myself with the data as I checked the accuracy of the transcripts from the typist by simultaneously reading the transcripts and listening to each digital recording. I then re-read transcripts, highlighted text, and wrote initial thoughts in the margins. As the data were collected over a 16 month period, when I finished a new interview, I read the new transcript and re-read previous transcripts and reflective logs to re-familiarise myself with all the data gathered at the time. Together with continuing to write in margins, I also kept notes of my thoughts on the data in a reflective journal. When data collection was complete, I re-listened to the digital recordings and re-read all the transcripts to gain a sense of the whole before I commenced initial coding.

Generating Initial Codes

Varying from Phase One, where I selected an inductive analysis from the outset, for Phase Two I initially considered the data using a deductive approach (Terry, 2021). I took a top-down perspective and viewed the data in relation to theories of established modes of clinical reasoning; specifically, procedural, interactive, pragmatic, and conditional. These reasoning modes have been described in Chapter 3. I was interested in seeing if organising the data from this viewpoint would be useful. I read transcripts to identify and group text

that fitted with the different reasoning modes and stages of the assessment process. Table 10 shows a sample of these first groupings associated with participants' thinking related to each mode of reasoning as they considered choosing an assessment.

Table 10.

Initial Codes Based on Modes of Clinical Reasoning Related to Choosing an Assessment

Initial codes using established reasoning modes	Initial groupings of participant thinking related to each mode of reasoning
Procedural reasoning	Client's diagnosis Knowledge of frontal lobe dysfunction and lack of insight Types of previous rehabilitation received Knowledge of different assessments Implications of conditions for assessment options Knowledge of conditions informing therapists' assessment actions
Interactive reasoning	Client's past medical and health experiences Clients' skill levels; low literacy, non-verbal Client's emotional well-being Client's goals and desires Need to build rapport, trust Assessments for client to be comfortable, safe Not wanting the client to fail No detrimental effects from an assessment Right time for an assessment for a client
Pragmatic reasoning	Restraints of where the assessment took place (e.g., in a clinic, acute hospital kitchen) Safety procedures needed for an assessment Not practically feasible to do an assessment (e.g., pig hunting) Organisational time constraints Assessments available within service
Conditional reasoning	Assessment results wanted by teams Future needs of client Future social situations Identifying possible intervention

On reflection, and following discussions with my supervisors, I decided not to pursue this deductive line of coding, although finding some fit between the data and established reasoning modes was reassuring as it confirmed the data could be viewed from well-recognised approaches to clinical reasoning. Presenting findings from these established modes of reasoning narrowed the information to matches with known ways of thinking,

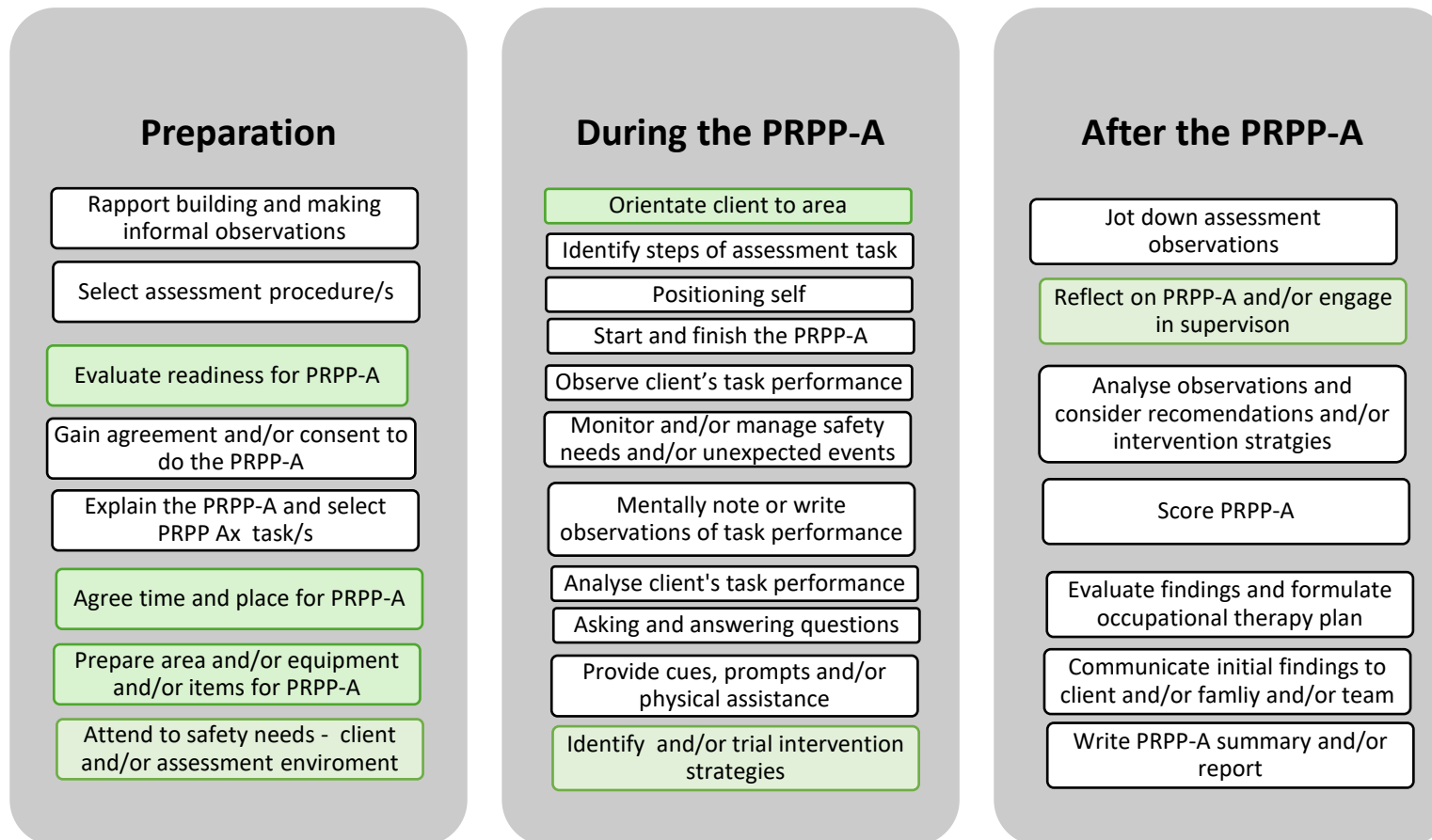
which I considered was unlikely to provide new insights. In addition, it was not a perspective that would enable me to explore and be open to different ways of looking at therapists' reasoning. I considered that developing these codes further from a practical perspective would not necessarily guide different understandings of specific thinking and decisions made by occupational therapists as they used the PRPP-A.

At this point, I made the decision to abandon a deductive method and opted, as with Phase One, to only be "data driven" (Braun & Clarke, 2006, p. 83), and took an inductive approach as described above. I chose to adopt a 'clean slate' and re-read the transcripts for a fresh look at the data. The data content was diverse and contextualised to participants' unique assessment situations, with many individual viewpoints expressed. It was challenging to know which direction to take to start grouping text. I was also aware my experiences were common when trying to group data from semi-structured interviews which "tend to follow in different directions, orientations and flow" (Terry, 2021, p. 13). I knew not to rush this stage and continued to reflect on the data and discussed multiple ideas with my supervisors. Through these conversations, it became clear that trying to organise data about thinking and decision making (clinical reasoning) without understanding what the participants were relating these reasoning processes to was making little sense. I decided that before a deeper analysis of clinical reasoning, an overview of what participants were doing as they reasoned the implementation of the PRPP assessment was needed. Consequently, I identified and grouped actions participants performed for the implementation of the PRPP assessment. Arranging the data in this way was in keeping with undertaking an analysis congruent with study aims (Thomas, 2006), which for this study was forming practical understandings of clinical reasoning.

From the early readings of the data, it seemed participants were describing steps they did for three stages of the PRPP assessment: 1) Preparation, 2) During the PRPP assessment, and 3) After the PRPP assessment (see Fig. 5). Transcripts were re-read and text highlighted in different colours to identify steps associated with these three stages. As described for the Phase One data analysis, multiple copies of transcripts were used for overlapping coding to be developed. An Excel spreadsheet was used to record the steps. Most steps were performed by all participations, except for a few that only some participants completed.

Figure 5.

Initial Coding: Main Actions Grouped Under Codes of Preparation, During the PRPP-A, and After the PRPP-A



Key: = All participants performed this step

= Some participants performed this step

Having grouped broad codes of actions I continued with a questioning process asking: What were the different ways participants did these actions? Why and how did they differ? What decisions did participants take in choosing these actions? What influenced these decisions? In answering these questions, I re-visited the transcripts and reflective logs, highlighted text, and started to group text onto spreadsheets. Broad codes (Table 11) began to form with text concerning decisions related to selecting the PRPP-A and the task, using theory, therapists' expectations, anticipating outcomes, natural assessment process, managing safety, reflecting and organising thinking, gauging feedback, challenges with competency, and strategies to use.

Table 11.

Summary of Phase Two Broad Codes and Groupings

Broad initial codes	Groupings
Selecting PRPP-A and task	Referral Diagnosis/health condition Client needs/outcome Team needs/outcome Therapist needs/outcome Risks Task options Suitability of tasks Cultural aspects of tasks
Using theory	OPM(A) Applying a PRPP framework Compatibility of PRPP-A and recovery approach Combining PRPP-A and COPM Combining PRPP-A and Favourite Words goal setting tool Knowledge of assessment tools available
Therapist expectations	Good assessment Fair assessment Pure assessment Best assessment Dynamic assessment
Anticipating assessment outcomes	Identifying goals Using goal tools Having a baseline Having a snapshot Identifying supports needed Finding main issues Identifying skills clients have, e.g., social skills, budgeting abilities
Managing safety	Managing risk – sexual disinhibition, flight risk, knives Managing emotional safety, levels of stress

Broad initial codes	Groupings
Reflecting, organising, questioning	Managing the unexpected Readiness of client to be assessed Choosing tasks
Gauging feedback	Timing of the task Cultural considerations Environmental considerations Positioning self
Challenges with competency	Cues and prompts Questioning observations
Strategies to use	Questioning analysis Time to organise thoughts Time to reflect Reflecting with peers Stage Two descriptors When to give feedback Provide score or not? Verbal/written To be understood Linked to recommendations/intervention Knowing/understanding Stage Two descriptors Fitting Stage Two descriptors to observations Percentage scores Spider graphs Ways to identify task steps Ways to recall observations Ways to analyse and score

Searching for Themes

I used the same process for searching for themes and interpretations as described in Phase One. Having established broad codes, I began questioning the connections between the codes and considered them in relation to the actions (see Fig. 5) that I had identified participants took to do a PRPP-A. I questioned why and how participants had taken certain actions, what they thought about or weighed up before deciding to do an action, and what influenced their decisions. These questions, when associated with the broad codes, aimed to deepen analysis and gain insights of participants' clinical reasoning and decision-making which lay behind their actions. Like Phase One, I drew mind maps with early theme ideas, transcript quotes, and notes to visualise the relationships between ideas (see Appendix U). I developed four early themes with descriptions and interpretations centred on practical understandings of the themes (see Table 12).

Table 12.*Summary of Phase Two Early Themes, Description, and Practical Interpretation*

Early themes	Description	Meanings/Practical implications
Shaping an assessment process	Selecting assessment/s to use for a specific client Wide range of information considered to inform selection including: Diagnosis, implications of health condition, referral information Client's readiness and skills for doing assessment Client's goals - links to goal setting tools Assessment purpose Team expectations Assessment outcomes for therapist and others Types of assessments available Reasons for selecting PRPP-A and other assessments Real-world, valid, standardised Compatible with recovery process Selecting PRPP-A task/s – different ways: Explaining process to clients Questioning options Gaining buy in Using set tasks Using tasks available Grading tasks Thinking about risks Thinking about task suitability Thinking about cultural aspects of tasks	Back and forth thinking using a range of information to shape assessment choices Questioning and matching process between information considered, assessment options, and features Rationale for decisions to choose PRPP-A similar to Phase One findings with addition of recovery process Selecting task – complex process Thinking about how to explain the need for a task Range of reasons for different methods of task selection Thinking and reasoning process between task options, suitability, risks, cultural aspects and finding the 'right' task Continued over...

Early themes	Description	Meanings/Practical implications
Choosing a kind of PRPP-A to do	A pure assessment - Natural process, minimal to no cues and prompts, positioning out of the way or hidden. An assessment to inform intervention strategies	Therapists made decisions on the type of assessment they want to do in certain ways. Therapist needed to adapt their actions to the context No environmental set up was required
	A fair assessment - A process that benefits client and assessor, meaningful for the client, avoids bias, lessens impact of mental health contexts by setting up environment like 'home', managing risks, orientating to environment and removing distractions, positioning, and prompts to support client performance, done a time right for client	Therapists chose when to start and finish assessment Needed quick flexible thinking – openness to change Careful considered decisions for positioning to minimise input, and use of cues and prompts Linking assessment process to identifying intervention strategies Actions taken to prepare environment so as not to disadvantage client, ensure they are familiar and not triggered by the environment Safety foremost in mind attended to before and during PRPP-A Actions to lessen stress and support emotional safety Time of PRPP-A and prompts to support 'best' performance
	A 'go with the flow' assessment - A fluid assessment process, strengths-based, assessing and intervention is intertwined. Varied positioning and prompts for intervention	Complex reasoning to switch between assessing and intervention and back. Dynamic reasoning process. Prompts as part of intervention
Continued over...		

Early themes	Description	Meanings/Practical implications
Theory informing assessment thinking	OPM(A) mixed and matched with existing familiar models of occupational performance Only previous existing models informing thinking Theories of task analysis, information processing used to inform assessment actions and give feedback PRPP-Stage Two wheel and spider graph used Have own 'PRPP framework' of reasoning	Develop own perspective of occupational performance and use models including OPM(A) to different degrees Direct application of PRPP underlying theory to explanations of PRPP-A and feedback Form own view of PRPP-A use like a 'lens' to think through informal and formal assessing
Degrees of competency and strategy use	Confident application of PRPP-A Stage One Varied competency with PRPP-A Stage Two Challenges with knowing descriptors, analysing descriptors, scoring Plan time to analyse, tease out observations, and match descriptors Strategies for: Avoiding cultural assumptions Observing - intently Identifying steps - ahead of PRPP-A, during PRPP-A Recalling steps - writing, mental rehearsal, categorising Simultaneous step identification and analysis Analysing - reflecting, questioning, manual, peers Giving feedback - when, how, scores or not, weaving recommendations/interventions	Automatic reasoning of PRPP-A Stage One using strategies to support skilled performance PRPP-A Stage Two varying degrees of competency Some automatic application of familiar descriptors Complex reasoning to fit descriptors to observations Sharpened observation skills Skills for cultural safety Strategies used for different purposes to support efficient performance Advanced level of competency, simultaneously observing and analysing Feedback sensitive to individualised process

Reviewing, Defining, and Naming Themes

I used the writing and rewriting of draft themes as a process to review, reflect, question, and refine my ideas. I regularly sought feedback from my supervisors, and we engaged in critical reflexive discussions checking out the early themes. I frequently returned to transcripts, reflective logs, and mind maps to review the data, and scrutinise and adjust the content of developing themes. I discounted and added data to themes in a checking process to ensure the data supported each theme. I questioned where the boundaries of each theme lay and looked for any overlaps to make sure themes contained “a strong central organising concept” (Terry, 2021, p. 57).

On reviewing the early theme ‘*Shaping an assessment process*’ and considering more deeply what participants were describing, it became clearer they were doing complex thinking and reasoning beyond what the term ‘shaping’ implied, which suggested merely adapting and modifying. Participants seemed to be putting together multiple sources of information using recursive non-linear thinking. The process was also more involved than simply selecting assessment/s and task/s. They needed to reason about the suitability and assessment/ task fit. On further reflection, I decided the term ‘configuring’ better conveyed the specific organising and unique building process described to formulate an assessment plan and task/s. I settled on naming the final theme ‘*Configuring a PRPP-A process*’ with sub-themes *forming an assessment plan* and *configuring assessment task/s*.

Likewise, the theme ‘*Choosing a kind of PRPP-A to do*’ was further refined as I realised what participants were portraying was less about choosing and more related to the therapists themselves and their own views, expectations, and intentions for the assessment. In thinking about the data from this perspective, and from conversations with my supervisors, the decision was made to create a clearer distinction between the first theme ‘*Configuring a PRPP-A process*’ being about thinking centred on a specific client and the subsequent themes which focused on the therapists’ views, knowledge, and skills. I then revisited the first theme to ensure the data all related to decisions concerning thinking about an assessment for the client and moved data about therapists’ beliefs, attitudes, and values to the theme which was renamed ‘*having an assessment intention*’. This title better captured the notion that therapists’ perspectives influenced their thinking and subsequent actions.

When reflecting on the third early theme of ‘*Theory informing assessment thinking*’, I felt a stronger link was needed to therapists’ use of their knowledge of theory in practice. I

first refined this theme to '*known theory*' before settling on '*drawing on theory*' to indicate how theory was applied.

The final early theme, '*Degrees of competency and strategy use*' had not sat well for me when I first formed it, as I thought some of the data suggested several participants' assessment applications went beyond just performing competently. However, others had expressed gaps or challenges with aspects of their practice; hence, why I originally considered '*degrees of competency*'. With deeper reflection, it occurred to me that the participants who were performing beyond competently had developed specific skills which supported their advanced practice. Using this new idea of skills, I returned to the data to see if 'developing skills' conveyed what participants had discussed. I also looked for data that indicated the nature of the skills they developed and strategies that supported their performance. In doing this, it was evident some of the data I had previously coded as actions were strategies and these were reworked into the theme '*Developing skills and strategies*'.

Producing the Report

The same methods were used for producing the report as I described in Phase One analysis above. That is, I concurrently wrote the report, reviewed themes and meanings, and evaluated the overall coherence of the findings.

Addressing Rigour

It is well recognised that the issue of rigour can be challenging in qualitative studies (Carpenter & Suto, 2008; Giddings & Grant, 2009). It is a notion that originates from a positivist worldview and can have an ill fit with subjective, socially constructed methodologies used in qualitative research (Ryan-Nicholls & Will, 2009; Sandelowski, 1993). Yet, it is equally important that qualitative research is of a high quality, valid, legitimate (Giddings & Grant, 2009), and "analytically rigorous and explicit" (McBrien, 2008, p. 1287) so that it can be considered credible by its audience (Lincoln & Guba, 1986). For "how can a practitioner be sure their practice is sound when it is based on research that has not been rigorously conducted?" (Stanley & Nayar, 2014, p. 10). Thus, good quality research forms an essential component of evidence-based practice and the importance of rigour, therefore, cannot be overstated. Nonetheless, determining how to ensure rigour in qualitative studies remains contentious, with no consensus as to how it is best achieved (Ryan-Nicholls & Will, 2009).

It has been argued that how rigour is demonstrated needs to align with the theoretical underpinnings of the research, methodology, and methods (Giddings & Grant, 2009).

Consequently, I have taken the well-established naturalistic approach to rigour proposed by Lincoln and Guba (1982, 1986) in which the concept of trustworthiness is used to demonstrate rigour with criteria of credibility, transferability, dependability, and confirmability. I have woven aspects of these criteria throughout the descriptions of the research design and study methods and in the next section explain these in more detail.

Credibility addresses the “truth value” (Lincoln & Guba, 1986, p. 246) of the research; that is, how much confidence or “believability” (Polit & Beck, 2006, p. 332) can be placed in the findings and the steps taken to show the credibility. Building such credibility into the research began at the study design stage with the selection of data collection methods. It was important that the data were collected in a way that would best elicit thick descriptions necessary for the type of research findings I sought (Curtin & Fossey, 2007). Open-ended questions were used as this type of questioning is associated with fuller and richer answers given in participants’ own words (Polit & Beck, 2006). I included the triangulation strategy of having several sources of data through using multiple individual interviews, which aimed to gain different perspectives, together with the addition of the focus group as a second source of data for Phase One and reflective logs for Phase Two. A focus group is a culturally appropriate method for partnering with Māori participants and can potentially foster creativity through the participant interactions which, in turn, may enrich the data (Thorne, 2016b). Reflective logs provided a way for participants to capture their thoughts and decisions as soon as possible after doing the assessment, while it was fresh in their minds. A recognised method to increase triangulation is to add breadth and depth to the data collection process in qualitative research (Giddings & Grant, 2009) and this was used for the purpose of “completeness... to capture a holistic view of the phenomenon” (Curtin & Fossey, 2007, p. 90).

When arranging the Phase One interviews and focus group, I carefully planned the time that would be needed so participants would feel connected and comfortable, allowing for trust to develop so stories could be shared without any sense of rushing. This process included deciding with the focus group participants to postpone an initial meeting and arrange a new date rather than risk hurrying when their preceding meeting over ran. Taking time for the interviews and focus group and collecting data over a 5 month period allowed for “prolonged engagement” (Guba & Lincoln, 1982, p. 247), a process which helped to develop deeper understandings of the information I was gathering. The setting up of Stage Two interviews was more complex due to repeated COVID-19 restrictions in place at different times during the 16 month data collection. However, the longer data collection

period allowed for further review of the data over time, with greater familiarisation and more involved questioning of the data from multiple angles.

To ensure that the information was accurately captured, the interviews and focus group were digitally recorded and transcribed, with scripts returned to each participant to check and make changes. In Phase One, five participants confirmed they had read the transcripts, and one made a small addition to the content. Four participants confirmed they read the transcripts in Phase Two, with no changes requested. Following both data analysis stages, all participants received a summary of the findings and an opportunity to give feedback. In Phase One, three participants acknowledged receipt of the summary, confirming the findings were interesting for them but gave no additional feedback. One participant confirmed receipt of the Phase Two summary, and two emails were returned with incorrect email addresses. In addition, the draft findings and discussion chapters were sent to the Māori participants as a form of member checking and a way to gain feedback. This was part of the ongoing partnership to afford protection by ensuring that their cultural perspectives had been accurately represented. Minor changes were made as a result of their feedback.

Throughout the data collection stage, I met frequently with my supervisors to debrief, check the process, share thoughts and ideas, and manage the influence of assumptions that I brought from my own experiences. Supervision assisted me to separate my own experiences from the data analysis and to be driven by the data rather than my own preconceptions. Additionally, it allowed for a review and cross-examination of the emerging findings, a process used to contribute to the rigour of the analysis.

Transferability acknowledges that while the findings of a qualitative study cannot be generalised, if thick descriptions and contextual information are provided, others can judge the level to which the findings may be applicable to their own circumstances (Lincoln & Guba, 1986). To assist with transferability, descriptions of the participants' practice settings, years they trained in PRPP-A, and cultural affiliations have been presented for both phases of the study.

Dependability in a qualitative study refers to how the findings "fit from the data from which they have been derived" so that the "plausibility" (Carpenter & Suto, 2008, p. 150) of the findings representing the data can be reviewed by others. In this study, I have endeavoured to be open and transparent in the choices and decisions taken throughout the research. I kept regular notes of decisions, and in this chapter provided an audit trail that has traced key

choices and actions (Carpenter & Suto, 2008) from the outset of the study through to the methods that were employed. This included tables and mind maps (Appendix U) of the emerging data analysis to show how the development of interpretations occurred. When writing the findings chapters, I also chose to insert direct quotations so that readers could consider the links between the participants' actual words and interpretations that I had formed (Thomas, 2006).

Confirmability addresses the neutrality of the findings and the extent to which researcher bias has been minimised. It is the notion that there would be agreement on the outcome of a study when it is viewed by another person (Polit & Beck, 2006); that is, that the data and findings can be confirmed (Guba & Lincoln, 1982). All the steps that I have described so far to address rigour, when collectively viewed, aim to establish the confirmability of the research, especially positioning myself as a researcher, the audit trail, and descriptions of the data analysis. In addition, ongoing supervision was a pivotal process for questioning my assumptions and biases with the use of reflexivity (Ballinger, 2004) to critically review the reasons for the directions I proposed to take.

Summary

In this chapter, I have addressed the methods which led to the research findings. In writing the chapter I have aimed to clearly provide information about the decision processes that I used with an audit trail of my actions and the guidance of supervision. The intent of these actions was that the overall trustworthiness of the study could be independently considered. The subsequent four chapters cover Phases One and Two research findings.

CHAPTER 7: PHASE ONE FINDINGS – PART 1

Training to Practice

Following analysis of the raw data from the participant interviews, described in Chapter 6, the findings from Phases One and Two are now presented in four chapters of themes and subthemes. The themes in this current chapter cover the participants' experiences from the outset of the PRPP-A training, through learning the assessment procedures to the translation of the PRPP-A and reporting of the assessment results in practice. Chapter 8 continues with the findings related to participants' actual use of the PRPP-A in practice, including the cultural application of the PRPP-A.

Chapters 7 and 8 cover five main themes, many of which have subthemes (see Table 13). The themes in Chapter 7 are resonating with practice as it should be, translating to practice, and reporting using an occupational performance focus on cognition. Resonating with practice, the first theme, it captures experiences from the beginning of the training when participants started learning through to their application of the assessment in practice. The second theme, translating to practice, has several subthemes and tracks the journey from participants' understanding the new assessment information, through the initial approaches used to translate the assessment, to the shared learning strategies that assisted the translation process. Within this theme, attention is given to both participants' experiences of challenges and successes translating the PRPP-A to their practice. The final theme, reporting using an occupational performance focus on cognition, addresses the learning and skills participants developed for reporting the PRPP-A. Each theme has an introductory overview with definitions of relevant terms.

Table 13.*Overview of Themes*

Theme	Subthemes
Resonating with practice as it should be	
Translating to practice	Assimilating information from the training Initial approaches to translating the PRPP-A to practice - <i>Preparing and Learning through doing</i> Learning together - <i>Learning with peers, Support groups, Supervision and Support from others</i>
Reporting using an occupational performance focus on cognition	Shifting from reporting on cognitive skills Utilising the PRPP descriptors Documenting the PRPP-A results
Validating the practice fit of the PRPP-A	Real-world application Client-centred approach Flexible assessment system Pertinent assessment results
Cultural application	Diverse application Actively involving clients Changing the power dynamics Cultural competence

Resonating with Practice as it Should Be

The term resonating is defined by the online Cambridge dictionary (2018) as an idea or action which meets with agreement, has a positive emotional impact, produces a quality or powerful effect, or evokes memories of something similar. Reflecting on what happens when things resonate with people, I consider it to occur when things come together which, once combined, are amplified, enhanced, clearer, or ‘in tune’ with one another. The resonating experiences described by participants were in relation to learning the PRPP-A and the use of the assessment in practice. These experiences evoked strong positive feelings, strengthened identity as occupational therapists, enhanced existing practice, and conveyed a sense that the PRPP-A was ‘in tune’ with participants’ views of how occupational therapy practice should be.

Positive emotions associated with completing the PRPP-A training were expressed as ‘feel good factors’ about their practice as occupational therapists. Participants portrayed these positive emotions as feeling “*inspired*” (Tracey), “*great*” (Irene), “*proud*” (Meiliani), being “*pumped*” (Tracey) and “*bouncing off... this is really cool*” (Sara). Rosie felt “*joy... of the possibilities of this assessment and intervention process*” for practice. There was immediacy to these positive emotions, which stemmed from when participants first attended the PRPP-A course. They emphasised the quality of the course and that the assessment resonated with their vision of how occupational therapy practice was supposed to be:

I think it's really positive that we have an assessment for us, that's very OTish. I am a passionate OT, so, I thought it was really nice that there's actually an assessment that we can do on activities rather than just looking at components but looking at a whole activity and coming away with a solid conclusion and being able to work on it. So as an OT it's a good feeling. (Jenny)

Many participants found that the PRPP-A training strengthened their identity as occupational therapists. Tracey explained how she felt better about being an occupational therapist and Meiliani realised what a “*cool career*” she had. Several others talked about how they had greater “*confidence*” (Ruth) as occupational therapists, that it “*helped explain more about OT*” (Kate). Aroha stated that “*it [PRPP-A] unravels things [issues], so I find it clarifies*”.

For some participants, clarity was in the form of the PRPP-A complementing and enhancing what they had already been doing. It helped them develop greater understanding of occupational performance issues which had previously only been more generally apparent. Tracey described:

You're still seeing the same thing as you were before, when you were just writing a kitchen assessment... you're still looking at exactly the same task, but PRPP allows you to break that task down so that it's [my assessment] more specific... PRPP hones the observation so that they're more specific.

Being ‘more specific’ involved noticing “*exactly what you saw and every part of the task*” as well as making “*you think about things a bit more*” (Sara), changing practice from “*generalised observational statements*” (Sara) to a more precise evaluation of occupational performance. In addition to enhancing practice, the PRPP-A training

provided many participants with a sense of harmony between assessment practice and their values. These perspectives were framed as:

The course was very in line with my thinking, and it was in line with what I do.
(Jenny)

I remember sitting down on that first day going 'This fits! This really fits with what we do'. (Sara)

Participants outlined how the PRPP-A fitted their perceptions of how an occupational therapy assessment should be. That it had 'struck a chord' with them as something which had a familiar quality to it, like something which had gone before or an earlier era of the profession. They provided insights that the PRPP-A deeply connected with their core foundational occupational therapy values. This feeling was encapsulated by Rosie as, "*it just felt like I was coming home... it encompassed my vision of what an OT should be doing in their assessments and interventions*". Jenny stated:

I felt stage one was just what OTs do anyway, except for the structure of errors, omissions [the score system] and actually I liked that structure, but you do that as an OT. So, I felt that was very in line with what OT does.

In contrast, other participants focused on their prior experience of assessment practices that were 'out of tune' with the occupational perspective to practice that they wanted to use. Their concerns generally centred on assessments of impairments and/or functional components, which proved difficult to relate to clients' occupational performance. Kate offered examples from practice with assessments such as the Montreal Cognitive Assessment (MOCA) and the Rowland Universal Dementia Assessment Scale (RUDUS) and described them as "*such rudimentary assessment of someone's basic cognitive functioning that doesn't show the implications of occupational performance*". In contrast, their experiences of using the PRPP-A conveyed messages that could be likened to the notion of 'singing from the same song sheet', creating harmony between their values and assessment practice:

So, they [clients] might not be able to do these things, but they can still do these things and we can help them by doing this... I think the profession's gone away from that... OT has gone into a lot of therapies that are based in psychology ...I was like 'Yes, yes this is what I want to be doing!' ...like this is what we're

supposed to be doing as OTs, is doing these kind of assessments...to really get back to the core of OT. (Tracey)

This harmony was also expressed by the two Māori participants. Peter felt PRPP-A “*resonates with me and makes sense to me*”, believing “*it’s one of the few assessments that could work really well for Māori clinicians*”. Aroha supported this view, explaining that her entire work was with Māori, and she did not “*use any other standardised assessment ...so this is the one that I do use*”. Peter considered that although this was their perspective, research was needed to “*prove that it is a really good cultural assessment that can be used*”.

The participants consistently shared views that the PRPP-A harmonised and resonated with their worldviews of how occupational therapy practice should be. They provided a sense that it fitted with their vision of how they wanted to assess; however, they also described facing many challenges in learning the assessment and translating the assessment to practice.

Translating to Practice

Assimilating Information from the Training

Assimilating is the process of thoroughly understanding and remembering new information to make it part of a person’s basic knowledge so that it can be used. Assimilating information for the PRPP-A began during the training course. Although many participants expressed that they had been excited by the content of the training, they also raised how learning, comprehending, and remembering the information had been challenging.

For some, this first challenge to assimilating all the new information related to the speed with which it was presented in the training. Tracey remembered working very quickly to record everything and how she focused on “*scribbling it down fast or you didn’t get all the information*”. Likewise, Rosie explained the consequence of her hurried note taking as “*when you go back and you’ve got scribbled things which were meaningful at the time! Sometimes when I go back, I’ve not always really understood what I’ve written because it might be half there*”. Irene had similar experiences of “*gaps*” in her notes and although she recognised the value of training where participants “*actively engage*”, she needed all the notes in the manual so that she could have listened without “*gaps*” that caused her to feel “*anxious*” she had “*missed out something*”.

Two others reported that it was hard to find key information in the manual, especially when they were still learning to apply the assessment and needed to quickly check a detail or grasp a concept. Hannah explained, *“I looked at the folder and I’d go ‘Oh,’ I don’t know where that would be”*. She suggested *“a quick guide”* to central information for assessing and scoring would have assisted her learning.

In addition to the speed of note taking and the layout of the manual, the sheer volume of new information contributed to the cognitive effort required to integrate the information. Rosie stated, *“you have to concentrate the whole time”* and Tracey recalled:

I think after day two [of training] we were driving home and I was like ‘I’m never going to get this. Like I’m not going to... this is crazy there is so much information’... It was a cognitively challenging 5 days, but it was good, you needed that much time to actually learn it.

Similarly, Ju had mixed feelings about the quantity of information. She explained the course was *“very in-depth... But I think, taking that all into practice can be ...a bit too much information”* although *“I think you need all the information”*. A sense of cognitive overload was juxtaposed with all the course content being relevant for future practice. Interestingly, despite the cognitive challenge of absorbing the material presented, none of the participants suggested reducing the course content or increasing the duration of the training, with several participants confirming that 5 days was required for their learning. Rosie did, however, suggest that perhaps the course could be divided into two blocks of time and, in between, therapists used the assessment and came back to discuss practical issues in the second block. She felt this was important as from *“talking to the others who have been on the courses... there were a lot of unanswered questions and uncertainty about what they’d seen or what to do next”*. Comments such as this imply the course contained too much information to absorb in one period of time, and that having some practical experience of using the assessment would help to embed the new learning.

Hannah felt overcome with the volume of new information that she was trying to absorb:

It was right at the end, and I was so overwhelmed with so much information that it just was gone. Because I was so new out of university, I didn’t have much to relate it to. I didn’t have the clinical experience that when they [instructors] were doing the examples I wasn’t like ‘Oh yeah, I’ve worked with someone like that before’.

Hannah revealed that part of the process of assimilation involved connecting new information to previous practice experiences. Thus, for a new graduate, it was not only the volume of information that was challenging but the information had less meaning since it was difficult to relate to previous clients and/or practice situations.

Ruth considered another aspect to integrating the information was the size of the assessment, which was “big” with all its “components”. The size created uncertainty as to which parts fitted best for her practice, especially since the assessment was “*not very prescriptive, so you have to do really a lot of thinking around it*” (Ruth). The assessment design involved understanding and reasoning about the parts of the tool to apply and required more ‘thinking’ than other, more directive assessments that have standard tasks and set instructions. Furthermore, having time for this thinking was consistently identified as a significant barrier to its application. Most therapists attributed the volume and pressure of their work as the main barrier to finding time to assimilate learning. Rosie clearly outlined the difficulty when trying to consolidate the PRPP-A to practice:

When you’re quite new to it [the PRPP-A] and you’re having to think through each new bit. Check for instance ...the glossary ...and check ‘Now have I got this right? Where did I see that?’ And so, it was quite an involved process that beginning learning ...there’s a lot to learn initially... I think it’s quite difficult to just go in and do it for instance, unlike the MOCA [test of cognition] and different, quick little things [other cognitive assessments]. This is not that, and I think there needs to be actual time for people to consolidate what they know. My question is whether in the DHBs (District Health Boards) there is actually that time built in for clinicians to be able to do that, because they’re so busy trying to just get on with seeing patients let alone with their professional development learning. And so, I think they are often looking for something that’s going to be really quick, that they can learn quickly, do quickly.

This account reveals the balance therapists must find between ‘busy’ caseloads and time for professional development. Hence, why more prescriptive or ‘quick’ assessments might be chosen that do not require as much assimilation and thinking. Significantly, it raised the need for support from employers for therapists to have dedicated time to make sense and fit the PRPP-A to practice. In addition to the influence of workload on time, Ruth offered a further reason why therapists may not allocate time to assimilate the assessment:

I'm just not sure why I haven't been using it as much and it's just that time, confidence and consolidation of really understanding it ...but at the same time when you go on these courses you don't want to spend another 6 months or even longer than that learning it either, you expect to come out of those courses thinking I can do this ...is quite a long time, 5 days.

This quote presumes that therapists would not necessarily expect after '5 days' training to find more time to understand the assessment and would not have allocated time after the training for this process. The reality for the majority of participants, however, was that applying the PRPP-A did not match this expectation as they had needed time outside of the training to think through and relate the assessment information to their individual setting. Sara summarised this perspective:

I think it [the course] gave me the tools, it's just, it was the working out how to fit it in the setting and working out how to use it myself and that's stuff I needed to do and I don't think it was anything the course could really provide.

Participants did, however, differ in when and how much time they allocated, which seemed to depend on the initial approach they used to apply the PRPP-A.

Initial Approaches to Translating the PRPP-A to Practice

On return to practice, the participants typically adopted one of two broad approaches to help them translate the PRPP-A to their practice. The approaches involved either a phase of preparing before using the assessment or an immediate start and refinement of its application as they learnt 'through doing' the assessment. These approaches are now reviewed as subthemes.

Preparing

Some participants took steps after the training to feel ready and prepared to use the PRPP in their practice. Participants varied in the amount of preparation time before they used the PRPP-A. For some, it was several weeks or months. Sara recalled getting prepared "took a little while, it took longer than I thought, I didn't go ...bang, do this". Reasons for this preparatory phase included to gain better understanding of the assessment, evaluate how they would use the assessment in their specific setting, be sufficiently organised, and select cases for the first assessments.

To comprehend the assessment, several participants took the initial step of re-reading the manual to identify the information they needed for their practice:

Re-read my notes because there was a bit of brain overload ...and I thought 'I need to really just sit down and get my head around it ...How is this actually going to look in practice?' (Sara)

I just found it was such a big folder, but of all that stuff in there, what were the most important things from that folder that I needed? (Ruth)

There was a sense they needed to evaluate the assessment material and find the most relevant parts for their practice. Ju explained her preparation:

I read through again... because I think every therapist has their own way of how they will put it into practice.... I've kind of done my own structure of how, from what I've learned from PRPP ...So I put the folder together before I put it into practice.

Ju's preparation included customising the PRPP-A resources to match her specific practice specifications. Likewise, Hannah recognised a need to get organised but found this, in itself, was challenging:

I do think just getting all the stuff together to do the assessment, just was a bit hard... I've been trying to pull together a folder of things that are already on clinical paper...this is just another thing that I don't feel like doing sometimes.

Finding energy to organise and prepare once back to work formed a barrier to actually using the assessment. Sara faced another issue in her preparation as she waited for an "easy" referral for the first assessment, one which looked "*relatively straightforward*". She explained that referrals were often a "*bit more woolly*" [vague], which she attributed to them coming "*from other professionals*" who were "*not recognising... the OT role*". Her comments reveal how referrals are often ill-defined and do not necessarily provide a clear occupational focus for assessment. Consequently, therapists need to clarify the occupational performance issues from real-world referrals before they can administer the PRPP-A. To overcome this challenge, Sara decided to assess a student performing handwriting in a classroom as it "*made sense*" to start with a familiar occupation she understood. She gradually built her skill level and competency to use the PRPP-A with other occupations. This approach of preparing and selecting cases contrasted with the approach of learning through 'doing'.

Learning Through Doing

Other participants applied the assessment quickly after the training and developed their learning through experiences of doing the assessment. These therapists remembered the impetus for this approach stemmed from the instructors' recommendations. Ann recalled the instructors saying “‘if you didn't use it within the first 2 weeks you're unlikely to use it'. So I did about five [assessments] in the first week”. Tracey, who trained alongside a peer, went back to practice determined to use it:

So, we were like 'Right, we've got 14 days. Who's [client] the first assessment coming up?' So as soon as one [referral] came up, we were 'Right, we'll just try to do it' ... So I think our first one was within a week of actually having come back from doing the course.

Similarly, Meiliani started using the assessment as soon as possible and, in doing so, realised that she could actually perform a PRPP-A in a real-life situation rather than just through video simulation during the training. Meiliani relayed a sense of achievement from this success. Even though, on reflection, the initial assessments had been “very basic”, she had succeeded in starting. Confidence in her ability to ‘do’ the assessment grew from this success, and over time, she then refined the “basic” early assessment procedures.

To develop her confidence, Kate took a more gradual approach to doing the assessment: “I used the stage one and then I practiced the stage two. Didn't feel entirely confident with the stage two... but I think by going ahead and practicing it, I felt a lot more confident”. By first applying only Stage One, Kate gained security in her ability to do part of the assessment. From there, even though not ‘entirely confident’, she was able to attempt Stage Two and advance her skills through practice and repetition. She was further heartened to use the assessment from positive feedback about the assessment results given by the team's speech language therapist and consultant. Ann also reflected on how the results of one of the first PRPP-As encouraged her to assess other clients, since the assessment had uncovered challenges for a client that “no one had ever noticed before”. She was reassured by the results that were relevant for her practice, which motivated her to further increase her proficiency.

These participants simultaneously performed assessments and continued to learn how to use the PRPP-A, together with creating resources/organisational systems. Tracey outlined this process from her first assessment with a peer, which:

Took us about an hour and a half to score it all up and ...work out exactly what we were doing. Referring back to the manual for a few things, just to make sure that we had an understanding of the different descriptors within the quadrants. Just making sure that we knew exactly where everything fitted. So, by the time we'd done the second one, we're like 'Okay well we've got a bit more down' and then by the time each one of us had done the third one, and we'd chatted about how we'd done with that, we were 'Like yeah we're starting to get this now'. And then [the peer] did sort of a half a template and I did another half, so now we've both got templates of how we're writing the reports... So, now we've got a system for doing it which helps.

Others gave examples of setting up systems alongside using the assessment, including laminating observation sheets that could be highlighted quickly during an assessment (Kate), Stage One templates for frequently assessed tasks (Ju and Ann), and documentation templates (Meiliani). This approach involved learning, as therapists applied the assessment, and customising resources along the way. In addition to discussing their initial approach, participants consistently expressed that learning with others helped the process of translating the assessment to practice.

Learning Together

All the participants relayed that translating the PRRP assessment into practice was easier with others supporting them. Some participants described either being directly supported by other PRPP-trained therapists or by other professionals. Those who were unsupported discussed how difficult they found the journey and identified the need for support from others. The descriptions of learning together have been grouped into four subthemes: learning with peers, support groups, supervision, and support from other professionals.

Learning with Peers

The majority of participants had some experience of sharing the learning of the PRPP-A with peers. Tracey had journeyed with a peer from the outset, deciding to train together on the same course. She enthusiastically remembered it was “*really, really good to have two of us doing it*” and how, when they returned to practice, they completed their first assessments together:

One of us was the therapist who was leading the assessment and the other one watched, observed and scored, and then we came back together, 'Okay, so what did you get? What did you see? and what did I see? What do you think? Why did

you give that person a two? [Assessment score] Why did you give them a three?’ And worked out that, for 95% of the time, we were both scoring the person the same ...And then we talked about them [the assessments]. And now we’re doing them obviously individually but then if we get stuck, then we can go back to the other one and say ‘Hey, what’s your understanding about this?’

Training together set up a shared path of learning that naturally continued into practice, where they could question, ‘check’ scoring, and provide each other with ongoing support. Furthermore, they shared the effort of creating service-specific resources, making it easier to use the assessment.

In contrast, three participants returned from the course to practice and had no other PRPP-trained therapists in their service. For two of them, the lack of PRPP-trained peers influenced their application of the assessment. Sara was slow to adopt the assessment, and Hannah intermittently used parts of the assessment but did not fully use the PRPP-A until she changed positions a few years later and had peers within the service. Sara explained how the isolation made it “*hard*” to learn on her own and so she had “*pushed for another person to be trained*”. She noted that since having a peer, her confidence had grown “*just knowing that there’s someone else there, to get some ideas around*” and now she more readily uses the assessment. For these participants, once they had a PRPP-trained peer, the peer support acted as a catalyst for using the assessment. They had someone to share the learning and were not the only one in the service using the new assessment.

Jenny’s experience differed. Working in isolation, she set up telephone support with a fellow peer on the course, ensuring she had support in place for when she returned to practice. She recalled, “*I’d ring her [PRPP-trained peer] and say... ‘I just want to run through my observations and see what you think’ and then she did the same with me with her first observations*”. Jenny explained that even though the peer worked in “*paediatrics and I’m adults. It [support with PRPP-A] still transfers across*”. Having PRPP training and a designated process to support each other seemed to be the key ingredients to learning rather than having a common field of practice. Over time, like Tracey, Jenny found the need for support lessened, and “*in the last year*” she had not needed any, since she felt secure using the PRPP-A.

Four participants outlined a more formal peer review method of learning. The peer review involved one therapist identifying areas of their PRPP-A practice to be reviewed and

another PRPP-trained therapist observing the assessment and providing feedback on the specified areas. Hannah explained it was “*really useful to have somebody’s feedback on how I use it [PRPP-A] ... from a perspective of someone who does it all the time*” and Irene commented, “*another OT to observe a task, because I wasn’t quite confident with what I was observing*”. Both these therapists were unsure of their assessment skills, and the peer review process provided an opportunity to clarify and develop their learning from someone with more experience of the PRPP-A.

In addition to supporting learning, Ju had used the peer review process to evaluate her assessment skills. She explained, “*someone [another therapist] seeing me in action doing the proper assessment*” provided a way to verify her competency. Kate had a similar experience when she reviewed a therapist and noticed that, following the review, the therapist increased proficiency in all stages of the assessment procedure. Kate regarded peer review as an essential process to both consolidate learning from the course and develop competency with the tool. She recommended that on completion of the training, therapists needed the “*opportunity to do peer reviews and to get the confidence with using it...having someone to precept or mentor or go to for questions to review documentation to come and observe sessions and give feedback*”.

Learning with peers was seen by most participants as important for successful translation of the assessment to practice. For some participants, for whom peers were not readily available, another option for shared learning was setting up support groups.

Support Groups

All but one of the participants who discussed support groups had experienced a support group within large organisations such as the DHBs, with therapists employed by the organisation and working in different service areas or geographic locations. The exception was Hannah, who had experienced a regional support group with therapists from different service providers, although the organisation and scheduling logistics resulted in the group only occasionally meeting. The infrequency of these meetings meant that Hannah’s learning needs were not met, as she did not benefit from the ad hoc meetings.

In contrast, Ju found the support group where she worked met regularly “*initially for a few months, maybe 3 months*” and supported “*each other to improve our level of confidence and consistency with the assessment*”. Likewise, Kate had been involved in a support group soon after training: “*I can’t remember if it was once a month or once every*

2 months. And we brought examples of our documentation, so our stage one, stage two and how we wrote it in the notes”.

These therapists explained how support groups were used to discuss cases, assessment results, review scoring, and documentation methods. The collective sharing of ideas and learning from other group members’ experiences was generally seen as helpful to practice, although some participants expressed significant challenges with the process. Rosie explained the difficulties the group she attended encountered:

We tried very hard to get together as a group to share and discuss our experiences of the use of the PRPP and to also talk about anything that we were unsure about. All of which, in theory, was a really good idea, but in practice everybody was so busy that it, it got to be a real challenge to get together.

Committing time and organising meetings were difficult to achieve, and often only 1-3 therapists attended, with the result that the group “*never really gelled*” (Rosie). Additionally, Rosie commented on the lack of direction of the group:

So, although we could sort of talk to each other, I don’t think any of us were really experts, if you know what I mean? We were all on a similar level. We’d done the course, we were trying to apply it in the best way we could, but I think we were... in many ways blindly trying to feel, find our way.

The group provided collegial support but had no one to guide it who was competent or experienced. Likewise, the support group Ju attended got “*stuck*” on issues; differences with the interpretations of the assessment arose, and there was no one with the expertise to clarify issues. Meiliani also experienced a group that “*fumbled our way through*”. She attributed the unclear direction to members working in different fields of practice and recalled:

We [OTs working in mental health] were trying to remember what we did in physical health ...to look at a young child using the scissors and cutting paper ...but what can they do as 5 year old or 4 year old... and then when we brought in our videos from mental health ... and then the physical [therapists] found it difficult.

The experience of this support group differed from Jenny’s experience, where the field of practice had not impacted on support between peers, and from the PRPP course, where occupational therapists from different fields all trained together and applied the PRPP-A

with clients of any age and background. Instead, Meiliani's group 'fumbled' and focused on age-related expectations, component skills, and client conditions rather than the client's occupational performance and applying the assessment.

For all three support groups, the absence of someone experienced to steer and guide the group seemed to impact on the individuals' learning, and left a couple of participants feeling more uncertain after attending a group. Despite these challenges, Meiliani felt there had been value in the support group, "*especially with the report writing*". Having a group with therapists from a physical health setting had been beneficial for developing reporting formats for her practice in mental health. Kate also noted that although the group had now "*gone by the wayside*," it had generated greater understanding and consistent use of the assessment between therapists across acute, rehabilitation, and community services.

Generally, support groups seemed to run for a few months after therapists had completed the training and then naturally cease. Most of the participants who had experienced them considered support groups useful, although the actual value seemed to vary. For some, significant challenges existed including scheduling meetings, infrequency of meetings, resolving different interpretations/opinions in the group, and the lack of an experienced therapist to clarify issues and steer the group. One proposed solution to overcome these issues was to have an online platform where therapists could "*chat ...ask questions*" (Rosie) and be supported by experienced PRPP therapists or instructors. Another option some participants used was supervision.

Supervision

As part of regulatory professional competence in Aotearoa New Zealand, all registered occupational therapists must be supervised and are required to use supervision for their "professional development and support" (OTBNZ, 2015b, p. 3). Six participants discussed using supervision to guide and reflect on their use of the PRPP-A and set specific goals for learning. One participant set up supervision with a PRPP-trained practitioner specifically for the purpose of helping her to use the assessment. Hannah recounted that the supervisor "*guided me through because she was quite experienced in using it ...she sort of helped guide me for the first few times that I used it*". Supervision of this nature focused on the practical application of the assessment, guiding and extending the learning from the course to develop competence in the practice setting.

For others, once they had applied the assessment, they explained how they used supervision to guide their clinical reasoning and “*problem solve*” issues (Jenny). They reflected on their actual performance through a series of “*questions*” (Hannah) to deepen their understanding and learning. Kate gave examples of aspects of her PRPP-A practice that she had reflected on, which included exploring “*concerns*”, “*the applicability of using the tool in practice*”, and how to support other PRPP-trained staff members. Supervision with critical reflection was used to enhance these participants’ future practice.

Setting goals related to learning the PRPP-A was another function of supervision for a few participants. The goals were typically developed as part of the OTBNZ regulatory requirements for continuing competency or for Career and Salary Progression Frameworks (CASP). Goals were established to target activities that the participants planned to do; examples included “*to go through the big file [manual] and find things that I find useful*” (Hannah), “*to summarise ... what the PRPP was about*” (Ruth), and “*to set up a support group within the DHB*” (Tracey). Setting PRPP-A related goals within pre-existing goal frameworks and regularly reviewing goals through supervision targeted learning areas. Supervision was used to continue to develop their PRPP-A practice and to keep their learning on track. A further method for continuing learning was to gain support from others.

Support from Others

A small number of participants discussed finding support from others in their workplace or from PRPP instructors. Meiliani used her line manager, who helped her set goals, reviewed documentation, and gave her feedback. Ju asked colleagues for feedback on the relevance of the assessment results, and Ann directly emailed the instructors when she was unsure of an aspect of the assessment. These participants spoke positively about the support they received and, although only a few examples were given, they highlighted the possible benefit of support from outside their own discipline or workplace. This possibility indicates that support from people outside of occupational therapy could be considered as another strategy when translating the PRPP-A to practice.

Reporting Using an Occupational Performance Focus on Cognition

Many participants shared experiences of how they found aspects of reporting PRPP-A results to be different from their previous reporting practices. The results of a PRPP-A can be quantifiably scored and/or qualitatively describe a client’s occupational performance linked to information processing criteria known as ‘descriptors’ (described in Chapter 2). Participants relayed that it was these methods of reporting that were

different from their previous experiences of reporting assessment results. Their narratives reflected these differences, together with the advantages and challenges of reporting in this way. These accounts are considered under three subthemes: Shifting from reporting on cognitive skills, reporting using the PRPP descriptors, and written reporting.

Shifting from Reporting on Cognitive Skills

It seemed that reporting the PRPP-A results necessitated a change for many participants in their approach, shifting from reporting on cognitive skills to reporting a person's occupational performance and related information processing capabilities. For these participants, this change had been hard to achieve. Irene articulated how altering her practice from a *"habitual kind of way of thinking"* had been a substantial challenge. It required changing ingrained *'thinking'* that centred on a client's cognitive function and was based on familiar cognitive assessments. She relayed how, in her practice setting, the commonly used assessments were derived from medical and psychology fields, such as the Cognistat (Kieran et al., 1987) and Cognitive assessment of Minnesota (Rustad et al., 1993). These types of assessment provide well-recognised methods and language to report on cognitive dysfunction. Reporting in this manner was familiar for her, and other team members had expectations of occupational therapy reports focused on cognitive skills like *"attention, memory and problem solving"* (Irene). Thus, in addition to learning to report foremost on occupational performance, rather than aspects of cognitive function, she had to manage team expectations of the reports. Irene voiced how changing thinking had required a determined effort and that her incentive to change was driven from the limitations of reporting with other cognitive assessments. She expressed these limitations as:

Then it is how to translate these results [from assessments of cognition] into the day-to-day functioning ...I always kind of struggled with how to interpret this. The person [client] showed issues with some visual memory, then how does this translate to the problems they're experiencing [with everyday occupations].

It was the need for interpretation and the frequent mismatch between results from cognitive assessments and real-life occupational performance that had motivated Irene to change practice; yet despite being motivated, parting from known and 'expected' cognitive terms was difficult. A big shift in her thinking, together with educating team members, had been needed, and although she trained a number of years ago it was an ongoing process. Ju shared the perspective that a conscious effort was needed to shift from biomedical reporting of cognitive skills:

It took a while for me to get used to the words and putting those [PRPP descriptors] in, because I tried to stay away from using the psychometric measures of labelling patients with neglect and things like that.

Both these accounts suggested that therapists had to consciously manage the change from using cognitive terminology to reporting with an occupational perspective. Kate described how she managed this shift by initially merging cognitive terms and the PRPP results in reports. She provided an example of a time she reported on a client's problem solving [cognitive skill] and then explained his occupational performance. She discussed her rationale for this approach:

For the purpose of the medical team, it was 'This person does have problem solving difficulties. Specifically, their difficulty is in these areas...'. Because I still had to find a way to write it so that other people in the team understood. I think it's [reporting using the PRPP-A] got better over time with a bit more use and a few more occupational therapists in our team having trained in it and using it. The team have understood the terms a lot more readily, but I still think it's one of the challenges we've got.

Kate's narrative emphasised how, when learning to report with the PRPP results, she had adapted the reporting and combined the two approaches, so it made sense for the team, yet still had some focus on cognitive skills as expected by the team. These expectations were gradually modified through continued exposure to the PRPP-A reports. As the team became familiar with the PRPP terms [descriptors], they progressively changed their expectations.

For Ruth, the impact of other team members' expectations went beyond their familiarity with previous assessment reports to apprehension that others might not consider PRPP-A reports on occupational performance as valid. This concern was raised by stressing that reports of PRPP-A needed to be:

Very clear, as it is still quite qualitative. You're explaining quite a lot of it, as very functional based, and maybe in some medical fields, people might not see that as strong enough [evidence] to see the issue. (Ruth)

Ruth highlighted a perspective that reporting on occupational performance (discussed above as 'functional based') was somehow less credible and provided weaker evidence compared to reporting on cognitive skills. This perspective that cognitive skills provided

stronger evidence than reporting on occupational performance was further evident as Ruth described reporting Stage Two PRPP descriptors without PRPP Stage One occupational performance steps. A report of this nature omitted an occupational perspective and neither used recognised terminology of cognitive skills nor explained occupational performance. It does, however, uncover some of the difficulties that can exist when occupational therapists are trying to shift to reporting on clients' occupational performance and how the PRPP descriptors have the potential to be used like cognitive terms and still be unrelated to occupational performance.

These examples revealed how biomedically and psychologically informed approaches to cognitive skills were often entrenched in the participants' practice and required conscious effort, motivation, and reasons to shift to reporting from an occupational perspective. Furthermore, for some, this process was influenced by the belief that occupational performance assessment results may not be as credible as reporting on cognitive skills or would not meet the expectations or be understood by team members. In addition to participants' shifting their approach to reporting, their ability to use the PRPP descriptors further influenced the reporting of the PRPP-A results.

Utilising the PRPP Descriptors

Participants consistently identified that in order to report PRPP results, they needed to understand and remember the descriptor definitions and practice using the descriptors in verbal and written reports. The majority of the therapists asserted this process required considerable effort and time. Many participants raised significant challenges with using descriptors.

Hannah, a recently qualified new graduate, found understanding and learning the descriptors especially difficult when she completed the PRPP training. She recalled how *"the language was a bit foreign"* and *"I went home [after the course] and was trying to understand what the words meant, more than, how to do it or use it"* (Hannah). Similarly, Sara felt her *"biggest worry was trying to get my head around the criteria [application of descriptors] for the Stage two"* and Irene noted, *"I got caught up with all the descriptors ...how to kind of use the language to describe what I observed"*.

Despite initial concerns, these three participants gradually found ways to use the PRPP descriptors, but significantly, for Hannah, although she used the PRPP-A in her practice, reporting remained an ongoing challenge. She still lacked confidence formally recording results and, at the time of the interview, was receiving supervision to assist her reporting.

She questioned, however, whether being a relatively new graduate when she had trained had contributed to this challenge.

In contrast Sara overcame her initial concerns about learning the descriptors by progressively building her skill level overtime. She started where she felt most comfortable and slowly increased her use of descriptors. She achieved this by first only reporting on Stage One of the assessment (i.e., focusing on the clients' level of occupational mastery and particularly the strengths in the clients' performance). Later, she added the Stage Two descriptors that she understood and those she saw as relevant for clients. More recently, she had completed the PRPP-I course, which further consolidated her understanding and enabled her to more confidently use all the descriptors. Likewise, Irene described steadily becoming more confident through practice and felt the turning point for her reporting was when she focused more on the issues for the clients' occupational performance than her own proficiency with the descriptors. She stressed the need for practice, "*When you repeat it [reporting the PRPP-A] a bit more, you feel more comfortable with some of the descriptors, still not all of them, still not yet*" (Irene).

Irene's account outlined how the learning was ongoing; however, with time, it slowly became easier, although some descriptors still required checking. Jenny had also experienced this challenge:

Checking the terminology of these [descriptors], checking the definition of what each one was and the difference between some of them that are very similar, when you're first learning... I still struggle with it. So, I still have to look up these particular descriptors.

Jenny highlighted difficulties with distinguishing between descriptors, especially when initially learning, but even after using the PRPP-A for a long time (6+ years) there was still a need to check some descriptors. Several other participants had similar experiences of some descriptors being harder to use or to distinguish between; although these participants all cited different descriptors that were challenging and there was no apparent pattern to which specific descriptors caused concern. There was, however, a consistent view that time and practice assisted, described by Rosie as "*time to embed that knowledge [of descriptors] into my everyday thinking*".

Tracey agreed that practice using the descriptors was necessary, and once she became familiar with the language then she developed a fluent reporting process:

So, I think that [using the descriptors] was the thing that I struggled with the most, getting used to the language part and I think it's taken me doing my fourth or fifth one [PRPP report] since the course. And I think now I actually feel like I've got it. Like this report [the latest one] has actually taken me a lot less time to do, because I think now, after doing it, for four or five times, the language is in my brain now ...it actually comes out without me having to really think about it.

Likewise, Meiliani remembered the initial process as being “*tough, it took me ages. The assessment was fine, it was actually putting things down in which categories, where the descriptors were going*”. To overcome this challenge, she asked for feedback from her manager [who had a nursing background] to ensure that the language made sense. Through this feedback and “*lots of practice, just doing it,*” she became more proficient at reporting on occupational performance and enthusiastically recounted how reporting with the PRPP-A was now “*just automatic*”.

Like Meiliani, feedback from colleagues encouraged Irene to further develop her skills in using descriptors to explain clients' occupational performance. Those participants who had reached a competent stage of using and linking the descriptors to clients' occupational performance indicated that there were advantages for their practice. Ann had found “*it helped me simplify reporting a bit more, rather than using... a whole lot of thinking terms like divided attention or something*”. Jenny described how clients had responded when she verbally reported on the PRPP-A:

I think generally, they [clients] have quite a lot of buy-in to it [reporting on the assessment findings]. It appears understandable to them, when I describe it. Particularly because you're relating it to something they've just done, or just done the week before... Because I'm giving them those concrete examples of when you did this, I noticed that this happened.

The focus on occupational performance made the descriptions especially relevant for clients. Peter and Aroha offered a further viewpoint on the descriptors, which they considered could be relevant for Māori clients, but felt that clinicians had an important role to ensure clients fully understood the descriptor terms and results. Peter viewed “*the language [PRPP descriptors]*” as “*pretty common language*” and so mostly understood by clients, but explained that sometimes it was the “*concepts that you're [clinician] trying to get across to them [clients]*” that needed further explanation. He emphasised that,

depending on the client and their family, the level of explanation the PRPP descriptors required varied, but it needed to match clients' understanding and their situation.

Peter further reflected that the descriptors had perhaps been the “*most beneficial*” for him as a clinician, as they gave him a language to verbally report what he had observed to his colleagues. The descriptors could be used with medical teams to make sense of clients' performance of culturally relevant occupations. He gave an example:

I know what I want to achieve from a boil up [traditional Māori meal] perspective, justifying it to a scientist or medical person, and that [PRPP-A] allows me language that justifies how I want to practice as a cultural clinician. (Peter)

Similarly, Aroha relayed how she had used the descriptors to explain clients' performance to community support workers. She highlighted that it worked best when the descriptors were directly connected with clients' actual occupational performance.

Overall, gaining proficiency with using the descriptors was mostly described as beneficial for practice, although achieving competency was generally challenging, and there was a sense that after the training participants still felt like novices when using the PRPP descriptors. Starting with the gradual use of the descriptors was a frequent strategy employed by therapists, and all participants identified that some practice using the descriptors was essential, together with establishing methods to use the descriptors in written reports.

Documenting the PRPP-A Results

Most participants described having concerns at the outset as to how they would begin the process of documenting the PRPP-A. Meiliani commented:

It was the report. Like when you do an assessment that's one of our core businesses as an occupational therapist, but trying to put everything [in a report]... like how we put ... things. And when I look at my reports back then [when she first tried to write reports], they're not that great! I was confident around the assessment but putting it [the PRPP-A results] down in words.

And Hannah stated:

Initially, I found it hard, how to document it. To sort of get my message across, if I was explaining it to patients or their families or to the team because it was an unknown thing, I wasn't sure of the best way to document it.

Feeling uncertain about how to write up the PRPP-A was a barrier for the majority of participants. They expressed a general lack of confidence in their ability to convey the assessment results to the intended audience. They feared reporting in the wrong way and whether the audience would value an assessment centred on occupations or understand the descriptor terms, as Ju expressed:

Sometimes I'm just not sure if I'm even writing it in a way that it should be... I have to think of 'Now, what I have seen' but putting it into the documentation so that it flows. Mmm, that is what I find difficult. Especially if I'm not confident that what I observe is right.

Together with feeling unsure about the process for written documentation, some participants, as they wrote reports, seemed to second-guess their occupation-focused observations and question their evaluations, not knowing how to write the occupation-focused results in a clear, meaningful way. As with using the descriptors, several participants considered practice as essential to overcome these documentation challenges. Irene had experienced it was “*just practice, I don't think there is any shortcut... with time actually I no longer feel the PRPP is difficult. You kind of get into a pattern*”.

Perseverance was needed, and finding methods for ‘a pattern’ of documentation was important but often necessitated fitting the PRPP-A results with existing documentation processes and frameworks, which also brought challenges. Irene explained:

With writing reports, I usually need to write the background, the demographics and what the problems [were] for the referral, and that takes a while... I like to use the COPM because the COPM gives a good structure... I feel I need to touch on these occupational areas. Then it takes a long time! To go through and fill out the cells [report template] that eventually my energy's almost exhausted, and eventually I come to the PRPP ...then what do I put?

Kate stressed the new ‘thinking’ involved in this occupation-focused documentation:

When you do PRPP and you need to add that into [the existing documentation] and figure out how that gets fitted into your local practice area. It does take time to adapt and to bring that documentation style [PRPP] in...Coming up with, that understanding [how to write the PRPP-A] at the end of the course, how you could add these [PRPP results] into your local documentation. Because it does need to be time efficient. It needs to be in your notes within 24 hours and that's hard when

you have to process that information and put it together and then get it into the notes. And this new way of thinking!

This narrative uncovered the time and effort needed to merge the new assessment results with previous practice procedures. To assist this process, it was suggested that starting during the training could provide a necessary link to help reporting in practice.

Despite the many challenges associated with learning to document the PRPP-A, advantages for persisting and overcoming these obstacles were expressed:

There's been really good feedback on the reports and how comprehensive they are. So, a couple of them have gone out to different agencies. One of them is going in as part of a court process for someone. There's been really good feedback from staff saying that the reports are very clear, and they're concise and they've got lots of information in there, but lots of useful information. (Tracey)

Similarly, Ju had received “positive feedback” from other team members and attributed the usefulness of the reports to the “specific” descriptions they portrayed that were unique to the client and the exact areas of occupational performance that challenged clients. Meiliani had equally experienced good feedback, and team members had confirmed the merit of the reports. She proudly explained, “they [team members] just look at the graph, Whoa!...then they look at the recommendations, they love it!”. She measured the success of the reports by the requests she had received from other services, which previously had not referred and now asked “Can you please do your OT assessment?” (Meiliani).

Interestingly, the ‘specific’ descriptions that generated ‘useful information’ in the PRPP-A reports and were valued by other team members appeared to be the very same descriptions of occupation performance focused on cognition and PRPP descriptors that so many participants had felt uncertain about and reported as difficult to learn to communicate and write.

Summary

This chapter has shown the ups, downs, twists, and turns of the learning journey from the outset to translating the PRPP-A to practice. All of the participants experienced some clear highs during the training, with the assessment resonating and being in tune with their worldview of how occupational therapy practice should be. There were, however, many challenges with assimilating the new information, which during the course often

led participants to feel ‘cognitively overloaded’ and that they were missing important information. Several participants expressed being ‘overwhelmed’.

Following the training there was ‘thinking’ to be done to consider how the assessment was going to fit in their practice setting. Time was needed to consolidate and decide which aspects of the assessment were most applicable. Difficulties were encountered with balancing time for learning and the reality of large caseloads. Employer support was seen as necessary for the period of translating the assessment to practice. On return to practice participants broadly took two different approaches. Some prepared by reading, customising resources, and waiting for a ‘relatively straightforward’ referral before attempting the assessment. Others learnt ‘through doing’ the assessment, starting quickly after the course and merging the process of developing their understanding, refining their application, and creating resources along the way.

All participants recognised that learning with others eased the translation process. One participant journeyed with a peer on a shared learning path that naturally continued from training into practice. Others used more formal peer review processes and those participants without PRPP-trained peers either set up their own support networks or experienced significant challenges using the assessment until they had peer support in place. Support groups were found useful for collegial support, discussing cases, sharing resources, and developing report templates. Support groups were often fraught with logistics, committing time to meet, and lacked direction without input from experienced PRPP-trained therapists. Supervision from a PRPP-trained therapist and/or support from others, such as managers, team members, and PRPP instructors, were other methods that participants used to guide, critically reflect, set goals, and ask questions related to their learning of the PRPP-A.

Reporting on the PRPP-A involved shifting thinking from known methods of reporting on cognitive skills to a focus on occupational performance. This was harder for some therapists, especially if they had ‘ingrained thinking’ based on cognitive components. For many participants, it took a conscious effort to report on occupational performance as it differed from the biomedical approach other team members used and required participants to manage and change team expectations of occupational therapy reports. Learning to use the language of PRPP descriptors took time, practice, and determination. Writing reports with PRPP-A results often necessitated finding ways to fit the assessment into existing documentation frameworks. Benefits were expressed of overcoming the many initial documentation challenges in the form of positive feedback from clients, families, and

team members, with the reports described as clear, specific, and useful. The following chapter continues the findings and presents the participants' experiences of using the PRPP-A in practice.

CHAPTER 8: PHASE ONE FINDINGS – PART 2

Using the PRPP-A in Practice

In addition to the narratives described in Chapter 7, two further themes were evident from the Phase One data analysis. Participants shared stories that validated the PRPP-A in their practice and described cultural applications of the assessment. The first theme, validating the practice fit of the PRPP-A, explores the features of the assessment that the participants valued, including the real-world application, client-centred approach, flexibility of the assessment system, and pertinent assessment results. The second theme, cultural application, recounts the diverse applications of the PRPP-A that the participants had used, and their views and experiences of the assessment process that they considered actively involves clients, changes the power dynamic, and requires cultural competency.

Validating the Practice Fit of the PRPP-A

The participants' validating experiences were expressed in terms of the common language meaning of validating, rather than the scientific view of proving validity. The descriptions were, therefore, more in keeping with the definitions of the term validating as affirming worth, supporting truth, and/or demonstrating value and giving approval to something (Cambridge Dictionary, 2018).

Real-world Application

Real-world application related to participants' experiences of the ecological features of the PRPP-A and their validation of its use in real-world practice settings. There was an impression that the PRPP-A was not contrived or reliant on being set up in a certain place. Rather, it was a natural method to assess, and many participants valued being able to use an assessment in the environment most relevant for clients.

Jenny outlined a range of situations where she had used the PRPP-A in real-world settings, which included a client "*working in an office on computers*"; one employed in a community role supervising people, and another client "*in a shed*" repairing a car. She considered the value for clients was an assessment process grounded in their realities; it naturally occurred in the usual place where they performed their occupations. Clients could be assessed where they actually lived their lives and the assessment process fitted their environments (i.e., homes, workplaces, and community facilities).

Three other participants affirmed the ecological value of the PRPP-A process even when clients were staying in unnatural environments such as acute hospitals or rehabilitation settings. Hannah viewed the benefit for clients staying in hospital wards, as they could be

assessed performing private and necessary self-care occupations such as showering and dressing, but in a less obtrusive manner. The assessment process did not require set-up procedures or instructions; it could be used as a natural evaluation, happening where the client did their self-care in that setting.

Similarly, Irene recounted how, in rehabilitation wards, the assessment took place in the actual situation where the client needed to relearn to do everyday occupations. She illustrated this value with an example from when she had used the PRPP-A with a client who had experienced a stroke and was eating a hospital meal by their bedside:

I used four steps: feeding, just opening container, picking up utensils, scooping and bring it to the mouth... based on that assessment I actually used stage one and stage two for this patient and it showed significantly a lot of inaccuracy and omissions [in the client's occupational performance]... and from there you [the therapist] could see ...the problem with the perceive ...and recognition of objects.

Irene drew attention to the assessment process having direct relevance for the client's rehabilitation and credited this to the PRPP-A being truly related to the client's here-and-now situation. The assessment process directly informed the recommendations made to the ward staff, which included the level of support and type of prompts to be given to the client to increase their occupational performance, and linked to the client's actual real-world performance that the ward staff had observed. This example demonstrated the value of using the PRPP-A in the ward context for all involved: the therapist, team members, and especially for the clients who benefited from undergoing an assessment process that immediately resulted in the ward staff knowing how best to support clients' occupational performance.

The use of the PRPP-A across a continuum of rehabilitation settings, from inpatient services through to community and clients' home environments, was validated by Kate. The assessment was relevant in each environment where clients received rehabilitation:

So I can do it in the ward kitchen, I can then do it when we go up to the shops and we're doing shopping and they actually have to buy their own things and handle their own money and they have to do the crossing of the street and finding their way back to the unit and then doing a home assessment with them and having a look at how they're going to perform those activities in their own home. And these are some very borderline people that the team would be saying, "Oh, they're not safe, they're not safe, they're not safe". But actually ... they're showing all the

signs of going through the right motions. There are some challenges, but it doesn't say the person is unsafe. With a bit of support and guidance and rehab, this person is able to return to their own home. (Kate)

This description revealed further insights into the worth of assessing within clients' relevant contexts. As the assessments were conducted in situationally relevant contexts, the therapist could attribute greater certainty to the assessment findings. This certainty, in turn, enabled the therapist to better advocate for the client's ongoing needs. By completing the PRPP-A in various natural contexts, the assessment was not based merely on team members' perspectives of how they thought a client might perform but was grounded in real occupational performance in real-world situations. Likewise, Aroha had experienced assessing a client "grocery shopping" and seeing his performance in the shop revealed his true challenges "I saw it was actually to do with memory and that changed my whole approach". Recommendations were then formed "that really helped him ...when he was doing shopping" (Aroha). In both these situations, the ecological nature of the findings provided evidence of the client's true abilities, validating the assessment process and recommendations to other team members.

Client-centred Approach

Many participants expressed that they found using the PRPP-A had allowed them to really take a client-centred approach to their assessment process, which they identified as very worthwhile. They highlighted how the assessment centred on clients selecting the occupation, task, role, or routine to be assessed. Jenny explained:

I've never thought about the type of activity. I think that's why I feel fine about saying to the client "Well it's your choice, what you want to do" ... It's [PRPP-A] fitted them all... it does not matter what they've wanted to do so long as I've known... the steps involved.

The clients really had a 'choice' and the PRPP-A, in Jenny's experience, had fitted 'all' the occupations clients had selected. Rosie further affirmed the individual fit for clients:

There is the ability to tailor it [PRPP-A] to the individual, and I think that's what's quite unusual about it. So many assessments are standardised and you have to try to fit the individual to it ... I just like this idea that it's [PRPP-A] the other way around.

Like Rosie, two other participants expressed the value of this client-centred fit by comparing the PRPP-A with prior experiences of assessments. Kate considered the PRPP-A had “*a lot more validity doing it that way [client selecting the occupation] than doing a BADS assessment [Behavioural Assessment of Dysexecutive Syndrome] that’s a tabletop assessment*”. Kate now questioned the use of tabletop assessments, as she had discovered the PRPP-A assessed what the client truly wanted to do. It centred on the client’s real occupations.

Peter reiterated this value, voicing that the “*PRPP is quite a personal goal-focused assessment*”. He contrasted the application of the PRPP-A with using the AMPS, where clients select tasks to be assessed from a list. He explained how the AMPS list really determines the choice, not the client, emphasising this point by stating “*I mean, you’re not going to get a boil up [a traditional method of cooking food for Māori people] on the AMPS*”. In contrast, he viewed that the PRPP-A afforded clients the opportunity to select what was actually relevant for them. “*It’s less stringent in terms of those limitations. It’s quite broad, which allows the client to choose and really be part of identifying what they feel is important*” (Peter).

The participants’ experiences of using the PRPP-A affirmed a method that was a truer representation of client-centred assessment than their previous practice. It let the clients set the parameters of what occupations were assessed.

Flexible Assessment System

Many of the participants attributed value to the PRPP-A being a flexible system that fitted with their varied practice requirements. The assessment could be used in different ways, with the three parts of the assessment system affording participants options. They could select the framework, use only Stage One, or complete the full assessment of Stages One and Two. Participants affirmed the worth of different parts of the assessment for their practice, and many gave reasons for using each part. Some participants had found they only used one or two of the parts, choosing the best match for their practice needs, while others used all the assessment parts. These latter participants described a fluid use of the assessment where they selected the parts that suited their assessment requirements at the time. The flexibility of PRPP-A system was seen in the choices of application that it provided therapists.

Many participants used the PRPP-A framework to help guide their clinical reasoning. This was identified as especially useful where standardised assessment results were not

required for a therapist's practice situation. Ruth most clearly articulated this value and discussed how using the PRPP-A as a framework had clarified her observations and supported her clinical reasoning:

As an OT, you can look at they [clients] are struggling with that aspect, but if you use that framework. You can dig a bit deeper and actually take a big step right back see another aspect... You can use the PRPP for your clinical reasoning and what you are processing... It can help you to reflect, so it's a very good tool from that perspective.

Using the PRPP-A framework fitted with Rosie's practice, which she described as based on "observation, interviews, and then intervention". Her narrative accentuated the value of having a framework to reflect on clients' occupational performance, which provided an informal pragmatic method of assessment that met her practice needs.

The selection of Stage One on its own was valued for being a quick assessment that directed observations and pinpointed issues. Peter used it as a fast "functional screen to see how they [clients] perform in that area", and Ju and Tracey explained when working in acute physical and mental health hospital settings respectively it was "very clear what am I supposed to be observing and what the patient was supposed to be doing" (Ju) and "being specific about exactly what you saw and every part of the task" (Tracey). These participants valued the flexibility whereby they could select only Stage One and administer it within a feasible time frame for their fast-paced acute work settings. Together with the speed of the assessment, the Stage One evaluations of clients' occupational performance issues were clear and informed practice decisions. Ju valued this when assessing clients living in the community with dementia. She only applied Stage One for these clients as this met her need for a "straightforward" assessment of occupational performance to identify the safety and support needs, and plan intervention.

The merit of being able to choose to complete just Stage One or both stages of the assessment was summed up by Irene as "Stage One gives you the structure that you do and score, and if you need to go into detail of steps, then there's Stage Two you can go to. So, it does give you this kind of flexibility and a great tool".

Ju considered that the selection of whether to use one or both stages was dependent on the complexity of a client's issues and whether deeper understanding of performance issues was needed. To explain, she gave an example of assessing a client with bipolar

disorder who had difficulty keeping a job. She briefly outlined the situation and her Stage One evaluation:

He was stable, but he still can't do his job, so it was in that context that I used PRPP [Stage One] just to figure out why he was slow...I asked him to multitask, making two cups of tea and a sandwich and he just did one thing at a time. (Ju)

The Stage Two assessment concluded:

He was too focused, did not modulate his attention [a PRPP descriptor]... so, you [the therapist] can identify the quadrants and descriptors that then make sense to why he's so slow and explain that. (Ju)

By adding Stage Two to the PRPP-A, Ju established the precise reasons for the breakdown in the client's occupational performance and could develop strategies based on the Stage Two descriptors to improve it. Other participants also valued the flexibility of being able to add the Stage Two assessment, as this was seen to deepen the overall assessment and provide a specific method to “drill down” (Kate) and really understand clients' occupational performance.

Tracey explained her rationale for using both stages of PRPP-A as it answered the question, “So what was that little part of the task that they [the client] had problems with?” To illustrate, she recalled a time when she had supervised a student who was not trained in the PRPP-A and consequently had selected a more general observational assessment. However, it had quickly become apparent that an observational assessment was insufficient to comprehend the client's performance.

Then, as we went through the assessment [general observations] I was like no! I need to do this in PRPP [full assessment]. There was just so much that happened during it, I was like we're never going to capture all of this unless, unless we do PRPP. (Tracey)

The overall value of having the flexibility of different parts of the PRPP-A system was discussed by Kate:

It [the whole PRPP-A system] gives me more validity as an occupational therapist; actually states the areas that a person's having difficulty. When everything's really, really fluffy in OT and it's very subjective, the way we're observing, the PRPP really helps to give a really good framework to describe what's happening and to use terms that have clear meaning. I think to be able to

do that ecological validity and the task analysis, and then to be able to do all that interpretation in Stage Two, I think it just adds so much value to the role of an OT in rehabilitation, to use that tool. Especially when we're looking at all those different components and how you put it together. I just don't think you will ever have the time to sit and do all the bottom-up assessments, and then what do they mean? Because if that person's got a neurological condition and it's not validated for someone with a neurological condition. I just think PRPP is applicable across all age groups and across all diagnoses, so I've been really enjoying using it.

This rich description acknowledged the true value of having a flexible assessment system that met practice demands. Furthermore, the quality and relevance of the assessment results were emphasised; the results were pertinent for practice.

Pertinent Assessment Results

When something is considered pertinent, it has “a clear decisive relevance to the matter in hand” (Merriam-Webster, 2018). Many participants shared stories of the pertinence of the PRPP-A results, which were seen as relevant and adding value to practice. They particularly validated the scoring system, the strength-based nature of the results, and the PRPP descriptors.

Two aspects of the scoring system were recognised as having specific relevance that enhanced practice. Firstly, the Stage One percentage score was described as being readily understood by colleagues and clearly communicated the level of clients' occupational performance. Tracey explained how doctors quickly interpreted the percentage score:

Generally, it seems to make sense to them. The doctors, they understand the task mastery part. So, if you say to them, so this person's task mastery was 42%. And they went 'Oh, like that's bad right?' 'Like yeah! That's bad'. Or you go, 'Their task mastery was 88%', and the doctors go 'Oh, okay, so not like, not perfect but that's only like 12% below 100 so they [client] did, quite well'. I'm like 'Yeah'. So, they kind of get that percentage thing. Which is good because the ACLS (Allens Cognitive Level Scales), when you talk about the levels, some of the doctors know what that is, but some of the other staff don't really know. So, the percentage in the Stage One part of PRPP, people get that quite easily.

In this example, since the score was expressed as a percentage, less explanation was needed from the therapist than for other assessments she had used. The score was clear,

and the doctors automatically had some understanding of the relevance. Meiliani further highlighted the pertinence of a percentage score from her practice experience as:

Like somebody did 25% [PRPP score], he just did one step and then a little bit more, and again those reports have been awesome. In the fact that they've got the weight to get them to Taikura Trust [a Needs Assessment Service].

On this occasion, the score was understood and strengthened the evidence of the assessment results, demonstrating the client's eligibility for other services.

The second aspect of the scoring method seen as valuable was the Stage Two radar graph. The graph provides visual representation of the results, which was useful for liaison with doctors and colleagues, especially those who had limited time to read reports. Rosie suggested that it was “welcomed by doctors” and Meiliani noted “some staff don't have to read my report, they just look at the graph”. Importantly, Ann had experienced clients also easily understood the radar graph, “the clients seem to prefer, to like seeing a graph”. She gave a specific example of showing the graph to a client who lacked confidence and how it clearly had shown the client's strengths:

When I showed her [the graph] she went 'Oh everything's fine except that one thing'. And I went 'Yeah!' She's like 'Oh, do you think I....?', and I said to her 'Well I talked to your OT who did your kitchen assessment, and you know she said that same thing. Isn't it funny how we both found the same thing out?' (Ann)

Alongside the radar graph summarising the results for Ann's client, the example revealed enhanced communication between the two occupational therapists, as they had both been able to use the PRPP-A and visually compare the results for the benefit of the client.

Two participants explained how reporting using the PRPP-A scoring systems provided pertinent evidence to justify why clients were not ready for discharge home from inpatient services. Meiliani gave an example of presenting a report with scores to a multidisciplinary team:

I've said, "He's [client] not for independent living, look at these reports" and then... in front of all the doctors and managers and different services say "This is the reason why he is unable to do this and this" and that's all off the PRPP.

In this situation, the PRPP-A scores clearly demonstrated safety concerns for the client and gave credibility to the occupational therapist's recommendations. Kate shared a

similar perspective, illustrated by comparing using the PRPP scores with previous observation-based reporting:

I think back to years of practice and not really being sure about how to articulate that or how to say confidently to a very, very strong medical team, that “These are my concerns for this patient ... I don’t think this person is actually safe to be discharged”. But I didn’t have any really strong way of saying that, it’s just my observation of how someone’s done. Whereas now we [therapists] have a really good standing against a medical model to say this performance, the mastery the areas that someone’s having deficits in.

The PRPP scores provide authentic evidence of clients’ occupational performance and level of safety. Additionally, some participants used the PRPP score percentages and graphs for quick, easy comparisons as outcome measures to evaluate progress. Meiliani noted:

We score it and then they have updates, so if they are under 85% we use that as a baseline. And then on discharge, just before we get to discharge, we do an updated one, and we usually see they improve.

Aroha used the scoring system to measure changes in clients’ occupational performance and to explain how she had evaluated the impact of her intervention. Her practice was enhanced as she used the scoring system to help her adjust intervention plans to achieve the best outcomes for clients. She recalled how she had worked with a client in this way:

So, they did show improvements in one area, and then it was still down in other areas [graph results] so it just showed that there’s still work to do on this particular area, but this one, the recall memory part, had been improved. (Aroha)

Similarly, Peter had been part of a pilot scheme evaluating interventions in which the PRPP-A score system was used as one of the outcome measures. He enthusiastically expressed the value of this as “*Oh yeah, it’s working! Yeah, that’s why they used it in the pilot*”. Likewise, Hannah affirmed:

I felt excited ...be able to use it as a measure of something that people say is so subjective. How people do their tasks and their routines and to be able to measure and use a number, felt good.

Significantly, these examples demonstrated the pertinence of a scoring system with an outcome measure for areas of practice in which occupational therapists typically have had difficulty showing evidence of change (i.e., measurements of occupational performance) and/or clients' abilities to apply cognitive strategies needed for occupational performance. Participants' experiences validated the potential for the PRPP-A scoring system to be a relevant outcome measure in practice.

A further aspect of the assessment results considered to be relevant and credited for enhancing practice was the strength-based nature of the results. Sara had experienced that being able to communicate results from a strength-based perspective had positively shifted teachers' focus. She relayed communicating results in this manner as:

This is what they can do, part of the task, because often especially with some of our students... teachers get just quite fixed with the whole things that they can't do. And you come in and there will be a lot of negativity ...and when I break it down into what they [student] actually can do ... that really helped. Because they [teacher] are like 'Wow, these are the skills that they can do'. (Sara)

Assessment results centred on the student's strengths facilitated a shift away from an impairment focus of student performance. Tracey conveyed a similar use of the results centred on clients' strengths and the value of building on these strengths, "*We're trying to provide that practical [perspective], so they [client] might not be able to do these things, but they can still do these things, and we can help them*".

The notion of building on strength-based assessment results was taken a step further by Jenny, who used the PRPP-A results to explain a client's performance to a family and guide intervention focused on the positive aspects of performance:

These were the areas that we [family and therapist] thought might be problematic, but actually he [client] did really well on those ones today and ...we've been working really hard on those ones. He showed really good improvement on that today... I [Jenny] like the visual side of using the Stage Two to show someone... which areas we're working on, and what we're going to work on in the next session.

This description revealed the pertinent strength-based nature of PRPP-A results that were central to a dynamic practice that intertwined assessment and intervention, maintaining a focus on positive gains.

The overall merit of the PRPP-A results lay in their strength-based focus and clear presentation that was easily understood by clients, families, and wider professional teams. The results were relevant, directly linked to things clients had done, and could be used to measure change, clients' progress, and the impact of intervention. These features enhanced therapists' practice.

Cultural Application

When applying an occupation-based assessment across cultures, multiple aspects that influence the success or otherwise of the assessment procedure and the results need to be considered. These aspects are complex and, in my view, the profession is only beginning to gain some understanding of the nature of these influences. In relation to the cultural application of the PRPP-A, the data provide preliminary insights into using the PRPP-A with people from a range of cultures. A deeper understanding was not the central focus of this study; however, the findings provide important considerations for the cultural application of the PRPP-A. The participants' experiences and views centred on four aspects of the cultural application of the PRPP-A: diverse applications, actively involving clients, changing the power dynamic, and cultural competency.

Diverse Applications

For an occupation-based assessment to be applied across cultures, it needs to be both suitable for a person of any ethnicity and allow for culturally relevant occupations to be assessed. The occupations need to be actual occupations a person does in their everyday lives. The PRPP-A was designed to be sufficiently flexible so that a person can be assessed performing any occupational role, routine, or task that they select.

The participants' experiences confirmed the PRPP-A to be a flexible tool, which they had used with people from cultures different from their own culture, in a range of environments, and performing varied occupations. It included clients from diverse ethnic groups such as people of Māori, Pacific, New Zealand European, Asian, Chinese, Nepalese, Sri Lankan, and European descent living in Aotearoa New Zealand. The participants consistently shared a view that the PRPP-A was an appropriate assessment to use with a person of any ethnicity. Significantly for practice within Aotearoa New Zealand, this included Māori clients.

The two Māori participants agreed that the PRPP-A was an option for PRPP-trained occupational therapy practitioners to consider with Māori clients; however, they had two caveats: the practitioner must understand Māori clients' cultural needs, and/or their

whānau needs, and the therapist must be culturally competent. These two important caveats will be discussed in detail later in this section. Peter summed up his view of the PRPP-A as:

My belief is that it's one of those assessments that's not rigid, that it allows you to apply it in so many different ways, in a flexible way that means that the nature of that, makes it culturally appropriate. And the clients choose the goals...that means that it's culturally appropriate from my perspective and from what I have seen.

The adaptable nature of the PRPP-A, expressed by Peter, was further portrayed through the multitude of occupations clients had chosen to perform that reflected their varied cultural heritage. Cultural variation was most evident in relation to assessments of meal preparation and cooking. Examples included: “*burgers... boil up... chops and mash ...roasts*” (Aroha); “*Pākehā meals like chicken; mashed spuds [potatoes] ... some of the Polynesian clients want to make their own taro leaf or corn beef and cabbage or raw fish so we do the PRPP for that meal*” (Meiliani); “*shopping for green bananas*” to use in a Pasifika meal (Meiliani); “*chop suey, curry or bananas on toast*” to suit people of Chinese, Indian, or Pākehā descent (Tracey); and a Nepalese “*fish head [dish] eaten [sitting] on the floor... with their hands*” (Hannah). It was also apparent that a diverse range of other categories of occupations had been performed with the PRPP-A. Occupations such as “*changing a car battery*” and “*making a horse shoe*” (Jenny), managing finances “*using an ATM card*” (Ju), working on the “*factory floor*”, “*leading an exercise group*”, “*gardening*” growing tomatoes (Ann), and “*decorating a Christmas tree*” (Hannah) were identified. Clients had also performed similar tasks but in different ways; for example, shopping at the supermarket as opposed to the local convenience store.

There was less variety of types of occupations discussed by participants working in hospital settings. As would be expected, they predominantly assessed self-care and kitchen occupations, such as making hot drinks and snacks, rather than a wider range of leisure and work occupations. Several participants, however, had noticed that since completing the PRPP-A training, they gave greater consideration to how a person specifically did these self-care and kitchen occupations, and explored the cultural expectations of the client’s occupational performance. Using the PRPP-A had changed their practice and widened their cultural awareness as they sought more understanding of the unique ways different clients performed occupations.

For Kate, it had included ensuring that culturally specific tools or ingredients such as a rice cooker, chopsticks, spices, and noodles were available for an assessment. Others explained that when working with clients who had severe impairments and/or clients who were unable to communicate their preferences, they gained an understanding of the relevant tasks to be assessed through close liaison with the clients' whānau members or significant others. Ju outlined how it was possible to use the PRPP-A in a culturally relevant way, even when a client was *“in a tilt in space wheelchair and they cannot speak or cannot communicate, you can still do an occupational task based on the PRPP”* by partnering with family to gain relevant information.

Overall, participants stressed how the choosing and setting up of occupations that clients would perform involved gaining understanding of the cultural requirements, the specific ways of doing, and the expected level of occupational performance needed from the clients and/or their families' cultural viewpoint. The participants' examples revealed the diverse and culturally specific nature of the occupations they had assessed with the PRPP-A and the partnering with clients' and their families that was necessary in the early stage of the assessment to ensure clients were actively involved in the process.

Actively Involving Clients

The process of actively involving clients was seen as essential to ensure relevant occupations were selected for assessment and that therapists gained an accurate understanding of the cultural specifications of occupations. Participants explained how they had developed new skills and a different way of questioning than they had used for other assessments. Tracey identified the process started by *“not making assumptions about what they're [clients] going to do”* and she had learnt *“to be mindful”* and give greater consideration to any assumptions that she might be making about how an occupation was to be performed. Irene also confirmed *“you really need to know what is okay according to that person's cultural background, context and what is not okay... And you go and find out more if you're not sure, you talk to the person”*. Kate discussed how the questions that she now asked before an assessment *“made sense”* to her and compared this process to the setup of more prescriptive style of assessment approaches.

The questions that we are asking, 'how would you do this?' and 'what would be the normal way of doing this?' And the patient is able to connect with that rather than saying 'Well you're coming into my kitchen and you're doing a cup of tea and toast'. (Kate)

Kate explained how some situations involved encouraging clients to be more active to ensure they had engaged in the process. She illustrated this point with an interaction where a client had asked her “*so don’t you [the therapist] want me [client] to do something that you want me to do?*” and her response “*No, no that’s not going to help us really understand how you would do things*”. This example demonstrates how clients do not necessarily expect to be actively involved during an assessment process and the need to form relationships with clients where they feel able to freely participate.

The consequences of clients not truly participating was described by Rosie who recalled a time when she had observed an occupational therapy assessment with a therapist not trained in the PRPP-A. “*This person was having a terrible time making a pot of tea ... and then it turns out the patient just didn’t make tea in the way the therapist had expected them to*”. She outlined how when using the PRPP-A this situation would not arise as “*you go in beforehand, and you sort out how they do something*”. The experiences described by both Rosie and Kate exposed differences between usual occupational therapy assessment practices, with set tasks which are not always culturally relevant, and the PRPP-A process, where clients are actively involved and can say what they want to do and the way they usually do it.

While participants supported the assessment process of having clients genuinely involved, they also reported that it could create practical challenges. For example, having the client choose an occupation had, at times, added complexity to the assessment process. It could be hard to develop a thorough understanding of how an occupation needed to be performed, especially gaining information on the level of performance considered acceptable for the clients’ cultural context. To generate these understandings, participants needed to stand back and question the cultural expectations to be certain that they were not being influenced by their own cultural perceptions of what they understood to be acceptable. Irene gave an example where, from her cultural background, the task of washing the dishes always involved rinsing the washing up water off the dishes before drying them. When a client put them away without rinsing, she was challenged about whether or not this was acceptable. She explained how she was aware that from her cultural perspective, she often did things in a different way to how she saw people in Aotearoa New Zealand doing the same task.

This example shows Irene’s awareness of her own cultural ways of doing, recognising the potential influence this has on her practice, and the need to actively engage

clients/families, encouraging them to explain their usual performance. Thus, practitioners need to reflect on their cultural expectations and really listen to clients and families to reduce the possibility of cultural assumptions being made. Furthermore, a few participants outlined challenges they had experienced when sourcing information on cultural expectations, especially when the client themselves could not be so involved (e.g., when they had communication challenges and/or when families were not available to ask). This created some concern for the participants as to whether the assessment was as accurate (i.e., was the client being assessed in the most relevant way), since clients were not as involved, and participants needed to make decisions on the clients' behalf.

Others recognised that interpreters were needed when there were language differences and how it was difficult to be certain that clients and/or their families had been given the opportunity to be involved when the conversation occurred through an interpreter. In these situations, participants stressed the need to ensure that the client was involved and to have awareness that limitations may exist that influenced the process, especially the extent to which clients had the power to decide what was important to them.

Changing the Power Dynamic

The Māori focus group described that the PRPP-A could provide a different way of assessing for therapists, one that changed the power dynamic between assessors and the clients. The power differential was seen to be different than most other occupational therapy assessment processes since the PRPP-A assessment process focuses on the client, their choices, occupations, and goals.

Peter and Aroha expressed this difference by contrasting the PRPP-A with other assessment experiences. They outlined how assessments typically involved clients being told what was going to happen, what they had to do, or that clients were presented with predetermined assessment task choices. Aroha explained how she had observed another therapist using an AMPS where the client was performing bathroom and kitchen occupations that were out of context with the client's usual lunchtime routine. The client's perspective of the process was "*But I don't do that at lunch time, you know I only do that in the evening*" and Aroha's perception was that "*It just made it very artificial*" where the client was not performing their usual occupations or doing what was important for them. Aroha compared this experience to how she set up the PRPP-A by saying to a client, "*Just make whatever you usually eat,*" with the decision and control sitting with the client rather than with her as the therapist. Peter extended this view, stating that the PRPP-A was "*not*

about what you [the occupational therapist] think they [the client] should be doing, based on what you are giving them". Instead

What the PRPP allows you [the occupational therapist] to do is balance that [power] up so that in fact you are not determining what they [the clients] choose at all. They take back some control and power for themselves, and they tell you this is what I [client] do...that works because people [clients] don't want to be told or spoken over. They want to be heard. So PRPP allows them to be heard, so that's dynamic, not being told what to do, but actually saying this is what I [the client] do, let's work on that. (Peter)

Although, the PRPP-A was described as having the potential to address the power dynamic with clients, the therapist's approach was seen as key to determining if power was actually addressed in their practice. The Māori participants cautioned that practitioners needed to be aware of power dynamics, which are always present and at play between therapists and clients. Thus, practitioners need to consider how they create partnerships and influence the power differentiation. To illustrate, Peter described how many traditional assessments start with a process where clients are told "*these are things that you [client] should be doing, you need to do this, and you have to do it at a certain time*" or "*choose one of these things*". By presenting an assessment in this way, Peter noted that "*straight away you [occupational therapist] are in a power dynamic*" where the practitioner controls the process and the client has a limited choice or influence on the assessment. This way of approaching an assessment has "*western systems operating*" (Peter) imposed on other cultures that create a power imbalance, with power quickly established over clients. To address power dynamics, practitioners need to move away from traditional ways that many assessments have been set up and develop partnerships in which practitioners take a different approach:

You're not telling them [clients] what they should be doing, they're telling you [therapist] 'Well this is my life, this is what's important in my life'. You open up the conversation by saying, 'Well, you've got a few things going on, what do you want to do?' 'Well, I used to do this.' Straight away it's what they want to do!... It just starts a conversation that allows you to explore with them... beside them, as part of a journey where you're walking together as opposed to needling them along or pushing them. (Peter)

Aroha explained how addressing issues of power and control was relevant for all clients, but especially clients involved with forensic mental health services. Clients served by these services had typically lost power and options to make decisions for their lives as *“they [clients] have got psychiatrists telling them what to do, they’ve got the police having told them what to do, the justice system, so that power thing is very in front of their minds”*. Aroha saw an opportunity that, with the right approach, the PRPP-A process readdressed the power so that clients could *“take ownership of their treatment”* and *“have an active role”*. The potential to address power dynamics using the PRPP-A was viewed by the Māori participants as only being possible if the assessor had sufficient cultural understanding and practiced with cultural competency.

Cultural Competency

The ability of practitioners to practice in a culturally competent way was regarded by many participants as essential to the effective cultural application of the PRPP-A. Cultural competency is widely recognised by health professionals to be a complex dimension of practice. Beagan (2015) completed an extensive synthesis of the literature on cultural competency and proposed that cultural competency centred on three areas. First, an awareness of one’s cultural values, beliefs, attitudes, and biases, with the ability to recognise that these were different from clients. Second, knowledge developed through openness and curiosity to learn about diverse cultures. Finally, skills required for cultural competency, which include *“effective communication, rapport building across differences, respect, active listening, advocacy... use of open-ended processes of inquiry, use of culturally appropriate occupations, and thinking outside the box to adapt practices, assessments, and interventions”* (Beagan, 2015, p. 274). The participants discussed similar characteristics of cultural competency as needed for the cultural application of the PRPP-A.

An awareness and understanding of therapists’ own values, beliefs, and a willingness to be open to clients’ views and different ways of doing was suggested as pivotal to practice with the PRPP-A. Kate recognised that *“cultural responsiveness”* was required when establishing the occupations to be assessed with clients and stressed that therapists need to be certain that their own perspectives were not influencing the process. She considered that practitioners need to be culturally aware to *“make sure that we [therapists] look at how somebody does something in their own way,”* using sensitivity and avoiding assumptions. Irene had experienced that sometimes it can be small differences in how an occupation is performed that are missed by therapists or assumed and taken for granted.

She cautioned that practitioners in hospital settings need to be aware that even when assessing common “*day to day activities, people still do their things differently because they come from different cultures*” (Irene), acknowledging important but very subtle differences that exist and can be presumed by therapists.

The implications if a therapist did not consider these differences or did not have cultural understanding were highlighted by Aroha. She explained that unless a therapist was open and willing to let clients share their own perspectives, then occupations being selected could be irrelevant to clients’ lives and the assessment findings meaningless:

You [therapist] can have the PRPP there, but if you’re not giving the client the freedom... they [the client] might choose something [an occupation] that they’re not familiar with, then that would skew it [PRPP-A findings]. (Aroha)

It was suggested that, in addition to occupational therapists having cultural awareness, understanding, and recognition of their cultural biases, they needed insight into how their own responses could influence the assessment process. Aroha described how even “*subtle reactions*” or “*body language*” reveal cultural differences which have the capacity to be disrespectful and significantly affect the outcome of assessments. Such subtle reactions from a therapist have the possibility of putting clients in ‘awkward positions’. Aroha gave an example that if a client described their ‘normal’ everyday occupations and these were received with inappropriate reactions from a therapist, the implication would be that the occupations the client did were less acceptable. Such a situation would impact the client relationship and jeopardise the assessment findings. Peter further proposed that if a practitioner has a “*staunch western way of thinking*” then they would struggle to understand the cultural perspective, which would affect the way the therapist worked. No matter how flexible the PRPP-A process was, if a practitioner was “*hardwired*” (Peter) with their own set values, attitudes, and beliefs; had a closed outlook; and responded inappropriately, they would not be able to see or understand their clients. Consequently, the assessment would be prejudiced, with no value for the client. Peter’s assertion signals that practitioners’ level of cultural competence is key to potential success or otherwise of the application of the PRPP-A.

Summary

The findings in this chapter pertained to the value that participants attached to using the PRPP-A in their practice and experiences of its cultural application. Many participants validated the real-world application of the PRPP-A process that fitted where clients lived

their lives. Clients were assessed in the place where they needed occupational therapists to see their actual real-life challenges. This included multiple real-world environments such as homes, workplaces, and community settings, and also unnatural environments of hospitals and rehabilitation facilities. Further, value was associated with the client-centred approach that was possible and offered clients' choice to select the parameters of occupations to be assessed.

The PRPP-A was affirmed as a flexible system that matched many of the therapists' assessment needs. Participants outlined this flexibility and the different parts of the assessment they valued, explaining its use as a framework to guide clinical reasoning; Stage One as a quick evaluation of occupational performance, and Stage Two to provide deeper analysis and precise reasons for breakdowns in clients' occupational performance. Moreover, many participants expressed worth in the pertinent scoring system which provided authentic evidence with clear percentage scores and visual graphs that clients, families, and other team members readily understood. In addition, a few participants had used the PRPP-A as an outcome measure of clients' occupational performance and/or their ability to apply cognitive strategies needed for occupational performance. These participants validated the potential for the PRPP-A to be considered as a relevant outcome measure in practice.

Many of these validated aspects of the PRPP-A were also seen to support the cross-cultural application of the assessment, with the majority of participants having experienced using it with a diverse range of clients of different ethnicities performing culturally specific occupations. Significantly, for practice in Aotearoa New Zealand, it included the application of the PRPP-A with Māori clients. Importantly, despite consistent endorsement of the cultural application, many participants cautioned that it was only possible if therapists practiced with cultural competency. Open-minded practice was essential to avoid culturally biased assumptions and create culturally sensitive partnerships, ensuring clients were heard by practitioners and actively involved. In addition, therapists needed to address the power balance constantly at play during an assessment. Although the PRPP-A afforded an opportunity to share power with clients, it was reliant on how the occupational therapist set up the assessment and whether they did indeed share power. If practitioners were 'hardwired' with 'staunch western ways of thinking', they would not understand clients and prejudice and 'skew' the assessment results. Cultural safety and competence were seen as keys to the potential success of applying the PRPP-A across cultures. Chapter 9 presents a summary of the Phase One

findings from both Chapters 7 and 8, together with a discussion and recommendations for further research in a peer-reviewed manuscript.

CHAPTER 9: SUMMARY AND DISCUSSION OF PHASE ONE FINDINGS

Introduction

In this chapter, I present a summary and discussion of the central Phase One findings that were shared in Chapters 7 and 8 in the form of a manuscript that has been published in the *British Journal of Occupational Therapy*. I have chosen to include the manuscript at this point in the thesis, since the Phase One findings will be foremost in a reader's mind. It seems a natural place to explore the implications of the Phase One findings, ahead of covering the Phase Two findings. In arranging the chapters in this format, I aim to provide the reader an opportunity to review how the findings relate to and answer the first research question posed at the outset of this study: What are the experiences of occupational therapists in Aotearoa New Zealand applying the Perceive, Recall, Plan and Perform System of Task Analysis (PRPP) assessment into their practice? I start the chapter with a short prelude to introduce the manuscript, followed by the final manuscript submitted for publication. A short summary concludes the chapter.

Prelude

The following manuscript encapsulates the central findings of Phase One of the study. An overview of the literature that informed the Phase One research question, together with an abridged version of the research methodology and methods (presented in Chapters 4, 5 and 6) is included. Within the manuscript, the themes and subthemes from Chapters 7 and 8 are drawn together into five condensed themes of: *Resonating with practice as it should be*, *Translating to practice*, *Communicating assessment findings using an occupational performance focus on cognition*, *Validating the practice fit*, and *Cultural application*. The Phase One central findings are then discussed and situated within the context of the wider existing professional knowledge known at the time of publication. Three key messages from the Phase One research are presented in the manuscript conclusion.

Full Publication Reference

Burrows, W., Hocking, C., & Chapparo, C. (2022). Learning, translating, and applying the Perceive, Recall, Plan, Perform System of Task Analysis Assessment to practice: Occupational therapists' experiences. *British Journal of Occupational Therapy*, 85(7), 496-504. <https://doi.org/10.1177/03080226211042264>

Introduction

Standardised occupation-based assessments are widely promoted for occupational therapy assessment practice, since these assessments are evidence-based and congruent with contemporary occupational therapy theories and models such as the Occupational Performance Model (Australia), Model of Human Occupation (MOHO), and Canadian Model of Occupational Performance and Engagement (CMOP-E). Taking an occupational focus from the start and using occupation-based assessments has been emphasised as key to ensuring practice is focused ‘on what occupational therapists can and should be helping clients address: problems with performing and managing occupations’ (Molineux, 2004, p. 11). However, the reality of actual assessment practices often differs from these recommendations, with variable usage of standardised occupation-based assessments (Holmqvist et al., 2014) often attributed to constraints in the practice environment (Holmqvist et al., 2014; Pilegaard et al., 2014). Occupational therapists working with adults and children with cognitive limitations typically use informal observations of activities of daily living (ADL) and/or instrumental ADL (IADL), in combination with standardised assessments/questionnaires which focus on cognitive function rather than occupation (Chevignard et al., 2012; Holmqvist et al., 2014; Stigen et al., 2017). While such combined assessment approaches provide occupational therapists with some information of activity limitations and specific cognitive impairments, this approach to assessment has been challenged as having many flaws. These include that non-standardised observations lack validity (Belchior et al., 2015) and fail to identify higher level cognitive challenges (Burns & Neville, 2016) while results of cognitive assessments have little correlation with clients’ real life performance issues (Edlin et al., 2018). To combat these limitations, standardised ecological assessments capable of measuring both occupational performance and ‘consequences of the cognitive impairments on everyday occupations’ (Stigen et al., 2018, p. 6) have been recommended (Burns & Neville, 2016; Chevignard et al., 2012; Edlin et al., 2018).

One contemporary assessment designed to address some of these assessment needs is the Perceive, Recall, Plan, Perform System of Task Analysis (PRPP) assessment (Chapparo et al., 2017). The PRPP assessment is a standardised criterion referenced, ecological, client-centred assessment of occupational performance designed for use with a person of any age, gender, culture, or disability, performing any relevant tasks in real-world contexts. The two-stage assessment involves observation of two to four chosen tasks

based on the person's occupational needs and desires. Stage One is a behavioural task analysis, which measures the person's level of occupational performance mastery (skill). Stage Two involves a cognitive task analysis to measure how efficiently the person applies cognitive strategies (termed 'descriptors') required for successful task performance.

To learn to use the PRPP assessment reliably, occupational therapists attend a 5 day training course. It was as a trainer involved in PRPP courses in Aotearoa/New Zealand (NZ), that the primary researcher became interested in understanding occupational therapists' experiences of applying the PRPP assessment in their real-world practice contexts. This is an important aspect to explore, given research into the implementation of other occupation-based assessments indicates therapists have often encountered challenges using these types of assessments (Larsen & Carlsson, 2012). It has been recognised the profession needs better understandings of challenges and barriers to using occupation-based assessments, together with research to identify 'any changes needed at the level of the practitioner's knowledge, skills, or priorities' (Pilegaard et al., 2014, p. 286). Therefore, this study focused on the clinical utility of the PRPP assessment and obtaining practical insights of occupational therapists' experiences as they learnt and applied the assessment in practice to 1) Inform occupational therapists considering the PRPP training, their managers, funding agencies and PRPP instructors designing the content of future course and 2) Assist future occupational therapists to effectively embed the PRPP assessment in practice.

Literature Review

To date, 17 studies have focused on establishing the PRPP assessment's psychometric properties, including its face validity (Lewis et al., 2016; Nott & Chapparo, 2008; Ranka & Chapparo, 2010; Voigt-Radloff, 2012), construct validity (Aubin et al., 2014; Nott & Chapparo, 2012), criterion validity (Stewart & Chapparo, 2011; White et al., 2020), inter-rater reliability (Steultjens et al., 2012; Van Keulen-Rouweler et al., 2016; Voigt-Radloff, 2012), and intra-rater reliability (Van Keulen-Rouweler et al., 2016). Despite the growing literature about the PRPP assessment, there remains a dearth of information about the knowledge, skills, or attributes needed to learn and apply the PRPP assessment or its utility, the degree of usefulness of the tool in practice.

The clinical utility of an assessment typically determines whether it is adopted in practice and is governed by practical features such as: administration procedures, financial

implications, time requirements, the assessment's flexibility, and the clinical relevance for the client group being evaluated. Currently, little published data on the PRPP assessment's clinical utility exists. At the time of this review only two small-scale unpublished studies (Lindskog & Kjellberg 2006; Lu, 2014) were found and these have examined the clinical utility of the Swedish and English versions of the PRPP assessment, respectively. Both studies collected data through questionnaires and reported findings through statistical analysis. Lindskog and Kjellberg (2006) found the PRPP assessment had clinical relevance and Lu (2014) established 95% (n=43) of participants applied the assessment in practice, with varied patterns of use revealed. Some occupational therapists regularly applied the full PRPP assessment, others only parts, some intermittently, and a small minority never applied it in practice. Differences between use across contexts were also identified, along with challenges which included: consolidating course information; learning the PRPP language; facing uncertainties when first applying the assessment; time limitations; and insufficient managerial support (Lu, 2014). Collectively these two studies have provided a broad overview of the PRPP assessment clinical utility, although unanswered questions remain such as: what are the reasons for varied use of the assessment? why did therapists find some aspects of the assessment challenging or beneficial? and why were certain parts of the assessment used but not others? A considerable knowledge gap remains, which has implications for both occupational therapists and funding organisations alike. Currently, decisions to train are made with limited information about the practice realities of applying the tool, the learning commitment required, or how useful or otherwise the assessment might be in different practice settings. This study was designed to address these unknowns. It explored the experiences of occupational therapists in Aotearoa/NZ applying the PRPP assessment in their practice. The research aimed to:

1. Gain perspectives from occupational therapists applying the PRPP assessment in a range of contexts
2. Describe some of the realities of translating the PRPP assessment to practice

Method

Design

A qualitative interpretive description methodology was used as this is recognised to be suitable for discipline specific exploratory research (Thorne, 2016b). Interpretive description is based on constructivism, naturalistic inquiry, and pragmatism, where the intention of creating knowledge is to make a practical difference. In keeping with this

philosophical stance, an inductive approach openly explored occupational therapists' experiences of therapeutic practice in their natural work settings (Thorne, 2016b).

Ethical approval

Ethical approval was granted on 27/04/2016 by (name of university will be added after review) Ethics Committee (Reference: will be added). Written informed consent was gained from all participants and pseudonyms are used in reporting the findings.

Cultural considerations

When conducting health research in Aotearoa/NZ there is an obligation to consider the research in relation to Māori as the tangata whenua (the indigenous people of Aotearoa/NZ) and partners of Te Tiriti o Waitangi (Treaty of Waitangi, the founding document of Aotearoa/NZ). This includes adhering to articles of Te Tiriti o Waitangi and honouring partnership, participation, and protection. An ongoing consultation process was established with (name of advisor will be added after review). Consultation occurred throughout the research to ensure the project was culturally safe and appropriate for Māori.

Recruitment and participants

Volunteers were recruited over a 6 month period, through an advertisement emailed by the Occupational Therapy Board of New Zealand (OTBNZ). Volunteers were emailed an information sheet and demographic and consent forms. New Zealand registered occupational therapists who had completed the 5 day PRPP assessment training were included in the sample and occupational therapists working in the same setting or in a supervisory relationship with the primary researcher were excluded. Fifteen occupational therapists volunteered, two were excluded as having supervisory relationships and the final sample was 13 participants. Table 14 outlines participants' demographics.

Table 14.*Participant Demographics*

Demographic Characteristic	Number
Gender	
Female	12
Male	1
Cultural affiliation	
NZ European	8
NZ Māori/European	2
Cook Island Māori	1
Filipino	1
Chinese	1
Year completed PRPP Assessment Course	
2009	1
2011	2
2013	3
2014	4
2016	3
Completed PRPP Intervention Course	3
Work setting	
Adult mental health services	
Older persons	2
Acute	2
Forensic	1
Vocational	1
Adult physical health services	
Acute hospital	1
In-patient Rehabilitation	2
Community Rehabilitation	1
Community private practice	1
Paediatric services	
Ministry of Education school service	1
Community private practice	1
Presence of OT colleagues	
Working in isolation without OT colleagues	1
Working with OT colleagues without PRPP training	3
Working with OT colleagues with PRPP training	9

Data collection

Two forms of data collection were used: Semi-structured interviews with a flexible interview approach and a focus group. Eleven individual interviews of 60-90 minutes duration were held in locations chosen by participants. The two Māori participants were given the option of a focus group and/or individual interview. They selected to meet in a focus group, which incorporated tikanga (traditional customs) and provided a culturally safe way for them to participate.

Interview guides were developed for both the interviews and focus group using open-ended questions that allowed participants to express their thoughts, emotions and experiences in their own way. Table 15 provides examples of these questions. The interviews and focus group were digitally recorded and transcribed by a contracted transcriber, with each participant emailed a copy of their transcript to check for content accuracy.

Table 15.

Examples of Questions and Prompts from the Semi-Structured Interviews and Focus Group

Question	Prompts
When you did the PRPP training, can you tell me some of the things you did when you first returned to work after the course?	Can you tell me more about that?
The PRPP training is an intensive 5 days. Thinking about the course, is there anything you would change, or which could have better prepared you for returning to practice?	Why?
Tell me about a client that you used the PRPP with after you completed your training.	Tell me what happened? How did it turn out?
Can you think of a client or situation that using the PRPP didn't work out in your practice?	What happened? What were the challenges?
Interviews only: Have you used the PRPP assessment with clients of cultural affiliations other than your own?	Can you give me some examples? How did it turn out?
Interviews only: Thinking about the PRPP, are there any aspects of it that are not culturally relevant / appropriate or suitable?	Why?
Focus group only: Thinking about the PRPP itself, are there any amendments or changes or anything that you think it needs from a Māori cultural perspective?	
When you've written reports of PRPP findings, how was that for you?	For the team? Clients?
How do you feel about "being an occupational therapist" since you completed the PRPP course?	Has anything changed for you? What's different?
Is there anything else you would like to say about your experiences of the PRPP?	

Data analysis

Data from the interviews and focus group were managed as a single data set. Analysis employed Braun and Clarke's (2006) latent approach to thematic analysis, which is a flexible inductive method that supports the emergence of themes direct from the data without predetermined codes or categories. Braun and Clarke's initial analytic steps were carried out by the primary researcher as follows: 1) familiarisation with the data through reading and re-reading transcripts to form preliminary ideas for sorting data; 2) ideas shaped into three initial codes and the transcripts re-read specifically for text related to these codes, notes kept and multiple copies of transcripts used to develop overlapping codes; 3) five emergent themes developed through mind mapping interactions within and across code groupings. After discussion and critique of the emergent themes involving all three researchers, the primary author combined steps 4, 5, and 6 in a recursive process where themes were reviewed, named, defined, written and re-written with relevant quotes to capture theme meanings.

Trustworthiness and rigour

The study design incorporated a naturalistic approach (Lincoln & Guba, 1986) to address trustworthiness and rigour. Methods included the following: two sources of data collection; participants checking transcripts and receiving a summary of findings; member checking with Māori participants reviewing research findings and future publications; an audit trail tracking all decisions; quotations used directly from the data; providing participant demographics (see Table 1); and supervision throughout the project with continual reflexivity to manage the primary researcher's assumptions and minimise bias.

Findings

Analysis established five themes which captured the PRPP assessment resonance with participants' practice expectations, translation to practice, communication of occupational performance focused assessment results, validation of the practice fit of the PRPP assessment and cultural application.

Resonating with practice as it should be

Participants described strong positive emotions in relation to learning and using the PRPP assessment, experiencing it as in line with their perspectives of occupational therapy practice:

The course was very in line with my thinking and it was in line with what I do (Jenny).

I remember sitting down on that first day going ‘This fits!’ This really fits with what we do (Sara).

The training strengthened and clarified their identity as occupational therapists. Participants were ‘proud’ (Meiliani), had ‘confidence’ (Ruth) and the PRPP assessment ‘helped unravel things’ (Aroha). It both complemented and enhanced existing practice through building on previous assessment understandings.

You’re still looking at exactly the same task but PRPP allows you to break that task down so that it’s more specific...PRPP hones the observation (Tracey).

As such, the PRPP resonated with the therapists’ worldviews of how occupational therapy practice should be.

It just felt like I was coming home ... it encompassed my vision of what an OT should be doing in their assessments (Rosie).

Translating to practice

The process of translating the PRPP assessment began during training where participants started to assimilate the information, to comprehend and interpret it for practice. For many, this was an ‘involved process’ (Rosie) keeping up with the volume of information, which led to concerns they were potentially missing content or misinterpreting. Rosie explained:

When you’re quite new to it [the PRPP assessment] and you’re having to think through each new bit. Check for instance ...the glossary ...and check ‘now have I got this right? Where did I see that?’

Others felt it was ‘cognitively challenging’ (Tracy) and were ‘overwhelmed’ (Irene). For Hannah, a recent graduate, relating to the information was also difficult:

I didn’t have the clinical experience that when they [instructors] were doing the examples I wasn’t like ‘oh yeah’ I’ve worked with someone like that before.

Despite the challenges, participants generally viewed five days as sufficient for training. On completing the course, there was a need to think about how to apply the PRPP assessment to participants’ specific contexts. Sara explained:

I think it [the course] gave me the tools it’s just, it was the working out how to fit it in the setting and how to use it myself and that’s stuff I needed to do. I don’t think it was anything the course could really provide.

Others questioned whether there was time for such ‘thinking’ (Ruth) in practice settings with ‘high caseloads’ where therapists ‘looked for something that’s going to be really quick, that they can learn quickly, do quickly’. Fitting the PRPP assessment into practice entailed balancing busy caseloads with professional development, which required dedicated time and support from employers.

When the assessment was translated to practice, all participants adopted a practical approach and described it was easier to do with support of others. They learnt together in four ways: 1) *Learning with peers* by attending the course with a peer or establishing a peer review process to observe one another doing an assessment; 2) *Support groups* set up to share ideas, discuss cases, assessment results, and review scoring and/or documentation; 3) *Supervision* with an experienced PRPP-trained clinician to reflect on the PRPP assessment and ‘the applicability of using the tool in practice’ (Kate), to guide clinical reasoning, ‘problem solve’ issues (Jenny) and develop learning goals; 4) *Support from others*, which involved other team members or managers assisting with forming goals, reviewing assessment results and reports.

Communicating assessment results using an occupational performance focus on cognition

Communicating PRPP assessment results differed from participants’ previous reporting practices and brought both challenges and benefits. It required a shift from focusing on cognitive skills per se and a change from their ‘habitual way of thinking’ (Irene). Ju explained:

It took a while for me to get used to ... because I tried to stay away from using the psychometric measures of labelling patients with ‘neglect’ and things like that.

Parting from known cognitive-focused reporting also involved managing other team members’ expectations. For some this was challenging, as biomedical approaches which focused on cognitive skills as separate from occupation were often entrenched in practice, and conscious effort was needed to report from an occupational perspective. An additional concern for some participants was occupation-based reports might not be considered valid by other team members.

It is still quite qualitative... it’s very functional based and maybe in some medical fields, people might not see that as strong enough [evidence] to see the issue (Ruth).

This revealed that before participants could communicate occupation-based results, they needed to view this type of communication as credible. Another aspect of communicating involved using PRPP descriptors (descriptions of cognitive strategies), which necessitated participants understanding criteria to apply the descriptors. Sara stated her ‘biggest worry was trying to get my head around the criteria [application of descriptors] for the Stage Two’ and Irene ‘I got caught up with all the descriptors ...how to kind of use the language to describe what I observed’.

Tracey, explained how time and practice was needed to write reports:

Like this report [the latest one] has actually taken me a lot less time to do, because I think now, after doing it, for four or five times, the language is in my brain now ...it actually comes out without me having to really think about it.

Participants conveyed that once they had mastered how to communicate PRPP assessment results, there had been benefits. Ann found:

It helped me simplify reporting a bit more, rather than using... a whole lot of thinking and terms like divided attention.

And Jenny:

It [the report] appears understandable to them [clients], when I describe it. Particularly because you’re relating it to something they’ve just done, or just done the week before... Because I’m giving them those concrete examples of when you did this, I noticed that this happened.

Similarly, Aroha relayed how she had used the descriptors as a common language to explain clients’ performance to community support workers. Peter also gave an example of occupation-based reporting making sense when explaining clients’ performance of culturally specific occupations:

I know what I want to achieve from a boil up [traditional Māori meal] perspective, justifying it to a scientist or medical person and that [PRPP assessment] allows me language that justifies how I want to practice as a cultural clinician.

Validating the practice fit of the PRPP Assessment

All the participants endorsed the ecological fit of the PRPP assessment, and how they could use it where clients lived their lives, whether in natural or unnatural contexts including: ‘an office’ (Jenny); ‘classroom’ (Sara); and ‘the shops’(Aroha); and a hospital

‘ward’ (Hannah). Participants also affirmed the PRPP assessment involved a truly client-centred process. Peter explained this as ‘PRPP is quite a personal goal focussed assessment... allows the client to really be part of identifying what they feel is important’ and Jenny confirmed ‘I feel fine saying to the client “Well it’s your choice, what you want to do” since the PRPP had fitted them all’.

The flexibility of the PRPP assessment was validated as the design allowed it to be applied in different ways, meaning participants could select parts of the assessment to fit clients and contextual requirements. This flexibility was seen in the choices of application it provided therapists. Examples included: Stage One as a quick ‘functional screen to see how they [clients] perform in an area’ (Peter): use of Stages One and Two, where Stage One ‘gives you the structure that you do and score...if you need to go into detail of steps then, there’s Stage Two... So, it gives you this kind of flexibility’ (Irene), as a ‘framework you can dig a bit deeper’ (Ruth), and as an outcome measure. Meiliani articulated that point as ‘we score it...use that as a baseline. And then on discharge... we do an updated one and we usually see they improve’.

Kate attested to the overall flexibility of the assessment and claimed:

When everything’s really fluffy in OT and its very subjective the way we’re observing, the PRPP really helps to give a really good framework to describe what’s happening and to use terms that have clear meaning. To be able to do that ecological validity and the task analysis and then to be able to do all that interpretation in Stage Two, I think it just adds so much value to the role of an OT in rehabilitation.

Participants also validated the fit of the scoring system in their practice. Especially the ease with which others understood the percentage scores and the spider graphs, which were ‘welcomed by doctors’ (Rosie) and ‘clients seem to prefer seeing a graph’ (Ann). Participants confirmed having an assessment with strength-based results focused on positive aspects of clients’ performance suited practice needs. Sara related this to school-based practice where:

Teachers get just quite fixed with the whole things that they [students] can’t do. And you come in and there will be a lot of negativity ...and when I break it down into what they actually can do ... that really helped.

Cultural application

Participants shared experiences of using the PRPP assessment with clients from different cultures than their own, with diverse ethnic backgrounds including people of Māori, Pacific, NZ European, Asian, Chinese, Nepalese, Sri Lankan, and European descent, choosing assessment occupations that reflected their heritage. This was most evident in relation to meal preparation, including preparing taro leaf with corn beef, chop suey, a Nepalese ‘fish head [dish] eaten on the floor... with their hand’ (Hannah) and ‘shopping for green bananas’ (Meiliani). Other examples of occupations assessed included changing a car battery, making a horseshoe, leading an exercise group, and decorating a Christmas tree.

Less variety was described for PRPP assessments with clients in hospitals/rehabilitation settings where predominantly self-care and simple kitchen occupations were performed. Even so, participants working in these settings recognised it had been possible to accommodate unique ways clients performed these occupations, for example by advocating for culturally specific tools or ingredients. They developed a different way of questioning, asking open questions like ‘what would be the normal way of doing this?’ (Kate). Tracey emphasised ‘not making assumptions about what they’re [clients] going to do’ and Irene identified needing ‘to know what is okay according to that person’s cultural background’. At times this challenged participants’ own cultural perception and highlighted the need to be ‘mindful’ (Irene). Many of the participants with different cultural affiliations agreed that when using the PRPP assessment, it was necessary to consider the potential influence of their own cultural bias on the assessment process and ‘important occupational therapists ensure they are culturally safe and competent’ (Aroha).

Discussion

This study provides insights of occupational therapists’ practice experiences of using the PRPP assessment, which both resonated with participants and challenged them. The PRPP assessment being the type of assessment participants wanted to use is a finding congruent with the profession’s ongoing promotion of occupation-based assessment practice (Stigen et al., 2017) and growing evidence which supports the PRPP assessment as a viable assessment. Despite these positive views, challenges lay in participants adopting the occupational perspective needed to fully implement the assessment. For some, even when they were committed to applying the PRPP assessment, ingrained reductionist, component-based reasoning remained in their practice. This component-based thinking

may perhaps endure since it is typically used for traditional assessments of cognition, which Holmqvist et al. (2014) have asserted is less demanding than reasoning associated with assessments focused on occupational performance.

For many participants in this study, a paradigm clash was evident. To effectively use the PRPP assessment they needed to consciously free their thinking from biomedical influences and place occupational performance foremost in the assessment process. Currently, although the profession readily acknowledges this paradigm clash influences practice, little is known about what changes to thinking or practice therapists need to make. Change has been likened to moving along an occupation-focused continuum, with biomechanical reductionist practice at one end and occupation-focused practice at the other. Gillen and Greber (2014) proposed any small steps therapists take in shifting thinking away from the reductionist end of the continuum will gradually increase their confidence to enact occupation-focused practice.

In this study, participants who engaged in occupation-focused practice prior to PRPP training appeared to implement the assessment and communicate with an occupational performance perspective of cognition more easily. In contrast, a conscious effort was needed by others to develop a stronger occupation-focused framework and mind-set, which required a paradigm shift. A shift that seemed to entail a philosophical leap to let go and trust an occupation-based assessment. While no reference of such a leap appears in the literature, it is perhaps only possible when occupational therapists are grounded in occupation-focused philosophy (Wilding & Whiteford, 2009) and have sufficient 'ontological security' (Molineux, 2011, p. 26). Briefly stated, ontological security is the notion that humans need a touchstone, familiar worldview or framework to feel safe, especially during times of change and/or challenge. In this study, a prior occupation-focused perspective seemed to facilitate the process of translating an assessment that focusses on the use of cognition in everyday life.

Other team members were a further influence on participants' use of the PRPP assessment. Some participants felt social pressure to perform traditional cognitive assessments and were unsure of presenting occupation-based assessment results. This finding is consistent with other studies which have reported how occupational therapists: want to fit in with multidisciplinary teams (Wilding & Whiteford, 2009); select cognitive-based assessments expected by others (Stigen et al., 2018); and perceive occupation-based results as less scientific (Stigen et al., 2017; Wilding & Whiteford, 2009). In this study, however, team members affirmed the benefit of the PRPP

assessment results, a finding similar to the enhanced profile occupational therapists experienced when assessment results from the Model of Human, Occupation Screening Tool were shared with an acute psychiatric team (Parkinson et al., 2008). Preparing occupational therapists to manage multidisciplinary team expectations during PRPP assessment training may help them more easily communicate PRPP assessment results when they return to practice.

Lu (2014) questioned whether fast-paced and community environments might limit use of the PRPP assessment. In contrast, this study supported its utility across a range of real-world contexts. Alternate explanations of Lu's finding of limited use in those settings might be therapists' lack of ontological security or that therapists who doubt the assessment's utility were more likely to participate in an anonymous survey rather than face-to-face interviews.

Consistent with the intent of the PRPP assessment design, the flexibility of the assessment enabled occupational therapists to tailor the assessment to meet client needs. This finding has added previously missing practice examples of the client-centred application of the PRPP assessment with clients of diverse cultural backgrounds performing culturally specific tasks. However, this flexibility was only possible when occupational therapists practised with cultural awareness, truly used a client-centred approach, avoided assumptions, asked open-ended questions and were genuinely amenable to clients selecting and performing their own assessment occupations. These traits are considered necessary for culturally responsive assessment practice (Muñoz, 2007). Likewise, for therapists to effectively use the COPM requires client-centred skills, a 'willingness to listen to the clients' points of view' (Enemark et al., 2018, p. 3) and understanding of client's cultural occupations, values and needs (Fisher, 2005). The findings from this study indicated it cannot be assumed occupational therapists have culturally responsive client-centred skills required for the application of occupation-based assessments, such as the PRPP assessment. Rather, participants in the current study needed to develop specific client-centred communication skills, which suggests that therapists may be better equipped for practice if these skills were incorporated into the PRPP training. While cultural safety and cultural competency were also seen as necessary traits for using the PRPP assessment, the specific nature of these traits was not investigated.

Flexibility was also shown in the varied ways the assessment was applied to fit practice requirements, some of which have previously been identified, for example Stage One

and Two to measure occupation performance and cognitive strategy application (Nott & Chapparo, 2008; Stewart & Chapparo, 2011; White et al., 2020), as an outcome measure following intervention (Nott & Chapparo, 2008) and to identify clients' need for assistance (Ranka & Chapparo, 2010). The other ways participants used the PRPP assessment were not evident in the existing literature such as for a quick screen in acute settings, a clinical reasoning tool and strength-based assessment. These applications, however, bear similarities to attributes recognised as important for occupational therapy assessment practice (Robertson & Blaga, 2013).

Learning and translating the PRPP assessment to practice was an involved process that required time, commitment, and disrupted previously established assessment practice. Equally, adopting other occupation-based assessments has required effort, and without persistence resulted in therapists being more likely to return to previous habitual assessment practices (Asaba et al., 2017). Consistent with the wider literature on occupational therapists' learning preferences, participants were social pragmatic learners. They learnt through interactions with peers, mentors and others (Barry et al., 2017; Cramm et al., 2013), with many participants also using a range of supervision processes acknowledged to advance therapists' knowledge and competency (Ayres et al., 2014). Alongside these well recognised approaches to learning, in recent years the profession has encouraged occupational therapists to adopt more targeted methods to translate knowledge and consider the use of knowledge translation (KT) models (Cramm et al., 2013). KT models and strategies were not investigated in this preliminary study, yet growing evidence supports the proposal that these methods may aid therapists embedding the PRPP assessment to practice (Donnelly & Cramm, 2016).

Implications for Future Research

Further investigation is needed to establish if KT models/strategies may aid the PRPP assessment translation process for occupational therapists. In addition, research focused on understanding clinical reasoning processes associated with applying the PRPP assessment may have potential to support occupational therapists to develop their thinking and decision making to effectively apply the assessment and provide culturally competent assessment practice. Finally, research into how the PRPP assessment results are understood by both clients and team members and the relevance or otherwise of the PRPP assessment results from their perspectives is warranted.

Limitations

There was a risk of recruiting highly motivated participants, rather than therapists who trained but do not use the PRPP assessment or who consider it does not represent the kind of practice they aspire to. A further limitation is that all participants practiced in or near cities rather than more isolated rural areas where therapists would have fewer opportunities for the social support and shared learning which participants in this study used. In addition, there was only one male in the sample, although this gender ratio is consistent with the occupational therapy workforce in Aotearoa/NZ (91% female). Lastly, the study only represented the views of occupational therapists rather than clients or other team members.

Conclusion

This study revealed that the PRPP assessment was the type of assessment participants wanted to use, with its ecological and flexible nature valued in practice. Learning to administer and interpret occupational performance using the PRPP assessment and translating the assessment to practice was an involved process, and as with all new learning required dedicated time and persistence. To address challenges participants connected as social pragmatic learners through observations of each other's practice, engaging in peer reviews, using supervision processes, and establishing support groups.

Using the PRPP assessment required an occupation-focused, client-centred, culturally responsive approach and for some this entailed significant changes to their thinking and was perceived as a challenging process that departed from their previous impairment-focused assessment practices. Many participants affirmed that communicating occupation-based assessment results was a positive change in practice, although it also involved managing other team members' expectations to be able to present results related to clients' occupational performance rather than their cognitive function.

Key Findings

- PRPP assessment added value to occupational therapists' practice
- Effective implementation required an occupation-focused perspective and client-centred, culturally responsive approach
- Communicating occupation-based assessment results both enhanced and challenged therapists' practice

What this Study Adds

This study provides practice-based evidence of the PRPP assessment usage across a range of contexts, together with insights and challenges associated with translating and applying it in practice.

Chapter Summary

The final manuscript submitted for publication has relayed the central Phase One findings and presented a discussion of these findings to the profession in a timely manner. In the manuscript, the added value of using the PRPP-A in occupational therapy practice was conveyed, and practical insights on the utility of the PRPP-A provided. The benefits of occupational therapists having a secure occupation-focused ontological foundation to their practice were highlighted, alongside the need to develop a culturally responsive client-centred assessment practice. Some strategies to aid the PRPP-A KT process were also presented.

In Chapter 1, I explained how the Phase One study findings informed the need for a second phase of this research, and the section on future research implications in the above manuscript affirmed how developing more in-depth understanding of the thinking and decision making involved with the application of the PRPP-A was needed. The findings of Phase Two of the study are reported in the next two chapters.

CHAPTER 10: CONFIGURING A PRPP-A FOR A SPECIFIC CLIENT

Introduction

Findings presented here and in Chapter 11 are derived from the data gathered and analysed in Phase Two of the study and are sequenced in the order participants enacted the PRPP-A process. Both chapters extend insights developed in Phase One (see Chapters 7, 8, and 9). In discussing the findings laid out in this chapter, I considered Phase Two study questions concerning how occupational therapists chose to use the PRPP-A with certain clients and how clinical reasoning shapes occupational therapists' different applications of the PRPP-A. One broad theme, 'configuring a PRPP-A process', covers the unique ways participants put a PRPP-A together for a specific client. The subsequent chapter presents the diverse thinking and decision-making participants used to set up and conduct the assessment, including decisions about participants' own actions.

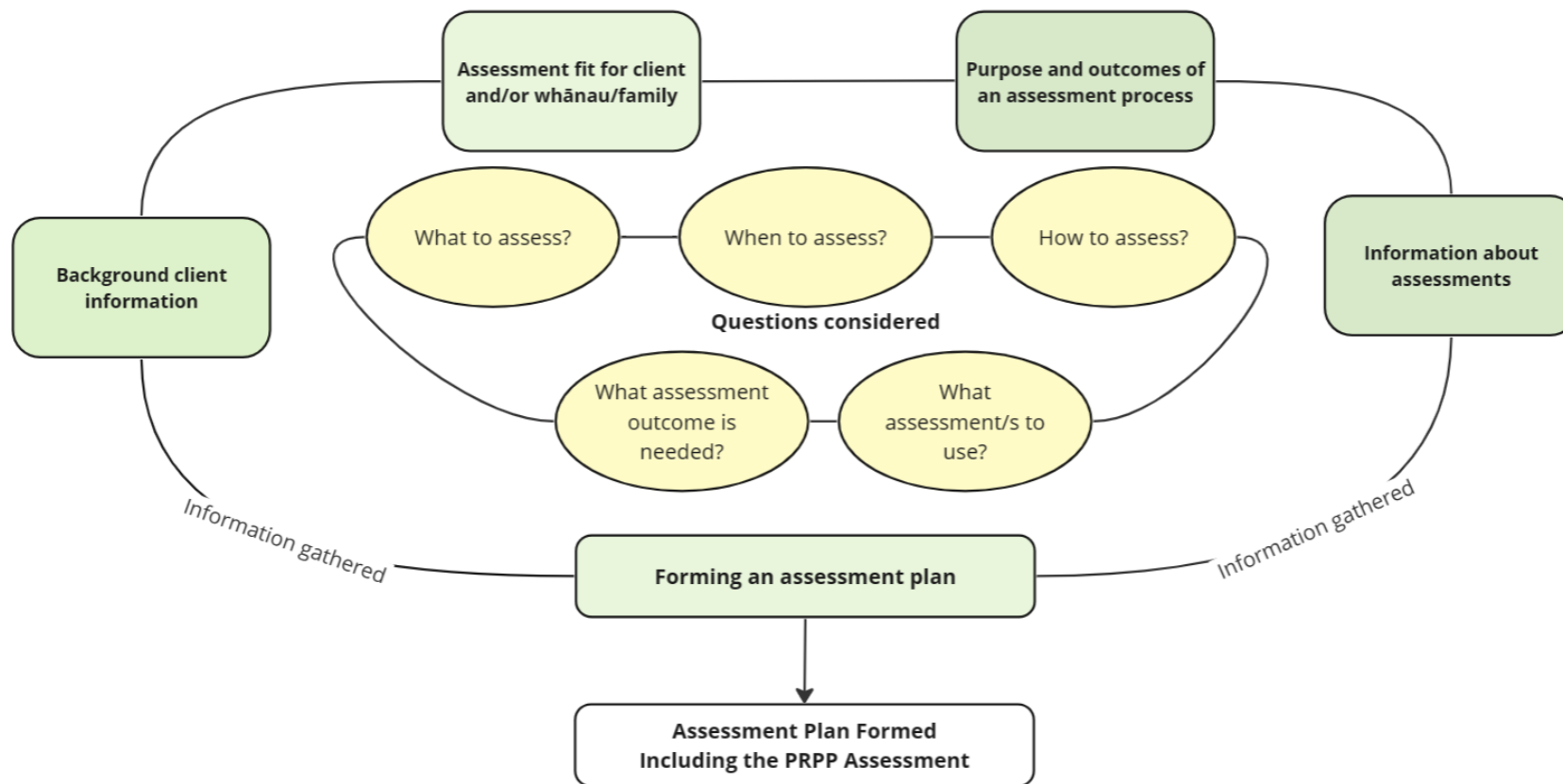
Configuring a PRPP-A Process

The process of configuring something is defined as "to set up for operation" (Merriam Webster n.d.a). To configure something implies more than simply putting the constituent parts together; it involves "arranging or putting parts together in a particular form" (Cambridge University Press n.d.b) for a specific purpose. The participants conveyed the need to configure a unique assessment process for each client. This process was seen as building a personalised assessment since "*it's [PRPP-A] not too rigid and you can look at the person... kind of build it around the person*" (Phoebe). To configure an assessment process involved gathering, thinking about, and evaluating a range of information that informed decisions as participants set up a suitable assessment.

The information considered and decisions participants made are explained under two subthemes, which relate to actions taken to configure a PRPP-A. The first, '*Forming an assessment plan*', encompasses the process of choosing assessments and involved gathering and reasoning about information provided by a client, the intended outcomes, and assessment options available in the practice context. The second subtheme, '*Configuring PRPP-A task/s*', addresses the process of explaining the PRPP-A to the client and considerations for settling on an assessment task with them. The configuration process is represented in diagrammatic forms (see Figs. 6 and 10). It is important to note that separating parts of the configuring process into subthemes and diagrams is a simplistic representation of a dynamic, recursive reasoning process, in which information was linked in multiple ways, culminating in a particular PRPP-A process.

Figure 6.

Information and Questions Considered as Participants Formed an Assessment Plan



Forming an Assessment Plan

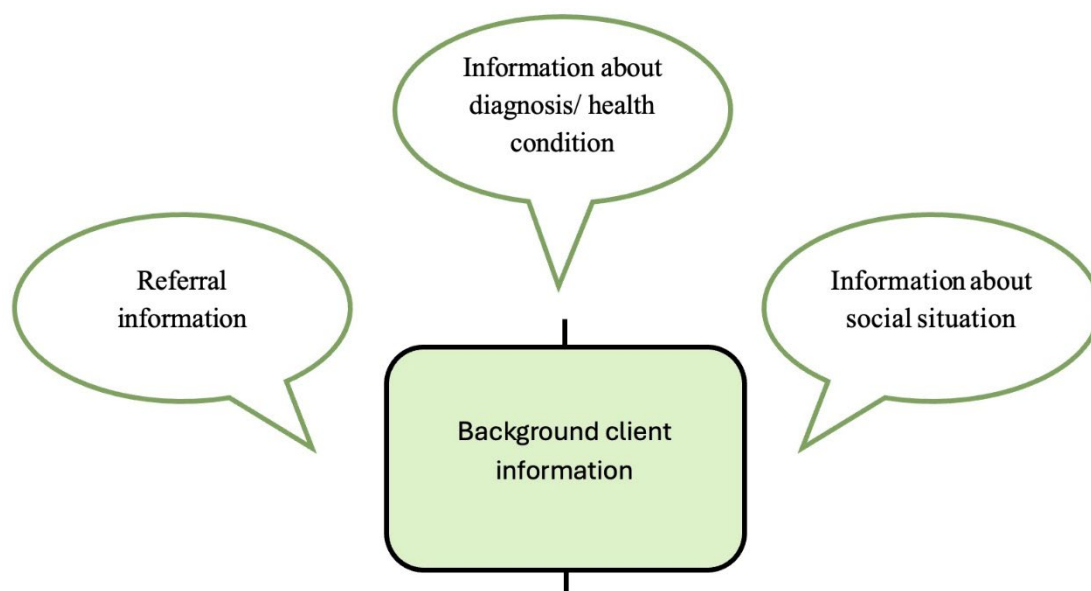
All participants described collecting, considering, and questioning a range of information to develop an assessment plan specifically suited for each client (Fig. 6). The information used for assessment planning has been organised into four categories 1) Background client information; 2) Assessment fit for client and/or whānau/family; 3) Purpose and outcomes of an assessment process; and 4) Information about assessments, as depicted in the outer layer of Figure 6. To form an assessment plan, participants thought about information within these categories and across categories and questioned what, when, and how they would assess, the intended assessment outcome/s, and what assessment tools to use. This questioning and reasoning process is illustrated in the inner layer of yellow circles of Figure 6 and is described below under the separate information categories.

Background Client Information

In line with a usual occupational therapy process (Davis et al., 2007) participants initiated their assessment planning by assembling background information. This included information from the referral, diagnosis/health condition, and for some, the client's social situation (see Fig. 7). They considered this background information in relation to the impact or potential impact on a client's occupations, to begin to hone an assessment plan.

Figure 7.

Elaboration of Background Client Information Section from Figure 6



Referral information provided a general starting point for participants to commence their thinking about what to assess. Referrers typically raised broad occupational concerns such as “*general lack of life skills*” (Awhina), client's ability to “*self-manage*” (Olivia), or

“transition to school” (Jade). Some requested specific assessment of tasks such as *“vacuuming, hanging the washing out on the line, his fine motor skills using a knife and fork and shoelaces”* (Sally) or had expectations of a type of assessment like a *“functional assessment”* (Phoebe and Olivia) which an occupational therapist would traditionally do. As most participants thought about the referral information, they raised questions and identified more information they needed to pursue. Questions included what life skills did a client really need and were suggested referral tasks *“meaningful”* (Sally) for clients.

Alongside the questions identified from the referral, many participants interpreted a client’s diagnosis/health conditions from an occupational perspective, considering both what and how they might assess; this thinking informed decisions on the suitability or otherwise of possible assessment options. This reasoning was illustrated as Jenny used her knowledge of *“frontal lobe injury”* and assessment options to rule out *“impairment”* component-based assessments as an initial assessment selection. She said:

We [team] had nothing like that [a discharge report] because he self-discharged from [rehabilitation service] and had posttraumatic amnesia. So, there was no history, there was nothing, there was no family involved, no one was telling us anything and he was frontal lobe injury... He’s [client] just had a neuropsych [assessment] so I don’t need to tap into any cognitive ones [assessments] at all and the PRPP I feel covers that [cognition] from the OT perspective more so than what a cognitive assessment would do... So, I want to have a good assessment that’s actually going to cover a lot, particularly in brain injury... So that eliminates all the impairment ones.

Likewise, Sally employed similar reasoning when she dismissed using norm-referenced assessments with a client with foetal alcohol syndrome, concluding *“it would be really unhelpful to be comparing him [client] to like age typical teens and what they’re expected to do... or any standardised norms or anything like that”*. In contrast, Nadia thought the absence of a diagnosis for a young child signalled the need for *“a developmental baseline to support the [child’s] delayed presentation for diagnostic purposes by the paediatrician”* and considered assessment options to compare the child’s development with typical expectations.

The three participants working in acute mental health, alongside information about the client’s diagnosis, gathered social background information related to past and future living arrangements and the need for social supports. Phoebe thought about a client who

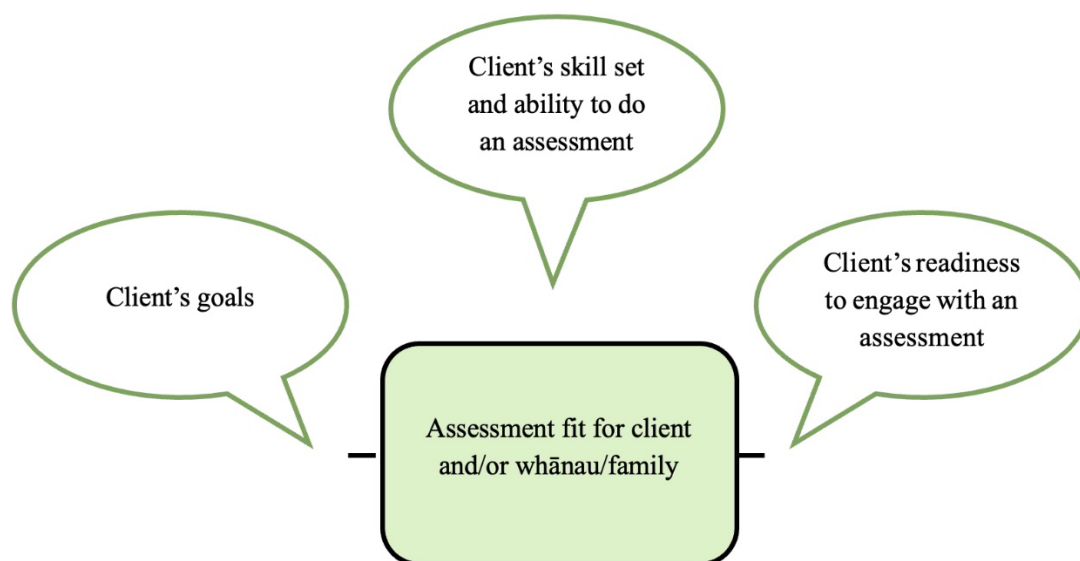
“lives alone in his own apartment. He does not have any face-to-face supports... it sounded like he was quite vulnerable with other people” and wondered *“what his social skills were like”* and *“what level of support he might need”*. Similarly, Awhina recalled how *“the family were unable to have him [client] home due to his aggression and unwellness... and there was concern, he would not be able to live alone without supports”*. By thinking about this client’s social background, Awhina recognised she needed an assessment to identify *“more information, regarding what is he capable to do? What is he not capable to do?”* which addressed the client’s safety and fitted the client.

Assessment Fit for Client and/or Whānau/Family

Considering the match of an assessment process for the client and/or whānau/family (hereafter referred to as ‘client/s’ to represent either an individual client and/or their whānau/family) was important for most participants’ assessment planning. Participants amassed information related to ‘assessment fit’ (i.e., the suitability and/or match of an assessment process for a client/s), which contributed to their thinking about what and how to assess and, for some participants, when to formally assess. No two participants sought the same information from client/s and consideration of assessment fit was a process apparent from the information collected and decisions or actions taken or not taken. The range of information considered included client/s’ goals, skill set, and readiness to engage in an assessment process (see Fig. 8).

Figure 8.

Elaboration of a Section from Figure 6 of the Information Gathered and Considered When Determining Assessment Fit for Client and/or Whānau/Family



Three community-based participants actively pursued knowledge of what client's goals were, by using goal setting tools. The outcomes of the goal setting process then contributed to the assessment direction chosen. Nadia explained how the Favourite Words Framework (Rosenbaum & Gorter, 2012) helped establish that a parent's broad goal for her child was *"to play in a way that had purpose... to play with a toy but together with her [mum]"*. The goal was then matched to a plan to assess the child and mum playing together. Similarly, Sally applied the COPM to *"establish where to focus, how to focus on things that were important to [client]"*. Goals from the COPM led Sally to think about assessing *"something that I thought would be achievable [for the client]"* and would maintain the client's self-esteem and highlight their strengths.

Like Sally, Jenny also applied the COPM and recalled *"so, the goals he identified were around returning to work... He had no money coming in at all because he wasn't tapping into any services, so budgeting, pig hunting, driving, and fixing cars [were his goals]"*. Although some broad client goals were identified, Jenny further questioned whether these were achievable, deciding she needed to encourage the client to *"grade them down a lot"* before she matched the goals with an assessment process. So *"we [Jenny and client] looked at volunteer work as a starting point to returning to work. Basic budgeting and linking into social services"*, with Jenny making a further judgement about maybe *"return to pig hunting, I think he'd be able to do that because he's got good support"*. Her example showed the complex reasoning involved when fitting an assessment process to clients' goals, especially when cognitive impairments affect clients' insight into their performance difficulties.

Jenny also reflected on what she knew about the client's existing skills and, particularly, the client's *"low literacy level"*. This thinking identified assessments involving *"any pen and paper task"* were unsuitable as they *"would have been daunting for him"* (Jenny). Likewise, Mary, who worked in a special school, thought about a student's skill level. She explained the student was *"completely non-verbal"* thus required an assessment of *"naturally occurring tasks embedded in real life situations that are highly meaningful to the student"* (Mary). Similarly, Awhina considered a mismatch between a client's language abilities and the demands of assessment tools, reasoning which led her to eliminate an assessment option. She recalled how the

Acer [Adam Brooks Cognitive Examination], wouldn't be appropriate because of his [client's] language barrier... generally anyone that's not New Zealand

European like, Acer doesn't work, because the kind of nautical theme and then there's another one [assessment task]. People always get that wrong. (Awhina)

The potential ill fit for clients of an assessment was also front of mind for the three participants who worked in mental health. For Phoebe, it extended to concern about any assessment process since *"it's quite hard, even the idea of an assessment or doing something with them [clients]. They can feel really nervous, unsure about doing it"*. Consequently, Phoebe focused on *"making sure it's [assessment process] done on his [client] terms"*. Likewise, the need for an affirming relevant assessment was important for Awhina. She recalled how a nurse had first explained the assessment to the client, with the result the client initially declined an occupational therapy assessment as *"he [client] thought it was just going to be like a sit-down kind of like ACER or paper style assessment. He didn't realise it would be anything to do with a functional test"* (Awhina). From Awhina's experience, it was apparent the client needed to fully understand what doing an assessment entailed and ultimately to decide if the assessment process fitted or not for him.

A client's *"readiness"* (Phoebe) to engage was another aspect of assessment fit considered by some participants. Awhina explained *"if they're [client] really angry or irritable or not even engaging in the groups [inpatient therapy groups], they're not likely to engage in the assessment"*. A client's *"readiness"* was determined through an informal process, which Olivia described as *"an overview...just building a bit of a picture of that person using observations"* and Phoebe relayed as:

I watched him because he joined our OT walks and he comes to the OT area... so I was able to watch him day by day until I noticed that he was able to maintain a conversation and use the area in an organised way and, be able to sort of focus, attend, like have his attention on something until it was done. So, I guess it was observing his attention and his levels of tolerating an activity for longer than a few seconds and being able to communicate clearly and appropriately.

These participants revealed how, through their observations, they completed a 'pre-assessment' evaluation of clients' current occupational performance to ascertain whether doing a formal assessment at that time fitted for the client.

Overall, participants' thinking about an assessment fit for client/s was a sensitive process. It involved building rapport and, for some participants, identifying goals, teasing out and grading goals, comparing the client's skills and assessment options, and a pre-assessment

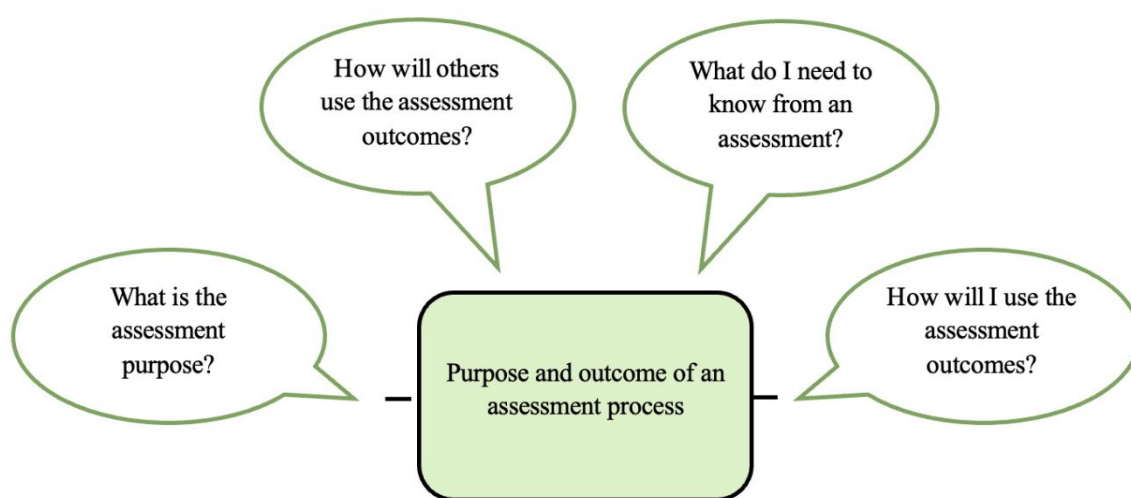
of client readiness. Participants also combined information about assessment fit with information about the purpose and outcomes of an assessment.

Purpose and Outcomes of Assessment Process

All participants reflected on the purpose and overall outcome/s of an assessment process. They questioned what they wanted to know from the assessment and envisioned how the anticipated outcomes might be used by others and/or themselves. Their questioning process is shown in Figure 9.

Figure 9.

Elaboration of the Assessment Purpose and Outcomes Section from Figure 6



Phoebe gave insights into her thinking about the purpose and outcomes of an assessment:

The purpose is to help with the discharge planning. So, it's to help with how I might be able to talk to the team about how this person might be able to cope, what the person might need or what level of support they might need. So, what I need is something which will give me a level of their performance... an everyday sort of activity. I can advocate or suggest that the person has some support or that they don't need support, or they have strengths in an area that the team wasn't even aware of.

Reasoning such as this led to recognition that an assessment suitable for evaluating everyday performance, that identified strengths and support needs, was required. Similarly, Awhina and Olivia questioned the future application of assessment outcomes by other team members: "NASC [Needs Assessor] team always looks at the OT report to see what the issues are and where would be the most appropriate person or provider to

support that person when they leave here [the service]” (Awhina). She elaborated that they [team] were also looking for recommendations. And Olivia thought “so, from the assessment, was there anything that stood out that could help him... and the thing it impacted the most was just thinking about, for his [client] report, I’m going to really make it very detailed. Consequently, Awhina and Olivia decided they needed assessment tools that would generate relevant outcomes for their reports.

Others also shaped assessment plans by thinking ahead. For Jade, this was what assessment outcomes “*might mean for expectations at school*” and Mary predicted a need for a sensitive outcome measure where a child could “*do exactly the same thing [assessment task] ... at the end and [Mary] be able to chart*” any “*little differences*”. In a similar way, Olivia also needed “*to see, in 6 months or a year, well before that person’s discharged, is that number [assessment score] still the same or has it improved significantly?*”. This thinking narrowed her assessment options to standardised outcome measures.

In addition to questioning whether or not an outcome measure was required, many participants thought about assessment processes to inform future intervention. For Jenny,

It was really establishing that nice baseline and a functional aspect, so I know my starting point and I know what I’m focussing on... to get an idea of where his [client] functioning was, to know where my grade, at the current time, is with his tasks... would he be able to go pig hunting with support? Would he be safe?

Jenny’s explanation revealed a linking of the assessment purpose to information about clients’ goals and how outcomes might assist her to set the level and identify suitable tasks for intervention planning. Likewise, Nadia reflected on establishing where to begin intervention:

Where do I [therapist] need to actually help him [child] more, so, what is it that is sitting more on top of the other things? Even though we [client and therapist] need all of it, but where is it that I need to focus?

Her questioning clarified Nadia’s need for an assessment process that would inform a meaningful intervention plan.

Having determined an assessment purpose and desired outcomes, participants linked this information to features of assessment tools required to achieve the intended outcomes. Jade provided a clear example of such thinking as she drew together information about

the purpose and outcome (indicated in green type in the quotation below) with features of a required assessment tool (indicated in orange type below). She explained:

It was reassessment to show where he'd come from [purpose], but I'm also sort of thinking this child's going to start school visits next term... want to see what he's doing [outcome]... I wanted a flexible observation-based instrument [assessment tool feature] that could be tailored to what the child was doing on a particular day at preschool. By nature, preschools and pre-schoolers are dynamic, and I wanted an assessment that I could quickly set up depending on what the child was doing in the context of preschool routines and play [assessment tool feature].

Jade's reasoning clarified her need for a quick observational assessment tool capable of measuring changes and assessing occupational performance of preschool occupations. Similarly, other participants also identified features of required assessment tools and matched these features with their existing knowledge of assessment options.

Information About Assessment Options

Participants all had knowledge and practical experience of the assessment options in their context, which they used to select suitable assessment tool/s and to sequence an order of assessments. Nadia outlined her thinking as:

The sensory profile... because ... he wasn't using his vision so well and mum had said that they'd [family] worked on it, so we just thought that we'd cover all of those areas in terms of hearing, seeing, and how he's feeding, oral motor control... so we had some baseline assessment and then we could do more task things around the play. All those other day to day routine and life tasks we could use the PRPP to do that and look at processing. But we also needed the developmental screen [Ages and Stages Questionnaire] and baseline for that.

To sequence the selected assessment tools, Nadia appeared to order the outcomes she wanted to achieve and applied her practical knowledge of assessment tools. She decided on an assessment plan which first assessed the child's sensory processing with the Sensory Profile assessment, followed by a developmental screen using the Ages and Stages Questionnaire, before the PRPP-A to evaluate his performance of daily routines, including play. Other participants similarly developed assessment plans that combined assessments with the PRPP-A; however, since understanding the rationales for other assessments is not central to this study, these are not discussed further.

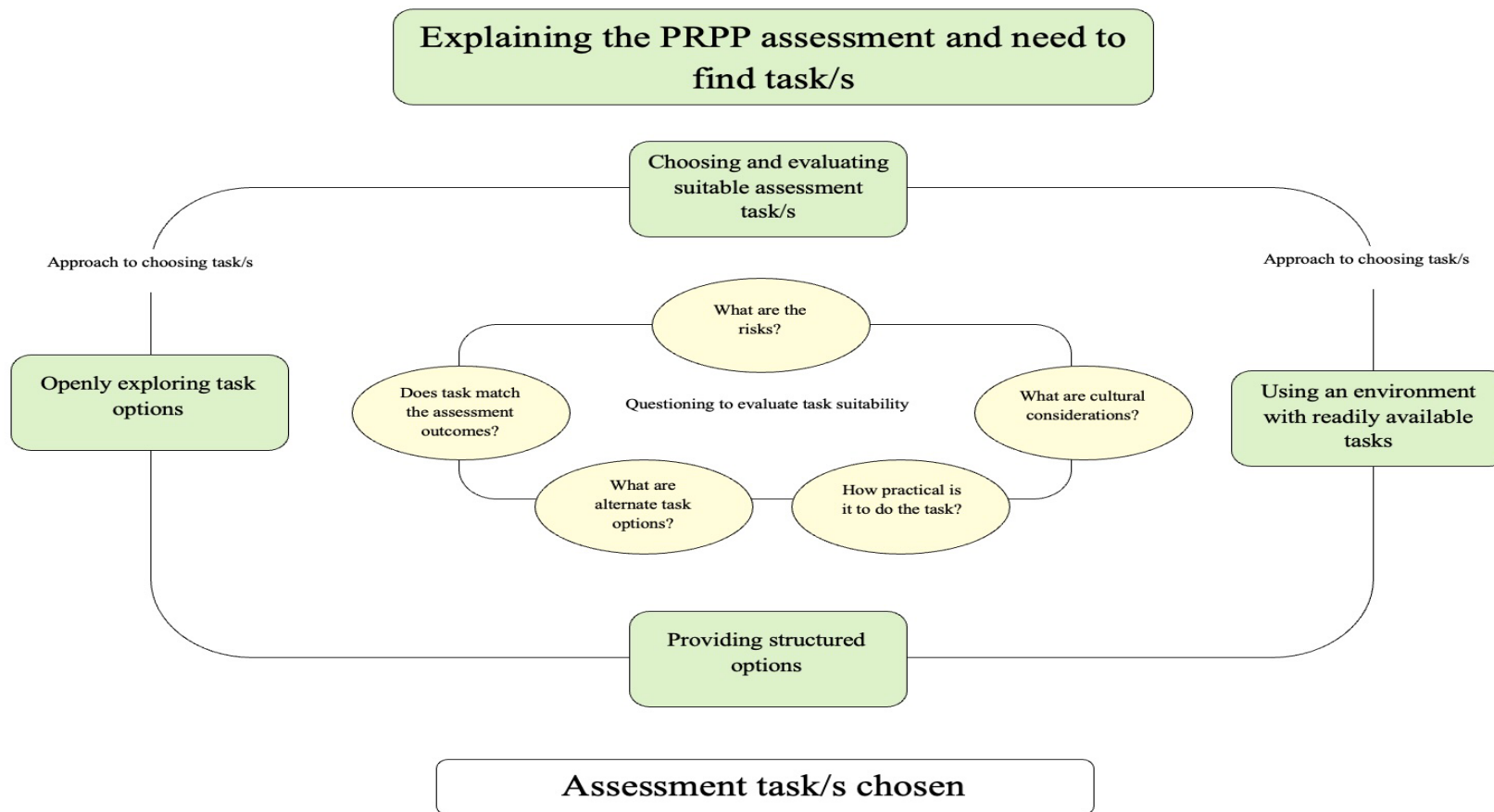
In keeping with the recruitment criteria for Phase Two, participants all chose the PRPP-A as a tool for their assessment plans. Their reasons for doing so shared commonality with the Phase One findings (see Chapter 8), such as valuing it as a “*standardised*” tool (Jenny and Phoebe) with established “*validity*” (Awhina), and because of its linkage “*to tasks and embedded in real life situations... really specific and all-encompassing*” (Mary), and its capacity to “*really drive task analysis*” (Jade) and to make it “*easier to track progress*” (Awhina). Of significance, Phoebe proposed a different reason for selecting the PRPP-A, since it aligned with the mental health Recovery Approach (Read & Stoffel, 2019) used in the service she worked for. She explained the PRPP-A provided “*the opportunity to go and do something with someone that they haven’t done for a while and to build that sense of who they are as an individual and how they can do those things in their own way*” and “*the Recovery Approach and PRPP come together in enabling that individual part of the person to come through*” (Phoebe). For Phoebe, the consistency between the PRPP-A and the Recovery Approach resulted in using it routinely as a first occupational therapy assessment option. Likewise, most of the participants typically used the PRPP-A, which Olivia saw as the “*go to one*” and Mary confirmed, “*I’ve used PRPP for so long that I just couldn’t think of any other go to thing*”. Having selected the PRPP-A within an assessment plan, participants described needing to configure suitable assessment task/s for each client.

Configuring Assessment Task/s

The PRPP-A, by design, has no preset assessment tasks. Consequently, to use the tool involves practitioners finding suitable task/s for each PRPP-A. The participants shared experiences of how they configured assessment task/s through different explanations they provided to client/s of the assessment and the need to find task/s, adopting a task selection approach, and questioning the suitability of task/s. The process of configuring assessment task/s is discussed below and represented in diagrammatic form in Figure 10, with the outer circle showing different task selection approaches participants used and the inner circle the questioning process to evaluate the suitability of task options.

Figure 10.

The Process of Configuring Assessment Task/s



Explaining the PRPP-A and the Need to Find Task/s

In contrast to standardised assessments, with set procedures and task instructions, participants needed to consciously think about how to introduce the PRPP-A to client/s. Specifically, they needed to determine how to explain the process to encourage the client's involvement in choosing an assessment task. Not surprisingly, participants gave different explanations. They chose the amount of information about the assessment tool to provide and thought about how best to engage clients in the assessment process.

For participants working with children, explaining the assessment process seemed relatively straightforward, with explanations given directly to parents and/or teachers. Practice contexts influenced the depth of their explanations, with the two participants in school/preschool settings providing concise information, stated by Mary as *"I talked to teacher and class staff about a targeted task-based assessment that is standardised. I showed them how the task(s) are broken down into steps"*. In contrast Nadia, in private practice, gave an in-depth explanation of the PRPP-A and included showing

the parent/whānau the form [PRPP score sheets] as I discuss the task/goal that they have, and I discuss how I break the task down into steps and then four main domains that I would be looking at, e.g., Perceive, Recall, Plan and Perform.

Nadia's explanation fitted a context where parents funded the service, and thus wanted to understand the details of the assessment and the assessment task/s their child would do.

In contrast, participants with adult clients, who would be doing the assessment tasks themselves, portrayed how they balanced the information they shared with *"maintaining rapport"* (Awhina) and ensuring *"buy-in from the client"* (Jenny). Phoebe likened the process to a *"bit of a dance"* providing a carefully choreographed explanation relayed as:

I explained to X [client] as part of the discharge planning process, it would be helpful to be able to find out whether there was anything he needed to do his meaningful activities. I asked whether I could observe him doing an everyday activity. It was to bring up what he might find challenging and what he can do well. I encouraged a collaborative angle, suggesting X consider how he does things and to let me know when something challenging came up. I avoided using the word assessment as I have found it causes anxiety; it prompts people to ask, 'Did I pass? What happens if I fail?'

Phoebe configured the assessment information to protect the client with mental health conditions from potentially detrimental effects of explaining a scored assessment process while still encouraging him to do the assessment. Her explanation was designed to promote collaboration, client agreement, avoid feelings of failure, and engage the client in finding a ‘meaningful activity’ to assess. However, the explanation also had a somewhat coercive message since, like the two other participants in mental health settings, Phoebe implied doing the assessment was something a client had to do before discharge, as it was part of the “*usual process*” (Olivia).

Jenny relayed a different way to engage the client, emphasising the overall benefits of doing the assessment. She recounted the gist of her conversation as:

As an occupational therapist, I work with you [client] in getting back to the activities that you [client] enjoy, such as’ I recited goals he determined on COPM. ‘For me to get a better idea of how you are going to get back to these tasks, I really want to see you participate in some activities. This will help me to see how you approach tasks and any difficulties that you may be experiencing as a result of your injury to your brain. Are you okay if I observe you doing something next week?’ (Jenny)

The flexible nature of the PRPP-A meant participants put together individual explanations of the assessment process to suit each client and practice context. They moulded information about the PRPP-A process and task selection for different reasons, including to assist client understanding, gain agreement to do the assessment, promote collaboration and ongoing rapport, and to set the scene for choosing assessment tasks.

Choosing and Evaluating Suitable Assessment Task/s

Having introduced the notion that a task needed to be selected, participants adopted different approaches to choosing the specific assessment task/s to use. These included openly exploring task options, providing structured task options, using an environment with readily available tasks, and combinations of the aforementioned approaches. Alongside selecting how to approach choosing a task, participants began, to differing extents, questioning the suitability of potential tasks in relation to the task match with the assessment purpose (identified above), any risks associated with doing the task, and cultural or practical considerations of doing a task. They also generated alternative task options and continued questioning task suitability, eventually narrowing options to

chosen assessment task/s (see the yellow loop in Fig. 10). The approaches adopted, and the questioning and evaluating involved with choosing task/s, now follows.

Openly Exploring Task Options

Two participants took an open approach to explore task options, encouraging clients to choose assessment task/s using a questioning process. These participants focused on what was important for clients to do from the client's perspective. Having established the client's goals (as outlined above), they sought culturally relevant task/s. Nadia explained how *"it was important that I heard what they [parents] valued in life to match [assessment task/s] where the family were at, and the tasks that they were wanting to work on"* and how she began to question the family about their values and usual routines. She asked:

Questions around, what's important for you, what is it that you're wanting to do in terms of next steps, what's happening at the moment, how you're feeling about that but also, what some of their values were and 'how can I help with whatever, wherever you're wanting to go, what is the best option here?'... they [parents] needed to know that I was listening to them because actually, she [mum] is more the expert of her child, not me, and I just needed to listen to her so that I could be part of that journey alongside them, rather than putting on my big expert hat... which I'm not. (Nadia)

Nadia emphasised the need to 'just' listen to hear the family's perspective and consciously put aside her 'expert' knowledge. She stressed how *"values are part of culture"* (Nadia) and understanding the family's culture assisted her therapeutic relationship by developing necessary trust to then ask more specific questions about:

Life routines and the tasks within that, to be able to understand how mum is doing things now and what's happening now for them [the family], [which] means that I can match that a bit more [with an assessment task]... what are the things that they are actually doing but also what is it that they're happy about... and what are the things that they might be finding a bit more challenging. (Nadia)

The questioning process gradually drilled down to the specifics of challenging tasks. In addition, Nadia considered the practicality of what was available in *"the clinic rooms"* and *"what would be similar to the infant's home setting?"*. She also thought about *"the toys and items that the family used at home to set up the environment to match that as much as possible"* (Nadia). Likewise, Jenny thought about the *"cultural fit"* of tasks and

what could be practically achieved, given the client was homeless and temporarily living in his sister's home. She relayed her reasoning as:

I really wanted him to choose something because I wanted him to be comfortable with it [the task] because of that sense of failure that he's experienced... that lack of confidence... probably not really understanding why, because he's got no insight. Telling the client 'You have that choice in what you want to do or what you feel comfortable doing' so I feel like that cultural fit's quite good. He is a Māori client. And he was quite happy with that process. (Jenny)

Jenny sought an affirming process with the client choosing the task to ensure the assessment task had a “good cultural fit”, one the client would be “comfortable” with. Like Nadia, Jenny adopted a questioning process to narrow task options, beginning with wide open questions and moving to shorter targeted questions related to a range of possible tasks. Her questions were designed to assist the client to think through options. Jenny summarised her conversation in her reflective log as:

So obviously the purpose [of choosing a task] is for me to observe something. Is there any task that you need or want to do now?

Client. He couldn't think of anything.

Me [Jenny]. Do you need to do the dishes, vacuuming, laundry?

Client. No.

Me. Do you want to mow the lawns?

Client. Did them yesterday.

Me. Do you need to do any other chores in your room or around the section?

Client. No, did them all this week.

Me. Do you need anything in the community, should we go shopping or something like that?

Client. No, don't have any money.

Me. Is there anything else you can think of?

Client. Pig hunting, riding a Harley.

Me. Okay, we are working towards that but possibly need to do something a little safer while I get an idea of how you go.

Jenny's conversation demonstrated challenges that can be involved when encouraging a client to choose an assessment task, particularly when cognitive impairments and social/economic situations limit task options. Her open questioning approach demanded Jenny continually think of alternative task options and weigh any risks associated with the client's suggested tasks, recounted as:

I can suggest some ideas, but I'm looking around the house thinking, there isn't anything because it's not his house, he's only been here 2 weeks... I didn't even feel like we could wander around the house and find a task because it's not his house. And he's been launched into this situation where his basic needs are not even being met. So, I was very aware that he's got no money, he's homeless. He's living in his sister's house that he can't stay in for a long period of time... Ah I'm like stuck because of that socio economic, it's like this is not a situation I'm ever in myself so, I'm in a foreign situation for me to be able to draw on my own resources... I've been doing OT for a long time now, so it's not like I start panicking or anything like that, but I'm just going through my brain of actually 'I'm void'.

Jenny's rich description of her reasoning conveyed how she thought through alternative strategies to search for options, considered solutions to practical challenges of financial factors, and managed her own emotions when confronted by a lack of task options. When Jenny hit a 'void', she decided to try another approach to assist the task selection (discussed later).

Both Jenny and Nadia's exploratory approach to task selection required skilful conversations, willingness to actively listen, the ability to think of open guiding questions, consider multiple task options, and be prepared to follow the client's lead on what they wanted assessed. All the while, they were simultaneously considering proposed task options with any safety implications and practicalities of using the task/s in an assessment. In addition, for Jenny, the approach required further negotiation of task/s when the client's options were unsuitable. Consequently, using an open approach took time to partner with client/s, evaluate the suitability of assessment tasks, and concurrently match client/s views and still meet the assessment purpose. Other participants opted for a more structured approach.

Providing Structured Task Options

Four participants approached selecting a task by presenting structured task options to clients, with some variability in the degree of structure from completely set options to some semi-structured choice. Sally was the only participant to initiate the selection with completely set task options based on the previously established COPM goals. She “*gave him [client] four functional tasks to choose... taking the rubbish out, folding his laundry and... either vacuuming the lounge or vacuuming the hallway*”. Sally’s approach was quick and controlled, a method which ensured the tasks selected readily aligned with the designated assessment purpose. The client’s voice, however, was somewhat limited and it was unclear how relevant doing the assessment tasks were from his perspective. Furthermore, Sally stated there were “*no cultural considerations*” to the tasks and she mainly thought “*I just didn’t want to get any negative feedback, anything that could be perceived as a negative. He’s quite sensitive, so that’s probably the only thing*”. Sally’s thinking revealed that cultural ways of doing the tasks may have been assumed and attending to the client’s and/or her own emotional well-being took precedence.

Differing from Sally’s set option approach, the three participants in mental health settings offered a semi-structured task option of cooking, with two participants also providing an option of shopping for ingredients. Cooking and shopping tasks were described as “*go-to*” (Olivia) and “*the usual tasks*” (Phoebe) for a PRPP-A for a range of reasons. Olivia saw “*cooking is generally a task people [clients] are having to do every day, so it’s a big task to see*”. As a task with multiple steps, Olivia knew

you can just see so many different cognitive processes and from the criteria [PRPP-A Stage Two cognitive strategies], you can see so many of those quite clearly, like the issues and the strengths for me when you see it in cooking are quite evident.

In addition to a cooking task being useful to assess strengths and issues, participants had found cooking “*really helps with engagement*” (Olivia) in the assessment process as “*food is a big motivator*” (Awhina) since the “*client gets a meaningful end product out of their assessment, they get to eat whatever they’ve particularly chosen*” (Olivia). Shopping was also promoted as a relevant assessment task portrayed as:

Community management is a big thing, as you can say ‘Oh someone functions really highly’ in here [inpatient unit] but maybe in a supermarket they can’t figure out where their items are... they’ve been able to cook absolutely fine but when it

comes to orientating to the supermarket or problem solving with an ingredient being too expensive or items being sold out or even just using the self-paying machine, and figuring out where you put the money and, what item they can do without if it's way over the budget, or how they're going to manage that. So, in some ways, it's really good having that extra thing where people, if they're looking for meat in the vegetable department, it kind of gives you an indication and that they're not able to move from that. Actually, that's an issue! They do need support with going to the supermarket, and kind of having someone coach them through, how to orientate themselves and writing a list and all of those things. (Awhina)

When suggesting broad shopping and cooking tasks, participants drew on knowledge of doing previous PRPP-A and offered two tasks they considered best matched the assessment purpose, while still offering flexibility and choice to clients.

Before discussing options with client/s, these participants had screened for any possible risks associated with doing shopping and cooking. This consideration was described by Phoebe as

Using my own informal assessment, but also hearing what's been happening from the team. And also, just acknowledging any safety concerns... like if people aren't ready for leave, they might have some really high risks around going out or... using a kitchen where there are knives in the cupboard.

This thinking influenced her “*decision making about when to do it [offer shopping and cooking tasks] or if cooking is the right activity*” (Phoebe). Likewise, Olivia contemplated safety risks and recalled how

He'd [client] been on two other outings within the week and he hadn't taken off so I considered 'Oh it's quite safe' because he's already had the opportunity to go out and he's returned without a problem... that's when I thought 'Now is a good time to do the assessment with him' and he had just started to come to our cooking groups.

From the groups Olivia had observed:

That he [client] had had a few difficulties with starting the task, and kind of looking around and hovering, but not being able to do the first step without a bit of a prompt. I'd noticed he was a bit clumsy with his fine motor movements, like often things would get a bit spilt on the bench. Like, even if he was just making

noodles, he would have trouble just opening the packet. Also, it was searching and locating, I think, he had some difficulties with.

Of interest is that Olivia appeared to have automatically applied the PRPP-A as an informal observational framework to guide her observations. She had evaluated errors in steps made by the client, prompts provided, and analysed the client's ability to process information 'using the PRPP language'. Similarly, the other two participants had also used the PRPP-A as a screening framework, and as they reflected on their group observations, they identified the group tasks could have been used for a formal PRPP-A. Awhina acknowledged "*we've made kawakawa [native plant] balm yesterday, bath bombs, just different stuff that actually you can probably do a PRPP on as well*". Although Awhina quickly discounted this task option, since "*you're not necessarily getting a quiet environment or it's not always the right environment for it [a formal assessment], whereas the kitchen you can kind of close off and it can be a bit more of a focus*". Olivia also preferred a "*one to one [cooking task] and he's [client] planned it and it's his chance to kind of do it all by himself*". Such accounts revealed the influence of participants' own views on how they considered the assessment environment needed to be; these views are analysed further in the next chapter.

Once a client had agreed to shopping and/or cooking tasks, participants encouraged the client to choose a specific food/meal to be assessed. Olivia explained that choice as just having "*a conversation with that person, around if there's a meal that they would like to cook, and they are provided with \$10 to go to the shop to get the ingredients to make their meal*". Olivia emphasised being open to the client's choice of meal, so it "*meant he [client] could kind of cook any food that was meaningful to his culture*". Furthermore, Olivia considered the client's ethnicity, although was careful not to make assumptions based on this consideration, and instead focused on ensuring the client selected their preferred meal. She recalled

He is half Samoan and half Māori and he has mentioned to me that one of his favourite dishes is chop suey and he's made it before. But he decided when we were talking about the assessment that he didn't want to make that meal... he selected to make noodles and sausages. (Olivia)

In a similar way, Awhina considered the client's ethnicity and made certain she had culturally relevant choices. However, since COVID-19 restrictions were in place she was unable to take the client shopping. Consequently, Awhina adapted her usual semi

structured approach and, like Sally, provided set task options. She thought of “*five different recipes*”, matched the level of recipe complexity with what she knew about the client, and opted for “*quite simple, not too complex*” recipes (Awhina). Awhina also considered the availability of “*all the ingredients*” and the time required to do the cooking, identifying she needed “*something that’s within like an hour timeframe... just because of timing on the ward*”. The client was offered “*Afghan [biscuits], shortbread, chopsuey, and ...two other recipes, I think corn fritters and there was another Samoan recipe... but out of that he selected Afghans*”. Awhina checked the client’s familiarity with the task and discovered he was unfamiliar with the recipe. Despite his unfamiliarity, like Olivia, Awhina went with the client’s task choice. She was, however, concerned whether the client understood the purpose of doing an assessment and what the possible implications of him choosing a novel task were. She questioned if she had adequately explained the assessment process or if the client “*just thought, just get it [cooking] done, something quick, instead of actually this needs to be something that I’m quite good at to demonstrate my skill. So, I have the right supports on discharge*” or if his choice was based on being “*a quick recipe*” or a “*nice treat*” (Awhina). Awhina’s experience highlighted potential complications associated with client’s choosing tasks and reasoning required to navigate institutional factors, offer culturally relevant tasks, honour client choices, ensure an assessment process was adequately explained, and constantly gauge if using the selected task was likely to provide accurate information for an assessment outcome associated with discharge planning.

Additional challenges associated with deciding the specifics of a task were raised by Phoebe, who was working with a client with limited communication. The client had agreed to do shopping and cooking; however, did not communicate what he wanted to cook. Phoebe explained he was “*quiet and nodding and he didn’t have eye contact... it was hard trying to engage him in a conversation*”. Consequently, Phoebe persisted with conversations over the following days, without success, before deciding to set a time to just go shopping. Changing the environment to one with readily available occupations, Phoebe looked to create natural assessment task opportunities, an alternative approach that several other participants also adopted.

Using the Environment with Readily Available Task Options

Participants who approached task selection by using an environment with readily available task options either situated the assessment in a certain environment from the outset or changed the environment to provide further task options after they had tried

other approaches. In both scenarios, despite there being readily available task/s within the environment, participants still needed to select specific tasks to assess and evaluate the task suitability.

Jade and Mary, who assessed children performing tasks at preschool and school, explained they had thought about preparation before arriving at the assessment environments. Preparation involved gaining consent from parents and/or teachers to complete an observational assessment in preschool and school environments, agreeing the purpose of the assessment, and broadly identifying potential assessment task/s that might be used. Jade sought to assess a child's progress since the last assessment and his readiness to transition to school, and Mary undertook an assessment of self-care tasks. Both participants considered which task/s from all the tasks performed at preschool and school would best match the assessment purpose and outcome. To make this choice Jade thought about

what might that [challenges in child's performance] mean for expectations at school in terms they sit down, and they do the roll at the start of the day then there's often the teacher will frame up what's going to happen, and they'll go into their reading groups. There's often a lot of sitting and focusing on something that may not necessarily be their first choice.

She compared the requirements of future school occupational performance with the range of preschool occupations available to her, and selected tasks involved in the mat time routine, as

there's just so many opportunities [for assessment of performance like school]. You [child] have to keep yourself in one spot, you have to be able to look to the front, you have to interact with your peers. Sometimes there's a response that's asked from you [child]. (Jade)

Choosing to assess the mat time routine aligned with the assessment purpose and was a routine that she had previously assessed. Jade recognised there were challenges with re-assessing a routine which naturally varied each time it occurred and said "*you never know exactly what's going to roll out with the mat time because often preschool teachers might change it on the hoof too, depending on the response that they're getting they might just change tack*" so "*its [re assessment] not a true kind of apples with apples, but like there's some parts of mat time that are the same, like coming to the mat and finishing off your play*" (Jade). To combat the challenges of re-assessing a changeable routine, Jade looked

for similar tasks within the mat time routine with which she could evaluate and compare any changes in the child's occupational performance. Such reasoning allowed some comparison between the two assessments of the child's performance.

Once Mary had agreed the assessment purpose and arranged to be in the environment where selfcare tasks occurred, selecting specific assessment tasks was straightforward. Mary explained it as grabbing "*an opportunity*" in the school routine when the student was going for a shower and that "*one of the beauties of the PRPP ... if an opportunity presents itself, then you can PRPP it*". Mary only had to decide what parts of the routine to assess and chose to separate the routine into three tasks, "*dressing, showering and toileting*" to "*compare and contrast*" (Mary) the student's performance across different tasks. A drawback Mary recognised to assessing available tasks in a school environment was that she overlooked cultural considerations and "*just didn't give it [cultural considerations] a moment's thought, which is terrible*", adding after further reflection, "*I probably should talk to parents and say what's the situation at home? But he is Māori background so probably, is touching his head an issue? I don't know, that's a preconceived idea that's tapu [sacred]*" (Mary). Mary's experience highlighted the need to find out more about the student's usual way of doing the task/s, instead of the school culture governing her expectations of how a student's self-care tasks were performed. This situation exposed how assumptions of cultural ways of doing can be made when using a task in a natural environment, particularly when the environment is structured according to a western culture and is different from a client's culture.

Unlike Jade and Mary, who approached choosing task/s through using a specific environment, Jenny and Phoebe each consciously changed the environment, having had no success with choosing tasks through conversations with clients. Jenny expressed this as "*rather than sitting there and talking about it [assessment tasks], I said, 'Oh let's go outside and have a look'*" and Phoebe decided to move from an acute hospital unit and go to the shops. Phoebe justified her decision, saying,

I find sometimes just sitting in the car with someone, you sort of have that parallel chat going on while you're doing something else... he [client] said he'd make what he described as a vegetable boil up... so he didn't have a list of any kind of idea until we got to the shop.

In both these examples, participants changed the environments to facilitate the client's active engagement in task selection. Jenny elaborated on her approach, stating:

I was trying to use a cue, an outside cue that he would be able to find something. Because we were sitting inside at the table so he was in an environment in his sister's house, with a sister that keeps telling him not to do anything... but I knew he had been doing stuff outside, so that's why I thought 'Oh we've just got to go outside because obviously he feels like that's more his area of control and we'll probably be able to find something more out there' ...the client then proceeded to grab a rake and just started raking leaves.

Jenny's account revealed her decision to use an alternate environment, one which gave the client more 'control' to find a task. She also mentally questioned the suitability of assessing raking leaves and noted she was "*very familiar with raking leaves*" and since the client had chosen the task, she viewed "*the cultural fit's quite good*" (Jenny). She then pondered what was typically safe and expressed "*it was more the rural fit... so he doesn't wear shoes*" and "*what's normal and what's not ... and you [participant] don't really get that clear even though you're questioning them. You don't get that clear idea on whether they actually would normally, mow the lawns or rake the leaves with a metal rake without shoes on*" and the complexity of "*I've got someone [client] who is in that frontal lobe where it's like 'I[client] always do that' and they'll say that even when there's a significant impairment they'll say 'I've always done that'*" (Jenny). Jenny's thinking showed challenges that can exist when choosing a naturally occurring task with a client who has cognitive impairments that impact their ability to accurately explain their usual performance and where there are no other people to clarify the information.

Summary

In this chapter, I have described the information gathered about and from client/s that participants considered as they put together an assessment plan for each individual. Examples of thinking and questioning processes used by participants to decide which assessment/s to apply and when to formally assess clients uncovered how some participants utilised the PRPP-A as a screen to reason the client's level of readiness and safety risks associated with the client partaking in a more formal assessment process. Ultimately, all of the participants assessment/s selections included a PRPP-A, with the decision typically based on participants' prior positive practice experiences of the tool, which they considered as a routine 'go to' assessment. Further endorsement for choosing the PRPP-A was its alignment with the mental health recovery process that, in some contexts, underpinned practice.

Having established a unique assessment plan for a client, participants varied the ways they explained the PRPP-A and the need to find a suitable assessment task/s with the client. Participants fitted their explanations to assist clients' understanding, maintain ongoing rapport, promote clients' 'buy in' and engagement in the selection of assessment task/s. Participants adopted three different approaches to choosing assessment task/s with clients, at times openly exploring task options and at other times providing structured tasks or using tasks within an environment. Choosing tasks with clients was a sensitive process, described as a dance that, at times, required participants to use negotiation skills, culturally safe practice, and lateral thinking to generate different task ideas. Participants also ensured the suitability of task/s through mental questioning of how possible task/s matched predetermined assessment purposes, and practical factors related to 'the doing' of the task, such as associated risks, and cultural and contextual considerations. Furthermore, when finding suitable assessment task/s, participants recognised challenges they had needed to navigate, including overcoming contextual limitations, hidden dominant cultural practices, and complexities that accompanied clients with cognitive impairments and/or limited communication being involved in choosing task/s.

Overall, the process of configuring a PRPP-A for a client entailed flexible, intricate, dynamic, context-specific reasoning by participants. In addition, participants were committed to setting up an assessment process that fitted clients' individual assessment needs, met the assessment purpose, managed risks, was culturally safe, and would achieve desired assessment outcomes. The next chapter presents findings related to participants' thinking and decision making as they practically applied a PRPP-A.

CHAPTER 11: REASONING AND ACTIONS INFLUENCING THE APPLICATION OF A PRPP-A

Introduction

The findings discussed in this chapter relate to the Phase Two study question: How does using the PRPP-A influence therapists' clinical reasoning through the occupational therapy assessment process? The findings presented build on those in Chapter 10, which were centred on configuring a PRPP-A for a specific client and are informed by the Phase Two data analysis. The focus of this discussion is an exploration of influences that steered participants' reasoning and actions as they used the assessment. Three main influences were identified and explained as: having an assessment intention, drawing on theory, and developing skills and strategies.

Having an Assessment Intention

At the outset of applying a PRPP-A, participants had an assessment intention. That is, they envisioned a particular way they would implement the PRPP-A. Participants' intentions typically aligned with identified assessment purposes and desired outcomes, as discussed in Chapter 10. Having an assessment intention was more than merely matching assessment purposes and outcomes with the implementation of the PRPP-A. Participants' feelings and opinions of how they wanted and expected the assessment to be also contributed to their intentions, ultimately guiding the way they enacted parts of the assessment. Three different assessment intentions were conveyed by participants: to do a pure assessment, to do a fair assessment, or to do a dynamic assessment. Each assessment intention is described, followed by an explanation of how each intention directly influenced specific actions taken.

To Do a Pure Assessment

Three participants had an intention to do what Jenny viewed as “*a pure assessment*”. That is, an assessment where participants aimed “*not to intervene*” (Mary) and “*to see how he [client] performed as if there was no one there... without me disturbing him or questioning him or anything like that*” (Jenny). These participants reckoned “*a good assessment*” (Jenny), one they did “*well*” (Mary), which portrayed a client's authentic occupational performance, was required. An accurate “*baseline... as close to the difficulties as possible*” (Jenny), to identify “*what is it that's enabling a performance or making it more difficult*” (Jade), and “*really pin down what OT intervention is needed*” (Mary). To achieve this ‘real’ view of a client's occupational performance, participants anticipated

keeping their own actions to a minimum and assessing without “*too much interjecting*” (Jenny).

To Do a Fair Assessment

The intention to do “*a fair assessment*” (Olivia) was apparent in descriptions by four participants. These participants strove to apply a “*meaningful*” (Olivia) assessment which did not disadvantage a client or cause “*stress*” (Pheobe). An assessment without disturbing or “*imposing on people [client]... or being anything too intrusive*” (Pheobe), where a client was “*comfortable*” (Sally). For the three participants in mental health, a fair assessment involved vigilance to lessen any bias and/or discrimination from the context. Pheobe explained, “*I’m looking at them [clients] from within an acute inpatient unit, so I have to be really careful, really aware that... what I’m noticing is... not too much, being too prejudiced or also just around my own background*”. In addition, it was important a fair assessment enabled clients to perform their “*best*” (Olivia), “*to be themselves*” (Pheobe), “*to really see what they’re [client is] like*” (Awhina), and to have “*an accurate picture*” (Pheobe) that captured clients’ full potential.

Participants aspired to use a positive assessment process with outcomes benefiting both clients and assessors. Sally emphasised how she wanted to avoid “*negative feedback*”, and Olivia hoped “*all [clients would be] able to complete everything independently and that they wouldn’t need, too much additional supports*”, and that clients got “*a meaningful end-product out of their assessment*”. These participants intended to assess in a meaningful way that was positive, minimised possible stress and bias, and provided clients a “*true*” (Pheobe) opportunity to do their best.

To Do a Dynamic Assessment

Nadia intended to do a “*very dynamic assessment*” with a “*toing and froing*” approach where assessment and intervention “*flow into each other*”. Since she “*didn’t really feel I can do one [assessment or intervention] without the other*”, Nadia anticipated switching between assessment and intervention as the situation demanded:

Assessing children you never know what to expect, you have this expectation of how the session might go, but it might not look like how you think it might go just because they are a child... it really does depend on what state they’re in and what’s happening and where, what they’re like on that day and how important it is for us to be able to match that and to have that ability to assess, re-assess, assess, re-assess constantly.

Nadia aimed for a flexible assessment/intervention process that was a positive experience for whānau (child and mum) to identify strengths and strategies “*to share with her [mum]... look at how well he [child] is doing that [aspect of play]*”.

Thinking and Actions Influenced by Assessment Intentions

Participants’ assessment intentions influenced their thinking and decision-making related to how they set up and started an assessment, positioned themselves before and during an assessment, used cues and prompts, and did or did not take notes during a PRPP-A.

Setting Up and Starting an Assessment

The way participants set up and/or started assessments seemed determined by their assessment intentions. Participants who planned a pure assessment all chose to assess in natural contexts and at a time when tasks typically occurred. Mary automatically began an assessment with taking an opportunity to “*get in there and do it [assessment] right there*”. Jenny followed the client’s lead, he “*just started so I started assessing*”; and the typical routine of “*mat time starts*” signalled to Jade the beginning of the assessment. These participants started an assessment without any instructions or environmental changes, reflecting their viewpoints that not interfering with the assessment process would lead to a “*good assessment*” (Jenny).

In contrast, participants doing a fair assessment, who aimed for observations of clients’ “*best*” (Olivia) performance, believed an assessment should occur at a time most suited for a client. Olivia explained “*some guys [clients] do better in the morning, some do better in the afternoon... so just seeing what would work best for him [client], what would he like to do...[it is] more meaningful if they have kind of chosen when*”. Sally reasoned “*it was important that it [the assessment] was at the end of the day, not the beginning of the day. I know he’s [client] generally calmer in the afternoon*”. Likewise, Awhina changed the assessment time to reduce stress for a client as

The assessment was scheduled for the afternoon. And he came back like four or five times in the morning and was like ‘When are we doing it? Is it time, is it time, is it time?’ and so I ended up just doing it in the morning because it kind of came to the point where... he just wanted to get it over and done with... I felt like there was a level of anxiety for him.

Decisions about assessment times seemed guided by participants’ feelings and expectations of the likely outcomes of an assessment occurring at different times of day and their overall intention to lessen clients’ stress and not disadvantage them.

In a similar vein, participants' desire to assess in a way that supported clients' optimal occupational performance resulted in modifying assessment environments. In mental health settings, participants chose to alter and set up kitchen spaces before they began a PRPP-A. By setting up the environment, participants hoped to combat what they viewed as potentially detrimental and unfair impacts of clients doing assessments in unfamiliar institutional kitchens. Pheobe "*thought it was only fair to make sure that the kitchen was in a presentable state*" as she considered

He [client] may have been having some perceptual disturbances... there could have been anxiety going on, I just allowed for space when I was setting that up and... there wasn't anything that was going to sort of cue him to feel, think he had to be doing something else, so it was just a nice clear presentable kitchen.

In clearing the kitchen, Pheobe removed possible obstacles she thought might trigger the client and lead to poorer assessment outcomes. This was a concern Olivia and Awhina shared. As well as clearing kitchens, they also checked that the kitchen cupboards had suitable contents. Olivia made sure the kitchen "*had everything that he [client] would potentially need... so it's kind of trying to make it as much like a kitchen... as possible*". Underlying Olivia's actions was the notion that a fairer assessment was one that took place in a kitchen "*more like a home*" as it provided greater opportunity for clients to do their best.

It was, however, a delicate balance when creating a 'fairer' kitchen environment as to how much to intervene. Olivia revealed this balancing act when she pondered:

The stove plugged in, I think, is quite a normal thing, so I do make sure that that's on... Whereas, let's say he was making a toasted sandwich or something where he required an extra appliance that's not normally set up within the kitchen, I would leave that to see if he would then go plug it in and if he could figure that out. Because... that makes sense or like a smoothie maker or something that's not generally found within the kitchen, I would leave that for them to find and plug in... So, I wouldn't put any extra ingredients. Like, he needs to let me know what ingredients he needs to buy to make the meal... I mean things like just having a pan, oil, things that would generally be within a normal kitchen.

Olivia's account revealed deeper thinking about what was fair, based on her perspective of 'normal' and how much the environment should assist a client. Her decisions about actions to set up were a balance between not wanting to limit nor overly assist. A further

consideration for doing a fair assessment was the provision of environmental cues and an orientation to the kitchen. Awhina described how

The setup is meant to be like a home kitchen so, generally, things are where one may place them at home, but everyone's home is different. So, that's why we [therapist] give the orientation, and that's why there's a lot of labels on the ingredients that are in canisters... to make it a little bit easier.

It seemed Awhina viewed cues of canister labels and instructions on where things were located as necessary to compensate for an unfamiliar kitchen, which might disadvantage a client and impact assessment outcomes.

Nadia, who intended to do a dynamic assessment in a therapy clinic, also saw the unnatural environment as a “barrier” to an assessment. Although, unlike what was involved with setting up prior to a ‘fair’ assessment, Nadia’s approach was more fluid with multiple environmental changes before and during the assessment. She first set up the clinic room with toys and furniture like the child’s home, and then, based on her informal observations of what a child was doing in the waiting room, quickly changed the environment. She realised his performance was different to her original expectations and thought “‘Oh right... I hadn’t quite set up for that’ but then... thought ‘Oh okay I’ll just need to, change, shift my thinking in terms of how I’m going to make this work’”. That thinking resulted in different equipment and toys being added to the environment. Nadia continued to adapt the environment throughout the assessment, in keeping with her intended plan to both assess and intervene.

Positioning Before and During the Assessment

All participants consciously positioned themselves at the beginning and during assessments, and their underlying assessment intentions contributed to the positions they chose. Aligned with doing a pure assessment and not distracting clients, Jade decided to be “out of the way because he [child] knows if he’s being watched. So, I try and be quite stealth”. Mary tried “to hide myself in one corner”, while Jenny placed herself “out of the task, out of the environment” and thought:

I didn’t want to move, either, because I wanted to see whether he would throw the obstacles into the same pile. Because he kept on coming up with foreign things, like there’s a stake or a bottle cap or whatever that he was pulling out of the leaves. And I didn’t want where I was standing to impact on where he put things. So, I

really wanted to stay in the same place... to see whether he was organising a pile of foreign objects.

Jenny's decision not to move minimised her impact on the assessment and, she considered, helped her to focus on what the client was doing. In a similar manner, those participants looking to do a fair assessment positioned to "*be able to see what he's [client] doing and how he's doing it*" (Olivia). Although, they were also mindful of being in just the right place and had developed strategies for their positioning. Olivia had a seat already set up by the kitchen access, which meant "*it's not like I'm getting a seat to put there, that he [client] might think 'why do I put a seat there?' It's already there*". A chair positioned ahead of time was intended to lessen questioning and any distractions for the client. Pheobe in the supermarket positioned "*myself as a friend would do*", I "*align myself in a way that they've [client] got a little bit of space, usually about an arm's length or a little bit less depending how the person fares that day. I always make sure I can understand what they're saying*". Pheobe's positioning reflected her intent to be helpful like a "*friend*" while also ensuring she could capture assessment information related to communication. Olivia focused her positioning on facilitating a client to initiate shopping, she was "*next to him [client] but just the littlest bit back*". She reasoned "*I think if you're [therapist]... in front of the client they look to you, to follow you where to go. So, if they're [client] ...in front, they can...hopefully take the lead*". These participants carefully positioned themselves to help clients show their full potential and support their best occupational performance.

Positioning to support the best performance for a child playing with his mum was also part of Nadia's assessment plan. Unlike the strategic positioning of participants doing a fair assessment, Nadia constantly varied positions to match the evolving dynamic assessment, which combined assessment and intervention. Nadia initially encouraged mum to position the child and start to play while she observed; then, having gathered some observations, she decided to intervene and changed the positioning. She reasoned that for the child to play with "*the toy, to be able to do that... it was the positioning that I needed to help with*" (Nadia). Nadia adjusted positions to "*constantly be in tune with what was going on*".

Using Cues and Prompts

Assessment intentions also influenced how participants used cues and prompts during the PRPP-A. Mary, who planned to do a pure assessment, adopted a purely observational role and did not prompt at all "*during assessment*". Instead, she identified intervention

prompts and cues to try later. Likewise, Jenny, who wanted to do an assessment as “*close to the difficulties as possible*” and identify intervention strategies, let a client continue to make errors for some time before she provided prompts. She recalled:

I didn't prompt, I didn't cue. I just let him just go for it... So, he went to clear the rake quite a few times and just left leaves in there, didn't really do a very effective clearing job and then he would carry on raking and it wasn't effective... I think it was probably about the fifth time, I wanted to see what he would do with the prompt... So how would he respond if I said, 'I think you need to look at that rake again'... 'Have you finished clearing the leaves?'... I wanted to see how he responded to that, whether he even would acknowledge the prompt... I wanted to see whether it was just impulsive not able to stop himself in that repetitive cycle, or whether my prompt would make him stop and think. (Jenny)

Jenny's narrative demonstrated how she saw it was important to give a client plenty of opportunity to correct his performance before she prompted. She acknowledged

The reason I wanted to know that [client's response to prompts] was moving on to that next stage of intervention, how am I going to work this? How am I going to intervene? What is this going to look like? Is he going to respond to prompts and cues?

Jenny's decision to try different prompts aligned with one of the aims of the assessment process; that is, to directly inform her intervention planning.

The reasons for prompting were different for participants planning fair assessments. These participants monitored whether clients needed a cue or prompt to help them achieve their best performance, as conveyed by Sally, who was prepared to “*step in and give that praise when needed for the right thing*”. She “*wanted to feel like I was a little bit of an inner coach going, 'Go, you're doing awesome, you can do this!'*” (Sally). Pheobe described a client “*in the kitchen, and he asked where a couple of things were, and... I said something like 'Oh, it should be there on the shelf there.'* So, I was trying to be like, *sort of helpful but without actually going and pointing it out*”. Pheobe also recognised she prompted to assist the client as

He has been using mental health services since early 1990s, so I'm wondering if that might have been part of... whether someone's always been telling him where things, or when you come in here [assessment kitchen] not everything's done for

you [client] so... that was part of what influenced my thinking around how I'd react when he did ask those questions or when he couldn't find things".

It seemed Pheobe thought she should compensate for the client's previous experiences and assist him in overcoming environmental factors she viewed may potentially disadvantage him.

In addition to using 'helpful' prompts, Pheobe also chose to prompt before a client was unsuccessful with a task. She observed "*that he'd [client] almost got to the checkout and could of, potentially been in a situation where he'd have to put things back because he didn't have enough money to pay for them*". To avert that outcome, Pheobe "*asked him if he could remember how much it was? Then he added it up*". Her questioning revealed his mathematical ability to add up, and Pheobe reasoned she had seen enough to know he did not automatically "*tally*" food items. Since she saw no benefit in him experiencing failure, she decided to help him. Her actions were in line with her expectation to find strengths, and that the assessment would have a positive outcome for the client. Yet, her actions illustrated a tension between the client having a positive experience and Pheobe's intent to view "*true*" performance, as she did not assess if the client could have handled the checkout without assistance.

Conversely, Awhina did observe a client's 'true' performance when she chose not to prompt. Her decision led to "*unsalvageable*" biscuits and concern the client maybe negatively impacted by the experience since he "*gifted out some of these biscuits and one of the patients came back and was like 'That was disgusting', and so like I felt quite bad in that sense*" (Awhina). Awhina later reflected on her decision and thought "*Oh, maybe I should have gotten in [to prompt] sooner... but I really wanted to see if he could self-correct in some ways without [prompts]*". Both Awhina and Phoebe's stories revealed some of the possible challenges associated with selecting what actions (cues/prompts) to take/or not take, and in deciding how much and when was 'fair' to prompt. It seemed that in aiming for a fair assessment, there was a thinking process where participants weighed up their own needs as assessors against the need to ensure clients had an affirming assessment experience. Such thinking was evident when Olivia chose not to "*stop the client when they deviate from the goal if it's still going to result in some form of success... like the meal can still be continued, whether it's bacon or sausages*". Olivia decided not to prompt to ensure the client would still experience 'success'. Hence, instead of interrupting the positive experience, she just noted the client changed the meal and deviated from his original goal.

Similarly, Nadia, who applied a dynamic assessment, balanced her decisions of when to prompt. She considered whether she should only be observing and not prompting or giving prompts for intervention to see how that might change performance. She likened her thinking about prompting to a “*wee dance with the child... a combination of intervention and assessment*” and recalled:

I just kept observing him going, ‘Ooh okay, this is where he’s at’ and yes I can see that... he wanted to hold the truck but then when he went to put it in his mouth... and then he put it down again and he was trying to sort of push it but then, then I thought ‘Ooh, I need to just help him sort of calm with it too’ because he was just sort of, starting to do things a little bit fast. So that’s where I just went ‘Ooh okay, I do need to help him slow down’ and, that’s part of the intervention how we [therapist] support some of that slowing down and helping him to attend a little bit more and calm and then be able to do that [play] again. (Nadia)

Nadia chose to give a physical prompt by picking up the child and integrating calming strategies as part of intervention, before she returned to assessing. She used a flexible approach to how and when to prompt and/or stop prompting and adapted her prompts to match the child’s needs at any given time.

Taking Notes or Not During a PRPP-A

All participants made decisions on whether to take notes during or after the assessment. The reasons they gave for when they recorded observations were associated with their different assessment intentions, and did not necessarily result in all participants taking the same actions. For example, Jade and Mary, who aimed for a pure assessment, chose to “*scribble*” (Jade) notes at the time of the assessment. In keeping with not wanting to impact on clients’ performance, these two participants positioned themselves out of the “*line of sight*” (Jade) as they wrote. In contrast, Jenny, who also planned not to intrude on the assessment process, chose not to write anything. Her choice to only observe the client’s performance was compatible with her intent to capture all observations for a “*baseline*” “*pure*” (Jenny) assessment. Jenny’s decision was based on her experience that writing interfered with the quality of the assessment “*because I find if I write things down, I miss things when I’m looking down on my paper*”. In both these examples, having an intention to do a pure assessment influenced participants’ decisions and resulted in different actions. However, their thinking and decision-making were consistent with plans not to interfere and to capture ‘good’ assessment findings.

Olivia presented a further rationale for not writing at the time of the assessment, striving to avoid any negative repercussions writing might have for the client. She justified her decision as

You still want them to do the best that they can and I think having a pen and a paper could be a bit off putting especially if some, lot of our guys are, a bit paranoid as part of their mental illness. So, I don't think it really helps with that... therapeutic interaction with them, and for them to do well.

Writing was viewed as potentially disadvantaging the client, an opinion also held by Pheobe, who commented, *"I just don't know if it's [writing] really helpful... I don't know if I'd feel comfortable writing down while I was watching someone doing it [the assessment] because I don't know if it would be unsettling"*. Olivia and Pheobe saw writing notes as a barrier to a fair assessment. Whereas for Nadia, it was more a practical reason that she did not write anything. Being actively involved in the dynamic assessment, it was simply not possible to write when providing intervention, environmental changes, and repositioning during the assessment.

Interestingly, none of the participants chose to explain to clients that they would be writing information as clients did an assessment. That practice is common with most standardised assessments, where notes and/or scores are routinely recorded at the time of the assessment. In this study, most participants chose not to take notes during the assessment and had developed other skills to recall their observations (explained later in this chapter).

It was apparent that participants' assessment intentions shaped many of their assessment actions; however, it is important to note their intentions were not fixed for all assessments. Participants formed different intentions to meet clients' specific needs, contextual demands, and type of assessment required (discussed in Chapter 10). Sally, for example, planned to follow a *"fair"* assessment with *"assessment and intervention at the same time"*. Jenny noted that after doing a *"pure"* baseline assessment the *"next one [assessment]... I'll let them go for it a little bit and then I might start prompting, cueing, and doing the sort of more the intervention aspect... so checking that I am still on the right track"*. For the second PRPP-A, Jenny planned a dynamic assessment to ascertain what intervention strategies might change performance. In opting for a different assessment intention, Jenny emphasised how the process still should be *"as true to that assessment [PRPP-A] as possible"*. She implied with a more fluid dynamic assessment

intention that there was a risk of wandering from the parameters of a PRPP-A, illustrating the need to stay within the framework of a PRPP-A by knowing the assessment criteria and underlying PRPP-A theory.

Drawing on Theory

All participants had an awareness of occupational therapy models that generally underpinned their assessment practice. Only two participants, Jenny and Nadia, considered the OPM-A (the model from which the PRPP-A emanates) (see Chapter 2) as actively contributing to their thinking during a PRPP-A. Jenny, who worked “*in brain injury*,” embraced the OPM-A as “*my model of practice*”, noting the OPM-A included “*rest*” as an occupational category and enabled her “*to go back into impairment but [was] not being impairment focused*”. Jenny applied the OPM-A as an occupation-focused model to think about the interconnections between a client’s occupational performance, their “*impairments*”, and “*the environment and cultural context*”. Overall, Jenny viewed the OPM-A as “*a good fit... in the community because it covers... everything you need when you’re working in a diverse population*”. Her application of the model was apparent in her analysis of the findings from a PRPP-A with a client where she thought about the client’s specific “*frontal lobe injury*”, his social situation of being “*homeless*”, his cognitive strategy use, and his occupational performance. Likewise, Nadia used the OPM-A to think about how “*all the parts interacted with each other*” and how “*you can’t have just one thing in isolation from another*”. Further, she explained the OPM-A and referred parents to the OPM-A “*website*” as part of her rationale for choosing the PRPP-A.

By contrast, other participants did not use the OPM-A. Some had “*no memory of the model*” (Awhina) from the training, although several recalled thinking during the PRPP-A course that the OPM-A “*aligns a bit*” (Pheobe) with the PEO¹⁸ and “*overlaps with the other models... like MOHO¹⁹ and the Canadian Model²⁰*” (Jade). It seemed participants decided the OPM-A had similarities with other existing practice models. Consequently, they appeared to have assimilated varying aspects of the OPM-A into their own existing theoretical perspectives of occupational performance. They merged models in a process Jade described as “*bring in [models] from different places*” and “*mixing and matching*”.

Alongside participants’ theoretical understanding of occupational performance, they all used specific theories associated with the PRPP-A. Notably, theories of procedural and

¹⁸ PEO abbreviation for Person, Environment, Occupation Model (Law et al., 1996)

¹⁹ MOHO abbreviation for Model of Human Occupation (Kielhofner & Forsyth, (1997)

²⁰ Canadian Model abbreviation for CMOP-E (Polatajko et al., 2013)

behavioural task analysis, and cognitive and information processing theory were used to explain the assessment process and subsequent findings. Several participants shared details of task analysis together with the PRPP-A Stage Two information processing model (see Chapter 2) with clients and/or others to interpret findings and provide feedback. Overall, participants referred to having a “framework” (Jade and Nadia) or “PRPP frame” (Sally) which guided their thinking, “*a framework that I always refer to, when I’m thinking about interventions or observing someone informally*” (Pheobe). Participants seemed to each have a PRPP reasoning framework, a lens from which they viewed occupational performance and developed expertise to apply the PRPP-A.

Developing Skills and Strategies

A ‘skill’ is defined as “the knowledge and ability that enables you to do something well” (Collins English Dictionary n.d.); and strategy as “a way of doing something” (Cambridge University Press n.d.b), “a careful plan or method” (Merriam-Webster n.d.b). Consistent with these definitions, participants had developed a range of skills and strategies to apply a PRPP-A. Each participant used a unique combination of skills and strategies, which influenced their abilities to do certain aspects of the PRPP-A and accounted for the degree of ease with which they applied the assessment. How various skills and strategies influenced the ‘doing’ of different aspects of the PRPP-A are now discussed and related to applying PRPP-A Stage One, teasing out and scoring PRPP-A, and in Stage Two, for figuring out feedback and recommendations.

Applying PRPP-A Stage One

All participants described skilful reasoning and strategies they had formed to confidently apply a PRPP-A Stage One. Underlying the participants’ assured assessment performance were proficient automatic actions they took to carry out parts of the assessment. These seamless actions resulted from quick thinking, decision-making skills, and efficient ways of doing (strategies) they had learnt to use. The skills and strategies participants utilised to apply PRPP-A Stage One are explained below and related to how they specifically shaped actions to identify task steps, observe performance and monitor/manage safety, and analyse and score the client’s performance during a PRPP-A Stage One.

Identifying Task Steps

In keeping with the PRPP-A training, participants took different actions to identify task steps. One previously mentioned strategy used by several participants who frequently observed clients performing the same tasks was a list of probable task steps, which Awhina stated “*already had the steps written out*” “*before the task*” (Olivia). If a client

performed different steps to the list, Awhina highlighted reasoning skills were required to question whether the step performed was the cultural way of doing something or an error in client performance. She gave an example of her thinking when she saw “*kind of unusual [performance] but maybe, usual within his home... he rinsed some of the things [cup] before putting them in the dry ingredients*”. Awhina questioned her observations and decided to find out more about cultural norms for this task; thereby revealing questioning skills used for culturally safe practice. Her skilful questioning and decision-making prevented the client potentially being disadvantaged by having an error recorded, which is a possible risk associated with using a prepared list of steps where a client could be automatically scored as inaccurate without a therapist checking cultural norms.

An alternate strategy was to write steps as clients started tasks, based on what Jade termed her “*internal schema... of how most preschools run mat time*” and Mary’s “*preconceived idea of general steps for showering*”. They generated a list of expected steps and modified the list as the assessment progressed. For instance, Jade “*added in some things [steps] as she [teacher] went to cross their legs [a step not expected for mat time]*”. Jade’s ability to flexibly think and make quick decisions to add, change, or remove steps avoided assumptions and ensured she accurately identified the steps used for the task. Although Mary was also adaptable and identified the actual steps performed in the school environment, as discussed in Chapter 10, she omitted finding out specifics of how the student showered at home. Mary’s experience draws attention to the skills required to safely apply a PRPP-A from a cultural perspective and the importance of establishing how tasks are truly done in a client’s own context.

Jenny and Sally used another strategy to identify steps, which Jenny termed as doing steps “*on the fly*” as clients performed tasks. This process was adopted by four participants, who simultaneously considered what they knew about a task, forming “*steps in my head*” (Sally) and starting observations. Recognising the steps as tasks unfolded required the ability to make fast decisions and “*quickly thinking about the steps that we needed to cover, so that I could evaluate where they’re at*” (Jenny). To confidently identify steps, observe, and start evaluating performance appeared to be an advanced level of applying PRPP-A Stage One.

Observing Performance and Monitoring/Managing Safety

A further skill all participants had sharpened was their abilities to “*intently observe*” (Jenny) and pick up small details of exactly what a person did. Mary likened such observations to “*going through with a pair of tweezers instead of having a wider, brush*

stroke vision". Alongside these close observations of client's occupational performance, participants carefully monitored safety, which Pheobe noted involved using all her senses to check "*if something's smelling burny or... listening for things crackling*". Monitoring safety involved thinking skills to evaluate risks associated with what clients were doing. It occurred along with decision-making skills to choose whether to continue or stop the assessment and/or provide the right level of prompt to manage safety risk, and still enable the client to continue doing the task.

Jenny gave two examples of her skillful evaluation of risks. One related to monitoring the client's safety, where Jenny explained

I'm monitoring it [client raking leaves without shoes on] but I wasn't concerned, I guess because my thought is, [what's] the worst... it's not like he's got diabetes or anything like that. The worst that can happen is he can scratch his foot at what he's doing at the moment or bruise his foot.

Jenny opted to continue the assessment, a decision made by weighing the likely outcome of continuing versus stopping the assessment and not knowing whether the client could safely rake. To evaluate this risk, Jenny applied her knowledge of conditions, likely consequences, and then ruled out chances of a significant injury.

In the second situation, Jenny considered her own safety as "*he [client] threw a metal spike at me! ...it was like a metre away from me, so it wasn't a bad thing. It's just it could have been closer; I did see it coming... it's going to miss me!*" She constantly analysed the probable risks involved and judged that both the client and she would likely remain safe without her changing anything. These skilful judgements were also influenced by her personal view that when working with clients with head injuries, safety risks were "*the hazards of the job*" and, that she was "*not a jumpy person*" whose "*safety range is low*" (Jenny). Jenny's personal attitude to safety was another contribution to her ultimate evaluation of safety, possible risks, and the subsequent decision to continue assessing, which she justified as:

The more extreme it [client's action] is, the more obvious there's a deficit, the more something that is completely inappropriate or completely not right or completely unsafe, the easier for me it is to be describing that to him [client] with his difficulties. So, I'm actually, inadvertently wanting to see something like that so I can have a more, rich description of what's happened to help him. (Jenny)

This justification revealed a further influence on Jenny's decision to continue, since she hoped assessment findings would show "*more obvious*" challenges in performance. She reasoned that obvious challenges would potentially be easier for the client with limited insight to understand (see 'Figuring out feedback' in the section below for further explanation).

In contrast, other participants' monitoring, thinking, and evaluation of safety led to different decisions and actions. They chose to more quickly intervene and prompt when they observed actions that might be dangerous or detrimental. Olivia recalled noticing "*his [client] pots and pans were leaning... with the handles out [from stove] but he was walking back and forth past. So, I prompted him on that because I think that was quite a big safety concern*" and Awhina's only concern was "*just the oven use... I was a little bit worried. That's why I kept asking him what time they [biscuits] needed to be [taken out] because I didn't want... the smoke alarms being set off... But, no massive safety risk really*". Olivia and Awhina both carefully gauged the level of prompting to provide to mitigate risks and carry on the assessment. Their examples, along with Jenny's accounts, unveiled complex thinking to make safety evaluations and judgments about degrees of risks, along with skilled decision-making used to manage physical safety during a PRPP-A.

Psychological/emotional safety was another aspect that participants monitored and thought about by preparing and/or enacting strategies to avert safety risks. Nadia monitored by "*constantly watching as to what, how he was feeling*" and Pheobe looked for "*any overt signs of distress or anxiety*". Emotional safety was foremost in these participants' minds. Sally also relayed how, together with tracking the client's emotional safety, she strategically positioned herself "*not too far away but not too close*" so that she was ready to intervene if needed.

Participants' conscious positioning was a strategy applied to manage other types of safety. Olivia recognised

I was still mindful around space between us. As he's a male of a similar age and... when he first came in, he was quite sexually disinhibited, so I think that was still on my mind a little bit. It's just maintaining a good amount of space so that he's able to do what he needs to do.

Likewise, Mary was "*concerned for the student's dignity*" as she observed the sensitive task of showering and tried to "*tuck myself right away out of his [the student's] line of*

vision”. In these two situations, the participants foresaw possible safety risks, and their anticipatory thinking and actions averted safety issues from occurring during an assessment.

Analyse Performance and Score Steps

Alongside participants’ abilities to make detailed observations, anticipate, monitor, and position for safety, they simultaneously used strategies to begin an initial analysis of the client’s performance. They mentally checked off whether or not a client had difficulties with a step. For Sally this entailed “*the steps are in my head and ... yes he can do it or no he can’t*” and Pheobe had “*some words that I hold onto in my mind when I’m watching, like the doing and the getting [steps clients take]. Just thinking a little bit ahead about how I analyse the tasks*”. Sally and Pheobe thought about sorting and categorising a client’s performance as the assessment progressed and began evaluating accurate and inaccurate steps.

As well as classifying steps, Jenny used a further strategy of “*mental rehearsal of the steps*” and “*what happened*” so she could recall after the assessment “*where he was at and what he had, repeated and omitted [errors in steps]*”. Likewise, participants who wrote during the assessment used marking strategies to quickly note correct or incorrect steps. Jade “*scribbled*” and put “*stars... just to remind myself and then I score it later*” and Mary jotted

the quality of what he [student] was doing, writing notes for myself, a checklist... Rather than being able to come up with answers immediately, I could then go away and think about it... so it’s really important to capture, think about it later, and make sure you can.

Mary, like other participants, planned time after the assessment to recall observations, think, question, and score.

Directly after the assessment, to remember observations and their initial analysis, most participants quickly wrote down what they had seen as “*the first priority in doing the task analysis... make sure I get all those tasks in and analysing and then I’ll do the scoring after that*” (Pheobe). They took time to reason and evaluate a client’s performance against PRPP-A Stage One criteria. Alongside Stage One evaluation, it was apparent, to varying degrees, that participants had automatically thought about some of the PRPP-A Stage Two cognitive strategy descriptors, which they matched to their observations. They applied a PRPP framework as a lens to figure out why a client experienced task breakdown/s. It

seemed even when participants had overtly chosen to only do a PRPP-A Stage One, they inherently applied deeper reasoning (based on PRPP-A Stage Two descriptors) and analytical skills to Stage One findings (explained further in the section on ‘teasing out and scoring PRPP-A Stage Two’).

Tallying an overall score of the number of correct steps completed by a client was a skill all participants routinely actioned. Sally was able to adeptly score during the assessment and provide immediate feedback with the score. *“I had [score] in my head already... I could say [to teenager’s mum] look he did the vacuuming really well, so we had a 5 out of 5 [correct steps] for the first vacuum task in the hall and 4 out of 6 for the lounge”* (Sally). Nearly all the participants could also calculate a final percentage score, although one participant did not have the mathematical skills to do so, which limited her Stage One reporting to qualitative findings and the number of correct steps completed.

Teasing Out and Scoring PRPP-A Stage Two

In the PRPP-A training, therapists are taught to evaluate clients’ capacity to use necessary cognitive strategies for successful task performance. That process entails linking specific aspects of a client’s performance to PRPP-A Stage Two cognitive strategy descriptors (hereafter termed ‘descriptors’), with the further option to score/or not the client’s behaviour in relation to descriptors (Chapparo & Ranka, 2016). Participants’ ability to make links between performance observations and descriptors was influenced by how fluently they recalled the descriptors, their capacity to “*tease out*” (Jade) descriptors during and after the assessment, and strategies they used to assist them.

All participants readily applied some of the descriptors when generally observing clients (described in Chapter 10 and in applying PRPP-A Stage One above). They rapidly and effortlessly matched familiar descriptors to clients’ behaviours and considered how effectively clients were using cognitive strategies. Mary illustrated this fluid thinking of descriptors (marked in bold in the following quotations) as she observed a student showering “*so he’s **recognising**, he’s... **searching and locating**, he’s not doing too badly*”. Jade found “[Stage Two descriptors] *quite useful like the **noticing, modulating, maintaining** so just to really frame it in my head to think about... what are the useful pieces?*” Thinking about descriptors helped her to question “*does he [preschooler] know the **goal**?... what’s expected?*” and in “***labelling** the behaviour... the sort of **continuing** and then the **controlling, times, coordinates, adjusts***” (Jade). Similarly, Jenny found many descriptors were “*more fluent*” and second nature, stating, “*I mean **organising**,*

choosing, sequencing, calibrate, it's so obvious to me, recognising, labelling all of the perceived ones are just extremely obvious".

Despite many descriptors being 'obvious', most participants recognised that they did not have the skills to recall and apply all descriptors fluently. Jenny attributed this challenge to some descriptors "*which never stuck in my mind [during the training]*" and not being able to remember subtle differences between descriptors. "*I still have to sit down and read through [training manual] some of those things [descriptor definitions] just to make sure*". (Jenny). She further noted that it was often more than just remembering since

I'm fine, but when I read it [descriptor definition] now, I'm like 'I get that' but sometimes when I'm thinking about what he [client] did and where it fits, it's sometimes I have to get the definition again... it's that fitting into the descriptors of what I've observed... I mean, I understand descriptors when I read them, it's just the application of them.

The process of "*teasing out*" (Jade) and "*fitting*" (Jenny) descriptors was complex and required deeper analysis and thinking to "*make sense*" (Awhina and Mary). There was a skill in organising the assessment information, which Awhina explained as "*afterwards sometimes if there's a lot of issues that arise, I think I feel a bit scrambled and I need to organise them [thoughts]*". Mary needed to clarify "*my messy thoughts and decide, well where is that going?*". It was a skilful process to "*carefully*" (Jade) think through observations, identify "*problem areas*" (Jenny), and recall specific details of the client's performance. Jenny gave insights into strategies which assisted her to order the client's performance in her mind, identify specific challenges, and think about the client's Stage One task performance before she linked the information to the descriptors. She 're-played' the client's performance in her head to remember "*he [client] wasn't carrying the rake very well. He was raking over his feet, he did two piles right next to each other ...he threw obstacles at me, he didn't throw them all in the same place. He didn't clear the leaves up afterwards*". Then began a questioning process, *like, why didn't he? What was happening?*" and started "*putting it [performance challenges] into the descriptors*" (Jenny).

Awhina utilised an alternate strategy to help her figure out a client's performance, particularly when the client had "*quite a few different issues*". She allowed *time to process it [assessment observations]. And... to have a debrief, with [colleague]... who also uses*

the PRPP, and we just discuss what I noticed, and she'll come up with some prompting questions and make me think a little bit more.

The reflective process aided Awhina's recall of details, promoting in-depth analysis, which assisted her to *"tease some of the issues out and have an idea on the bigger issues or the small issues"*, thus providing a way to prioritise the client's challenges.

Olivia described a seamless application of strategies to analyse both Stages One and Two during and after the assessment. Her account of how she fitted descriptors to performance, provided prompts, and checked her analysis demonstrated expert reasoning and skill level:

I say things just in my head and particularly think of the words [descriptors] that are from the criteria and the glossary, think of those words and then when I see something say it over in my head so that I remember it... so if he's [client] doing something that's a safety risk, like the stove I'll say that over in my head and when I give a prompt, especially when I give a prompt I remember that, yes I did plug in the stove for him... and then as soon as they're [client] finished cooking, go and just jot down everything, not in a report format yet, but just jot down all the points that I can remember and go through the glossary [PRPP Manual] and make sure I've got every point done before kind of making it make sense into a report. Just bullet point everything.

The final part of figuring out Stage Two centred on whether or not to score findings. For two participants, their lack of competency influenced their decision to only present qualitative findings. Jade explained her reason for not scoring as *"during the course [PRPP-A Training], I found it was quite complex"*; consequently, she never felt *"confident in scoring the Stage Two"*. Mary had never grasped the percentages. Both participants, however, saw potential benefits of scoring and generating a *"concrete score I think would be useful particularly with resourcing [to advocate for more support or funding]"* (Jade) and to use a *"spider graph [graphic diagram of Stage Two score]"* as an outcome measure *"to show that lovely little compact meaty piece of information ... and say here, this is what it looked like at the very beginning, here's what it looked like at the end"* (Mary). To achieve these benefits, Jade considered *"a refresher course"* was needed *"to reskill in Stage Two"*.

In contrast, all other participants had learnt to score Stage Two from their initial PRPP-A training, and once they were certain of the Stage Two descriptor definitions scoring was

relatively straightforward. However, not all participants who could score did so. Pheobe commented, *“I just do use the first level of PRPP because usually it’s the team is just wanting to know whether someone can look after themselves at home... even though I’ve done the Level Two training, I don’t often need to do that second level of assessment”*. Participants’ decision to only use Stage Two as a reasoning framework and not score seemed more associated with the assessment outcomes they sought (see findings, Chapter 10) and the type of feedback they planned to provide than their skills to apply Stage Two. It is, however, conceivable that they lacked confidence with the analytical thinking skills necessary to fully use PRPP-A Stage Two.

Figuring out Feedback and Recommendations

After analysing a PRPP-A, there was *“figuring out how I [participant] was going to give feedback”* (Jenny) to client/s, team members and/or others. Providing feedback was depicted as a sensitive, nuanced skill since *“the way in which we [therapists] give feedback is really important to families so that it’s not just full on and prescriptive. I think there’s a relational element to all of what we’re doing as well”* (Nadia). Feedback was customised and shaped to *“make sense”* (Jade) for client/s and other audiences. To provide this coherent, audience-specific information involved participants’ thinking, figuring out, and deciding what, when, and how much feedback to give.

Olivia expressed this customised feedback as *“I don’t really sit down with a paper and go through the whole thing [PRPP-A findings] with him [client]. It’s more little things at a time”* delivered in real-world meaningful situations. She further explained:

In a cooking group, if there’s a specific issue that he’s [client] had [in the assessment] then I can go back to him and say ‘remember when the pans were falling off the elements, what can we do now?’... at appropriate timing when it’s real-life timing. As well, I don’t think to go tell him, if he’s sitting watching TV, that he didn’t hold the pan. Like, the pans weren’t secure on the thing [stovetop] is not going to really make sense to him at that moment because it’s got nothing to do with his real-life context. So, the best time for me to give that feedback and then talk through it with him is when he’s actually doing it. So, for those recommendations, it’s as he’s doing it next time within groups... that’s how I’d do it [feedback] with everybody, but probably particularly this client because ...huge amounts of information and long sentences ...he does struggle with ...slow information processing, so I think it’s to make it more relevant to him and for it to make more sense for him.

Olivia's feedback was specific, relevant, timely, and set at a level to help the client understand. She also had the ability to directly link her feedback to intervention recommendations, which assisted the client with 'slow information processing' to learn to do the task safely. Similarly, Jenny thought about giving feedback which would "*be the closest to his reality and understanding his difficulties because of his insight*". Consequently, she compared the PRPP-A findings with the client's goals and "*what my target was, what I wanted him to think about or to work on*", and recalled how she:

Sat down with him [client] and said we did the raking ...I went through it in very basic terms ...I just described perceive, recall, plan, and performance ...I put it into pig hunting, I did the wheel [PRPP-A Stage Two model] ... discussed the difficulties with two areas, stop and think plan (PRPP descriptors). I related these back to the assessment and what had made me consider these areas with exact examples of the activity [raking]. I then discussed that these areas were what we needed to work on to help him return to work and pig hunting.

Both Jenny and Olivia's examples of feedback revealed expert dynamic reasoning where they integrated assessment findings and PRPP-A theory with recommendations and intervention strategies. Jade, too, crafted her feedback to promote intervention, although since she worked in a consultative role, she had developed a different set of feedback skills. She had learnt to provide feedback that promoted collaboration and encouraged teachers to contribute to intervention plans.

The component parts [task analysis] of an activity and when you [Jade] talk about things like being able to sit by yourself[child], being able to look, it kind of makes sense to teachers, so you get that buy-in. And then if you talk about things like 'I wonder if' or 'I've noticed when we've done this, this has gone well', just trying to sort of feed in some of that information [PRPP-A findings] about where might be a better place to sit or what is a really motivating story for that first time to set up the routine... So, you can just use it [PRPP-A findings] as an in-road and then... thinking about how we [Jade and pre-school staff] can change an activity or an environment to support that just-right level for the repetition for learning to happen. (Jade)

In giving this feedback, Jade appeared to effortlessly weave the PRPP-A findings with questions to foster 'buy-in' from teachers and form a joint intervention plan. Jade also talked about another way she used the same PRPP-A findings to give feedback to a

funding agency. Thinking about the different audience led Jade to write a summary that was “*quite specific and concrete... these were the things that were more difficult ...and what we think [are] some strengths*” with “*a good rationale of the child’s needs at school*”. Moulding feedback for different audiences involved flexible thinking skills, where Jade adapted her feedback to match assessment outcomes (see Chapter 10) required for each audience.

Similarly, Awhina fitted feedback for a specific audience and selected not to share an assessment score. That decision was taken since “*he [client] scored 30%, so I just felt that would be a real bummer for him*”. As well as a score being a potentially negative experience, Awhina thought clients

can interpret it [score] differently, and they might not see it for what it is, which is just establishing that you [client] need support in these areas. So, I always share the areas that I think people need support with, but I sometimes think it can be a bit disheartening to say, ‘Oh you only scored 30% or even 50% as people always want to be 100%.

It was apparent from Awhina’s thinking that whether to provide a score or not was a particularly sensitive aspect of giving feedback. Overall, providing feedback involved skilful decision-making by participants and finding ways to deliver specific feedback in a sensitive, relevant, meaningful, and timely manner to different audiences.

An overall summary of the skills and strategies participants had developed are presented next in Table 16.

Table 16.

Summary of the Skills and Strategies Related to Actions Participants Performed Before, During, and After a PRPP-A

Actions before and during a PRPP-A Stage One	Skills	Strategies
Identify task steps	The ability to: Use open and flexible thinking to adapt steps as task progresses Use knowledge of possible steps with a flexible approach and question/check cultural “norms” of steps, particularly when steps performed differ from those anticipated by assessor. Apply culturally safe practice and avoid cultural assumptions	Use pre-written list of steps for commonly assessed tasks Write steps at beginning of assessment using own knowledge of steps
Make accurate observations of performance	Recognise steps as client performs them Use knowledge of how to classify steps Quickly recognise and classify steps Select suitable position and focus attention using all senses Identify precise details of performance	Mentally form steps as task progresses “on the fly” Mentally classify steps into “getting” and “doing” actions Position self to intently watch Use all senses to observe
Monitor and manage safety	Recognise and anticipate potential physical, psychological, emotional, cultural safety issues Recognise potential risks associated with managing client’s dignity, sexual disinhibition, paranoia Evaluate and judge level of risks for client and assessor Use knowledge of health conditions to evaluate possible outcomes of risk	Take actions to advert safety risks prior to the assessment

....continued over

Actions before and during a PRPP-A Stage One	Skills	Strategies
	The ability to:	
	Recognise assessor's own attitude to safety and possible influence of own attitude to evaluating degree of risk Decide where to position self as an assessor to minimise risks and /or intervene as needed Decide whether to intervene or not Decide on the level of prompt to provide to manage safety and fast application of knowledge of prompt hierarchy	Reflect on own attitudes to safety Position yourself to quickly intervene if needed Prompt at right level e.g. ask questions to prompt an action, give verbal guidance of a required action, intervene with physical assistance
Recall steps and begin task analysis	Observe performance and simultaneously remember steps Observe performance and quickly analyse correct /incorrect steps using a PRPP lens Quickly shift attention between observing and writing notes Observe performance, quickly analyse correct /incorrect steps and record with marking strategy	Have a method to capture observations Mental rehearsal of observed steps Mental screening of client's performance - "yes" or "no" as a step is correctly performed /or not Jot quick notes of key performance observations Quicky record against list of steps using a marking strategy e.g., star for correct step
Recall steps and begin PRPP-A Stage Two cognitive strategy descriptor analysis	Rapidly and fluently recall PRPP-A Stage Two descriptors Reason using a 'PRPP lens' Use advanced analysis skills to apply PRPP-A Stage Two descriptors simultaneously with observing performance	Mentally analyse behaviours with familiar PRPP-A Stage Two descriptors

.... Continued over

Action Performed after PRPP-A	Skills	Strategy
Analyse PRPP-A Stage Two cognitive strategy application	The ability to:	
	Time management – to organise observations, record, analysis and score	Take time directly after assessment observations or as soon after as possible to organise thoughts, reflect and think
	Remember observations, reflect, visualise, and organise what happened	Mental ‘re-play’ of client’s performance with questioning process of what happened?
	Record key details of strengths and errors in performance, specific actions taken for safety, exact prompts and intervention strategies used Identify problem areas / specific task performance challenges	As quickly as possible write down assessment observations and any actions assessor took Use bullet points of observations
	Questioning skills to answer: Why did a client do certain things? Why was prompting needed? What changed (if anything) with intervention? Recall and figure out which PRPP-A cognitive strategy Stage Two descriptors fit with observed challenges	Use questioning process of why did that happen? and What cognitive strategy [Stage Two descriptor] does that fit?
	Use peer support, reflective skills, be open to supervision and deeper questioning to analyse	Debrief/reflection with peer
	Time management - to read manual, reflect on definitions in relation to client’s performance Recall Stage Two scoring system and have mathematical ability for calculating percentage scores	Check manual cognitive descriptor definitions

..... continued over

Action Performed after PRPP-A	Skills	Strategy
Provide customised feedback	The ability to:	
	Use sensitive nuanced thinking to consider what feedback to provide and link to assessment outcomes required by different audiences	Reflect on audience's expected assessment outcomes Use different report formats for feedback to match audience needs (e.g., short summary of bullet points of strengths and needs for a funding agency)
	Choose most relevant assessment findings and time to feedback	Give feedback at the time the client is next doing the task
	Adapt feedback to the level the audience will understand	Simplify language for client to understand
	Use feedback as an opportunity to provide intervention	Make assessment feedback relevant by linking it directly to client goals
	Consider whether providing the PRPP-A scores is useful or not	Use PRPP-A Stage Two cognitive descriptors and the PRPP-A Stage Two diagram and relate the assessment findings to descriptors and future occupations the person wants to do
Provide feedback to promote collaborative intervention planning		When giving feedback provide opportunities to check out the opinion of the audience on the assessment findings. Ask if they have ideas, solutions to address performance and information processing issues that arise from the PRPP-A

Summary

The findings in this chapter have centred on participants' reasoning and decision-making related to the varied ways the PRPP-A was applied. Three main influences on participants' reasoning have been presented: having an assessment intention, drawing on theory, and developing skills and strategies. How these influences shaped participants' choice of assessment actions were explored and are summarised as follows:

- Having an assessment intention framed how participants anticipated they would implement an assessment in a certain way for a particular client. Three different assessment intentions were apparent: to do a pure assessment, a fair assessment, or a dynamic assessment based on participants' feelings, opinions, experiences, and expectations. Having an assessment intention influenced participants' thinking, decisions, and actions as they set up and started a PRPP-A; positioned themselves during an assessment; used cues and prompts; and took notes or not as they assessed.
- Drawing on theory influenced participants' theoretical perspective of the PRPP-A and, consequently, their reasoning and assessment actions. Participants mostly adopted their own theoretical perspective by 'mixing and matching' to differing extents familiar models of occupational performance (e.g., the OPM(A)) and knowledge of foundational PRPP-A theories from their PRPP-A training. These combined theories informed a theoretical perspective which participants referred to as 'having a PRPP framework' or 'lens' from which they viewed, reasoned, and evaluated occupational performance. Examples of the influence of applying a 'PRPP lens' to participants' assessment practice were described.
- The skills and strategies developed by participants also contributed to their different PRPP-A applications. Participants all confidently applied PRPP-A Stage One using a range of skills and strategies which supported their proficiency. The skills participants had established included flexible thinking abilities, reasoning multiple parts of a PRPP-A Stage One simultaneously, and making quick evaluations of clients' performance. Participants also, to different degrees, had developed automatic skills to concurrently observe and begin analysis of a client's performance using some well-versed Stage Two cognitive strategy descriptors. Skills for complex, deeper analysis after an assessment to organise their thinking and 'make sense' of observations had also been learnt, together with sensitive, nuanced thinking and dynamic reasoning skills to

provide customised assessment feedback for different audiences that integrated unique assessment findings, PRPP-A theory, and recommendations.

Alongside these thinking skills, specific strategies were employed for cultural safety, identifying task steps, making precise observations, mentally recalling a client's occupational performance, monitoring safety, and the analysis and scoring of Stages One and Two.

In the following chapter, the Phase Two findings are discussed and related to wider professional knowledge and research. The overall implications of the study are presented and recommendations for further research made, together with the final study conclusion.

CHAPTER 12: DISCUSSION

Introduction

In this chapter, I bring together the overall findings of this two-phase study; consider the findings in relation to current literature; critique the strengths and weaknesses of the study; and make recommendations for occupational therapy practice, PRPP training, and research. Most of the Phase One findings (see Chapters 7 and 8) related to the first research question, *What are occupational therapists' experiences in Aotearoa New Zealand applying the Perceive, Recall, Plan and Perform System of Task Analysis assessment (PRPP-A) into their practice?* have already been discussed within the published manuscript presented in Chapter 9. Chapter 12 contains pertinent Phase One findings, not previously included in that manuscript, and which are of relevance to the discussion focus of this chapter.

The initial focus in Chapter 12 is on the central findings relevant to the research question posed at the outset of Phase Two, *How does using the PRPP-A shape occupational therapists' clinical reasoning through the occupational therapy assessment process?* The chapter contains a brief summary of the purpose and the themes from the findings of Phase Two, followed by consideration of the findings in the context of current theory and research. This discussion is organised under three sections: 1) Learning and translating the PRPP-A to practice, 2) Understanding occupational performance through a PRPP lens, and 3) Reasoning to enact an occupation-focused assessment process. The third of these sections involves a more substantial discussion about the intricacies of clinical reasoning. Those sections are followed by consideration of the strengths and limitations of the study, and the overall study implications, together with recommendations for further research. Finally, the overall conclusions of the study are drawn together.

Revisiting the Purpose of Phase Two of the Study

Revisiting the purpose of a study provides background to the discussion and situates the findings within the context of the original question. Following findings from Phase One, which revealed using the PRPP-A had influenced occupational therapists' clinical reasoning, I was interested in understanding more. Hence, I decided to further explore clinical reasoning through a second phase of research. I knew from my own experiences and my work with others that learning the PRPP-A re-shaped therapists' assessment thinking and actions (see Chapter 1), and I believed that applying the PRPP-A involved the development of specific clinical reasoning abilities. I considered that each occupational therapist learnt their own unique ways to think through and make decisions

related to how they applied the PRPP-A in their practice context. A further premise was that PRPP-A trained occupational therapists had developed some common clinical reasoning skills to efficiently apply the assessment. I wanted to understand about both individuals' thinking and decision making as they applied the PRPP-A and any common reasoning skills they used. I sought to gain understandings of the influences on clinical reasoning and to identify strategies which might assist occupational therapists to apply the PRPP-A from completion of the training through to when they established skilled practical applications of the assessment in their specific practice contexts.

In line with an interpretive description methodology, I aimed to generate pragmatic understandings that relate directly to real-world occupational therapy practice. Therefore, the intention of the research was threefold: 1) to assist occupational therapists translating the PRPP-A from training to practice, 2) to gain insights that would inform occupational therapists applying the PRPP-A in practice, and 3) to inform forthcoming PRPP-A teaching practice.

Reflecting on the Findings

I presented the Phase Two findings from the eight participant interviews through four themes outlined in Chapters 10 and 11: 1) *Configuring a PRPP-A process*, 2) *Having an assessment intention*, 3) *Drawing on theory*, and 4) *Developing skills and strategies*. In the following discussion, I reflect on the central aspects of these Phase Two findings, as well as considering relevant points from the Phase One findings in relation to current literature and research. My overall intention for this discussion is to generate insights which align with the practical purpose of this study.

Learning and Translating the PRPP-A to Practice

Many of the participants in Phase One found the process of learning and applying the PRPP-A to be a demanding task. Prior to learning the PRPP-A, the participants had a range of familiar assessments they routinely and competently used. Adding the PRPP-A to their practice disrupted this established assessment practice, and rather than working as proficient assessors, they faced being novices with the associated uncertainty of being beginner learners (Benner, 2004; Jenson et al., 2025). Other studies (Chard, 2000, 2006; Wimpenny et al., 2010) have recognised that developing competency with occupation-based assessments requires considerable effort, particularly when learning to analyse and document results (Pilegaard et al., 2014), and takes longer compared with familiar assessments (Kristensen et al., 2012). Further, after initially learning the basics of an occupation-based assessment, therapists need to have a clear commitment to change their

assessment practice (Wimpenny et al., 2010), remain focused and persevere (Chard, 2000), or risk returning to their habitual assessment practice rather than using the new assessment (Asaba et al., 2017). Participants in both phases of the current study had persevered, and all used the PRPP-A to some extent; although, like the learning associated with other occupation-based assessments, resolve, effort, and time were required.

One interesting finding was the process of learning the PRPP-A from the training through to translating it in practice tracked a similar progression to the stages of learning theories (Shuell, 1990) outlined in Chapter 3. At the outset of training, the participants, although experienced practitioners, were novice learners (Benner, 2004; King, 2009) relative to the PRPP-A, and their initial learning was consistent with the acquisition or novice stage of learning (Dreyfus, 2004; Jenson et al., 2025). Learning focused on the facts of the PRPP-A, including the criteria, descriptor terms and definitions, the assessment procedures, and the scoring rubric. Acquiring this knowledge was exacting for many participants and for some even overwhelming; a finding consistent with the emotional responses and challenges frequently associated with new learning (Ericsson, 2008; Unsworth, 2001). Additionally, some participants felt anxious and had difficulty keeping up with the learning during the training. This difficulty was attributed to the manual layout and fast delivery of a large volume of new information. The acquisition stage involves learning and memorising facts (Shuell, 1990) and for some participants the PRPP-A training and presentation of material did not necessarily match their ability to follow and learn the new information.

On return to practice, time was needed to consolidate the PRPP-A knowledge. Participants applied parts of the assessment they understood (often Stage One), chose familiar tasks to first assess, and performed the assessment slowly. These descriptions are congruent with learning transitioning between the acquisition and maintenance stages of learning (Shuell, 1990). The participants were still assimilating facts (i.e., all parts of the PRPP-A), and in keeping with the maintenance stage of learning, they needed time and applied their learning in set ways (Dreyfus, 2004; Jenson et al., 2025; Shuell, 1990). Finding time and balancing the need to learn with the pressure of caseloads is a well-recognised barrier for occupational therapists when they have applied other occupation-based assessments (Chard, 2006; Pilegaard et al., 2014) in practice situations that require proficient, quick assessment processes (Robertson & Blaga, 2013). Managerial support at this stage of learning is known to help overcome these difficulties (McCluskey & Cusick, 2002).

With ongoing practice, participants gradually became faster and proficient using the PRPP-A; an indication that their learning had reached the fluency stage of learning (Chapparo & Ranka, 2016). Practice had resulted in increased speed, efficiency, and the new learning could be smoothly applied within real-world timeframes (Chapparo & Ranka, 2016). Phase Two findings revealed how participants developed specific clinical reasoning skills and strategies that supported their efficient use of the PRPP-A. Clinical reasoning skills and strategies, which are context-specific and based on real practice experiences, are known to be important for advancing expertise (Jenson et al., 2025). The particular PRPP-A clinical reasoning skills and strategies identified in this study will not only help guide future novice practitioners wanting to develop their thinking and expert practice of the PRPP-A but may also be used to enhance current training strategies.

The findings of both research phases indicated that participants' progression to the fluency stage of learning occurred as they gained confidence analysing occupational performance and found ways to document the PRPP-A. Many participants reported initially struggling to recall the information and referred to the manual to use the PRPP descriptor terms (acquisition stage of learning). With ongoing practice of analysing occupational performance, participants were able to quickly link their observations to some PRPP descriptors during assessments and then used critical thinking and reflection after the assessment to figure out a deeper analysis. It was apparent that the thinking processes participants used had parallels to the two thinking systems of Dual-Process Theory (Kahneman, 2011; McNab & Rutherford, 2020) (as described in Chapter 3), where using both System 1 and System 2 thinking provides health practitioners with "methodical approaches to decision making" (Church & Carroll, 2023, p. 120). This study provides some preliminary understandings of dual systems thinking being used for occupational performance analysis. It is an aspect of clinical reasoning which to date has not been explored in depth by occupational therapists. Further investigation has the potential to identify metacognitive strategies to assist with managing complexity and decision making in real-world practice. The final stage of learning is generalisation, where knowledge is used without undue mental exertion (Chapparo & Ranka, 2016; Shuell, 1990). For participants at this stage, using the PRPP-A had become a routine part of their assessment practice and was evident when they automatically applied a PRPP lens.

Understanding Occupational Performance Through a PRPP Lens

In the following section, I reflect on four aspects of understanding occupational performance through a PRPP lens. These aspects are discussed under the subheadings: the

concept of a PRPP lens, theories informing a PRPP lens, automatic use of a PRPP lens, and having a strength-based view.

The Concept of a PRPP Lens

The concept of occupational therapists viewing clinical reasoning through different lenses is well-established (Burns et al., 2017; Schell, 2025b), with occupation-based tools recognised to provide an occupational lens for practice (Larsen & Carlsson, 2012). This study found that participants viewed, analysed, and understood clients' occupational performance through a PRPP lens. When writing this chapter, no other evidence was found reporting the use of such a lens. However, the function of the PRPP lens appeared similar to the "professional lens" (Schell, 2025b, p. 104) described in the Ecological Model of Professional Practice (EMPR). The professional lens in the EMPR is described as providing a view through which information is considered, filtered, and interpreted, and to be formed from professional knowledge, practice theories, beliefs, skills, and experiences (Schell, 2025b). Likewise, participants in the current study constructed their own unique PRPP lens by combining theory learnt from the PRPP-A training with their existing knowledge of occupational therapy models and theories, and practical experiences of using the PRPP-A.

Theories Informing a PRPP Lens.

Occupational therapists typically blend theories to inform their thinking in practice (Gillen & Brown, 2024), a method of reasoning termed "theoretical reasoning" (Ikiugu et al., 2019, p. 289). Theoretical reasoning involves drawing together multiple theories where no one theory sufficiently explains the complexity of occupational performance (Ikiugu et al., 2009). In this study, participants melded a variety of occupational therapy models with the foundational theories underlying the PRPP-A (i.e., procedural and behavioural task analysis, cognitive and information processing theories) to form their own theoretical viewpoint. Three occupational performance models influenced their theoretical views, with participants referring mostly to the CMOP-E (Polatajko et al., 2013) and/or PEO model (Law et al., 1996) and less frequently to the OPM(A) (Chapparo et al., 2017) (the OPM(A) underpins the PRPP system; see Chapter 2). It is likely this finding reflects the undergraduate education in Aotearoa New Zealand, since occupational therapists are known to more often use models from their training rather than embrace new models (Davis-Cheshire, 2019; Ikiugu et al., 2009; Ikiugu et al., 2019; Owen et al., 2014). Another consideration is that the OPM(A), as an Australian-based model, may not be so relevant in the cultural context of Aotearoa New Zealand, although two participants did apply the

OPM(A), which suggests the model resonated with their practice setting (McColl, 2024). While the specific reasons why participants selected different models were not explored, all participants were found to include foundational PRPP theory in their theoretical reasoning for a PRPP lens and gave descriptions of using this evidence in their practice. This is a heartening finding, given that, although the use of theory is recognised as an important aspect evidence-based practice (Boniface, 2012), the uptake of theory by occupational therapists can be limited (Ikiugu et al., 2009; Leclair et al., 2013; Robertson et al., 2013).

Automatic Use of a PRPP Lens

Having a PRPP lens provided participants with a secure occupation-focus to their practice and their use of a PRPP lens had become a ‘go to’ automatic way of thinking about occupational performance. Automatic clinical reasoning is typically associated with practitioners’ development of competency and expertise (Dreyfus, 2004; Unsworth, 2001) and forming tacit knowledge (Patnaude & O'Brien, 2023). In stage two of the study participants were all experienced and regular users of the PRPP-A and their automatic PRPP thinking reflects skilled thinking and reasoning patterns developed through time and practice (Robertson, 2012; Vermeulen et al., 2024). Furthermore, some participants intuitively used PRPP reasoning, which they did not necessarily recognise in their thinking, but nevertheless was seen to influence their assessment practice decisions. Intuitive reasoning, which is difficult for practitioners to explain, is an acknowledged trait of expert practitioners’ thinking (Robertson, 2012; Unsworth & Baker, 2016; Vermeulen et al., 2024). Intuitive thinking is also a characteristic of System 1 thinking (Kahneman, 2011) (see Chapter 3) and cognitive strategy application, where sensory information is quickly compared with schemas (memories of experiences), particularly procedural knowledge (past experiences) (Chapparo & Ranka, 2025). Intuitive thinking thus leads experienced occupational therapists to know what to do without thinking (Chapparo & Ranka, 2019). The findings of this study suggest that once participants had established procedural and tacit knowledge of the PRPP-A, they intuitively observed occupational performance through a PRPP lens. That lens resulted in participants rapidly interpreting occupational performance in terms of a client’s accuracy/inaccuracy of performance and specific aspects of both task strengths and breakdown/s. Additionally, having a PRPP lens enabled participants to automatically match cognitive descriptors to explain clients’ occupational performance.

Having a Strength-Based View

A further finding was that having a PRPP lens afforded some participants a strength-based view of occupational performance. This finding is consistent with existing evidence of the PRPP-A generating strength-based findings that led to meaningful intervention goal setting with two Aboriginal and Torres Strait Islander people (Smith et al., 2023). This study adds insights into how, from the outset of meeting a client, participants used a PRPP lens that enabled them to quickly pinpoint strengths and mentally note successful occupational performance and associated cognitive strategy application. Having a strength-based focus is recognised to be beneficial since greater attention is paid to talents and abilities rather than only challenges and deficits (Murthi et al., 2023). A focus on strengths promotes reciprocal exchanges with Indigenous clients (White & Beagan, 2020), builds confidence (Hocking & Whalley Hammell, 2024), and enhances life satisfaction (Dunn, 2017). Strength-based practice is promoted as an important direction for the profession to continue to develop (Dunn, 2017; Hocking & Whalley Hammell, 2024). Currently however, little literature exists to guide occupational therapists about how to do strength-based assessments, and few tools are available to inform their reasoning for this aspect of practice. The findings of this study provide initial support for the premise that reasoning with a PRPP lens advances occupational therapists' strength-based occupational thinking.

Reasoning to Enact an Occupation-focused Assessment Process

The intricacies of reasoning to enact an occupation-focused assessment process are discussed in this section, under 11 subsections: 1) Nature of occupation-focused assessment clinical reasoning, 2) Questioning and thinking to form an occupation-focused assessment plan, 3) Reasoning a bespoke PRPP-A plan, 4) Explaining a PRPP-A, 5) Considering power dynamics, 6) Reasoning just right assessment tasks, 7) Reasoning procedures for task selections, 8) Thinking about safety implications, 9) Navigating cultural influences on tasks, 10) Recognising influences of personal intentions on a PRPP-A, and 11) Reasoning within a dynamic PRPP-A process.

Nature of Occupation-focused Assessment Clinical Reasoning

The process of setting up and enacting an occupation-focused assessment required participants to use flexible, recursive, complex, and contextually specific clinical reasoning. This finding is in keeping with a scoping review of occupational therapy qualitative and conceptual clinical reasoning literature (da Silva Araujo et al., 2022). The authors of the latter review, characterised occupational therapists' clinical reasoning as

being dynamic, iterative, circular, and contextually based, while noting the fast nature of reasoning, which aligns with the discussion of intuitive thinking above. The same review identified growing evidence of occupational therapists using client-centred reasoning alongside the emergence of occupation-focused and contextually based reasoning, with the authors encouraging the profession to obtain more understanding about all three of these aspects of reasoning (da Silva Araujo et al., 2022). A call for greater understandings of contextually based reasoning has also been echoed by Sánchez-Zamorano et al. (2025) in their recent scoping review of occupational therapy professional reasoning literature. The current study responds to needs identified in both these scoping reviews with findings related to clinical reasoning that was client-centred, context-specific, and involved uniquely occupation-focused thinking.

Questioning and Thinking to Form an Occupation-focused Assessment Plan

Study participants formed a distinct occupation-focused assessment plan for each client through an information gathering, questioning, analysing, and decision-making process. The questions posed by participants had similarities to questions recommended for gathering information for assessment selections (Reidy & Andrejow, 2023) and guiding questions proposed for making choices related to measuring outcomes in occupational therapy (Law & MacDermid, 2017). Unlike the current study however, the questions suggested by Law and MacDermid (2017) and Reidy and Andrejow (2023) are conceptual rather than research-based. This study adds practice-based understandings of information and questions that occupational therapists reasoned through to generate a unique occupation-focused assessment plan for each client.

Reasoning a Bespoke PRPP-A Plan

Once participants had formed an assessment plan, which included a PRPP-A, they used client-centred, contextually specific reasoning to tailor explanations of the PRPP-A, the selection of suitable assessment task/s, and choices about when and where to assess. No other studies were located that have captured the reasoning participants used for tailoring a PRPP-A plan. The PRPP-A manual (Chapparo & Ranka, 2024) and training provide theoretical information for occupational therapists to base their explanations of the assessment on, along with action steps to follow to determine assessment task/s in a procedure called occupation sampling (Chapparo & Ranka, 2024). Clinical reasoning for occupation sampling is known to be a sensitive process that involves a series of judgement calls (Chapparo & Ranka, 2024). This study revealed how participants had learnt how to reason bespoke PRPP-A plans with clients.

Explaining a PRPP-A

Bespoke PRPP-A planning began by participants offering reasoned explanations of the PRPP-A to assist clients' understanding, maintain rapport, and promote client buy-in. Thinking about ways to aid a client's comprehension and uphold trust and respect are familiar aspects therapists think about as they use procedural (Schell, 2025a) and interactive reasoning (Turpin & Copley, 2025) (see Chapter 3). Securing buy-in for a PRPP-A, however, has not previously been reported, although professionals are known to consider buy-in as part of interprofessional client-centred reasoning when evaluating housing modifications (Burns et al., 2017). Gaining buy-in is also recognised as an essential component of client-centred practice (Gupta & Taff, 2015) that requires both collaboration and negotiation (Burns et al., 2017). In addition, a similar relational process to gaining buy-in found in this study, has been reported in the practice of occupational therapists and families in Aotearoa New Zealand (Harvey et al., 2022). Where collaborative partnership was fostered for "getting on the same page" (p.204) to establish shared directions for therapy. Likewise, occupational therapists engaging people with cognitive impairments in assessments have also adapted their assessment explanations for comparable reasons (White et al., 2014). Differing from the purposes explained by White et al., for the PRPP-A, establishing buy-in was also intended to set up shared involvement in the assessment task/s selection.

Considering Power Dynamics

For clients to genuinely be involved in an assessment process, Phase One findings revealed that occupational therapists need to consider power dynamics at play within an assessment relationship. Understanding power dynamics when providing services involves occupational therapists acknowledging the power they hold, including the "hidden" (Iwama, 2007, p. 22) power that their privileged professional position affords. It is asserted that health professionals practicing with cultural humility enhances their awareness of power dynamics (Agner, 2020; Singh et al., 2022). Approaching assessment practice with cultural humility would assist occupational therapists to address inherent power imbalances (Singh et al., 2022), examine their own biases and assumptions (Agner, 2020), be open (Anderson, 2022), actively listen (Trentham et al., 2022), let go of preconceived ideas (Nelson et al., 2007), and be comfortable with "coming from a place of not knowing" (Trentham et al., 2022, p. 46). These are factors which, in both phases of the study, many participants described thinking about as they set up a PRPP-A. Despite the growing evidence supporting occupational therapists' adoption of cultural humility in

practice (Agner, 2020; Anderson, 2022; Beagan, 2015; White & Beagan, 2020), little is known about the practical applications of the approach (Singh et al., 2022). The current study provides some information, although further in-depth investigations are needed concerning clinical reasoning associated with cultural humility.

Reasoning ‘Just Right’ Assessment Tasks

The process of selecting and tailoring suitable assessment task/s for a PRPP-A involved complex reasoning. This finding is consistent with a recent Norwegian study concerning the PRPP-A utility (Haghshenas, 2022), which implied reasoning was difficult, since choosing tasks with people with higher-level cognitive impairments was challenging for occupational therapists. Currently, the profession continues to have a scarcity of knowledge about the challenges experienced or the processes occupational therapists use to reason assessment tasks when an assessment has no pre-determined tasks. At the time of writing, only limited information on reasoning for task selection for one other standardised assessment, the Assessment of Work Performance (AWP) (Sandqvist et al., 2008), was sourced. Sandqvist et al. (2008) noted that establishing the right degree of assessment task complexity was hard for many occupational therapists and involved consideration of “adequacy of the work task” (p. 449), although they provided no guidance as to how this was done. Adequacy is defined as something being “satisfactory for a particular purpose” (Cambridge University Press, n.d.), and participants’ thinking about the adequacy of tasks was described in the current study when they weighed up the suitability of task options. Participants compared and evaluated the task challenge, cultural fit, associated risks, and practicalities of doing different tasks in certain contexts, against their planned assessment purpose and a client’s known skills. They sought ‘just right’ assessment task/s. Evaluating the ‘just right’ aspects of tasks is a well-recognised practice for occupational therapy intervention planning and involves thinking of a range of tasks, grading tasks, and matching tasks to “particular difficulty they [clients] are facing” (Kuhanek & Spitzer, 2024, p.2). “The ‘just right’ challenge is the one that stretches the client’s competence” (Rogers, 1982 p. 713). Similarly, when configuring a PRPP-A plan, participants used lateral thinking to generate multiple task options and grade tasks with the differing purpose of comparing task suitability with an assessment rather than an intervention plan. Finding that potentially similar thinking processes are used for evaluating just right tasks for interventions and selecting suitable assessment tasks for occupation-based assessments may assist occupational therapists to draw on existing reasoning skills when they encounter challenges with selecting assessment tasks.

Knowledge also exists on how decisions are made for establishing just right tasks for interventions (Gillen & Brown, 2024; Kuhaneck & Case-Smith, 2020; Kuhaneck & Spitzer, 2024; Rogers, 1982), which can perhaps be applied to selecting suitable assessment tasks. Further research is needed, as there is still much to understand about the subtleties of finding just right assessment tasks.

The current lack of understanding about how assessment task/s are reasoned is perhaps to be expected, since most other standardised occupational therapy assessments typically prescribe assessment tasks or provide a list of tasks to pick from (Fisher, 1992), requiring less reasoning. More surprising, though, is a gap in the literature related to reasoning for task selection for informal non-standardised ecological observational assessments (hereafter called informal ecological assessments). Informal ecological assessments require occupational therapists to decide which specific aspect/s of occupational performance to evaluate. This process is recognised to often be challenging (Law & MacDermid, 2017) and to rely on occupational therapists having “a clear rationale for what is included and what is left out” (Hocking & Whalley Hammell, 2025, p. 23). The findings of the current study provide some initial insights concerning how occupational therapists approached and formed rationales for their assessment task choices, as well as how they navigated challenges that arose as they sought suitable assessment tasks. These are important aspects of reasoning to gain some understandings of, since there are increasing calls for occupational therapists to move away from assessment practices with set western tasks which are not client-centred (Gupta & Taff, 2015) or culturally relevant for Indigenous people (Thorley & Lim, 2011; White & Beagan, 2020) and, at worse, perpetuate a colonising form of practice (Hocking & Whalley Hammell, 2024).

Reasoning Procedures for Task Selections

Despite the PRPP-A affording open choices of task selection, some study participants who worked within acute and rehabilitation mental health settings were found to reason set procedures with limited task options rather than suggesting wider possibilities of occupations to clients. Occupational therapists developing their own routine ways of assessing has also occurred with the translation of the AMPS to practice, with the creation of such routines posited as assisting therapists to gain competent methods of assessment practice (Asaba et al., 2017). Therefore, it seems possible that an occupational therapist applying the PRPP-A with set task options would more readily establish competency using the PRPP-A within those parameters rather than developing the complex and lateral thinking strategies associated with generating multiple alternate task choices that other

study participants described. However, the reasons for habitual practices of offering shopping and cooking tasks by participants in mental health settings were based more on other factors known to influence occupational therapists when they are choosing what to assess. Those factors included that assessments which involve food are motivating and engaging for clients and still allow for some culturally relevant client choices to be made (White et al., 2014). Service expectations (Douglas et al., 2007; Stigen et al., 2018; Stigen et al., 2017) were a further factor shaping their reasoning of task options, since shopping and cooking tasks are viewed as an “effective assessment of functional living skills” (White et al., 2014, p. 6) and the type of assessment commonly associated with occupational therapy practice in mental health contexts of Aotearoa New Zealand (Scanlan et al., 2015).

Thinking About Safety Implications

Safety implications for a PRPP-A were found to be significant considerations because participants in mental health settings had established protocols for managing risks associated with assessments of shopping and cooking tasks. Managing risks when providing occupational therapy is a key duty of care (Collins, 2023). By narrowing task options and having safety procedures in place, participants had attended to the most likely safety risks to arise during assessments. It has been argued that such defensive risk management limits occupational opportunities and occupational therapists are encouraged to adopt a more dynamic, positive risk-taking approach, where risks are collaboratively identified and strategies sought (Collins, 2023). Perhaps a positive risk-taking approach could be incorporated as part of a PRPP-A, allowing for the widening of assessment options. This idea warrants further investigation since the restricted task options currently provided resemble a type of choice which others have likened to “the illusion of client-centred practice” (Gupta & Taff, 2015, p. 244). Limiting options for a client is an illusion in that, at best, therapists and clients are jointly navigating structural barriers and finding solutions, rather than engaging in a “full partnership” (Gupta & Taff, 2015, p. 249). It appears that to genuinely let clients do a task of their choosing, occupational therapists would need to fully commit to providing real choices, finding ways to overcome contextual barriers (Goodchild et al., 2023), taking a positive risk-taking approach (Collins, 2023), and influencing other team members’ and managers’ expectations of assessments (Douglas et al., 2007). Developing a unified occupational therapy team (Goodchild et al., 2023) with a strong work culture (Asaba et al., 2017) and a shared vision to promote the value of occupation-performance assessments are suggested ways to bring

about these kinds of assessment practice changes (Asaba et al., 2017; Goodchild et al., 2023).

Navigating Cultural Influences on Tasks

The study also found that when selecting tasks that occurred naturally within a context, such as an education setting, assumptions may be made that the ways tasks were performed were culturally relevant for clients. This is a concerning finding which reveals how cultural blindness (Nelson, 2007) can exist with task selection if pervasive western ways of doing are not questioned (White & Beagan, 2020). For the PRPP-A, if an occupational therapist does not critically think (Hammell, 2013) and appraise the cultural relevance (Manee et al., 2020) of a task, a client could be assessed doing an unfamiliar and/or meaningless task (Thorley & Lim, 2011) or be expected to do a task in a way that differs from their norm. The likely outcome of an invalid assessment is that it could negatively impact and disadvantage clients (Muñoz, 2007).

Recognising Influences of Personal Intentions on a PRPP-A

One hypothesis for explaining occupational therapists' clinical reasoning is the use of an "Internal Personal Reference System" (IPRS) (Chapparo & Ranka, 2025, p. 296). An IPRS is based on occupational therapists' own knowledge, attitudes, and expectations about how therapy actions should be, which informs "an intention to achieve a specific outcome" (p. 296) and subsequently guides actions taken or not taken. Congruent with this theory of clinical reasoning, participants' own beliefs and attitudes were found to lead to intentions about how they envisioned a particular assessment should be. Three different intentions were uncovered that influenced a variety of specific actions participants chose to do as they set up, started, and performed PRPP-A observations. Health practitioners' intentions are known to drive their behaviours (Casper, 2007) and many social cognitive theories have been used to explain factors which underlie intentions in order to predict behaviours and, ultimately, change clinical practice (Appleby, 2019; Godin et al., 2008; Limbert & Lamb, 2002). Currently, little attention has been given to how occupational therapists' intentions, underlying attitudes, and values shape their clinical reasoning and actions. At the time of writing this discussion, only two studies were found with such focus (Chapparo, 1997; Hoppes & Hellman, 2007). Both sources and the findings of the current study, show the benefit of further investigation into the influences of therapists' intentions on their practice. In addition, it would be useful for occupational therapists currently using the PRPP-A in practice and those attending future PRPP-A training to know how intentions may shape their assessment practice.

Reasoning Within a Dynamic PRPP-A Process

When applying a PRPP-A, many participants used flexible reasoning where they switched their attention and thinking between assessing, intervening, and re-assessing processes in a recursive, fluid interaction led by clients' occupational performance. This dynamic application of the PRPP-A is consistent with the design of the PRPP System of Task Analysis (Chapparo & Ranka, 2024), where a PRPP-A process informs PRPP-Intervention (PRPP-I) and/or is directly linked to trialling PRPP-I strategies within the same session (Chapparo & Ranka, 2016; Smith et al., 2023). Dynamic assessment approaches (Missiuna, 1987; Polatajko et al., 2000; Toglia, 2011) are promoted to be: quicker than traditional assessment practice (Missiuna, 1987); more aligned with realities of occupational therapy practice than static assessments with separate intervention processes (Haworth et al., 2023; Toglia, 2011); provide a “‘try it and see’ approach” (Haywood & Lidz, 2006a, p. 13) to overcome barriers; allow for solutions to be trialled; and, importantly, avoid unnecessary assessment task failure for clients (Hocking & Whalley Hammell, 2024). These attributes were also seen in this study, where it was apparent participants used PRPP-A training knowledge to test out PRPP-I strategies during assessments and aimed for clients to have positive assessment experiences and outcomes. However, deciding when and how to intervene, weighing up the right level of intervention to provide and, at times, navigating competing tensions between how much to let a person try and when to step in, involved complex reasoning. For some such decisions seemed to be influenced by prior traditional views about what should constitute an assessment process and/or the kind of assessment data they should gather. Similar challenges have been reported when occupational therapists use the Cognitive Orientation to Daily Occupational Performance Approach, another dynamic mode of cognitive intervention, where therapists faced uncertainty when determining how much guidance to provide (Chui et al., 2020). For occupational therapists, there seems to be a dearth of information to guide their thinking and decision-making for doing dynamic assessments. To date, no other studies were found which have discussed clinical reasoning underlying the actions occupational therapists take when they apply the PRPP-A as a dynamic assessment or any other occupational therapy dynamic assessment approaches.

Study Strengths and Limitations

From the outset of this study, I was aware that my extensive experience, both using the PRPP-A in practice and involvement with the PRPP-A training, had potential to influence the research findings. Those influences represented both strengths and limitations. Most

participants knew me as an organiser or instructor of PRPP-A courses in Aotearoa New Zealand. This familiarity potentially assisted participants to feel at ease when interviewed; although may have limited what they disclosed, particularly if they were uncertain of how they used the PRPP-A or thought they incorrectly applied it. However, it seemed during the interviews, regardless of this prior relationship, participants openly discussed their challenges and parts of the assessment they were not using. My depth of prior experience of learning, applying, and teaching the PRPP-A provided a useful knowledge base, giving me some perspective and understandings of participants' experiences and thinking. There was, however, the potential to introduce bias or for me to have a restricted interpretation of what participants shared. To address these limitations, throughout the study I endeavoured to be open and transparent in describing my connections to the PRPP training, including the assumptions I held prior to undertaking the study and the influence of these as the research progressed. To manage these assumptions and minimise undue influence on the findings I used regular supervision, reflective practice, and a process of critical questioning to examine possible influences, examine my bias and actively detach myself to proceed with fresh eyes.

In Chapter 6, the strategies I put in place to ensure rigour in this study were outlined. However, several issues arose during the research process, which may have introduced potential bias to the sample. As with any study that relies on people who volunteer, there was a risk of a positive bias within the recruitment process. Volunteers are often highly motivated, and so the Phase One sample may not truly have represented occupational therapists who have completed PRPP training. Occupational therapists not using the PRPP-A or who did not perceive the PRPP-A to represent the kind of practice they aspired to, were unlikely to have volunteered. In Phase One, most of the volunteers were females with only one male in the sample. This gender ratio was consistent with the spread of registered occupational therapists in Aotearoa New Zealand at the time of recruitment, with more females (91%) than males (9%) (Stokes & Dixon, 2018) and was a realistic representation of the workforce. In contrast, the sample in Phase Two was entirely female, with male voices missing from this phase.

One volunteer in the Phase One sample had previously received support from myself in the PRPP support group discussed in Chapter 1. At the time of recruitment, while there was no ongoing relationship with myself, it is possible that the previous support I had given within the group may have influenced this participant's experiences of applying the PRPP-A.

The Phase One sample was predominantly made up of occupational therapists practicing in Auckland, with only two volunteers from cities outside of Auckland and no participants who practiced rurally. Likewise, the Phase Two sample only had one volunteer outside of Auckland, who also practiced in a city. This is a limitation since practitioners working in more isolated rural areas may well have less social support (Campbell et al., 2012; Steenbergen & Mackenzie, 2004), and this study identified that social learning was a main support for many occupational therapists learning the PRPP-A. In addition, applying the PRPP-A in a rural community may involve consideration of factors and clinical reasoning not captured in the Phase Two research, where volunteers were city-based. The experiences, therefore, of rural occupational therapists translating the PRPP-A and their clinical reasoning may well be different from city therapists represented in this study.

The Phase One focus group had only two Māori members, which undoubtedly limited the diversity of views and interactions that are usually possible from this type of data collection. Both volunteers were active members of the occupational therapy profession and OTNZ-WNA and committed to Te Umanga Whakaora²¹ the “strategy designed to increase cultural, clinical and technical capacity and competency of the occupational therapy workforce in Aotearoa” (Te Rau Matatini, 2009, p. 11). Therefore, I considered their opinions provided an important contribution to this research. Phase Two only had one Māori volunteer, so the Indigenous voice on PRPP-A and clinical reasoning was limited. In both phases, however, the percentage ratios of Māori volunteers to non-Māori were greater than the workforce at the time of recruitment. Māori made up 4% of registered occupational therapists in Aotearoa New Zealand (Stokes & Dixon, 2018) during Phase One recruitment and 11% of the workforce (OTBNZ, 2022) during Phase Two.

The data collection in Phase Two was interrupted by COVID-19 related restrictions, impacting prospective participants’ availability to participate and the overall number of volunteers. However, the extended data collection period allowed for deeper reflection on data as it was collected and preliminary analysis of early data sets. This time provided opportunities to refine questions and explore emerging reasoning in more detail during subsequent interviews. A limitation was data gathering methods had to be switched to online interviewing. A recording error made in one interview required repeating the

²¹ Te Umanga Whakaora Accelerated Māori occupational therapy workforce development

interview several days later and likely influenced the data, as the participant had prior knowledge of the questions and time to reflect on their answers.

A limitation for Phase Two was the time between participants completing a PRPP-A and being available for an interview with me. The complications associated with collecting retrospective clinical reasoning, particularly ‘in the moment’ thinking, are well known (Unsworth & Schell, 2025) and the greater the time lag after an event, the more the data are reliant on a participant’s memory of the situation, which may be inaccurate (Unsworth & Schell, 2025). To combat this limitation, participants completed reflective logs immediately after doing an assessment, and one participant videoed the session and watched the video before being interviewed. These methods were used to capture participants’ thinking as soon after the assessment as practically possible (see Chapter 5). In addition, receiving the reflective logs ahead of the interview meant I shaped questions to pick up on participants’ immediate thoughts and delve more deeply during the interview. This method aimed to assist participants’ recall and elicit more detail. I do acknowledge that some inaccuracies or distortion between participants’ thinking at the time of the assessment and their recall later probably exist.

Implications of the Study and Recommendations

Throughout both phases of the study, I have aimed to gain understandings that had practical relevance. In reviewing my research, I have questioned what this study found, how it might be applicable, and for whom? In answering these questions, I consider that the findings from both phases of the study may have some practical relevance to the following groups: occupational therapists in practice, occupational therapists considering PRPP-A training, and associated funding agencies/organisations and PRPP-A instructors. Recommendations for future research are integrated with the sections below.

For Occupational Therapists in Practice

The implications and recommendations for occupational therapists in practice include: 1) clinical reasoning supporting collaborative occupation-focused assessment plans, 2) clinical reasoning for strength-based assessment practice and dynamic assessment approaches, 3) PRPP-A and cultural safety, and 4) claiming unique occupation-focused clinical reasoning.

Clinical Reasoning Supporting Collaborative Occupation-focused Assessment Plans

Further research is required to gain more understanding of the clinical reasoning occupational therapists use when forming collaborative occupation-focused assessment plans. This study provided preliminary insights of clinical reasoning, information gathering, specific questioning, and decision-making processes which helped participants to shape occupation-focused assessment plans that included the PRPP-A. These insights will assist other occupational therapists wanting to advance their collaborative occupation-focused assessment planning, which is a direction the profession has been urged to embrace (Hocking & Whalley Hammell, 2024). Additional research of how occupational therapists, in different contexts, think through and navigate the complexities of developing occupation-focused assessment plans could help to change current prevalent assessment practices based on past reductionist, biomedical, impairment-focused and traditional evidence-based perspectives. By generating such understandings, occupational therapists would have more knowledge of what information they need to consider when formulating assessment plans focused on the core domain of occupation. Furthermore, research exploring clinical reasoning from an information processing cognitive strategy approach (Chapparo & Ranka, 2025) and exploring dual thinking systems is suggested to identify thinking strategies occupational therapists could use to assist their occupation-focused assessment planning. It is envisioned that generating deeper understandings of thinking strategies would support occupational therapists to develop necessary clinical reasoning skills for their assessment planning.

Conducting the study also revealed that little is known about what influences occupational therapists' thinking and decision-making when selecting assessment tasks for assessments with no predetermined set tasks. Clinical reasoning of suitable assessment tasks for the PRPP-A was found to involve critical evaluation of the adequacy of tasks and to be a uniquely client-centred, contextually specific process which necessitated thinking about the cultural relevance of tasks. For some participants, considering and navigating dominant contextual ways of doing and/or service expectations was also evident. These are complex, skilled reasoning processes which the profession would benefit from researching further. This knowledge gap is particularly salient, given that for clients to be assessed doing meaningful and culturally relevant occupations, assessment processes need to be free from predetermined occupational categories or tasks, and occupational therapists need to

know how to collaboratively reason about suitable assessment task selections. More research exploring shared decision-making of assessment task selection for ecological, standardised, and non-standardised assessments is needed.

Clinical Reasoning for Strength-based Assessment Practice and Dynamic Assessment Approaches

Another area for further investigation is clinical reasoning which supports strength-based practice. Assessing for strengths in occupational performance is an aspect of occupational therapy practice which is increasingly drawing the profession's attention. The findings of this study indicated that the PRPP-A assisted some participants to identify strengths and also raised unanswered questions as to how it informed their intervention plans and influenced intervention outcomes. Future research which examines how the PRPP-A and other strength-based assessments shape occupation-focused practice is warranted.

The study's findings uncovered different ways and reasons that participants used dynamic applications of the PRPP-A. Skilled, flexible, and quick reasoning was required to respond to clients' occupational performance as it unfolded, and to judge when and how to intervene and reassess in a continuous reflexive process. These are important initial findings about reasoning used with a dynamic assessment approach, since, unlike other disciplines that have established guidelines for performing dynamic assessment processes (Haywood & Lidz, 2006b), no such guidance exists for occupational therapists. Dynamic assessment approaches are recognised to offer more relevant ways for occupational therapists to practice than many of the profession's traditional assessment practices, where assessment and intervention processes are artificially separated, and which often better serve the needs of services, funders, and others, rather than clients (Hocking & Whalley Hammell, 2024). Developing greater understandings of how occupational therapists think through dynamic assessment approaches, including the clinical reasoning skills and strategies they use, would advance future assessment practice.

PRPP-A and Cultural Safety

Participants in both phases of the study, across a range of practice contexts in Aotearoa New Zealand, were found to have positive experiences of using the PRPP-A and saw it as a flexible, culturally relevant assessment that was a valuable addition to practice. Three Māori occupational therapists confirmed, in their view, that the PRPP-A was applicable to their work. Only recipients of an assessment practice, however, can

determine if an assessment is culturally safe for them (Curtis et al., 2019). Research into clients' (client, whānau/family, or significant others) experiences of the PRPP-A is needed. In Aotearoa New Zealand, views of Māori clients are paramount to understanding whether the PRPP-A has relevance for their hauora (health and well-being). Including client views on whether the PRPP-A was safe for them, met their needs, and if they considered the assessment beneficial or not, and eliciting ideas on ways occupational therapists can better partner for the collaborative application of a PRPP-A would be valuable. This is particularly important since findings of this study highlighted that to apply the PRPP-A, occupational therapists need abilities to work in partnership with clients to attend to cultural safety and cultural humility. Further research is also indicated regarding how occupational therapists practically apply cultural humility with diverse populations in different contexts.

Claiming Unique Occupation-focused Clinical Reasoning

Following the PRPP-A training, and on translating the tool to practice, participants were found to have changed the way they viewed and reasoned occupational performance. The PRPP-A sharpened their occupational perspective, and they automatically saw and reasoned occupational performance through a PRPP-A lens. Consistent with expert practitioners' clinical reasoning, participants experienced using the PRPP-A intuitively, such that they were not always cognisant of their reasoning. Having more awareness of using their PRPP-A reasoning and outwardly claiming how it informed their observations of a client's occupational performance would likely give more credibility to occupational therapists' skilled, informal observations. That clarity would assist clients, other team members, students, and occupational therapists not trained in the PRPP-A to see and understand the value of occupational performance analysis linked to cognitive strategy application. Occupational therapists claiming and communicating their unique occupation-focused practice can raise their profile within multidisciplinary teams (Parkinson et al., 2008), strengthen professional identity (Walder et al., 2022), provide meaningful experiences of occupational therapy practice (Nicholson, 2013), and foster resilient workforces (Scanlan & Hazelton, 2019). It is recommended that PRPP-A trained occupational therapists reflect on the influence of a PRPP lens on their clinical reasoning and acknowledge this unique perspective when explaining occupational performance observations to others.

For Occupational Therapists Considering PRPP-A Training and Associated Funding Agencies/Organisations

The Phase One findings imply that for occupational therapists to become proficient users of the PRPP-A entails a learning process that progresses through recognisable stages of learning. This insight provides useful guidance for future occupational therapists considering PRPP-A training, as they will have awareness that learning the PRPP-A can mean being thrown back to the discomfort of being a novice assessor. In addition, they could plan for the acquisition stage of learning and the commitment required beyond attending the training. For example, when applying for funding and time for training, occupational therapists could negotiate with managers/funding agencies for extra time to translate the assessment to practice and set realistic timeframes for becoming a proficient user of the assessment. Supports for learning could be planned ahead of training, including supervision and time for reflection.

Recommendations for PRPP-A Instructors

During the PRPP training, some participants reported struggling with notetaking, missing information, and having challenges finding information within the manual. These issues have implications for future training and imply that course material and manual layout may need some revision. In addition, to support translation to practice, PRPP-A instructors might consider how to incorporate further support for occupational therapists transitioning from impairment-focused to an occupation-focused assessment practice. Acknowledging that KT is a shared responsibility, there may also be merit in prospective PRPP-A trainees attending to their ontological security prior to attending the training. This could perhaps be achieved by sharing information from the experiences of participants in this study, encouraging prospective trainees to reflect on their occupation focus to practice and giving resources before the course; for example, relevant reading or a pre-course questionnaire.

Another aspect for consideration in future PRPP courses in Aotearoa New Zealand is the inclusion of training related to clinical reasoning associated with cross cultural applications of the assessment. Sharing and exploring the implications of the study's findings related to client-centred practice, power dynamics in assessment relationships, cultural humility, and cultural safety would better prepare PRPP-A trainees for later applying the assessment across cultures.

These findings point to the potential value of attending to KT from the outset of a course. In particular, that might mean incorporating reflection to connect existing, new,

and future changes to practice within the course, to help cement new learning. Other ideas arising from Phase One of this study are discussing KT early in the PRPP-A training, with the progression through stages of learning explained, and sharing KT strategies from this study. PRPP-A trainees could then select KT strategies they felt best supported their learning.

Conclusion

At the start of this study, I was interested in gaining practical understandings of occupational therapists' experiences applying the PRPP-A in Aotearoa New Zealand. As the research progressed, it was apparent that participants were describing changes in their thinking and decision-making associated with using a PRPP-A and I was curious to know more. Consequently, a second phase of study was designed to focus on clinical reasoning and the PRPP-A process. Since both phases of the research were exploratory in nature, open study aims were developed to guide the investigation and an interpretive description methodology was selected to foster practically orientated inductive findings.

As the study concludes, I realise the exploratory nature of this research has led to findings that are broader than initially envisioned. Throughout both phases, new discoveries surfaced, alongside familiar issues previously associated with other occupation-based assessments. In addition, some findings have shown consistency with the existing literature on occupational therapists' clinical reasoning.

The key findings included that the occupational nature of the PRPP-A strongly resonated with participants, who validated the assessment as a useful ecological framework and measure of occupational performance in their practice. In the Aotearoa New Zealand context, the flexibility of the PRPP-A was found to fit occupational therapists' practice across a range of settings. It allowed participants to assess clients from diverse cultural backgrounds, engaging in culturally specific occupations. However, ensuring a culturally relevant assessment for clients required occupational therapists to form collaborative relationships, practice with cultural humility by truly being open, actively listening, and critically reflecting on their own cultural assumptions and biases. Considering contextual influences and addressing cultural safety includes having awareness of and attending to the power dynamics present in the assessment process. Ultimately, the effectiveness of the PRPP-A was reliant upon the skill and approach of the occupational therapist performing it.

Learning and translating the PRPP-A to practice was revealed to be a demanding process, in two senses. Learning the assessment and translating it into practice threw the participants back to novice assessors at the acquisition stage of learning, which they had not fully anticipated. Transitioning to using the PRPP-A also called on therapists to relinquish familiar, reductionist impairment-based practices and embrace occupation-focused practice. The KT process was recognised as progressing through recognisable stages of learning, where using the PRPP-A soon after training appeared to aid the process. This valuable knowledge will inform future efforts to support occupational therapists to implement the PRPP-A after training.

Occupational therapists used complex, flexible, and recursive clinical reasoning to shape bespoke PRPP-A plans with clients. Choosing suitable assessment tasks was a skillful process that involved matching potential task attributes with unique assessment requirements to find just right assessment task/s which fitted an assessment purpose. The process could be challenging and, at times, required quick, lateral, and creative thinking. The actions that participants chose to take, or not take, before and during an assessment were influenced by their own intentions. Participants' intentions were based on personal beliefs and attitudes about how they envisioned a particular assessment should be, which shaped how the assessment was performed. This finding may assist occupational therapists who are using or wanting to use client-centred assessments that are free of set instructions and structured assessment tasks. Insights from this study provide awareness of possible influences on this form of assessing, as well as knowledge of the nature of the clinical reasoning and decision-making that can be involved.

Participants with expertise in applying the PRPP-A used both intuitive reasoning and slower, deeper analytical thinking after the assessment to analyse the occupational performance and cognitive strategy application they had observed. In addition, when participants were faced with complex assessment findings or were unsure, they used peer review and/or supervision to check their thinking and analysis. Using social supports was one of many strategies identified that participants had developed to skilfully apply the PRPP-A. Having an understanding of clinical reasoning skills and a range of strategies to apply in practice will assist future PRPP-A trained occupational therapists to more easily develop expertise and confidence using the assessment. To my knowledge, this is the only study which has currently investigated clinical reasoning associated with the PRPP-A. The findings may also have relevance for

occupational therapists wanting to know about likely clinical reasoning processes for other occupation-based assessments.

A major contribution of this study was finding that using the PRPP-A provided occupational therapists a lens through which to automatically view and interpret occupational performance and cognitive strategy application. It was a way for therapists to confidently enact occupation-focused practice and explain complexities of occupational performance. Furthermore, having a PRPP lens afforded participants both a strength-based approach to assessing occupational performance and a dynamic method of assessing. While the latter two features were built into the PRPP-A at the assessment design stages, little attention has previously been given to understanding the practical applications of these features of the tool. These are important preliminary insights, as the profession needs strength-based and dynamic assessment options for future assessment practice. These types of assessments are considered to have potential to better meet clients' needs than many existing standardised, deficit-focused assessments.

The study has broadened my understandings of the practice realities and challenges associated with learning and translating the PRPP-A to occupational therapy practice. It has confirmed that complex clinical reasoning skills are required to enact a uniquely client-centred, ecological assessment process. Moreover, it has strengthened my resolve to further my own cultural humility and cultural safety, as well as provided useful insights to assist me in better supporting clients and other occupational therapists in the future. I treasure the opportunities the study has given me to work in partnership and hear the stories from the occupational therapists who volunteered and so generously shared their time and energy. The guidance and wisdom of Iris Pahau, Tikanga advisor, was invaluable, and the importance of working in partnership is symbolised in this final whakataukī:

Me mahi tahi tatou mo te oranga o te katoa

We should work together for the well-being of everyone

REFERENCES

- Agner, J. (2020). Moving from cultural competence to cultural humility in occupational therapy: A paradigm shift. *American Journal of Occupational Therapy*, 74(4), 1-7. <https://doi.org/10.5014/ajot.2020.038067>
- Allison, J., & Shotwell, M. (2018). Mental health. In B. Schell & J. Schell (Eds.), *Clinical and professional reasoning in occupational therapy* (pp. 369-381). Wolters Kluwer.
- Alotaibi, N. M., Reed, K., & Nadar, M. S. (2009). Assessments used in occupational therapy practice: An exploratory study. *Occupational Therapy in Health Care*, 23(4), 302-318 <https://doi.org/10.3109/07380570903222583>
- Alsop, A. (1997). Evidence-based practice and continuing professional development. *British Journal of Occupational Therapy*, 60(11), 503-508. <https://doi.org/10.1177/030802269706001112>
- Anderson, S. H. (2022). Cultivating cultural humility in occupational therapy through experiential strategies and modeling. *Open Journal of Occupational Therapy*, 10(4), 1-7. <https://doi.org/10.15453/2168-6408.1962>
- Appleby, B. E. (2019). Implementing guideline-checklists: Evaluating health care providers intentional behaviour using an extended model of the theory of planned behaviour. *Journal of Evaluation in Clinical Practice*, 25(4), 664-675. <https://doi.org/10.1111/jep.13075>
- Arntzen, C. (2017). An embodied and intersubjective practice of occupational therapy. *OTJR: Occupation, Participation & Health*, 38(3), 173-180. <https://doi.org/10.1177/1539449217727470>
- Asaba, E., Nakamura, M., Asaba, A., & Kottorp, A. (2017). Integrating occupational therapy specific assessment in practice: Exploring practitioner experiences. *Occupational Therapy International*, 2017, 1-8, 7602805. <https://doi.org/10.1155/2017/7602805>
- Aubin, G., Béliveau, M., & Klinger, E. (2018, 2018/07/04). An exploration of the ecological validity of the Virtual Action Planning–Supermarket (VAP-S) with people with schizophrenia. *Neuropsychological Rehabilitation*, 28(5), 689-708. <https://doi.org/10.1080/09602011.2015.1074083>
- Aubin, G., Chapparo, C., Gélinas, I., Stip, E., & Rainville, C. (2009). Use of the Perceive, Recall, Plan and Perform System of Task Analysis for persons with schizophrenia: A preliminary study. *Australian Occupational Therapy Journal*, 56(3), 189-199. <https://doi.org/10.1111/j.1440-1630.2007.00725.x>
- Aubin, G., Lamoureux, J., Gélinas, I., Chapparo, C., Stip, E., & Rainville, C. (2014). Daily task performance and information processing among people with schizophrenia and healthy controls: A comparative study. *British Journal of Occupational Therapy*, 77(9), 466-474. <https://doi.org/10.4276/030802214X14098207541117>

- Aubin, G., Stip, E., G  linas, I., Rainville, C., & Chapparo, C. (2009). Daily activities, cognition and community functioning in persons with schizophrenia. *Schizophrenia Research*, 107(2), 313-318. <https://doi.org/10.1016/j.schres.2008.08.002>
- Awaad, T. (2003). Culture, cultural competency and occupational therapy: A review of the literature. *British Journal of Occupational Therapy*, 66(8), 356-362. <https://doi.org/10.1177/030802260306600804>
- Ayres, J., Watkeys, F., & Carthy, J. (2014). Quality and effectiveness of clinical supervision: Evaluation of an occupational therapy service. *British Journal of Occupational Therapy*, 77(9), 447-450. <https://doi.org/10.4276/030802214x14098207540992>
- Bagatell, N., Hartmann, K., & Meriano, C. (2013). The evaluation process and assessment choice of pediatric practitioners in the Northeast United States. *Journal of Occupational Therapy, Schools, & Early Intervention*, 6(2), 143-157. <https://doi.org/10.1080/19411243.2012.750546>
- Ballinger, C. (2004). Writing up rigour: Representing and evaluating good scholarship in qualitative research. *British Journal of Occupational Therapy*, 67(12), 540-546. <https://doi.org/10.1177/030802260406701204>
- Bannigan, K., & Moores, A. (2009). A model of professional thinking: Integrating reflective practice and evidence based practice. *Canadian Journal of Occupational Therapy*, 76(5), 342-350. <https://doi.org/10.1177/000841740907600505>
- Barry, M., Kuijer-Siebelink, W., Nieuwenhuis, L., & Scherpbier-de Haan, N. (2017). Communities of practice: A means to support occupational therapists' continuing professional development. A literature review. *Australian Occupational Therapy Journal*, 64(2), 185-193. <https://doi.org/10.1111/1440-1630.12334>
- Baum, C. M., & Law, M. (1997). Occupational therapy practice: Focusing on occupational performance. *American Journal of Occupational Therapy*, 51(4), 277-288. <https://doi.org/10.5015/ajot.1997.51.4.277>
- Beagan, B. (2015). Approaches to culture and diversity. A critical synthesis of occupational therapy literature. *Canadian Journal of Occupational Therapy*, 82(5), 272-282. <https://doi.org/10.1177/0008417414567530>
- Belchior, P., Korner-Bitensky, N., Holmes, M., & Robert, A. (2015). Identification and assessment of functional performance in mild cognitive impairment: A survey of occupational therapy practices. *Australian Occupational Therapy Journal*, 62(3), 187-196. <https://doi.org/10.1111/1440-1630.12201>
- Benner, P. (2004). Using the Dreyfus model of skill acquisition to describe and interpret skill acquisition and clinical judgement in nursing practice and education. *Bulletin of Science, Technology and Society*, 24(3), 188-199. <https://doi.org/10.1177/0270467604265061>

- Bezyak, J. L., Ditchman, N., Burke, J., & Fong, C. (2013). Communities of practice: A knowledge translation tool for rehabilitation professionals. *Rehabilitation Research, Policy & Education*, 27(2), 89-103. <https://doi.org/10.1891/2168-6653.27.2.89>
- Bhattacharyya, O., Reeves, S., Garfinkel, S., & Zwarenstein, M. (2006). Designing theoretically-informed implementation interventions: Fine in theory, but evidence of effectiveness in practice is needed. *Implementation Science*. 23(1), 5. <https://doi.org/10.1186/1748-5908-1-5>
- Binder, C. (1996). Behavioral fluency: Evolution of a new paradigm. *The Behavior Analyst*, 19(2), 163-197. <https://doi.org/10.1007/bf03393163>
- Boniface, G. (2012). Defining occupational therapy theory. In Boniface, G., & Seymour, A. (Eds.). *Using occupational therapy theory in practice* (pp. 37-53). John Wiley & Sons, Incorporated.
- Bootes, K., & Chapparo, C. (2010). Difficulties with multitasking on return to work after TBI: A critical case study. *Work*, 36(2), 207-216. <https://doi.org/10.3233/WOR-2010-01021>
- Boyt Schell, B., & Benfield, A. (2018). Aspects of professional reasoning. In B. Boyt Schell & J. Schell (Eds.), *Clinical and professional reasoning in occupational therapy* (2nd ed., pp. 127-144). Wolters Kluwer Health.
- Brangan, J., & O'Neill, G. (1998). Assessment practices of Irish occupational therapists: A study. *British Journal of Therapy & Rehabilitation*, 5(11), 565-585. <https://doi.org/10.12968/bjtr.1998.5.11.565>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. <https://doi.org/10.1191/1478088706qp063oa>
- Brewer, K. M., Harwood, M. L. N., McCann, C. M., Crengle, S. M., & Worrall, L. E. (2014). The use of interpretive description within kaupapa Māori research. *Qualitative Health Research*, 24(9), 1287-1297. <https://doi.org/10.1177/1049732314546002>
- Buchan, T. (2002). The impact of language and culture when administering the Assessment of Motor and Process Skills: A case study. *British Journal of Occupational Therapy*, 65(8), 371-373. <https://doi.org/10.1177/030802260206500804>
- Burns, S. C., & Neville, M. (2016). Cognitive assessment trends in home health care for adults with mild stroke. *American Journal of Occupational Therapy*, 70(2), 1-8. <https://doi.org/10.5014/ajot.2016.016543>
- Burns, S. P., Pickens, N. D., & Smith, R. O. (2017, 2017/07/03). Interprofessional client centered reasoning processes in home modification practice. *Journal of Housing for the Elderly*, 31(3), 213-228. <https://doi.org/10.1080/02763893.2017.1280579>

- Cambridge Dictionary. (2018). *Cambridge dictionary*.
<https://dictionary.cambridge.org/dictionary/english/>
- Cambridge University Press. (n.d.a). Adequacy. In *Cambridge Online Dictionary*.
 Retrieved February 15, 2025, from <https://dictionary.cambridge.org>
- Cambridge University Press. (n.d.b). Configurng. In *Cambridge Online Dictionary*.
 Retrieved November 21, 2023, from <https://dictionary.cambridge.org>
- Cambridge University Press. (n.d.c). Strategy. In *Cambridge Online Dictionary*.
 Retrieved April 10, 2024, from <https://dictionary.cambridge.org>
- Campbell, N., McAllister, L., & Eley, D. (2012). The influence of motivation in recruitment and retention of rural and remote allied health professionals: A literature review. *Rural and Remote Health Online Journal*, 12, 1-15.
<https://www.rrh.org.au/>
- Carpenter, C., & Suto, M. (2008a). Developing a research plan. In C. Carpenter & M. Suto (Eds.), *Qualitative research for occupational and physical therapists: A critical guide* (pp. 40-59). Blackwell Publishing.
- Carpenter, C., & Suto, M. (2008b). *Qualitative research for occupational and physical therapists: A critical guide*. Blackwell Publishing.
- Carr, J., & Shepherd, R. (2000). *Movement science: Foundations for physical therapy in rehabilitation* (2nd ed.). Aspen Publishers.
- Carr, M., & Shotwell, M. (2018). Information processing theory and professional reasoning. In B. Schell & J. Schell (Eds.), *Clinical and professional reasoning in occupational therapy* (pp. 73-104). Wolters Kluwer.
<https://doi.org/9781496335890>
- Carrier, A., Levasseur, M., Bédard, D., & Desrosiers, J. (2010). Community occupational therapists' clinical reasoning: Identifying tacit knowledge. *Australian Occupational Therapy Journal*, 57(6), 356-365.
<https://doi.org/10.1111/j.1440-1630.2010.00875.x>
- Case-Smith, J. (1997). Variables related to successful school-based practice. *OTJR: Occupational Therapy Journal of Research*, 17(2), 133-153.
<https://doi.org/10.1177/153944929701700208>
- Casper, E. (2007). The theory of planned behavior applied to continuing education for mental health professionals. *Psychiatric Services*, 58(10), 1324-1329.
<https://doi.org/10.1176/ps.2007.58.10.1324>
- Castro, D., Dahlin-Ivanoff, S., & Mårtensson, L. (2014). Occupational therapy and culture: A literature review. *Scandinavian Journal of Occupational Therapy*, 21(6), 401-414. <https://doi.org/10.3109/11038128.2014.898086>
- Chaffey, L., Unsworth, C., & Fossey, E. (2010). A grounded theory of intuition among occupational therapists in mental health practice. *British Journal of Occupational Therapy*, 73(7), 300-308.
<https://doi.org/10.4276/030802210X12759925544308>

- Chaffey, L., Unsworth, C. A., & Fossey, E. (2012). Relationship between intuition and emotional intelligence in occupational therapists in mental health practice. *American Journal of Occupational therapy*, 66(1), 88-96.
<https://doi.org/10.5014/ajot.2012.001693>
- Chapparo, C. (1997). *Influences on clinical reasoning in occupational therapy* [PhD, Macquarie University]. Australia.
- Chapparo, C. (2010). Perceive, Recall, Plan and Perform (PRPP): Occupation-centred task analysis and intervention system. In S. Rodger (Ed.), *Occupation-centred practice with children: A practical guide for occupational therapists* (pp. 183-200). Blackwell
- Chapparo, C., & Ranka, J. (2016). *The Perceive, Recall, Plan, & Perform System Intervention course manual*.
<https://www.occupationalperformance.com/courses/>
- Chapparo, C., & Ranka, J. (2024). *The Perceive, Recall, Plan, & Perform System Assessment course manual*.
<https://www.occupationalperformance.com/courses/>
- Chapparo, C., & Ranka, J. (2019). Clinical reasoning in occupational therapy. In J. Higgs, G. Jenson, S. Loftus, & N. Christensen (Eds.), *Clinical reasoning in the health professions* (4th ed., pp. 271-284). Elsevier.
- Chapparo, C., & Ranka, J. (2025). Clinical reasoning in occupational therapy. In J. Higgs, G. Jenson, S. Loftus, F. Trede, & S. Grace (Eds.), *Clinical reasoning in the health professions* (5th ed., pp. 292-306). Elsevier.
- Chapparo, C., Ranka, J., & Nott, M. (2017). Occupational performance model (Australia): A description of constructs, structure and propositions. In M. Curtin, M. Egan, & J. Adams (Eds.), *Occupational therapy for people experiencing illness, injury or impairment. Promoting occupation and participation* (pp. 134-147). Elsevier.
- Chapparo, C., Ranka, J., & Nott, M. (2017). Perceive, Recall, Plan and Perform (PRPP) System of task analysis and intervention. In M. Curtin, M. Egan, & J. Adams (Eds.), *Occupational therapy for people experiencing illness, injury or impairment: Promoting occupation and participation* (7th ed., pp. 243-257). Elsevier.
- Chard, G. (2000). An investigation into the use of the Assessment of Motor and Process Skills (AMPS) in clinical practice. *British Journal of Occupational Therapy*, 63(10), 481-488. <https://doi.org/10.1177/030802260006301005>
- Chard, G. (2006). Adopting the Assessment of Motor and Process Skills into practice: Therapists' voices. *British Journal of Occupational Therapy*, 69(2), 50-57.
<https://doi.org/10.1007/s40037-019-00542-7>
- Chevignard, M. P., Soo, C., Galvin, J., Catroppa, C., & Eren, S. (2012). Ecological assessment of cognitive functions in children with acquired brain injury: A systematic review. *Brain Injury*, 26(9), 1033-1057.
<https://doi.org/10.3109/02699052.2012.666366>

- Chui, A., Mazzitti, D., Nalder, E., Cameron, D., Polatajko, H. J., & Dawson, D. R. (2020). Therapists' experience of the cognitive orientation to daily occupational performance (CO-OP) approach: Shifting from conventional practice. *Scandinavian Journal of Occupational Therapy*, 27(2), 133-141. <https://doi.org/10.1080/11038128.2018.1483424>
- Church, D., & Carroll, M. (2023). How does metacognition improve decision-making in healthcare practitioners? *Journal of Paramedic Practice*, 15(3), 113-123. <https://doi.org/10.12968/jpar.2023.15.3.113>
- Classen, S., & Velozo, C. A. (2014). Critiquing assessments. In A. Boyt Scheell, G. Gillen, E. Scaffa, & E. Cohn (Eds.), *Willard & Spackmans's occupational therapy* (12th ed., pp. 302-321). Lippincott Williams & Wilkins.
- Cleary, M., Horsfall, J., & Hayter, M. (2014). Data collection and sampling in qualitative research: Does size matter? *Journal of Advanced Nursing*, 70(3), 473-475. <https://doi.org/10.1111/jan.12163>
- Cole, M., & Creek, J. (2016). *Global perspectives in professional reasoning*. SLACK.
- Collins, B. (2023). Professional accountability. In W. Bryant, J. Fieldhouse, & N. Plastow (Eds.), *Creek's occupational therapy* (6th ed., pp. 133-149). Elsevier.
- Collins English Dictionary. (n.d.). Skill. In *Collins English Dictionary*. Retrieved April 10, 2024, from <https://www.collinsdictionary.com/dictionary/english/skill>
- Colman, W. (1992). Structuring education: Development of the first educational standards in occupational therapy, 1917-1930. *American Journal of Occupational Therapy*, 46(7), 653-660. <https://doi.org/10.5014/ajot.46.653>
- Colorafi, K. J., & Evans, B. (2016). Qualitative descriptive methods in health science research. *Health Environments Research & Design Journal*, 9(4), 16-25. <https://doi.org/10.1177/1937586715614171>
- Colquhoun, H. L., Letts, L. J., Law, M. C., MacDermid, J. C., & Missiuna, C. A. (2010). A scoping review of the use of theory in studies of knowledge translation. *Canadian Journal of Occupational Therapy*, 77(5), 270-279. <https://doi.org/10.2182/cjot.2010.77.5.3>
- Cope, P., Cuthbertson, P., & Stoddart, B. (2000). Situated learning in the practice placement. *Journal of Advanced Nursing*, 31(4), 850-856. <https://doi.org/10.1046/j.1365-2648.2000.01343.x>
- Cramm, H., & White, C. (2007). KT and OT: A context for knowledge translation for occupational therapy. *OT Now*, 13, 24-26.
- Cramm, H., White, C., & Krupa, T. (2013). From periphery to player: Strategically positioning occupational therapy within the knowledge translation landscape. *American Journal of Occupational Therapy*, 67(1), 119-125. <https://doi.org/10.5014/ajot.67.1.119>
- Creek, J. (2003). *Occupational therapy defined as a complex intervention*. College of Occupational Therapists.

- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Allen & Unwin.
- Curtin, M., Egan, M., & Adams, J. (Eds.). (2017). *Occupational therapy for people experiencing illness, injury or impairment. Promoting occupation and participation* (7th ed.). Elsevier.
- Curtin, M., & Fossey, E. (2007). Appraising the trustworthiness of qualitative studies: Guidelines for occupational therapists. *Australian Occupational Therapy Journal*, 54(2), 88-94. <https://doi.org/10.1111/j.1440-1630.2007.00661.x>
- Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S. J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, 18(1), 174. <https://doi.org/10.1186/s12939-019-1082-3>
- Cusick, A., & McCluskey, A. (2000). Becoming an evidence-based practitioner through professional development. *Australian Occupational Therapy Journal*, 47(4), 159-170. <https://doi.org/10.1046/j.1440-1630.2000.00241.x>
- da Silva Araujo, A., Kinsella, E., Thomas, A., Demonari Gomes, L., & Quevedo Marcolino, T. (2022). Clinical reasoning in occupational therapy practice: A scoping review of qualitative and conceptual peer-reviewed literature. *American Journal of Occupational Therapy*, 76(3), 1-11. <https://doi.org/10.5014/ajot.2022.048074>
- Davis, C., Craik, J., & Polatajko, H. (2007). Using the Canadian Process Practice Framework: Amplifying the process. In E. T. H. Polatajko (Ed.), *Enabling occupation II: Advancing an occupational therapy vision for health, well-being, & justice through occupation* (pp. 247-272). CAOT Publications ACE.
- Davis-Cheshire, R., Davis, K., Drumm, L., Neal, S., Norris, E., Parker, M., Prezzia, C., & Whalen, C. (2019). The perceived value and utilization of occupational therapy models in the United States. *Occupational Therapy Education*, 3(2), 1-21. <https://doi.org/10.26681/jote.2019.030211>
- de Clive-Lowe, S. (1996). Outcome measurement, cost-effectiveness and clinical audit: The importance of standardised assessment to occupational therapists in meeting these new demands. *British Journal of Occupational Therapy*, 59(8), 357-362. <https://doi.org/10.1177/030802269605900803>
- Delany, C., & Galvin, J. (2014). Ethics and shared decision-making in paediatric occupational therapy practice. *Developmental Neurorehabilitation*, 17(5), 347-354. <https://doi.org/10.3109/17518423.2013.784816>
- DePoy, E., & Gitlin, L. (Eds.). (2005). Essentials of research. *Introduction to research. Understanding and applying multiple strategies* (3rd ed., pp. 3-33). Elsevier Mosby.
- Dickie, V. A. (2003). Data analysis in qualitative research: A plea for sharing the magic and the effort. *American Journal of Occupational Therapy*, 57(1), 49-56. <https://doi.org/10.5014/ajot.57.1.49>

- Doherty, R., & Purtilo, R. (2016). *Ethical dimensions in the health professions* (6th ed.). Elsevier.
- Donnelly, C., & Cramm, H. (2016, Spring 2016). Knowledge translation activities in occupational therapy organizations: The Canadian landscape. *Open Journal of Occupational Therapy* 4(2), 1-10. <https://doi.org/10.15453/2168-6408.1189>
- Donnelly, C., & Carswell, A. (2002). Individualized outcome measures: A review of the literature. *Canadian Journal of Occupational Therapy*, 69(2), 84-94. <https://doi.org/10.1177/000841740206900204>
- Douglas, A., Liu, L., Warren, S., & Hopper, T. (2007). Cognitive assessments for older adults: Which ones are used by Canadian therapists and why. *Canadian Journal of Occupational Therapy*, 74(5), 370-381. <https://doi.org/10.2182/cjot.07.010>
- Dreyfus, S. (2004). The five-stage model of adult skill acquisition. *Bulletin of Science, Technology and Society*, 24(3), 177-181. <https://doi.org/10.1177/0270467604264992>
- Dunn, W. (2017). Strengths-based approaches: What if even the ‘bad’ things are good things? *British Journal of Occupational Therapy*, 80(7), 395-396. <https://doi.org/10.1177/0308022617702660>
- Duran, L., & Fisher, A. (1999). Evaluation and intervention with executive functions impairment. In C. Unsworth (Ed.), *Cognitive and perceptual dysfunction. A clinical reasoning approach to evaluation and intervention* (pp. 209-252). F. A. Davis Company.
- Durie, M. (2011). Indigenizing mental health services: New Zealand experience. *Transcultural Psychiatry* 48(1-2), 24-36. <https://doi.org/10.1177/1363461510383182>
- Dyck, I. (1989). The immigrant client: Issues in developing culturally sensitive practice. *Canadian Journal of Occupational Therapy*, 56(5), 248-255. <https://doi.org/10.1177/000841748905600507>
- Dyck, I. (1991). Multiculturalism and occupational therapy: Sharing the challenge. *Canadian Journal of Occupational Therapy*, 58(5), 224-226. <https://doi.org/10.1177/000841749105800502>
- Egan, M., & Zakutney, L. (2017). Reasoning for people experiencing neurological conditions In M. Curtin, M. Egan, & J. Adams (Eds.), *Occupational therapy for people experiencing illness, injury or impairment: Promoting occupation and participation* (7th ed., pp. 265- 292). Elsevier.
- Edlin, K., Thompson, E., Spillane, C., Farquhar, M., Schmidt, J., & Lannin, N. A. (2018). Assessments of cognition in older people after traumatic brain injury: An appraisal and review. *New Zealand Journal of Occupational Therapy*, 65(2), 4-12.

- Elliott, R., & Timulak, L. (2006). Descriptive and interpretive approaches to qualitative research. In J. Miles & P. Gilbert (Eds.), *A handbook of research methods for clinical and health psychology* (pp. 147-159). Oxford University Press.
- Enemark, L. A., Rasmussen, B., & Christensen, J. R. (2018). Enhancing a client-centred practice with the Canadian Occupational Performance Measure. *Occupational Therapy International*, 2018, 5956301. <https://doi.org/10.1155/2018/5956301>
- Ericsson, K. (2008). Deliberate practice and acquisition of expert performance: A general overview. *Academic Emergency Medicine*, 15(11), 988-994. <https://doi.org/10.1111/j.1553-2712.2008.00227.x>
- Fawcett, A. L. (2007). The importance of clinical reasoning and reflective practice in effective assessment. In *Principles of assessment and outcome measurement for occupational therapists and physiotherapists: Theory, skills and application* (pp. 281-336). John Wiley & Sons.
- Feaver, S., & Creek, J. (1993). Models for practice in occupational therapy: Part 2, what use are they? *British Journal of Occupational Therapy*, 56(2), 59-62. <https://doi.org/10.1177/030802269305600207>
- Fisher, A. (1992). Functional measures, Part 1: What is function, what should we measure, and how should we measure it? *American Journal of Occupational Therapy*, 46(2), 183-185. <https://doi.org/10.5014/ajot.46.2.183>
- Fisher, A. (2006). Assessment of motor and process skills. Development, standardization and administration manual. 6th ed. Colorado ,USA. Retrieved from <http://www.ampsintl.com/>
- Fisher, S. (2005). The Canadian Occupational Performance Measure: Does it address the cultural occupations of ethnic minorities? *British Journal of Occupational Therapy*, 68(5), 224-234. <https://doi.org/10.1177/030802260506800506>
- Fitzgerald, M., Mullavey-O'Byrne, C., & Clemson, L. (1997). Cultural issues from practice. *Australian Occupational Therapy Journal*, 44(1), 1-21. <https://doi.org/10.1111/j.1440-1630.1997.tb00749.x>
- Fleming, M. H. (1991). The therapist with the three-track mind. *American Journal of Occupational Therapy*, 45(11), 1007-1014. <https://doi.org/10.5014/ajot.45.11.1007>
- Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). "Mini-mental state". A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, 12(3), 189-198. [https://doi.org/10.1016/0022-3956\(75\)90026-6](https://doi.org/10.1016/0022-3956(75)90026-6)
- Fricke, J. (1993). Measuring outcomes in rehabilitation: A review. *British Journal of Occupational Therapy*, 56(6), 217-221. <https://doi.org/10.1177/030802269305600608>

- Fry, K., & O'Brien, L. (2002). Using the Perceive, Recall, Plan and Perform system to assess cognitive deficits in adults with traumatic brain injury: A case study. *Australian Occupational Therapy Journal*, 49(4), 182-187. <https://doi.org/10.1046/j.1440-1630.2002.00337.x>
- Gentile, A. M. (1972). A working model of skill acquisition with application to teaching. *Quest*, 17(1), 3-23. <https://doi.org/10.1080/00336297.1972.10519717>
- Giddings, L., & Grant, B. (2009). From rigour to trustworthiness: Validating mixed methods. In S. Andrew & E. Halcomb (Eds.), *Mixed methods research for nursing and the health sciences* (pp. 119-134). Wiley- Blackwell.
- Gillen, A., & Greber, C. (2014). Occupation-focused practice: Challenges and choices. *British Journal of Occupational Therapy*, 77(1), 39-41. <https://doi.org/10.4276/030802214X13887685335580>
- Gillen, G., Brown, C. (2024). Core concepts and skills. *Willard and Spackman's occupational therapy* (14th ed., pp.282-298) Lippincott Williams & Wilkins
- Gillette, N. P., & Mattingly, C. (1987). Clinical reasoning in occupational therapy. *American Journal of Occupational Therapy*, 41(6), 399-400. <https://doi.org/10.5014/ajot.41.6.399>
- Gilsenan, J., Hopkirk, J., & Emery-Whittington, I. (2012). Kai whakaora ngangahau Māori occupational therapists' collective reasoning in clinical reasoning. In L. Robertson (Ed.), *Occupational therapy* (pp. 130-149). Wiley & Sons Incorporated. <https://doi.org/10.1002/9781118702833>
- Gitlin, L. N., & Burgh, D. (1995). Issuing assistive devices to older patients in rehabilitation: An exploratory Study. *American Journal of Occupational Therapy*, 49(10), 994-1000. <https://doi.org/10.5014/ajot.49.10.994>
- Godin, G., Bélanger-Gravel, A., Eccles, M., & Grimshaw, J. (2008, 2008/07/16). Healthcare professionals' intentions and behaviours: A systematic review of studies based on social cognitive theories. *Implementation Science*, 3(1), 36. <https://doi.org/10.1186/1748-5908-3-36>
- Goldkuhl, G. (2012). Pragmatism vs interpretivism in qualitative information systems research. *European Journal of Information Systems*, 21(2), 135-146. <https://doi.org/10.1057/ejis.2011.54>
- Goodchild, K., Fleming, J., & Copley, J. A. (2023). Assessments of functional cognition used with patients following traumatic brain injury in acute care: A survey of Australian occupational therapists. *Occupational Therapy in Health Care*, 37(1), 145-163. <https://doi.org/10.1080/07380577.2021.2020389>
- Goto, S., Fisher, A. G., & Mayberry, W. L. (1996). The Assessment of Motor and Process Skills applied cross-culturally to the Japanese. *American Journal of Occupational Therapy*, 50(10), 798-806. <https://doi.org/10.5014/ajot.50.10.798>
- Graham, I. D. (2010). *Knowledge translation-definition*. Canadian Institutes of Health Research. <http://www.cihr-irsc.gc.ca/e/29418.html#2>

- Graham, I. D., Logan, J., Harrison, M. B., Straus, S. E., Tetroe, J., Caswell, W., & Robinson, N. (2006). Lost in knowledge translation: Time for a map? *Journal of Continuing Education in the Health Professions*, 26(1), 13-24. <https://doi.org/10.1002/chp.47>
- Gray, M., & McPherson, K. (2005). Cultural safety and professional practice in occupational therapy: A New Zealand perspective. *Australian Occupational Therapy Journal*, 52(1), 34-42. <https://doi.org/doi:10.1111/j.1440-1630.2004.00433.x>
- Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. *Milbank Quarterly*, 82(4), 581-629. <https://doi.org/10.1111/j.0887-378X.2004.00325.x>
- Griffin, P. (1995). Competency assessment: Avoiding the pitfalls of the past. *Australian and New Zealand Journal of Vocational Education Research* 3(2), 34-59.
- Guba, E. G., & Lincoln, Y. S. (1982). Epistemological and methodological bases of naturalistic inquiry. *Educational Communication and Technology*, 30(4), 233-252. <http://www.jstor.org/stable/30219846>
- Gupta, J., & Taff, S. D. (2015). The illusion of client-centred practice. *Scandinavian Journal of Occupational Therapy*, 22(4), 244-251. <https://doi.org/10.3109/11038128.2015.1020866>
- Gustafsson, L., Mitchell, G., Fleming, J., & Price, G. (2012). Clinical utility of the Canadian Occupational Performance Measure in spinal cord injury rehabilitation. *British Journal of Occupational Therapy*, 75(7), 337-342. <https://doi.org/10.4276/030802212X13418284515910>
- Gutman, S. A., Mortera, M. H., Hinojosa, J., & Kramer, P. (2007). Revision of the occupational therapy practice framework. *American Journal of Occupational Therapy*, 61(1), 119-126. <https://doi.org/10.5014/ajot.61.1.119>
- Haghshenas, M. (2022). "Feeling like a powerful occupational therapist". *The experience of community-based occupational therapists from implementing the Perceive, Recall, Plan and Perform (PRPP) system of task analysis in practice* [Masters, Norwegian University of Science and Technology]. NTNU Open. <https://hdl.handle.net/11250/3009232>
- Haider, M., & Kreps, G. L. (2004, 2004/01/01). Forty years of diffusion of innovations: Utility and value in public health. *Journal of Health Communication*, 9(sup1), 3-11. <https://doi.org/10.1080/10810730490271430>
- Hamilton, T. (2018). Narrative reasoning. In B. Schell & J. Schell (Eds.), *Clinical and professional reasoning in occupational therapy* (2nd ed., pp. 171-202). Wolters Kluwer Health.
- Hammell, K. (2009). Sacred texts: A sceptical exploration of the assumptions underpinning theories of occupation. *Canadian Journal of Occupational Therapy*, 76(1), 6-13. <https://doi.org/10.1177 / 000841740907600105>

- Hammell, K. (2013). Client-centred practice in occupational therapy: Critical reflections. *Scandinavian Journal of Occupational Therapy*, 20(3), 174-181. <https://doi.org/10.3109/11038128.2012.752032>
- Hammell, K., Carpenter, C., & Dyck, I. (2000). *Using qualitative research: A practical introduction for occupational and physical therapists* (1st ed.). Churchill Livingstone.
- Harvey, C., (2022). *Responsive learning: Learning from and with each other - A grounded theory* [Doctoral dissertation Auckland University of Technology]. New Zealand.
- Haworth, C., Cyrs, G., & Chi-Kwan, S. (2023). Initial validity and user experience of a dynamic assessment of occupational performance for transitional age youth. *Open Journal of Occupational Therapy (OJOT)*, 11(2), 1-21. <https://doi.org/10.15453/2168-6408.2013>
- Haywood, H., & Lidz, C. (2006a). Dynamic assessment: Introduction and review. In H. Haywood & C. Lidz (Eds.), *Dynamic assessment in practice: Clinical and educational applications* (pp. 1-20). Cambridge University Press. <https://doi.org/10.1017/CBO9780511607516.004>
- Haywood, H., & Lidz, C. (2006b). General procedural guidelines for conducting an assessment that includes dynamic assessment. In H. Haywood & C. Lidz (Eds.), *Dynamic assessment in practice: Clinical and educational applications* (pp. 35-46). Cambridge University Press. <https://doi.org/10.1017/CBO9780511607516.006>
- Heck, C., Hendryson, M., & Rowe, C. (1966). *Joint motion. Method of measuring and recording*. Churchill Livingstone.
- Herbert, B. M., & Pollatos, O. (2012). The body in the mind: On the relationship between interoception and embodiment. *Topics in Cognitive Science*, 4(4), 692-704. <https://doi.org/10.1111/j.1756-8765.2012.01189.x>
- Higgs, J., Jenson, G., Loftus, S., & Christensen, N. (2019). *Clinical reasoning in the health professions*. Elsevier.
- Hocking, C. (2001). Implementing occupation-based assessment. *American Journal of Occupational Therapy*, 55(4), 463-469. <https://doi.org/10.5014/ajot.55.4.463>
- Hocking, C., & Whalley Hammell, K. R. (2017). Process of assessment. In M. Curtin, M. Eagan, & J. Adams (Eds.), *Occupational therapy for people experiencing illness, injury or impairment: Promoting occupation and participation* (7th ed., pp. 171-184). Elsevier.
- Hocking, C., & Whalley Hammell, K. R. (2024). Process of exploring occupational participation. In M. Curtin, M. Eagan, & J. Adams (Eds.), *Occupational therapy for people experiencing illness, injury or impairment: Promoting occupation and participation* (8th ed., pp. 171-184). Elsevier.

- Holmqvist, K., Ivarsson, A.-B., & Holmefur, M. (2014). Occupational therapist practice patterns in relation to clients with cognitive impairment following acquired brain injury. *Brain Injury*, 28(11), 1365-1373. <https://doi.org/10.3109/02699052.2014.919529>
- Hooper, B. (2018). Therapists' assumptions as a dimension of professional reasoning. In B. Schell & J. Schell (Eds.), *Clinical and professional reasoning in occupational therapy* (pp. 24-51). Wolters Kluwer.
- Hopkirk, J., & Wilson, L. (2014). A call to wellness - Whitiwhitia i te ora: Exploring Māori and occupational therapy perspectives on health. *Occupational Therapy International*, 21(4), 156-165. <https://doi.org.ezproxy.aut.ac.nz/10.1002/oti.1373>
- Hoppes, S., & Hellman, C. M. (2007). Understanding occupational therapy students' attitudes, intentions, and behaviors regarding community service. *American Journal of Occupational Therapy*, 61(5), 527-534. <https://doi.org/10.5014/ajot.61.5.527>
- Hubbard, I. J., Parsons, M. W., Neilson, C., & Carey, L. M. (2009). Task-specific training: Evidence for and translation to clinical practice. *Occupational Therapy International*, 16(3-4), 175-189. <https://doi.org/10.1002/oti.275>
- Hudson, M., Milne, M., Reynolds, P., Russell, K. & Smith, B. (2009). *Te Ara Tika guidelines for Māori research ethics: A framework for researchers and ethics committee members*. Heath Research Council of New Zealand.
- Hunt, M. R. (2009). Strengths and challenges in the use of interpretive description: Reflections arising from a study of the moral experience of health professionals in humanitarian work. *Qualitative Health Research*, 19(9), 1284-1292. <https://doi.org/10.1177/1049732309344612>
- Ikiugu, M., Smallfield, S., & Condit, C. (2009). A framework for combining theoretical conceptual practice models in occupational therapy practice. *Canadian Journal of Occupational Therapy* 76(3), 162-170. <https://doi.org/10.1177/000841740907600305>
- Ikiugu, M. N., Plastow, N. A., & van Niekerk, L. (2019). Eclectic application of theoretical models in occupational therapy: Impact on therapeutic reasoning. *Occupational Therapy in Health Care*, 33(3), 286-305. <https://doi.org/10.1080/07380577.2019.1630884>
- Ikiugu, M. N., & Schultz, S. (2006). An argument for pragmatism as a foundational philosophy of occupational therapy. *Canadian Journal of Occupational Therapy*, 73(2), 86-97. <https://doi.org/10.2182/cjot.05.0009>
- Iwama, M. K. (2007). Embracing diversity: Explaining the cultural dimensions of our occupational therapeutic selves. *New Zealand Journal of Occupational Therapy*, 54(2), 16-23.
- James, C., & Mackenzie, L. (2009). The clinical utility of functional capacity evaluations: The opinion of health professionals working within occupational rehabilitation. *Work*, 34(2), 231-239. <https://doi.org/10.3233/WOR-2009-0871>

- Jenson, G., Osborne, R., & Haddad, A. (2025). Expertise and clinical reasoning In J. Higgs, G. Jenson, S. Loftus, F. Trede, & S. Grace (Eds.), *Clinical reasoning in the health professions* (5th ed., pp. 96-106). Elsevier.
- Juntorn, S., Sriphetcharawut, S., Lerslip, S., & Munketvit, P. (2016). Information processing strategy dysfunctions during the play activities in Thai children with learning disabilities. *Bulletin of Chiang Mai Associated Medical Sciences*, 49(1), 17.
- Kahneman, D. (2011). *Thinking, fast and slow* (1st ed.). Penguin Random House.
- Kerner, J. F. (2006). Knowledge translation versus knowledge integration: A “funder's” perspective. *Journal of Continuing Education in the Health Professions*, 26(1), 72-80. <https://doi.org/10.1002/chp.53>
- Kielhofner, G. (1993). Functional assessment: Toward a dialectical view of person-environment relations. *American Journal of Occupational Therapy*, 47(3), 248-251. <https://doi.org/10.5014/ajot.47.3.248>
- Kielhofner, G., & Forsyth, K. (1997). The model of human occupation: An overview of current concepts. *British Journal of Occupational Therapy*, 60(3), 103-110.
- Kielhofner, G. (2006). *Research in occupational therapy: Methods of inquiry for enhancing practice*. F.A. Davis Company.
- Kielhofner, G. (2009a). The development of occupational therapy practice in mid-century: A new paradigms of any mechanisms. In *Conceptual foundations of occupational therapy practice* (4th ed., pp. 30- 40). F.A. Davis Company.
- Kielhofner, G. (2009b). Emergence of the contemporary paradigm: A return to occupation. In *Conceptual foundations of occupational therapy practice* (pp. 41-55). F.A. Davis Company.
- Kieran, R., Mueller, J., & Langston, W. (1987). *Cognistat paper test*. Retrieved from <https://www.cognistat.com/about-original-paper-test>
- Kilbride, C., Perry, L., Flatley, M., Turner, E., & Meyer, J. (2011). Developing theory and practice: Creation of a community of practice through action research produced excellence in stroke care. *Journal of Interprofessional Care*, 25(2), 91-97. <https://doi.org/10.3109/13561820.2010.483024>
- King, G. (2009). A framework of personal and environmental learning-based strategies to foster therapist expertise. *Learning in Health & Social Care*, 8(3), 185-199. <https://doi.org/10.1111/j.1473-6861.2008.00210.x>
- Kinsella, E. (2018). Embodied reasoning in professional practice. In B. Schell & J. Schell (Eds.), *Clinical and professional reasoning in occupational therapy* (pp. 105-124). Wolters Kluwer.
- Kinsella, E. A. (2001). Reflections on reflective practice. *Canadian Journal of Occupational Therapy. Revue Canadienne D'ergotherapie*, 68(3), 195-198. <https://doi.org/10.1177/000841740106800308>

- Kitson, A., Harvey, G., & McCormack, B. (1998). Enabling the implementation of evidence based practice: A conceptual framework. *Quality in Health Care*, 7(3), 149-158. <https://doi.org/10.1136/qshc.7.3.149>
- Kitson, A., Rycroft-Malone, J., Harvey, G., McCormack, B., Seers, K., & Titchen, A. (2008). Evaluating the successful implementation of evidence into practice using the PARiHS framework: Theoretical and practical challenges. *Implementation Science*, 3(1), 1. <https://doi.org/10.1186/1748-5908-3-1>
- Klein, S., Barlow, I., & Hollis, V. (2008). Evaluating ADL measures from an occupational therapy perspective. *Canadian Journal of Occupational Therapy*, 75(2), 69-81. <https://doi.org/10.1177/000841740807500203>
- Koh, C., Hoffmann, T., Bennett, S., & McKenna, K. (2009). Management of patients with cognitive impairment after stroke: A survey of Australian occupational therapists. *Australian Occupational Therapy Journal*, 56(5), 324-331. <https://doi.org/10.1111/j.1440-1630.2008.00764.x>
- Kramer, J., Bowyer, P., O'Brien, J., Kielhofner, G., & Maziero-Barbosa, V. (2009). How interdisciplinary pediatric practitioners choose assessments. *Canadian Journal of Occupational Therapy*, 76(1), 56-64. <https://doi.org/10.1177/000841740907600114>
- Kristensen, H. K., Borg, T., & Hounsgaard, L. (2012). Aspects affecting occupational therapists' reasoning when implementing research-based evidence in stroke rehabilitation. *Scandinavian Journal of Occupational Therapy*, 19(2), 118-131. <https://doi.org/10.3109/11038128.2011.556197>
- Kuhaneck, H., & Case-Smith, J. (2020). The occupational therapy process in pediatrics: Overview of essential concepts. In J. C. O'Brien & H. Kuhaneck (Eds.), *Case-Smith's occupational therapy for children and adolescents* (8th ed., pp. 1-17). Mosby.
- Kuhaneck, H., & Spitzer, S. L. (2024). The importance of conceptual origins: The case of the just-right challenge. *American Journal of Occupational Therapy*, 78(4), 1-9. <https://doi.org/10.5014/ajot.2024.050619>
- Kuipers, K., McKenna, K., & Carlson, G. (2006). Factors influencing occupational therapists' clinical decision making for clients with upper limb performance dysfunction following brain injury. *British Journal of Occupational Therapy*, 69(3), 106-114. <https://doi.org/10.1177/030802260606900303>
- Kuzel, A., & Engel, J. (2001). Some pragmatic thoughts about evaluating qualitative health research. In J. Morse, J. Swanson, & A. Kuzel (Eds.), *The nature of qualitative evidence* (pp. 1-26). SAGE. <https://doi.org/10.4135/9781412986236>
- Larsen, A., & Carlsson, G. (2012). Utility of the Canadian Occupational Performance Measure as an admission and outcome measure in interdisciplinary community-based geriatric rehabilitation. *Scandinavian Journal of Occupational Therapy*, 19(2), 204-213. <https://doi.org/10.3109/11038128.2011.574151>

- Law, M. (1987). Measurement in occupational therapy: Scientific criteria for evaluation. *Canadian Journal of Occupational Therapy*, 54(3), 133-138. <https://doi.org/10.1177/000841748705400308>
- Law, M. (1993). Evaluating activities of daily living: Directions for the future. *American Journal of Occupational Therapy*, 47(3), 233-237. <https://doi.org/10.5014/ajot.47.3.233>
- Law, M., Baptiste, S., McColl, M., Opzoomer, A., Polatajko, H., & Pollock, N. (1990). The Canadian occupational performance measure: An outcome measure for occupational therapy. *Canadian Journal of Occupational Therapy*, 57(2), 82-87. <https://doi.org/10.1177/000841749005700207>
- Law, M., Baptiste, S., & Mills, J. (1995). Client-centred practice: What does it mean and does it make a difference? *Canadian Journal of Occupational Therapy*, 62(5), 250-257. <https://doi.org/10.1177/000841749506200504>
- Law, M., Cooper, B. A., Strong, S., Stewart, D., Rigby, P. & Letts, L. (1996). The Person-Environment-Occupational Model: A transactive approach to occupational performance. *Canadian Journal of Occupational Therapy*, 63(1), 9-23. <https://doi.org/10.1177/000841749606300103>
- Law, M., & Letts, L. (1989). A critical review of scales of activities of daily living. *American Journal of Occupational Therapy*, 43(8), 522-528. <https://doi.org/10.5014/ajot.43.8.522>
- Law, M., & MacDermid, J. (2017). Guiding therapist decisions for measuring outcomes in occupational therapy. In M. Law, C. Baum, & W. Dunn (Eds.), *Measuring occupational performance: Supporting best practice in occupational therapy* (3rd ed., pp. 43-56). SLACK. <https://doi.org/10.1201/9781003525042-4>
- Law, M., Missiuna, C., & Pollock, N. (2008). Knowledge exchange and translation: An essential competency in the twenty-first century. *Occupational Therapy Now*, 10(5), 3-5. https://caot.in1touch.org/document/3901/OTNow_Sept_08.pdf
- Law, M., Polatajko, H., Pollock, N., Mccoll, M. A., Carswell, A., & Baptiste, S. (1994). Pilot testing of the Canadian Occupational Performance Measure: Clinical and measurement issues. *Canadian Journal of Occupational Therapy*, 61(4), 191-197. <https://doi.org/10.1177/030802260106400607>
- Leclair, L., Ripat, J., Wener, P., Cooper, J., Johnson, L., Davis, E., & Campbell-Rempel, M. (2013). Advancing the use of theory in occupational therapy: A collaborative process *Canadian Journal of Occupational Therapy*, 80(3), 181-193. <https://doi.org/10.1177/0008417413495182>
- Leicht, S. B., & Dickerson, A. (2002). Clinical reasoning, looking back. *Occupational Therapy in Health Care*, 14(3-4), 105-130. https://doi.org/10.1080/J003v14n03_07

- Lencucha, R., Kothari, A., & Rouse, M. J. (2007). Knowledge translation: A concept for occupational therapy? *American Journal of Occupational Therapy*, 61(5), 593-596. <https://doi.org/10.5014/ajot.61.5.593>
- Lewis, J., Chapparo, C., Mackenzie, L., & Ranka, J. (2016). Work after breast cancer: Identification of cognitive difficulties using the Perceive, Recall, Plan, and Perform (PRPP) system of task analysis. *British Journal of Occupational Therapy*, 79(5), 323-332. <https://doi.org/10.1177/0308022616639983>
- Limbert, C., & Lamb, R. (2002). Doctors' use of clinical guidelines: Two applications of the Theory of Planned Behaviour. *Journal of Psychology, Health and Medicine*, 7(3), 301-310. <https://doi.org/10.1080/13548500220139377>
- Lincoln, Y. S., & Guba, E. G. (1982). Establishing dependability and confirmability in naturalistic inquiry through an audit. <https://files.eric.ed.gov/fulltext/ED216019>
- Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Directions for Program Evaluation*, 1986(30), 73-84. <https://doi.org/10.1002/ev.1427>
- Lindskog, M., & Kjellberg, A. (2006). Test of clinical utility and content validity of the Swedish version of the Perceive, Recall, Plan & Perform System (PRPP). Linköping University (English abstract), Linköping, Sweden.
- Lockyer, J., Fidler, H., Ward, R., Basson, R., Elliott, S., & Toews, J. (2001). Commitment to change statements: A way of understanding how participants use information and skills taught in an educational session. *Journal of Continuing Education in the Health Professions*, 21(2), 82-89. <https://doi.org/10.1002/chp.1340210204>
- Losada, C. (1936). Some values in occupational therapy. *American Journal of Physical Medicine & Rehabilitation*, 15(5), 285-290.
- Lowe, S., & Chapparo, C. (2010). Work at school: Teacher and parent perceptions about children's participation. *Work*, 36(2), 249-256. <https://doi.org/10.3233/WOR-2010-1025>
- Lu, F. (2014). *An exploratory study into the use of Perceive, Recall, Plan and Perform system of task analysis in clinical practice in New Zealand* [Unpublished Masters thesis, Otago Polytechnic]. <https://online.op.ac.nz/assets/OPRES/6a6e8b9e74/Lu-Running-head-a-study-into-the-use-of-PRPP-2014.pdf>
- Macdonald, E., MacCaul, G., Mirrey, L., & Morrison, E. (1976). *Occupational therapy in rehabilitation* (E. Macdonald, Ed.; 4th ed.). Bailliere Tindall.
- Macdonald, M. (1949, January 1, 1949). Occupational therapy and mental health. *British Medical Bulletin*, 6(3), 191-196. <http://bmb.oxfordjournals.org/content/6/3/191.short>

- Manee, F. S., Nadar, M. S., Alotaibi, N. M., & Rassafiani, M. (2020). Cognitive assessments used in occupational therapy practice: A global perspective. *Occupational Therapy International*, 1-8. <https://doi.org/10.1155/2020/8914372>
- Mann, K., Gordon, J., & MacLeod, A. (2007). Reflection and reflective practice in health professions education: A systematic review. *Advances in Health Sciences Education*, 14(4), 595. <https://doi.org/10.1007/s10459-007-9090-2>
- Márquez-Álvarez, L.-J., Calvo-Arenillas, J.-I., Talavera-Valverde, M.-Á., & Moruno-Millares, P. (2019). Professional reasoning in occupational therapy: A scoping review. *Occupational Therapy International*, 1-9. <https://doi.org/10.1155/2019/6238245>
- Maslow, P., Frostig, M., Lefever, D. W., & Whittlesey, J. R. (1964). The Marianne Frostig development test of visual perception, 1963 standardisation *Perceptual And Motor Skills*, 19, 463-499. <https://doi.org/10.2466/pms.1964.19.2.463>
- Mattingly, C. (1991a). The narrative nature of clinical reasoning. *American Journal of Occupational Therapy*, 45(11), 998-1005. <https://doi.org/10.5014/ajot.45.11.998>
- Mattingly, C. (1991b). What is clinical reasoning? *American Journal of Occupational Therapy*, 45(11), 979-986. <http://doi.org/10.5014/ajot.45.11.979>
- Mattingly, C., & Fleming, M. H. (1994). *Clinical reasoning: Forms of inquiry in a therapeutic practice*. F.A. Davis.
- Mattingly, C., & Gillette, N. (1991). Anthropology, occupational therapy and action research. *American Journal of Occupational Therapy* 45(11), 972-978. <https://doi.org/10.5014/ajot.45.11.972>
- McBrien, B. (2008). Evidence-based care: Enhancing the rigour of a qualitative study. *British Journal of Nursing*, 17(20), 1286-1289. <https://doi.org/10.12968/bjon.2008.17.20.31645>
- McCluskey, A., & Cusick, A. (2002). Strategies for introducing evidence-based practice and changing clinician behaviour: A manager's toolbox. *Australian Occupational Therapy Journal*, 49(2), 63-70. <https://doi.org/10.1046/j.1440-1630.2002.00272.x>
- McColl, M. (2024). Review of occupation-focused models. In M. McColl (Ed.), *Theoretical basis of occupational therapy* (4th ed., pp. 161-166). Routledge. <https://doi.org/10.4324/9781003526759-23>
- McColl, M., Law, M., Baptiste, S., Pollock, N., Carswell, A., & Polatajko, H. (2005). Targeted applications of the Canadian Occupational Performance Measure. *Canadian Journal Of Occupational Therapy. Revue Canadienne D'ergotherapie*, 72(5), 298-300. <https://doi.org/10.1177/000841740507200506>
- McGrath, M., & O'Callaghan, C. (2014). Occupational therapy and dementia care: A survey of practice in the Republic of Ireland. *Australian Occupational Therapy Journal*, 61(2), 92-101. <https://doi.org/10.1111/1440-1630.12081>

- McNab, D., & Rutherford, G. (2020). Systems thinking. In G. Rutherford (Ed.), *Human factors in paramedic practice* (pp. 31-48). Class Publishing.
- Menon, A., Korner-Bitensky, N., Kastner, M., McKibbin, K., & Straus, S. (2009). Strategies for rehabilitation professionals to move evidence-based knowledge into practice: A systematic review. *Journal of Rehabilitation Medicine*, 41(13), 1024-1032. <https://doi.org/10.2340/16501977-0451>
- Merriam-Webster. (2018). *Merriam-Webster*. <https://www.merriam-webster.com/dictionary/pertinant>
- Merriam Webster (n.d.a). Configuring. In *Merriam Webster Online Dictionary*. Retrieved November 21, 2023, from <https://www.merriam-webster.com/dictionary/configuring>
- Merriam Webster (n.d.b). Strategy. In *Merriam Webster Online Dictionary*. Retrieved April 10, 2024, from <https://www.merriam-webster.com/dictionary/strategy>
- Metzler, M. J., & Metz, G. A. (2010a). Analyzing the barriers and supports of knowledge translation using the PEO model. *Canadian Journal of Occupational Therapy*, 77(3), 151-158. <https://doi.org/10.2182/cjot.2010.77.3.4>
- Metzler, M. J., & Metz, G. A. (2010b). Translating knowledge to practice: An occupational therapy perspective. *Australian Occupational Therapy Journal*, 57(6), 373-379. <https://doi.org/10.1111/j.1440-1630.2010.00873.x>
- Mew, M. M., & Fossey, E. (1996). Client-centred aspects of clinical reasoning during an initial assessment using the Canadian Occupational Performance Measure. *Australian Occupational Therapy Journal*, 43(3-4), 155-166. <https://doi.org/10.1111/j.1440-1630.1996.tb01851.x>
- Mills, C., Chapparo, C., & Hinitt, J. (2016). The impact of an in-class sensory activity schedule on task performance of children with autism and intellectual disability: A pilot study. *British Journal of Occupational Therapy*, 79(9), 530-539. <https://doi.org/10.1177/0308022616639989>
- Ministry of Health. (2003). *Health practitioners competence assurance act 2003*. Author. <https://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html>
- Ministry of Health. (2014). *Equity of health care for Māori: A framework*. Author. <https://www.health.govt.nz/system/files/documents/publications/equity-of-health-care-for-maori-a-framework-jun14.pdf>
- Missiuna, C. (1987). Dynamic assessment: A modal for broadening assessment in occupational therapy. *Canadian Journal of Occupational Therapy*, 54(1), 17-21. <https://doi.org/10.1177/000841748705400105>
- Mitchell, R., & Unsworth, C. A. (2005). Clinical reasoning during community health home visits: Expert and novice differences. *British Journal of Occupational Therapy*, 68(5), 215-223. <https://doi.org/10.1177/030802260506800505>

- Molineux, M. (2004). Occupation in occupational therapy: A labour in vain. In M. Molineux (Ed.), *Occupation for occupational therapists* (1st ed., pp. 1-14). Blackwell Publisher.
- Molineux, M. (2011). Standing firm on shifting sands. *New Zealand Journal of Occupational Therapy*, 58(1), 21-28.
- Moon, J. (2004). Using reflective learning to improve the impact of short courses and workshops. *Journal of Continuing Education in the Health Professions*, 24(1), 4-11. <https://doi.org/10.1002/chp.1340240103>
- Moore, K., & Lewis, N. (2008). Implementing knowledge translation strategies: Integrating the Assessment of motor and Process Skills to practice. *Occupational Therapy Now*, 10(5), 15-16. https://caot.in1touch.org/document/3901/OTNow_Sept_08.pdf
- Morse, J. (1991). *Qualitative nursing research: A contemporary dialogue*. SAGE. <https://doi.org/10.4135/9781483349015>
- Moulton, C. (1997). Current trends in the practice of home health care of occupational therapists treating patients who have had a stroke. *Occupational Therapy International*, 4(1), 31-51. <https://doi.org/10.1002/oti.46>
- Moyer, E. A. (1984). A review of initial assessments used by occupational therapists in mental health settings. *Occupational Therapy in Health Care*, 1(2), 33-43. https://doi.org/10.1080/J003v01n02_04
- Mulligan, S., White, B. P., & Arthanat, S. (2014). An examination of occupation-based, client-centered, evidence-based occupational therapy practices in New Hampshire. *OTJR: Occupation, Participation & Health*, 34(2), 106-116. <https://doi.org/10.3928/15394492-20140226-01>
- Muñoz, J. P. (2007). Culturally responsive caring in occupational therapy. *Occupational Therapy International*, 14(4), 256-280. <https://doi.org/10.1002/oti>
- Munroe, H. (1996). Clinical reasoning in community occupational therapy. *British Journal of Occupational Therapy*, 59(5), 196-202. <https://doi.org/10.1177/030802269605900502>
- Murthi, K., Chen, Y.-L., Shore, S., & Patten, K. (2023). Strengths-based practice to enhance mental health for autistic people: A scoping review. *American Journal of Occupational Therapy*, 77(2), 1-12. <https://doi.org/10.5014/ajot.2023.050074>
- Nelson, A. (2007). Seeing white: A critical exploration of occupational therapy with Indigenous Australian people. *Occupational Therapy International*, 14(4), 237-255. <https://doi.org/10.1002/oti.236>
- Nelson, A., Allison, H., & Copley, J. (2007). Understanding where we come from: Occupational therapy with urban indigenous Australians. *Australian Occupational Therapy Journal*, 54(3), 203-214. <https://doi.org/10.1111/j.1440-1630.2006.00629.x>

- Nicholls, D. (2009). Qualitative research: Part three - Methods. *International Journal of Therapy & Rehabilitation*, 16(12), 638-647.
<https://doi.org/10.12968/ijtr.2009.16.12.45433>
- Nicholson, E. (2013). *Collective action and the transformation of occupational therapy practice* [Doctoral thesis, Auckland University of Technology]. Auckland University of Technology. <https://hdl.handle.net/10292/6075>
- Nieto, A., & Villarejo, M. (2020). Influence of experience on the thought process of clinical psychologists: An analysis from the Dual-Process Theories Framework. *The Spanish Journal of Psychology* 23(16), 1-9.
<https://doi.org/10.1017/SJP.2020.18>
- Nott, M., & Chapparo, C. (2008). Measuring information processing in a client with extreme agitation following traumatic brain injury using the Perceive, Recall, Plan and Perform system of task analysis. *Australian Occupational Therapy Journal*, 55(3), 188-198. <https://doi.org/10.1111/j.1440-1630.2007.00685.x>
- Nott, M., & Chapparo, C. (2012). Exploring the validity of the Perceive, Recall, Plan and Perform system of task analysis: Cognitive strategy use in adults with brain injury. *British Journal of Occupational Therapy*, 75(6), 256-263.
<https://doi.org/10.4276/030802212X13383757345067>
- Nott, M., Chapparo, C., & Heard, R. (2009). Reliability of the Perceive, Recall, Plan and Perform system of task analysis: A criterion-referenced assessment. *Australian Occupational Therapy Journal*, 56(5), 307-314.
<https://doi.org/10.1111/j.1440-1630.2008.00763.x>
- Øberg, G. K., Normann, B., & Gallagher, S. (2015). Embodied-enactive clinical reasoning in physical therapy. *Physiotherapy Theory and Practice*, 31(4), 244-252. <https://doi.org/10.3109/09593985.2014.1002873>
- Occupational Therapy Board of New Zealand. (2004). *Continuing competence framework for recertification: Practitioner handbook*. Author.
<https://www.otboard.org.nz/document/4842/Competencies-Handbook.pdf>
- Occupational Therapy Board of New Zealand. (2015a). *Code of ethics for occupational therapists*. https://www.otboard.org.nz/wp-content/uploads/2018/01/Code-of-Ethics_April2015-1.pdf
- Occupational Therapy Board of New Zealand. (2015b). *Competencies for registration and continuing practice*. <https://www.otboard.org.nz/wp-content/uploads/2018/01/Competencies-Handbook.pdf>
- Occupational Therapy Board of New Zealand. (2022). *Competencies for registration and continuing practice for occupational therapists*.
- Orton, Y., Hocking, C., & Reed, K. (2015). Ideas occupational therapists take up from the international literature. *New Zealand Journal of Occupational Therapy*, 62(1), 12-19.

- Owen, A., Adams, F., & Franszen, D. (2014). Factors influencing model use in occupational therapy. *South African Journal of Occupational Therapy*, 44(1), 41-47.
- Oy, S., & Campbell, B. (2015). An Indigenous epistemological approach to promote health through effective knowledge translation. *Journal of Indigenous Research*, 4(2015), Article 2. <https://doi.org/10.26077/gwjd-0p42>
- Parker, D. M., & Sykes, C. H. (2006). A systematic review of the Canadian Occupational Performance Measure: A clinical practice perspective. *British Journal of Occupational Therapy*, 69(4), 150-160. <https://doi.org/10.1177/030802260606900402>
- Parkinson, S., Chester, A., Cratchley, S., & Rowbottom, J. (2008). Application of the Model of Human Occupation Screening Tool (MOHOST Assessment) in an acute psychiatric setting. *Occupational Therapy in Health Care*, 22(2-3), 63-75. <https://doi.org/10.1080/07380570801989465>
- Paterson, M., Higgs, J., & Wilcox, S. (2006). Developing expertise in judgement artistry in occupational therapy practice. *British Journal of Occupational Therapy*, 69(3), 115-123. <https://doi.org/10.1177/030802260606900304>
- Patnaude, M., & O'Brien, J. (2023). Occupation as a foundation for reasoning. In J. O'Brien, M. Patnaude, & T. Reidy (Eds.), *Therapeutic reasoning in occupational therapy* (pp. 18-49). Elsevier.
- Pelaccia, T., Tardif, J., Tribby, E., & Charlin, B. (2011). An analysis of clinical reasoning through a recent and comprehensive approach: The Dual-Process Theory. *Medical Education Online*, 16. <https://doi.org/10.3402/meo.v16i0.5890>
- Perkins, B., Di Tommaso, A., Molineux, M., Power, P., & Young, A. (2020). *Knowledge translation approaches in occupational therapy: A scoping review*. *Journal of Occupational Therapy Education*, 4(3), 1-34. <https://doi.org/10.26681/jote.2020.040312>
- Pierce, D. (2005). The usefulness of video methods for occupational therapy and occupational science research. *American Journal of Occupational Therapy*, 59(1), 9-19. <https://doi.org/10.5014/ajot.59.1.9>
- Piernik-Yoder, B., & Beck, A. (2012). The use of standardized assessments in occupational therapy in the United States. *Occupational Therapy in Health Care*, 26(2-3), 97-108. <https://doi.org/10.3109/07380577.2012.695103>
- Pilegaard, M., Pilegaard, B., Birn, I., & Kristensen, H. (2014). Assessment of occupational performance problems due to cognitive deficits in stroke rehabilitation. *International Journal of Therapy & Rehabilitation*, 21(6), 280-288. <https://doi.org/10.12968/ijtr.2014.21.6.280>

- Polatajko, H. J., Davis, J., Stewart, D., Cantin, N., Amoroso, B., Purdie, L., & Zimmerman, D. (2013). Specifying the domain of concern: Occupation as a core. In E. A. Townsend & H. J. Polatajko (Eds.), *Enabling occupation II : Advancing an occupational therapy vision for health, well-being, & justice through occupation* (2nd ed., pp. 13-32). CAOT Publications ACE.
- Polatajko, H. J., Mandich, A., & Martini, R. (2000). Dynamic performance analysis: A framework for understanding occupational performance. *American Journal of Occupational Therapy*, 54(1), 65-72. <https://doi.org/10.5014/ajot.54.1.65>
- Polit, D. F., & Beck, C. T. (2006). *Essentials of nursing research: Methods, appraisal, and utilization* (6th ed.). Lippincott Williams & Wilkins.
- Pollock, N., Baptiste, S., Law, M., McColl, M. A., Opzoomer, A., & Polatajko, H. (1990). Occupational performance measures: A review based on the guidelines for the client-centred practice of occupational therapy. *Canadian Journal of Occupational Therapy*, 57(2), 77-81. <https://doi.org/10.1177/000841749005700206>
- Quiroga, V. (1995a). Education of "the handicapped". In *Occupational therapy: The first 30 years 1900 to 1930* (pp. 115-139). American Occupational Therapy Association.
- Quiroga, V. (1995b). Introduction: The first generation of occupational therapists. In *Occupational therapy: The first 30 years 1900 to 1930* (pp. 13-26). American Occupational Therapy Association.
- Quiroga, V. (1995c). Nurses for invalid occupations. In *Occupational therapy: The first 30 years 1900 to 1930* (pp. 71-89). American Occupational Therapy Association.
- Quiroga, V. (1995d). Professional culture and education in occupational therapy in the 1920's. In *Occupational therapy: The first 30 years 1900 to 1930* (pp. 211-232). American Occupational Therapy Association.
- Ranka, J. (2014). *Description of the PRPP system*. www.occupationalperformance.com/assessments/cognitive-component/prpp-system/
- Ranka, J., & Chapparo, C. (2010). Assessment of productivity performance in men with HIV Associated Neurocognitive Disorder (HAND). *Work*, 36(2), 193-206. <https://doi.org/10.3233/WOR-2010-1020>
- Rappolt, S., & Tassone, M. (2002). How rehabilitation therapists gather, evaluate, and implement new knowledge. *Journal of Continuing Education in the Health Professions*, 22(3), 170-180. <https://doi.org/10.1002/chp.1340220306>
- Read, H., & Stoffel, V. (2019) Recovery. In C. Brown, V. Stoffel & J. Muñoz (Eds). *Occupational Therapy in Mental Health : A Vision for Participation*. (2nd ed., pp.3-13) F.A. Davis.

- Reagon, C., Bellin, W., & Boniface, G. (2010). Challenging the dominant voice: The multiple evidence sources of occupational therapy. *British Journal of Occupational Therapy*, 73(6), 284-286.
<https://doi.org/10.4276/030802210X12759925469069>
- Reason, D. (2012). *A clinical reasoning framework for community occupational therapists. A formative evaluation study*. Otago Polytechnic.
<https://online.op.ac.nz/assets/OPRES/25aed53bab/Reason-Clinical-reasoning-framework-2012.pdf>
- Reed, K. L. (2017). Pioneering occupational therapy and occupational science: Ideas and practitioners before 1917. *Journal of Occupational Science*, 24(4), 400-411. <https://doi.org/10.1080/14427591.2017.1296369>
- Reidy, T., & Andrejow, N. (2023). Assessment: Gathering information and making hypotheses. In J. O'Brien, M. Patnaude, & T. Reidy (Eds.), *Therapeutic reasoning in occupational therapy* (pp. 114-138). Elsevier.
- Reilly, M. (1962) Occupational therapy can be one of the great ideas of 20th century medicine. *American Journal of Occupational Therapy*, 16 (1),61-67
- Roberts, A. E. (1996). Clinical reasoning in occupational therapy: Idiosyncrasies in content and process. *British Journal of Occupational Therapy*, 59(8), 372-376.
<https://doi.org/10.1177/030802269605900807>
- Robertson, L. (1996a). Clinical reasoning, Part 1: The nature of problem solving, a literature review. *British Journal of Occupational Therapy*, 59(4), 178-182.
<https://doi.org/10.1177/030802269605900407>
- Robertson, L. (1996b). Clinical reasoning, Part 2: Novice/expert differences. *British Journal of Occupational Therapy*, 59(5), 212-216.
<https://doi.org/10.1177/030802269605900507>
- Robertson, L. (Ed.). (2012). *Clinical reasoning in occupational therapy*. Blackwell Publishing. <https://doi.org/10.1002/9781118702833>.
- Robertson, L., & Blaga, L. (2013). Occupational therapy assessments used in acute physical care settings. *Scandinavian Journal of Occupational Therapy*, 20(2), 127-135. <https://doi.org/10.3109/11038128.2012.737369>
- Robertson, L., Graham, F., & Anderson, J. (2013). What actually informs practice: Occupational therapists' views of evidence. *British Journal of Occupational Therapy*, 76(7), 317-324.
<https://doi.org/10.4276/030802213X13729279114979>
- Rodger, S. (2010). Becomming more occupation-centred when working with children. In S. Rodger (Ed.), *Occupation-centred practice with children. A practical guide for occupational therapists* (pp. 28-40). Willey-Blackwell.
- Rogers, E. (1995). *Diffusion of innovations* (4th ed.). Free Press.
- Rogers, J. (1982). The Spirit of Independence: The Evolution of a Philosophy. *American Journal of Occupational Therapy*, 36(11), 709-715.

- Rogers, J. (1983). Eleanor Clarke Slagle lectureship-1983; Clinical reasoning: The ethics, science, and art. *American Journal of Occupational Therapy*, 37(9), 601-616. <https://doi.org/10.5014/ajot.37.9.601>
- Rogers, J. C., & Holm, M. B. (1991). Occupational therapy diagnostic reasoning: A component of clinical reasoning. *American Journal of Occupational Therapy*, 45(11), 1045-1053. <https://doi.org/10.5014/ajot.45.11.1045>
- Rosenbaum, P., & Gorter, J. W. (2012). The 'F-words' in childhood disability: I swear this is how we should think!. *Child: Care, Health & Development*, 38(4), 457-463. <https://doi.org/10.1111/j.1365-2214.2011.01338.x>
- Ross, M. (2009). *For the love of occupation. Reflections on a career in occupational therapy*. American Occupational Therapy Association.
- Rouleau, S., Dion, K., & Korner-Bitensky, N. (2015). Assessment practices of Canadian occupational therapists working with adults with mental disorders. *Canadian Journal of Occupational Therapy*, 82(3), 181-193. <https://doi.org/10.1177/0008417414561857>
- Rustad, A., DeGroot, T., Jungunz, M., Freeberg, K., Borowick, L., & Wanttie, A. (1993). Cognitive assessment of Minnesota.
- Ryan-Nicholls, K. D., & Will, C. I. (2009). Rigour in qualitative research: Mechanisms for control. *Nurse Researcher*, 16(3), 70-85. <https://doi.org/10.7748/nr2009.04.16.3.70.c6947>
- Sánchez-Zamorano, S., Rolack-Jaramillo, S., Ossandón-Pérez, M., & Moruno-Miralles, P. (2025). Exploring professional reasoning in occupational therapy: A scoping review of recent research. *British Journal of Occupational Therapy*, <https://doi.org/10.1177/03080226241310724>.
- Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science Methods of Inquiry*, 16(2), 1-8. <https://doi.org/10.1097/00012272-199312000-00002>
- Sandelowski, M. (2000). Whatever happened to qualitative description? *Research In Nursing & Health*, 23(4), 334-340. [https://doi.org/10.1002/1098-240x\(200008\)23:4%3C334::aid-nur9%3E3.0.co;2-g](https://doi.org/10.1002/1098-240x(200008)23:4%3C334::aid-nur9%3E3.0.co;2-g)
- Sandqvist, J. L., Gullberg, M. T., Henriksson, C. M., & Gerdle, B. (2008). Content validity and utility of the Assessment of Work Performance (AWP). *Work*, 30(4), 441-450. <https://doi.org/10.3233/wor-2008-00714>
- Sansonetti, D., & Hoffmann, T. (2013). Cognitive assessment across the continuum of care: The importance of occupational performance-based assessment for individuals post-stroke and traumatic brain injury. *Australian Occupational Therapy Journal*, 60(5), 334-342. <https://doi.org/10.1111/1440-1630.12069>
- Scanlan, J. N., & Hazelton, T. (2019). Relationships between job satisfaction, burnout, professional identity and meaningfulness of work activities for occupational therapists working in mental health. *Australian Occupational Therapy Journal*, 66(5), 581-590. <https://doi.org/10.1111/1440-1630.12596>

- Scanlan, J. N., Pépin, G., Haracz, K., Ennals, P., Webster, J. S., Meredith, P. J., Batten, R., Bowman, S., Bonassi, M., & Bruce, R. (2015). Identifying educational priorities for occupational therapy students to prepare for mental health practice in Australia and New Zealand: Opinions of practising occupational therapists. *Australian Occupational Therapy Journal*, 62(5), 286-298. <https://doi.org/10.1111/1440-1630.12194>
- Schell, B. (2014). Professional reasoning in practice. In B. Schell, G. Gillen, & E. Scaffa (Eds.), *Willard and Spackman's occupational therapy* (12th ed., pp. 384-397). Wolters Kluwer.
- Schell, B. (2018). Pragmatic reasoning. In B. Schell & J. Schell (Eds.), *Clinical and professional reasoning in occupational therapy* (2nd ed., pp. 203-223). Wolters Kluwer Health.
- Schell, B. (2025a). Aspects of professional reasoning. In B. Schell & J. Schell (Eds.), *Clinical and professional reasoning in occupational therapy* (3rd ed., pp. 127-142). Wolters Kluwer.
- Schell, B. (2025b). An ecological model of professional reasoning In B. Schell & J. Schell (Eds.), *Clinical and professional reasoning in occupational therapy* (3rd ed., pp. 97-124). Wolters Kluwer.
- Schell, B., & Cervero, R. M. (1993). Clinical reasoning in occupational therapy: An integrative review. *American Journal of Occupational Therapy*, 47(7), 605-610. <https://doi.org/10.5014/ajot.47.7.605>
- Schell, B., & Schell, J. (Eds.). (2018a). *Clinical and professional reasoning in occupational therapy* (2nd ed.). Wolters Kluwer Health.
- Schell, B., & Schell, J. (2018b). Professional reasoning as the basis of practice. In B. Schell & J. Schell (Eds.), *Clinical and professional reasoning in occupational therapy* (2nd ed., pp. 3-22). Wolters Kluwer.
- Schön, D. A. (1995). Knowing-in-action: The new scholarship requires a new epistemology. *Change: The Magazine of Higher Learning*, 27(6), 27-34. <https://doi.org/10.1080/00091383.1995.10544673>
- Scott, S., Albrecht, L., O'Leary, K., Ball, G., Hartling, L., Hofmeyer, A., Jones, C., Klassen, T., Burns, K., & Newton, A. (2012). Systematic review of knowledge translation strategies in the allied health professions. *Implementation Science*, 7(1), 1. <https://doi.org/10.1186/1748-5908-7-70>
- Seedhouse, D. (2009). *Ethics: The heart of health care* (3rd ed.). John Wiley & Sons.
- Sewell, L., & Singh, S. J. (2001). The Canadian Occupational Performance Measure: Is it a reliable measure in clients with chronic obstructive pulmonary disease? *British Journal of Occupational Therapy*, 64(6), 305-310. <https://doi.org/10.1177/030802260106400607>
- Shuell, T. J. (1990). Phases of meaningful learning. *Review of Educational Research*, 60(4), 531-547. <https://doi.org/10.3102/00346543060004531>

- Singh, H., Sangrar, R., Wijekoon, S., Nekolaichuk, E., Kokorelias, K. M., Nelson, M. L. A., Mirzazada, S., Nguyen, T., Assaf, H., & Colquhoun, H. (2022). Applying 'cultural humility' to occupational therapy practice: A scoping review protocol. *BMJ Open*, 12(7), e063655. <https://doi.org/10.1136/bmjopen-2022-063655>
- Skawski, K. (1987). Ethnic/racial considerations in occupational therapy. *Occupational Therapy in Health Care*, 4(1), 37-48. https://doi.org/10.1080/J003v04n01_04
- Smith, R. L., Ranka, J., & Nott, M. (2023). Using the Perceive, Recall, Plan and Perform Assessment of cognitive strategy use with Aboriginal and Torres Strait Islander peoples: Initial exploration of clinical utility. *Australian Occupational Therapy Journal*, 70(4), 446-459. <https://doi.org/10.1111/1440-1630.12866>
- Stamm, T. A., Cieza, A., Machold, K., Smolen, J. S., & Stucki, G. (2006). Exploration of the link between conceptual occupational therapy models and the International Classification of Functioning, Disability and Health. *Australian Occupational Therapy Journal*, 53(1), 9-17. <https://doi.org/10.1111/j.1440-1630.2005.00513.x>
- Stamm, T. A., Haider, S., Luschin, S., & Sturma, A. (2017). Reasoning underpinning assessments for people experiencing musculoskeletal conditions. In M. Curtin, M. Egan, & J. Adams (Eds.), *Occupational therapy for people experiencing illness, injury or impairment: Promoting occupation and participation* (7th ed., pp. 273- 292). Elsevier.
- Stanley, M., & Nayar, S. (2014). Methodological rigour: Ensuring quality in occupational therapy qualitative research. *New Zealand Journal of Occupational Therapy*, 61(1), 6-12.
- Stanley, P. (1995). Culture and its influence on occupational therapy evaluation. *Canadian Journal of Occupational Therapy*, 62(3), 154-161. <https://doi.org/10.1177/000841749506200307>
- Steenbergen, K., & Mackenzie, L. (2004). Professional support in rural New South Wales: Perceptions of new graduate occupational therapists. *Australian Journal of Rural Health*, 12(4), 160-165. <https://doi.org/10.1111/j.1440-1854.2004.00590.x>
- Steultjens, E. M., Voigt-Radloff, S., Leonhart, R., & Graff, M. J. (2012). Reliability of the Perceive, Recall, Plan, and Perform (PRPP) assessment in community-dwelling dementia patients: Test consistency and inter-rater agreement. *International Psychogeriatrics*, 24(04), 659-665. <https://doi.org/10.1017/S1041610211002249>
- Stewart, K., & Chapparo, C. (2011). School readiness: Agreement between the Perceive, Recall, Plan and Perform (PRPP) system of task analysis and teacher assessment. *Australian Occupational Therapy Journal*, 58, 8-9. <https://doi.org/10.1111/j.1440-1630.2011.00937.x>

- Stigen, L., Bjørk, E., & Lund, A. (2018). The conflicted practice: Municipal occupational therapists' experiences with assessment of clients with cognitive impairments. *Scandinavian Journal of Occupational Therapy*, 26(4), 261-272. <https://doi.org/10.1080/11038128.2018.1445778>
- Stigen, L., Bjørk, E., Lund, A., & Cvancarova Småstuen, M. (2017). Assessment of clients with cognitive impairments: A survey of Norwegian occupational therapists in municipal practice. *Scandinavian Journal of Occupational Therapy*, 25(2), 88-98. <https://doi.org/10.1080/11038128.2016.1272633>
- Stokes, F., & Dixon, H. (2018). *The occupational therapist workforce. Making sense of the numbers* Occupational Therapy Board of New Zealand. <https://www.otboard.org.nz/wp-content/uploads/2018/10/OTB-18299-Making-sense-of-the-numbers-report-WEB.pdf>
- Straus, S. E., Tetroe, J. M., & Graham, I. D. (2011). Knowledge translation is the use of knowledge in health care decision making. *Journal of Clinical Epidemiology*, 64(1), 6-10. <https://doi.org/10.1016/j.jclinepi.2009.08.016>
- Strong, S., Rigby, S., Stewart, D., Law, M., Letts, L., & Cooper, B. (1999). Application of the Person-Environment-Occupation Model: A practical tool. *Canadian Journal of Occupational Therapy* 66(3), 122-133. <https://doi.org/10.1177/000841749906600304>
- Sudsawad, P. (2005). A conceptual framework to increase usability of outcome research for evidence-based practice. *American Journal of Occupational Therapy*, 59(3), 351-355. <https://doi.org/10.5014/ajot.59.3.351>
- Swinth, Y. (2018). School-based practice. In B. Schell & J. Schell (Eds.), *Clinical and professional reasoning in occupational therapy* (2nd ed., pp. 319-335). Wolters Kluwer.
- Te Rau Matatini. (2009). *Te umanga whakaora: Accelerated Māori occupational therapy workforce development*. New Zealand Association of Occupational Therapy.
- Terry, G. H., N. (2021). Data analysis. Familiarization and coding. In G. Terry & N. Hayfield (Eds.), *Essentials of thematic analysis* (pp. 29-41). American Psychological Association. <https://doi.org/10.1037/0000238-00>
- Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, 27(2), 237-246. <https://doi.org/10.1177/1098214005283748>
- Thorley, M., & Lim, S. (2011). Considerations for occupational therapy assessment for Indigenous children in Australia. *Australian Occupational Therapy Journal*, 58(1), 3-10. <https://doi.org/10.1111/j.1440-1630.2010.00852.x>
- Thorne, S. (2016a). Cultivating questions in the applied practice field. In *Interpretive description: Qualitative research for applied practice* (2nd ed., pp.43-58). Routledge.

- Thorne, S. (2016b). Qualitative research in the applied disciplines. In *Interpretive description: Qualitative research for applied practice* (2nd ed., pp. 25-41). Routledge.
- Thorne, S., Kirkham, S. R., & MacDonald-Emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health*, 20(2), 169-177.
[https://doi.org/10.1002/\(SICI\)1098-240X\(199704\)20:2](https://doi.org/10.1002/(SICI)1098-240X(199704)20:2)
- Thorne, S., Kirkham, S. R., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods*, 3(1), 1-11. <https://doi.org/10.1177/160940690400300101>
- Thorne, S., Stephens, J., & Truant, T. (2016). Building qualitative study design using nursing's disciplinary epistemology. *Journal of Advanced Nursing*, 72(2), 451-460. <https://doi.org/10.1111/jan.12822>
- Toglia, J. P. (2011). The Dynamic Interactional Model of cognition in cognitive rehabilitation. In N. Katz & J. Toglia (Eds.), *Cognition, occupation, and participation across the life span: Neuroscience, neurorehabilitation, and models of intervention in occupational therapy* (3rd ed., pp. 161-201). American Occupational Therapy Association.
- Toth-Cohen, S. (2008). Using cultural-historical activity theory to study clinical reasoning in context. *Scandinavian Journal of Occupational Therapy*, 15(2), 82-94. <https://doi.org/10.1080/11038120701534975>
- Townsend, E., & Polatajko, H. (2007). *Enabling occupation II: Advancing an occupational therapy vision for health, well-being, & justice through occupation*. CAOT Publications ACE.
- Trentham, B., Laliberte Rudman, D., Smith, H., & Phenix, A. (2022). The socio-political and historical context of occupational therapy in Canada. In M. Egan & G. Restall (Eds.), *Promoting occupational participation: Collaborative relationship-focused occupational therapy* (pp. 31-55). Canadian Association of Occupational Therapists.
- Tromby, C. (1993). Anticipating the future: Assessment of occupational function. *American Journal of Occupational Therapy*, 47(3), 253-257.
<https://doi.org/10.5014/ajot.47.3.253>
- Tse, D. W., & Spaulding, S. J. (1998). Review of motor control and motor learning. *Physical & Occupational Therapy in Geriatrics*, 15(3), 19-38.
https://doi.org/10.1080/J148v15n03_02
- Turpin, M., & Copley, J. (2025). Interactive reasoning. In B. Schell & J. Schell (Eds.), *Clinical and professional reasoning in occupational therapy* (3rd ed., pp. 239-252). Wolters Kluwer.
- Unsworth, C. (2000). Measuring the outcome of occupational therapy: Tools and resources. *Australian Occupational Therapy Journal*, 47(4), 147-158.
<https://doi.org/10.1046/j.1440-1630.2000.00239.x>

- Unsworth, C. (2001). The clinical reasoning of novice and expert occupational therapists. *Scandinavian Journal of Occupational Therapy*, 8(4), 163-173. <https://doi.org/10.1080/110381201317166522>
- Unsworth, C. (2004). Clinical reasoning: How do pragmatic reasoning, worldview and client-centredness fit? *British Journal of Occupational Therapy*, 67(1), 10-19. <https://doi.org/10.1177/030802260406700103>
- Unsworth, C. (2011). Gaining insights to the clinical reasoning that supports an on-road driver assessment. *Canadian Journal of Occupational Therapy*, 78(2), 97-102. <https://doi.org/10.2182/cjot.2011.78.2.4>
- Unsworth, C. (2013). The evolving theory of clinical reasoning. In E. A. S. Duncan (Ed.), *Foundations for practice in occupational therapy* (5th ed., pp. 209-231). Churchill Livingstone/Elsevier.
- Unsworth, C., & Baker, A. (2016). A systematic review of professional reasoning literature in occupational therapy. *British Journal of Occupational Therapy*, 79(1), 5-16. <https://doi.org/10.1177/0308022615599994>
- Unsworth, C. A. (2005). Using a head-mounted video camera to explore current conceptualizations of clinical reasoning in occupational therapy. *American Journal of Occupational Therapy*, 59(1), 31-40. <https://doi.org/10.5014/ajot.59.1.31>
- Unsworth, C. A., & Schell, B. A. B. (2025). Research and scholarship in clinical and professional reasoning. In J. W. Schell (Ed.), *Clinical and professional reasoning in occupational therapy* (3rd ed., pp. 625-638). Lippincott Williams & Wilkins.
- Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences*, 15(3), 398-405. <https://doi.org/10.1111/nhs.12048>
- Van Keulen-Rouweler, B., Sturkenboom, I., Kottorp, A., Graff, M., Nijhuis-Van der Sanden, M., & Steultjens, E. (2016). The Perceive, Recall, Plan and Perform (PRPP) system for persons with Parkinson's disease: A psychometric study. *Scandinavian Journal of Occupational Therapy*, 24(1), 65-73. <https://doi.org/10.1080/11038128.2016.1233291>
- VanderKaay, S., Jung, B., & Letts, L. (2019). Continuing competency in ethical decision making: An interpretive description of occupational therapists' perspectives. *Canadian Journal of Occupational Therapy*, 86(3), 209-219. <https://doi.org/10.1177/0008417419833842>
- VanderKaay, S., Letts, L., Jung, B., & Moll, S. E. (2020, 2020/02/17). Doing what's right: A grounded theory of ethical decision-making in occupational therapy. *Scandinavian Journal of Occupational Therapy*, 27(2), 98-111. <https://doi.org/10.1080/11038128.2018.1464060>

- Vermeulen, P., Dyer, J. O., Rochette, A., & Collins, T. (2024). The place of intuition in the clinical reasoning of occupational therapists: A multiple-case study. *Health & Social Care in the Community*, 1-11. <https://doi.org/10.1155/2024/8385716>
- Voigt-Radloff, S. (2012). *Cross-national transfer of community occupational therapy in dementia*. University Hospital Freiburg.
- Voigt-Radloff, S., Graff, M., Leonhart, R., Schornstein, K., Vernooij-Dassen, M., Olde-Rikkert, M., & Huell, M. (2009). WHEDA study: Effectiveness of occupational therapy at home for older people with dementia and their caregivers-the design of a pragmatic randomised controlled trial evaluating a Dutch programme in seven German centres. *BMC Geriatrics*, 9(1), 44. <https://doi.org/10.1186/1471-2318-9-44>
- Walder, K., Bissett, M., Molineux, M., & Whiteford, G. (2022). Professional identity in occupational therapy: A scoping review. *Scandinavian Journal of Occupational Therapy*, 29(3), 175-197. <https://doi.org/10.1080/11038128.2021.1974548>
- Ward, J. D. (2003). The nature of clinical reasoning with groups: A phenomenological study of an occupational therapist in community mental health. *American Journal of Occupational Therapy*, 57(6), 625-634. <https://doi.org/10.5014/ajot.57.6.625>
- Warner, G., & Townsend, E. (2012). KT & OT. Applying knowledge translation theories to occupation. *Occupational Therapy Now*, 14(2), 19-21. https://caot.ca/document/6067/OT%20now_MAR_2012.pdf
- Weinstock-Zlotnick, G., & Hinojosa, J. (2004). Bottom-up or top-down evaluation: Is one better than the other? *American Journal of Occupational Therapy*, 58(5), 594-599. <https://doi.org/10.5014/ajot.58.5.594>
- Wenger-Trayner, E., & Wenger-Trayner, B. (2012). *What is social learning*. <http://wenger-trayner.com/all/what-is-social-learning/>
- Wenger, E. (1998). Communities of practice: Learning as a social system. *Systems Thinker*, 9(5), 2-3. <https://thesystemsthinker.com/communities-of-practice-learning-as-a-social-system/>
- White, A., Hocking, C., & Reid, H. (2014). How occupational therapists engage adults with cognitive impairments in assessments. *British Journal of Occupational Therapy*, 77(1), 2-9. <https://doi.org/10.4276/03080214X13887685335427>
- White, C., Basiletti, C., Carswell, A., Head, B., & Lin, L. (2008). Online communities of practice: Enhancing scholarly practice using web-based technology. *Occupational Therapy Now*, 10, 6-7.
- White, T., & Beagan, B. L. (2020). Occupational therapy roles in an indigenous context: An integrative review. *Canadian Journal of Occupational Therapy*, 87(3), 200-210. <https://doi.org/10.1177/0008417420924933>

- White, J., Nott, M., Barr, C., Chapparo, C., & George, S. (2020). Stroke survivors' occupational performance and cognitive strategy use: A pilot exploration of strengths and difficulties using the Perceive Recall Plan Perform System of Task Analysis. *British Journal of Occupational Therapy*, 83(11), 701-709. <https://doi.org/10.1177/0308022620951028>
- Whiteford, G., Townsend, E., & Hocking, C. (2000). Reflections on a renaissance of occupation. *Canadian Journal of Occupational Therapy*, 67(1), 61-69. <https://doi.org/10.1177/000841740006700109>
- Wilcock, A. (1998). *An occupational perspective of health*. Slack.
- Wilding, C., Curtin, M., & Whiteford, G. (2012). Enhancing occupational therapists' confidence and professional development through a community of practice scholars. *Australian Occupational Therapy Journal*, 59(4), 312-318. <https://doi.org/10.1111/j.1440-1630.2012.01031.x>
- Wilding, C., & Whiteford, G. (2009). From practice to praxis: Reconnecting moral vision with philosophical underpinnings. *British Journal of Occupational Therapy*, 72(10), 434-441. <https://doi.org/10.1177/030802260907201004>
- Wilkins, S., Pollock, N., Rochon, S., & Law, M. (2001). Implementing client-centred practice: Why is it so difficult to do? *Canadian Journal of Occupational Therapy*, 68(2), 70-79. <https://doi.org/10.1177/000841740106800203>
- Wilson, L. H., & Cheetham, K. (2008). Tools of practice: A view of changes in occupational therapy in Aotearoa New Zealand. *New Zealand Journal of Occupational Therapy*, 55(2), 32-39
- Wimpenny, K., Forsyth, K., Jones, C., Matheson, L., & Colley, J. (2010, 2010/11/01). Implementing the Model of Human Occupation across a mental health occupational therapy service: Communities of practice and a participatory change process. *British Journal of Occupational Therapy*, 73(11), 507-516. <https://doi.org/10.4276/030802210X12892992239152>
- World Health Organization. (2001). *International classification of functioning, disability and health: ICF*. Author.
- Wright, N., Stuart, L., Hedges, M., Lavin, B., & Donnet, L. (2014). An approach to assessment for older adults. *Insight May*, 20-21.

APPENDICES

Appendix A: AUTECH Ethical Approval 2016



AUTECH Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

27 April 2016

Clare Hocking
Faculty of Health and Environmental Sciences

Dear Clare

Re Ethics Application: **16/97 The experiences of occupational therapists in Aotearoa New Zealand applying the Perceive, Recall, Plan, Perform System of Task Analysis (PRPP) into their practice.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTECH).

Your ethics application has been approved for three years until 27 April 2019.

As part of the ethics approval process, you are required to submit the following to AUTECH:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 27 April 2019;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 27 April 2019 or on completion of the project.

It is a condition of approval that AUTECH is notified of any adverse events or if the research does not commence. AUTECH approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTECH grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

A handwritten signature in black ink, appearing to read 'K O'Connor', is placed above the typed name of the signatory.

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Wendy Burrows wendy.burrows@xtra.co.nz

Appendix B: AUTECH Ethics Approval 2019



Auckland University of Technology Ethics Committee (AUTECH)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

11 December 2019

Clare Hocking
Faculty of Health and Environmental Sciences

Dear Clare

Re Ethics Application: **19/441 Adopting the perceive, recall, plan and perform system of task analysis (PRPP) assessment into practice in Aotearoa New Zealand: Influences on clinical reasoning**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTECH).

Your ethics application has been approved for three years until 11 December 2022.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the [Auckland University of Technology Code of Conduct for Research](#) and as approved by AUTECH in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTECH prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTECH Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTECH Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

AUTECH grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted. When the research is undertaken outside New Zealand, you need to meet all ethical, legal, and locality obligations or requirements for those jurisdictions.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through <http://www.aut.ac.nz/research/researchethics>

Yours sincerely,

A handwritten signature in black ink, appearing to read 'K O'Connor'.

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: wendy.burrows@xtra.co.nz

Appendix C: AUTECH Amendment Approval 2020



Auckland University of Technology Ethics Committee (AUTECH)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

18 March 2020

Clare Hocking
Faculty of Health and Environmental Sciences

Dear Clare

Re: Ethics Application: **19/441 Adopting the perceive, recall, plan and perform system of task analysis (PRPP) assessment into practice in Aotearoa New Zealand: Influences on clinical reasoning**

Thank you for your request for approval of an amendment to your ethics application.

The minor amendment to the recruitment strategy is approved.

Non-Standard Conditions of Approval

1. Include Occupational Therapy PRPP Instructors Network in the 'How was I identified' section of the Information Sheet.

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to or reviewed by AUTECH before commencing your study.

I remind you of the **Standard Conditions of Approval**.

1. The research is to be undertaken in accordance with the [Auckland University of Technology Code of Conduct for Research](#) and as approved by AUTECH in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTECH prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTECH Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTECH Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

AUTECH grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted. When the research is undertaken outside New Zealand, you need to meet all ethical, legal, public health, and locality obligations or requirements for those jurisdictions.

Please quote the application number and title on all future correspondence related to this project.

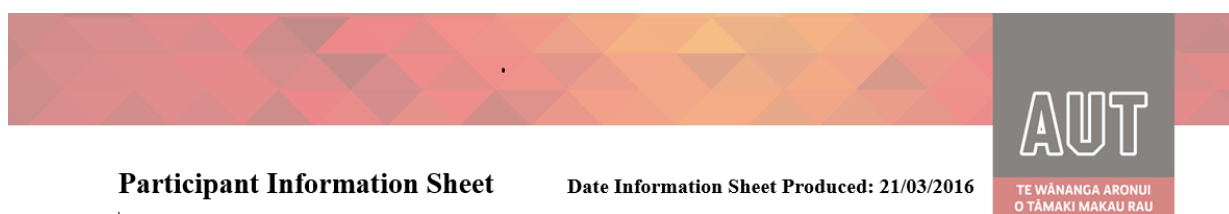
For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through <http://www.aut.ac.nz/research/researchethics>

(This is a computer-generated letter for which no signature is required)

The AUTECH Secretariat
Auckland University of Technology Ethics Committee

Cc: wendy.burrows@xtra.co.nz

Appendix D: Phase 1 Participant Information Sheet



Participant Information Sheet

Date Information Sheet Produced: 21/03/2016

AUT

TE WĀNANGA ARONUI
O TĀMAKI MAKĀU RAU

Project Title

The experiences of occupational therapists in Aotearoa New Zealand applying the Perceive, Recall, Plan, Perform System of Task Analysis (PRPP) into their practice

An Invitation

You are invited to consider participating in an interview with Wendy Burrows, as part of a research project exploring how occupational therapists have experienced the PRPP in practice. If you are a Māori practitioner there is also an invitation to discuss in a group and/or in an individual interview whether there is any relationship between the PRPP theory system, its use in clinical practice and Māori worldview.

I am a PRPP-trained Occupational Therapist working in Aotearoa New Zealand and also a partner of Chameleon Courses (the organisation which brings PRPP courses to Aotearoa New Zealand). If you completed your PRPP training in this country, then I will be familiar to you in this role. I am currently training to be a PRPP international instructor and this research will form the thesis for a Masters of Health Science degree.

My supervisors are Professor Clare Hocking (primary supervisor) and Dr Christine Chapparo (secondary supervisor). Dr Christine Chapparo is one of the authors and an instructor of the PRPP assessment and if you trained in Aotearoa New Zealand you will be familiar with Dr Christine Chapparo as a PRPP instructor.

This research will have no direct financial gain for either myself in my role as a Chameleon Courses' partner or Dr Chris Chapparo as an instructor, since all participants involved in the research including yourself, have already completed the PRPP training.

Your participation in this project is entirely voluntary i.e. your choice with no obligation to participate and you can withdraw at any time up to one month after the interview or group discussion without needing to give any reasons for this.

What is the purpose of this research?

This research aims to gain some understandings of the realities of the PRPP in clinical practice including: -

- Identifying any practical strategies that could assist the translation of the PRPP knowledge from the training stage to the clinical setting.
- Providing insights on the PRPP theory and practice and its fit with Māori perspectives/worldview
- Raising concerns or challenges that occupational therapist need to consider when using the PRPP .

The research findings will inform future PRPP training courses and workshops both nationally and overseas and will be presented for publication to an international OT journal and in papers for conferences.

How was I identified and why am I being invited to participate in this research?

A general call for registered occupational therapists has been advertised through the Occupational Therapy Board of New Zealand (OTBNZ), Occupational Therapy New Zealand Whakaora Ngangahau Aotearoa Association (OTNZWNA) and the Chameleon Courses website. Only occupational therapists that have completed the PRPP training can participate and occupational therapists that work with me, are supervised by me or supervise me will be excluded from the study.

What will happen in this research?

A demographic form and consent form will be emailed to volunteers and then I will contact participants by email or phone to arrange an individual interview at a mutually suitable time and location. The interview can be a face to face meeting or held through skype. If you are Māori then you will be invited to choose whether you participate in a Māori occupational therapist group and /or in an interview. If you choose to attend the group I will be asking all participants to suggest a suitable time and location for the group and if needed joining the discussion by skype or teleconference could be arranged.

You are welcome to bring support people to the interview which will last 1-1.5 hours. The interview will be audio recorded and then transcribed (typed from the audiotape). The transcription will be emailed to you to confirm whether you are in agreement with its content.

What are the possible discomforts and risks involved in this research?

Being individually interviewed or participating in a group which discusses your work experiences for some people could raise unexpected emotions or trigger previous events which may be upsetting or distressing for you. Also, if you are participating in a group there is the potential risk that the discussion may raise sensitive cultural issues for you or that a group member could break the confidentiality agreement of the group and share information outside of the group situation.

How will these discomforts and risks be alleviated?

At all times during the interview or group you choose which aspects to talk about and how much you disclose. You are also free to withdraw from the interview or group and/or request to stop the recording of the interview at any time.

Issues of confidentiality will be discussed at the start of both interview and group process and you will be asked to sign the consent form prior to the interview or group discussion.

Iris Pahau (OTNZWNA Tikanga Advisor) is advising me on cultural safety, tikanga (customs) and kawa (protocols) for the group meeting and she may attend or be involved through teleconference or skype.

What are the benefits?

There are no immediate benefits for you taking part, although for some occupational therapists discussing experiences that have occurred can be a self-reflective process which may help you in your practice.

If you are participating in the Māori occupational therapist group discussion there may be some benefits for you in sharing your thoughts, experiences and cultural perspective in relation to the PRPP with other Māori occupational therapists.

You may gain practical understandings / strategies from the study and a summary of the findings will be emailed to you. This research is likely to have benefits for the wider occupational therapy profession by adding to the body of knowledge about the experiences and issues facing occupational therapist implementing occupation centred assessments in their practice. There may also be benefits for service managers and fund holders who are likely to be better informed from the research findings when they are considering funding an occupational therapist to attend a PRPP training course.

What compensation is available for injury or negligence?

In the unlikely event of a physical injury as a result of your participation in this study, rehabilitation and compensation for injury by accident may be available from the Accident Compensation Corporation, providing the incident details satisfy the requirements of the law and the Corporation's regulations.

How will my privacy be protected?

Audio recordings and transcripts will only be accessed by the research team who have all signed confidentiality agreements. The typist transcribing the interviews, will have also signed a confidentiality clause and will type onto a computer which is password protected.

Any demographic information will be stored separately from transcripts in two locked cabinets at AUT for six years following the completion of the research and then subsequently destroyed. Your name will not be used in any publication with a pseudonym being used instead and the publishing of any identifying information will be minimised.

What are the costs of participating in this research?

There is the cost to you in the time taken for the interview and/or group. If you travel to the interview or group a contribution in the form of petrol vouchers will be made.

What opportunity do I have to consider this invitation?

You will be given up to two weeks to consider this invitation before any further contact is made.

How do I agree to participate in this research?

By expressing your interest and emailing your contact details to prppresearch@gmail.com

Will I receive feedback on the results of this research?

On completion of this study an email summary of the research findings will be sent to you

What do I do if I have concerns about this research?

- Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Clare Hocking by email: clare.hocking@aut.ac.nz or phone: 09 921 9162

Concerns regarding the conduct of the research should be notified to the Executive Secretary of ATEC, Kate O'Connor, ethics@aut.ac.nz , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details: Wendy Burrows email: prppresearch@gmail.com

Project Supervisor Contact Details: Professor Clare Hocking: clare.hocking@aut.ac.nz

or ph:09 921 916

Dr Christine Chapparo: chris.chapparo@sydney.edu.au

Approved by the Auckland University of Technology Ethics Committee on 18th July 2016, ATEC Reference number 1697_27042016.

Appendix E: Phase 2 Information Sheet for Occupational Therapists



Participant Information Sheet

27/07 2020

Project Title

Adopting the Perceive, Recall, Plan and Perform System of Task Analysis (PRPP) Assessment into practice in Aotearoa New Zealand: Influences on clinical reasoning.

Researcher

Wendy Burrows

An Invitation

You are invited to participate in a research project which explores occupational therapists' **thinking and decisions** before, during and after using the PRPP assessment with clients/tangata whaiora. It is a follow-up to my previous study of occupational therapists' **experiences** of applying the PRPP assessment in Aotearoa New Zealand.

I am a PRPP trained Occupational Therapist working in Aotearoa New Zealand, guest lecturer at AUT and also a partner of Chameleon Courses (the organisation which brings PRPP assessment courses to Aotearoa New Zealand). If you completed your PRPP assessment training in this country, then I will be familiar to you in this role. I am currently training to be a PRPP international instructor and this research will form the thesis for a PhD.

My supervisors are Professor Clare Hocking (primary supervisor) and Associate Professor Christine Chapparo (secondary supervisor). Dr Christine Chapparo is one of the authors and an instructor of the PRPP assessment and if you trained in Aotearoa New Zealand you will be familiar with Dr Christine Chapparo as a PRPP instructor.

What is the purpose of this research?

The study aims to gain understandings of occupational therapists' thinking, reasoning and decision-making processes as they apply the PRPP assessment in practice. It includes thinking which underlies assessment selection, the set up and application of the PRPP assessment, interpretation and communication of assessment results and subsequent intervention planning and/or interventions.

The research findings will inform future PRPP training courses and workshops both nationally and overseas and will be presented for publication to international OT journals and in papers for conferences.

How was I identified and why am I being invited to participate in this research?

A general call for registered occupational therapists has been advertised through the Occupational Therapy Board of New Zealand (OTBNZ), PRPP Instructors network and PRPP courses held in Australia in 2020. In addition, occupational therapists have been asked to share information about the research with their colleagues so you may have heard in that way. Only occupational therapists that have completed the PRPP assessment training can participate and occupational therapists that work with me, are supervised by me or supervise me will be excluded from the study.

How do I agree to participate in this research?

By expressing your interest and emailing your contact details to prppresearch@gmail.com. A consent form will be emailed to you to read. You are encouraged to ask any questions you may have concerning the consent process by sending an email to prppresearch@gmail.com. If you wish to consent then sign, scan and email the signed form to prppresearch@gmail.com. Once a signed consent form has been received and you have selected the way in which you wish to be involved (see options below) you will be sent information on the reflective log and/or video process and can begin your involvement in the research.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study up to one month after the interview without needing to give any reasons for this. If you choose to withdraw, you will be offered the choice of having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the data has been analysed and findings have been produced, removal of your data may not be possible.

What will happen in this research?

You will be asked to attend an interview with Wendy Burrows at a mutually agreed venue. You will be emailed a demographic form giving details of your practice context and experience, to assist with participant selection, and a consent form to complete and sign prior to beginning the interview.

You will be asked to select one to two clients / tangata whaiora with whom you plan to use the PRPP assessment and asked to choose an option (outlined below) to record information associated with your thinking and the assessment process you use. Since this research is focused on your thinking as the occupational therapist, no details related to the

cases are required and no information which could identify a client will be included. There are two different ways you could participate in the research: -

Option 1

Keep an ongoing written, typed or digital audio reflective log (e.g. on mobile phone or laptop/computer) of your thinking at each stage of the PRPP assessment process for each client/tangata whaiora. Questions will be provided to guide your reflective log entries and include selecting the PRPP assessment, choosing the assessment tasks, thoughts you had before, during and on completion of the assessment, interventions based on the PRPP findings, scoring and/or reporting/communicating the assessment results to others. On completion of the reflective log you would email it to prppresearch@gmail.com and an interview will be set up with Wendy to further explore your thoughts, decisions and actions.

Option 2

With their permission, video a PRPP assessment session and/or a session communicating results of the PRPP assessment to a client/tangata whaiora/whanau and/or a subsequent intervention session with a client/tangata whaiora. The intention of a video recording is to assist recall of your thoughts and decisions and assist you to complete either a written or digital audio reflective log and interview as above. Other studies investigating clinical reasoning report that videoing sessions with a client/tangata whaiora can be a valuable tool to trigger and promote recall of thinking from therapy sessions.

If selecting this option, you would inform Wendy of this choice prior to inviting any clients/tangata whaiora to participate. She will then request information concerning your work organisation and complete the process to obtain research approval to recruit clients/tangata whaiora in your organisation. The research will only progress once your work organisation has granted approval and an appropriate process for informing clients/tangata whaiora has been formally agreed with an information flyer and video recording consent forms. For children and young people this will include information for parents/ legal guardians and the child/young person, together with consent and assent forms. This will include clients/tangata whaiora being given the opportunity to have a copy of the video recording (a memory stick will be provided for this). With the agreement of the client/tangata whaiora you can video yourself or have someone else record the session. You will be provided instructions on setting up to film a session.

You and the clients/tangata whaiora must both agree to the video being made, and whether it will only be used for the purpose of assisting you with the written/digital reflective log and interview or whether it can also be shared with Wendy and her supervisors. If either of you select not to share the video recording with the research team you will be asked to delete it within a week after attending an interview. If you both select to share the video, a memory stick and a courier envelope will be provided for you to send it along with the written or digital reflective log prior to the interview. The memory stick will be stored in a locked AUT office and the content deleted six years after completion of the research. On completion of the reflective log, an interview will be set up with Wendy to further explore your thoughts, decisions and the actions you took during the PRPP assessment process with each client/tangata whaiora.

For adult clients/ tangata whaiora there is a further option for the video recording to be kept for educational purposes for occupational therapy students and qualified occupational therapists. There is no option for a video of a child/young person being used in this way. If you chose to select this option, the adult client/tangata whaiora would also need to consent to the video recording being used for educational purposes.

For both options 1 and 2 above, once you have completed the reflective log, Wendy will contact you by email or phone to arrange the interview. It can be a face to face meeting or held through skype/zoom. You are welcome to bring support people to the interview which will last 1-1.5 hours. The interview will be audio recorded and then transcribed (typed from the audiotape). The transcription will be emailed to you to confirm whether you are in agreement with its content.

What are the discomforts and risks?

Being individually interviewed and discussing your assessment practice and work experiences for some people could raise unexpected emotions or trigger previous events which may be upsetting or distressing for you. In addition, you may feel worried that the answers you give or the way in which you do assessments are somehow not correct. Filming your practice might provide insights of ways that you do things or say things that you had not previously seen or considered which may have potential to be confronting or upsetting.

How will these discomforts and risks be alleviated?

At all times when keeping a reflective log, videoing or during interview it is your choice to continue participating and which aspects to talk about and how much you disclose. All information you provide is viewed as useful. There are no right or wrong answers and no judgements will be made concerning your assessment practice or any other aspects of your practice. Honest, frank answers are sought as these portray the true realities, complexities and challenges of occupational therapy practice. In addition, you are free to withdraw from the interview and/or request to stop the recording of the interview at any time.

It is your decision whether you use the video recording to inform your thinking and preparation for the reflective log and interview and whether you share the video recording with the researchers.

What are the benefits?

There are no immediate benefits for you taking part, although some occupational therapists find that discussing their thinking and experiences can be a self-reflective process which may help them in their practice. A summary of the findings will be emailed to you and you may gain practical understandings / strategies from the study and be able to reflect on the accounts of others' clinical reasoning to further develop your own thinking and use of the assessment.

This research is likely to have benefits for the wider occupational therapy profession by adding to the body of knowledge concerning clinical reasoning and assessment practice. In particular, insights gained may benefit occupational therapists attending future PRPP training courses as the training can be aligned with how occupational therapists use the PRPP assessment in practice. Occupational therapists gaining relevant clinical reasoning skills during the PRPP assessment training is likely to better prepare them for later using the PRPP assessment in their practice.

How will my privacy be protected?

Audio recordings, video recordings and transcripts will only be accessed by Wendy, her supervisors and the typist transcribing the interview, who will have signed a confidentiality agreement that requires using a password protected computer and deleting all data once completed.

Any demographic information will be stored separately from transcripts and video in locked office at AUT for six years following the completion of the research and then the recordings destroyed (unless consent has been provided for ongoing education use of the video recording).

Your name will not be used in any publication with a pseudonym being used instead, unless you opt on the consent form to use your real name rather than to have a pseudonym. Your workplace and any other information that may identify clients /tangata whaiora you assessed will be omitted or obscured.

If you opt to share the video for educational purposes (an option only available to adult clients/tangata whaiora and not children or young people), a pseudonym will be used, and no identifiable information shared. It is, however, still possible that a person in the audience might recognise you.

What are the costs of participating in this research?

There is the cost to you in the time taken for keeping a reflective log over the assessment period, which is anticipated be a total of 30-45 minutes over 1-4 weeks. If you select to video a session then there is a cost in time taken to inform and gain client consent, set up the filming, and review the film. There is also a cost in time for the interview which is anticipated will be 1-1.5 hours duration. If you travel to the interview a contribution in the form of petrol vouchers will be made.

What opportunity do I have to consider this invitation?

You will be given at least one week to consider this invitation before any further contact is made.

Will I receive feedback on the results of this research?

On completion of this study an email summary of the research findings will be sent to you if you indicated you wish to receive that information.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Clare Hocking by email: clare.hocking@aut.ac.nz or phone: 09 921 9162

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTC, Kate O'Connor, ethics@aut.ac.nz, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details: Wendy Burrows email: prppresearch@gmail.com

Project Supervisor Contact Details: Professor Clare Hocking: clare.hocking@aut.ac.nz or ph:09 921 916

Dr Christine Chapparo: chris.chapparo@sydney.edu.au

Approved by the Auckland University of Technology Ethics Committee on 11th Dec 2019, AUTC Reference number Hocking19441_11122019

Appendix F: Participant Demographic Form

PARTICIPANT DEMOGRAPHIC FORM

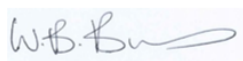
|

21 /3/16

Thank you for considering participating in this research and for completing this form. This form will be used so that a varied group of Occupational Therapists are interviewed for this research.

Please complete this form and return it to me by email: prppresearch@gmail.com

I will be in touch by email to confirm the next stage of the research

A handwritten signature in blue ink, appearing to read 'W.B. Burrows', is placed over a light blue rectangular background.

Wendy Burrows
Researcher

Gender (circle)	Female / Male				
Which ethnic group / groups do you belong to (circle)	New Zealand European Māori Samoan Cook Island Māori Tongan Niuean Chinese Indian Other such as Dutch, Japanese, Tokelauan				
Please describe you current client group and clinical practice e.g. Acute adults, community paediatrics, adult mental health, elderly etc					
Please describe your work setting e.g. DHB, MOE, School, Private practice					
Please describe the geographic area you work in (circle, those relevant)	North Island		South Island		
	City	Town	Rural Area		
	Auckland Wellington Christchurch Dunedin Hamilton Whangarei Palmerston North Rotorua Napier Hastings Nelson Queenstown Other				
Which year did you completed your PRPP- A training In Aotearoa New Zealand (circle)	2007	2009	2011	2013	2014
Indicate the approximate frequency that you use the PRPP in your practice (circle)	Daily	2-3 Times a Week			Weekly
	Monthly	Never			
Do you work in isolation i.e. in a team without other Occupational Therapists?(circle)	Yes / No				
Do you work with other Occupational Therapists trained in the PRPP(circle)	Yes / No / Sometimes				

Appendix G: Transcriber Confidentiality Agreement



Confidentiality Agreement

Project title: The experiences of occupational therapists in Aotearoa New Zealand applying the Perceive, Recall, Plan, Perform System of Task Analysis (PRPP) into their practice.

Project Supervisor: Professor Clare Hocking

Researcher: Wendy Burrows

- ☐ I understand that all the material I will be asked to transcribe is confidential.
- ☐ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ☐ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature:

Transcriber's name:

Transcriber's Contact Details (if appropriate):

.....
.....
.....
.....

Date:

Project Supervisor's Contact Details (if appropriate):

.....
.....
.....
.....

Approved by the Auckland University of Technology Ethics Committee on 27th April 2016 AUTEK Reference number 1697_27042016

Note: The Transcriber should retain a copy of this form

Appendix H: Recruitment Email to OTBNZ Phase One



Calling for registered Occupational Therapists who are trained in the Perceive, Recall, Plan and Perform System (PRPP) to participate in an AUT research project which explores Occupational Therapists experiences of the PRPP in clinical practice here in Aotearoa New Zealand

Participation in this study will involve discussing your views, concerns, challenges and experiences of the PRPP in your practice through an individual interview with Wendy Burrows as the researcher. A focus group option is also offered for Māori Occupational Therapists.

This project is supervised by Professor Clare Hocking and Dr Christine Chapparo.

To find out more about the project and receive an information sheet, ask any questions and express your interest please email prppresearch@gmail.com

Thank you for considering this request and I look forward to hearing from you,

Wendy

Wendy Burrows NZROT

Appendix I: OTBNZ Campaign Overview

Hi Wendy,

Here is the email campaign overview for your research request. Because of the nature of the email service we use, these numbers aren't 100% accurate, but I've found them fairly useful still.

Total recipients – 1819

Total opens – 1386 (717 unique)

Not opened – 1090

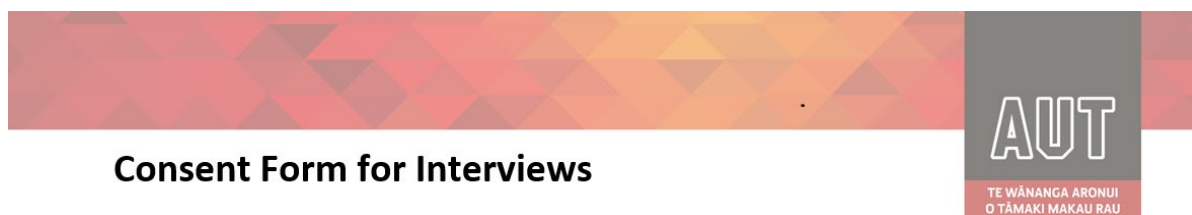
Undeliverable – 12

Kind Regards,

Tim Signal

Registration Officer Occupational Therapy Board of New Zealand

Appendix J: Consent Form for Interviews and Focus Groups Phase One



Consent Form for Interviews

Project title: The experiences of occupational therapists in Aotearoa New Zealand applying the Perceive, Recall, Plan, Perform System of Task Analysis (PRPP) into their practice

Project Supervisor: Professor Clare Hocking

Researcher: Wendy Burrows

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 18/07/2016.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Participant's signature:

Participant's name:

Participant's Contact Details:

.....
.....
.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 27/4/16
AUTEC Reference number Hocking1697_21062016

Note: The Participant should retain a copy of this form

Appendix K: Recruitment Email to OTBNZ Phase Two



Clinical Reasoning and the Perceive, Recall, Plan and Perform System (PRPP)

Registered Occupational Therapists who are trained in the PRPP Assessment are invited to participate in a study of how using this assessment influences their clinical and professional reasoning.

This research builds on Wendy's previous study which explored the experiences of PRPP trained occupational therapists applying the PRPP assessment in Aotearoa New Zealand.

The next stage of the research is focussed on occupational therapists' thinking i.e. what occupational therapists consider when they decide to use the PRPP assessment with a person, the conclusions they draw as they observe someone, what puzzles them, what they're confident about, how they report the results and the decisions they make about intervention based on the results.

The study aims to provide insights into how using the PRPP assessment influences occupational therapists' clinical reasoning and how an occupation-based assessment shapes occupational therapists' thinking, decision making and therapeutic actions.

Findings will be of interest to existing PRPP trained occupational therapists, those considering the training, funding agencies and the wider occupational therapy profession. It is anticipated the findings will also guide the content of future PRPP assessment courses to align with occupational therapists' practice realities.

Wendy is currently seeking volunteers to participate in this study – both those who participated in stage one and new volunteers for this part. To find out more about the project, ask any questions, receive an information sheet and to express your interest please email prppresearch@gmail.com.

This project is supervised by Professor Clare Hocking and Dr Christine Chapparo.

Thank you for considering this request and I look forward to hearing from you,

Ngā mihi nui

Wendy

Wendy Burrows NZROT

Indicative Questions for the Semi Structured Interviews

Project title: The experiences of occupational therapists in Aotearoa New Zealand applying the Perceive, Recall, Plan, Perform System of Task Analysis (PRPP) into their practice

Project Supervisor: Professor Clare Hocking

Researcher: Wendy Burrows

The questions are numbered in topic themes with possible probes and follow up questions bulleted under each topic.

1. Tell me about a client that you used the PRPP with after you completed your training?
 - Tell me what happened?
 - How did it turn out?
2. The PRPP assessment can be used in several ways for example; to guide your thinking, to use when talking to people, as an outcome measure: Can you tell me how you use it? Or don't use it?
 - Are there things that helped with that?
 - Things that hindered?
3. Have you used the PRPP assessment with clients of cultural affiliations other than your own? Can you give me some examples?
 - How did it turn out?
4. Can you think of a client or situation that using the PRPP didn't work out in your practice?
 - What happened?
 - What were the challenges?
- How do you feel about "being an occupational therapist" since you completed the PRPP course? Has anything changed for you?
- What's different?
5. The PRPP training is an intensive 5 days. Thinking on the course is there one thing you would change or which could have better prepared you for returning to your own practice?
 - Why?
6. Do you have any concerns about using the PRPP assessment in your work practice?
 - What are these?
 - Do you have any solutions to these?
7. Is there anything else you would like to tell me about how you experience applying the PRPP assessment?

Appendix M: Phase 1 Indicative Questions for the Focus Groups



TE WĀNANGA ARONUI
O TĀMAKI MAKĀU RAU

Indicative Questions for the Focus Group

Project title: The experiences of occupational therapists in Aotearoa New Zealand applying the Perceive, Recall, Plan, Perform System of Task Analysis (PRPP) into their practice

Project Supervisor: Professor Clare Hocking

Researcher: Wendy Burrows

It is planned that before any discussion on the research took place the group would be welcomed, thanked for participating and introductions made. An initial discussion around the purpose of the meeting would also take place so that a shared understanding within the group of the purpose was developed.

Topics would be introduced with aroha (care) to the group for discussions about rather than set questions being asked.

Topics will be related to the research question but guided by the group process and may include:

- The PRPP was developed from western worldview which is different from Māori worldview given these differences how does it fit for you?
 - As Māori occupational therapists?
 - For your clients?
- Considering Māori worldview and the underpinning theory of the PRPP assessment i.e. its base in occupational performance theory (Occupational Performance Model Australia), task analysis and information processing theories, do you see any connections or relationships between them?
- Thinking about the PRPP are there any aspects of it that are not culturally relevant / appropriate or suitable?
- Do you modify or think about the PRPP a bit differently than other OTs?
- Is there anything else you would like say about how your experiences of the PRPP?

Appendix N: Phase 2 Occupational Therapist Participant Consent Form



Occupational Therapist Participant Consent Form

9th March 2020

Project title: Adopting the Perceive, Recall, Plan and Perform System of Task Analysis (PRPP)
Assessment into practice in Aotearoa New Zealand: Influences on clinical reasoning.

Project Supervisor: Professor Clare Hocking **Researcher:** Wendy Burrows

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 3rd March 2020.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand I can choose whether or not I wish to make a video of an occupational therapy session and that if I agree this would involve Wendy Burrows contacting me and applying for and gaining ethical approval through my work organisation.
- ☐ I understand that if I choose to video a session, I would explain the research to the tangata whaiora /client, give them the information sheet and explain they have an option to participate or not. If they select to participate, I would gain their signed consent before a video recording is made.
- ☐ I understand that if I video a session the tangata whaiora /client would be given a choice to have a copy of the video recording.
- ☐ I understand that it is my choice as to whether or not I give Wendy Burrows access to the video recording and if I chose to give the video recording to her the video recording will be kept in a secure office at AUT for six years.
- ☐ I understand that if I video an occupational therapy session and choose not to give Wendy Burrows the video recording, then I would only keep the video recording until the interview with her and delete the video recording within one week after the interview.
- ☐ I understand that there is an option to agree to video recordings involving adult clients/tangata whaiora, but not children, being used for future educational purposes for occupational therapy students and qualified occupational therapists. If I decide to select this option, the tangata whaiora would also need to consent to the video recording being used for educational purposes

If you have chosen to make a video recording, please select one of the options below:

- ☐ I do not wish for the video recording to be used for future educational purposes for occupational therapy students and qualified occupational therapists
 - ☐ I give my consent for the video recording to be used for future educational purposes for occupational therapy students and qualified occupational therapists
- ☐ I understand I can choose as to whether a pseudonym or my real name is used in any future publication or presentation related to this research
- Please select one option below**
- ☐ I give my consent that a pseudonym be used in any future publication or presentation related to this research
 - ☐ I give my consent that my real name be used in any future publication or presentation related to this research

- ☐ I understand that notes will be taken during the interview and that it will also be audio-taped and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data analysis, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research **(please tick one)**: Yes ☐ No ☐

Participant's Signature:

Participant's Name:

Date

Participant's Contact Details:

Email.....

Phone.....

Approved by the Auckland University of Technology Ethics Committee 11th Dec 2019
AUTEC Reference number Hocking19441_11122019

Note: The Participant should retain a copy of this form.

Appendix O: Phase 2 Information Sheet and Consent Form for Tangata Whaiora Clients



Participant Information Sheet for Video Recording of Occupational Therapy Session

4/08/2020

Project Title

Adopting the Perceive, Recall, Plan and Perform System of Task Analysis (PRPP) Assessment into practice in Aotearoa New Zealand: Influences on clinical reasoning.

Kia ora,

My name is Wendy Burrows. I am an occupational therapist and researcher at AUT University in Auckland. My research explores the use of a relatively new occupational therapy assessment called the Perceive, Recall, Plan and Perform System of Task Analysis (PRPP) Assessment. I am interested to learn how occupational therapists' thinking and decision making is influenced by using the PRPP assessment. (Name of OT), who is the occupational therapist working with you, has volunteered to participate in this study by videoing a session with a client. This information sheet describes the purpose of the study, what is involved for clients, the risks and benefits and what happens afterwards.

In addition to being a researcher, I also am a partner in Chameleon Courses the education provider of Perceive, Recall, Plan and Perform System of Task Analysis (PRPP) Assessment Courses here in New Zealand. Dr Christine Chapparo who is second supervisor for this research is one of the original authors of the PRPP assessment and teaches the PRPP assessment internationally to occupational therapists.

As you consider whether to agree to one of your sessions being videoed, it is important that you understand taking part in this project is entirely voluntary i.e. your choice. There is no obligation to participate and you can withdraw at any time up to two days after the video is filmed without needing to give any reasons. Involvement in this study or declining to be involved will not affect any other care or services that you or your family are receiving.

If you agree to take part in this study, you will need to sign the consent form on the last page. You, (Name of OT) and I will have a copy of the signed consent form.

This study has been approved by AUT Ethics Committee (AUTC) and name of OT's work place have been consulted and agreed to the research taking place (date of approval).

Purpose of this study

This study is focused on developing understandings of occupational therapists' thinking, reasoning and decision-making processes as they apply the PRPP assessment. It includes learning about the kind of thinking occupational therapists use as they choose the PRPP assessment, set up and do the assessment, consider and talk about the results and plan any interventions that follow the assessment.

It is the intention that the study findings will help future and existing occupational therapists to learn and develop thinking strategies and decisions-making skills for their practice. The findings will also shape future PRPP training courses and workshops so that skills occupational therapists need for using the assessment can be included in the training.

How was I identified and why am I being invited to participate in this research?

.... (Name of OT) has volunteered to be involved in the study and he/she plans to or has used the PRPP assessment with you and he/she has invited you to take part.

What will happen in this research?

When you take part in an occupational therapy session with (Name of OT) he/she will video the session. The session to be videoed might be the PRPP assessment, or the therapist talking about the assessment with you, or an intervention session. The video will be viewed by (Name of OT) to help her/him remember the thinking and decisions he/she made.

After the session (Name of OT) will record his/her thinking and I will interview him/her to learn about his /her thinking and decision-making from the occupational therapy session.

What will happen to the video recording?

You can request a copy of the video recording for your own record. If you choose this option a copy on a memory stick will be made for you. If you and the therapist both agree, the video recording will be sent to me to help her prepare for

the interview. You do not have to give permission for this to happen. If you do give permission for me to see the video, it will be stored in a secure office at AUT for six years and then deleted.

If you chose not to share the recording with me it will be deleted by(Name of OT) one week after the interview. If you are comfortable to share the video more broadly, you can also give permission for it to be used for future education purposes with occupational therapy students and/or qualified occupational therapists. You can freely choose whether or not you give this consent without any consequences.

What are the possible discomforts risks and benefits?

Being filmed while doing something can add extra stress and you may say or do things that you would prefer were not filmed. If you feel uncomfortable at any time during the occupational therapy session, you can ask for the video recording to be stopped and filming would only continue if you agreed.

It is not the intention that involvement in this study will cause any distress or harm. If you do have any concerns, you can withdraw any time before or during the occupational therapy session and up to two days after the session.

There are no immediate benefits for you as a result of taking part in this study. The likely benefits will be for the occupational therapy profession and future clients receiving PRPP assessments from occupational therapists, since this research adds to the knowledge concerning thinking and decision-making skills required for occupational therapists' assessment practice.

How do I agree to take part in this research?

By signing the consent form below.

You are encouraged to ask(Name of OT) any questions you may have before you sign the consent form.

How will my privacy be protected?

The video recordings will only be accessed by(Name of OT) and, with your permission, by me and my supervisors Professor Clare Hocking, AUT University and Associate Professor Christine Chapparo Sydney University. None of your personal or medical information will be shared with us. There will be no identifiable information within the PhD thesis or any related future publications.

If you agree that the video can be used for teaching purposes, a false name will be used, however, since you are visible in the video your confidentiality cannot be maintained.

What are the costs of participating in this research?

There is no financial cost to your being involved, only your time reading this information sheet and discussing the study with(Name of OT) and to sign the consent form.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Clare Hocking by email: clare.hocking@aut.ac.nz or phone: 09 921 9162

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTC, Kate O'Connor, ethics@aut.ac.nz , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details: Wendy Burrows email: prppresearch@gmail.com

Project Supervisor Contact Details: Professor Clare Hocking: clare.hocking@aut.ac.nz or ph:09 921 916

Dr Christine Chapparo: chris.chapparo@sydney.edu.au

Thank you for considering taking part in this research,

Wendy

Wendy Burrows AUT researcher

Appendix P: Phase 2 Information sheet for Parent /Legal Guardian



4/08/2020

Project Title

Adopting the Perceive, Recall, Plan and Perform System of Task Analysis (PRPP) Assessment into practice in Aotearoa New Zealand: Influences on clinical reasoning.

Kia ora,

My name is Wendy Burrows. I am an occupational therapist and researcher at AUT University in Auckland. My research explores the use of a relatively new occupational therapy assessment called the Perceive, Recall, Plan and Perform System of Task Analysis (PRPP) Assessment. One of my supervisors (Dr. Chris Chapparo) is one of the developers of the PRPP, and I am a partner in Chameleon Courses, an educational provider through which occupational therapists in New Zealand are trained to use the PRPP.

I am interested to learn about occupational therapists' thinking and choices as they use the PRPP assessment. Your occupational therapist..... has agreed to take part in this study. As part of the research he/she is asking people if they would like to take part.

This information sheet explains the purpose of the study, what your child/young person's involvement would be, the risks and benefits and what happens afterwards.

Your giving permission for your child/young person to take part in this project is entirely voluntary i.e. your choice with no obligation to participate and you can withdraw your permission at any time up to two days after the video is filmed without needing to give any reason. Your child/young person's involvement in this study is your choice and will not affect any other care or services that you or your family are receiving. The research will be explained by(Name of OT) to your child/young person and they will need to give their consent/ assent to take part.

If you and your child agree to take part in this study, you will need to sign the consent form on the last page on behalf of your child/young person. You,(Name of OT) and I will have a copy of the signed consent form.

This study has been approved by AUT Ethics Committee (AUTEC) and by (details of OT's work place agreement for the research)

Purpose of this study

This study is focused on developing understandings of occupational therapists' thinking, reasoning and decision-making processes as they apply the PRPP assessment. It

includes learning about the kind of thinking occupational therapists use as they choose the PRPP assessment, set up and do the assessment, consider and talk about the results and plan any interventions that follow the assessment.

It is the intention that the study findings will help future and existing occupational therapists to learn and develop thinking strategies and decisions-making skills for their practice. The findings will also shape future PRPP training courses and workshops so that skills occupational therapists need for using the assessment can be included in the training.

How was I identified and why am I being invited to participate in this research?

.....(Name of OT) has volunteered to be involved in the study and he/she plans to or has used the PRPP assessment with you and he/she has invited you to take part.

What will happen in this research?

When your child/young person takes part in an occupational therapy session with.....(Name of OT) he/she will video the session. The session to be videoed might be the PRPP assessment, or the therapist talking about the assessment with you, or an intervention session. The video will be viewed by(Name of OT) to help her/him remember the thinking and decisions he/she made.

After the session(Name of OT) will record his/her thinking. I will interview him/her to learn about his /her thinking and decision-making from the occupational therapy session.

What will happen to the video recording?

You can request a copy of the video recording for your own record. If you choose this option a copy on a memory stick will be made for you. If you and the therapist both agree, the video recording will be sent to me to help me prepare for the interview. You do not have to give permission for this to happen. If you do give permission for me to see the video, it will be stored in a secure office at AUT for six years and then deleted. If you choose not to share the recording with me it will be deleted by(Name of OT) one week after the interview.

What are the possible discomforts risks and benefits?

Being filmed while doing something can add extra stress and you or your child/young person may say or do things that you would prefer were not filmed. If you feel uncomfortable at any time during the occupational therapy session, you can ask for the video recording to be stopped and filming would only continue if you agreed.

It is not the intention that involvement in this study will cause any distress or harm for you or your child/young person. If you do have any concerns, you can withdraw any time before or during the occupational therapy session and up to two days after the session.

There are no immediate benefits for you as a result of taking part in this study. The likely benefits will be for the occupational therapy profession and future clients receiving PRPP assessments from occupational therapists, since this research adds to the knowledge concerning thinking and decision-making skills required for occupational therapists' assessment practice.

How do I agree to take part in this research?

By signing the consent form below.

You are encouraged to ask.....(Name of OT) any questions you may have before you sign the consent form

How will my privacy be protected?

The video recordings will only be accessed by(Name of OT) and with your permission by me and my supervisors Professor Clare Hocking, AUT University and Associate Professor Christine Chapparo Sydney University. None of your child/young person's personal or medical information will be shared with us. There will be no identifiable information within the PhD thesis or any related future publications.

What are the costs of participating in this research?

There is no financial cost to your being involved, only your time for reading this information sheet and discussing the study with(Name of OT) and to sign the consent form.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Clare Hocking by email: clare.hocking@aut.ac.nz or phone: 09 921 9162

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTC, Kate O'Connor, ethics@aut.ac.nz , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details: Wendy Burrows email: prppresearch@gmail.com

Project Supervisor Contact Details: Professor Clare Hocking: clare.hocking@aut.ac.nz or ph:09 921 916

Dr Christine Chapparo: chris.chapparo@sydney.edu.au

Thank you for considering taking part in this research,

Wendy Wendy Burrows AUT researcher



Consent and Release Form

4th August 2020

Project title: Adopting the Perceive, Recall, Plan and Perform System of Task Analysis (PRPP) Assessment into practice in Aotearoa New Zealand: Influences on clinical reasoning.

Project Supervisor: Professor Clare Hocking

Researcher: Wendy Burrows

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time up to two days after the video recording without being disadvantaged in any way.
- ☐ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the interview with (name of OT) has occurred removal data may not be possible.
- ☐ I understand that I can choose to have a copy or not of the video recording
Please select by ticking
 - ☐ I would like to be given a copy of the video recording
 - ☐ I do not want a copy of the video recording
- ☐ I understand that it is my choice whether the video recording is either used solely by (name of OT) occupational therapist to assist him/her review his/her thinking and reasoning from the occupational therapy session or whether I choose for it to be given to Wendy Burrows researcher at AUT. If I select solely for (name of OT) Occupational therapist to use the video recording, then the video recording will be destroyed one week after (name of practitioner) has been interviewed by Wendy Burrows. If I choose and (name of OT) consents to giving the video recording to Wendy Burrows, then the video will be stored securely at AUT for a period of 6 years and then destroyed.
Please select by ticking one or both circles
 - ☐ I agree to (name of OT) using the video recording
 - ☐ I agree to Wendy Burrows Researcher AUT being given the video recording
- ☐ I understand that I can choose for the video recording to be used for education purposes with occupational therapists and/or qualified occupational therapists.
Only tick if in agreement
 - ☐ I agree to the video recording being used for education purposes with occupational therapists and/or qualified occupational therapists.
- ☐ I agree to take part in this research.

Participant's Signature :

Participant's Name :

Date:

Appendix Q: Phase 2 Information Sheet and Assent Form for Children 4-10 Years



Information Sheet and Assent Form for Children (4-10 years old)



Hello, my name is Wendy Burrows and I am doing some research at AUT University in Auckland which..... (name of OT participant) is helping me with.

I am interested in learning how occupational therapists make choices about what they ask children like you to do and what they think about as they play and work with children.

We would like to video you with (name of OT participant) as you play and work together.



Once the video has been made (name of OT participant) and I will watch it and I will ask (name of OT participant) how he / she made some choices.

I will be videoing other children, grown-ups and occupational therapists and in the end, I will write a paper that includes everyone's ideas

You do not have to be in my study and it's OK to change your mind later.

You can say no to being in the study even if your parent has said yes

Your decision will not affect your family or the things you and(name of OT participant) do together.

How do you feel about doing this? (Please circle)



HAPPY



NOT SURE



WORRIED

Appendix R: Phase 2 Information Sheet and Consent Form for Young Persons



Young Person (11-16 years) Information Sheet for Video Recording of Occupational Therapy Session

4/08/2020

Project Title

Adopting the Perceive, Recall, Plan and Perform System of Task Analysis (PRPP) Assessment into practice in Aotearoa New Zealand: Influences on clinical reasoning.

Kia ora, Hello,

My name is Wendy Burrows. I am an occupational therapist and researcher at AUT University in Auckland. My research explores the use of a relatively new occupational therapy assessment called the Perceive, Recall, Plan and Perform System of Task Analysis (PRPP) Assessment. I am interested to learn about occupational therapists' thinking and choices they make as they use the PRPP assessment. Your occupational therapist, has agreed to take part in this study. As part of the research he/she is asking people if they would like to take part.

This information sheet explains what you will be asked to do in the study, the benefits and risks, and what will happen afterwards. It is your choice and if you don't want to, you don't have to give a reason. Your decision will not affect anyone else. You can also change your mind and pull out later.

If you have questions, you can ask (Name of OT). You do not have to decide today. It's OK to talk about the study with other people before you decide.

If you agree to take part in this study, you will need to sign the Consent Form. It's on the last page. You will be given a copy to keep.

Purpose of this study

This study is to understand how occupational therapists' think and the choices they make when use the PRPP assessment. Things like what thinking occupational therapists use as they set up and do the assessment, talk about the results and plan sessions that follow the assessment.

It is hoped that the study will help future and existing occupational therapists to learn thinking strategies and decisions-making skills for their practice.

How was I identified and why am I being invited to participate in this research?

..... (Name of OT) has agreed to take part in the research and he/she plans to or has used the PRPP assessment with you.

What will happen in this research?

When you take part in an occupational therapy session with (Name of OT), he/she would film the session. At the end of the session the video will be used by (Name of OT) to help her/him to remember the thinking and choices he/she made.

After the session (Name of OT) will write down his/her thinking and talk with me about that.

What will happen to the video recording?

You can ask for a copy of the video recording if you want one. It will be put on a memory stick. You and (Name of OT) will be asked if it is OK for a copy to be sent to me before I meet with (Name of OT). The video will only be sent to me if both of you agree. It will be kept in a locked office at AUT and deleted in six years time. If you chose not to share the video with me it will be deleted by (Name of OT) one week after she/he has talked with me.

What are the possible risks and benefits to doing this research?

Being filmed while doing something can feel uncomfortable and you may say or do things that you would prefer were not filmed. If you feel uncomfortable during the filming, you can ask for the camera to be stopped.

Taking part in this study should not cause any distress or harm, but if you are worried you can ask to stop and pull out at any time before or during the occupational therapy session and up to two days after the session.

You may not benefit from being in this study. The possible benefits will be for occupational therapists to learn about doing the assessment and for people, like you, who do a PRPP assessment with an occupational therapist in the future.

How do I agree to take part in this research?

By signing the consent form below.

You are encouraged to ask(Name of OT) any questions you may have before you sign the consent form. Your taking part in this research is your choice and you can say you do not want to be involved even if your parent or guardian has said yes.

How will my privacy be protected?

The video recordings will only be seen by(Name of OT) and, with your agreement, by me and my supervisors Professor Clare Hocking AUT University and Associate Professor Christine Chapparo Sydney University. Only the signed consent form will be sent to me and none of your personal information will be shared with me or my supervisors.

What are the costs of taking part in this research?

There is no cost to you, only your time for reading this information sheet and talking about the study with(Name of OT) and signing the consent form.

Who do I contact if I have any worries or want some more information about this research?

Any worries about this research, let Clare Hocking supervisor know by email: clare.hocking@aut.ac.nz or phone: 09 921 9162 or Wendy Burrows researcher email: prppresearch@gmail.com

Thank you for thinking about taking part in this research,

Wendy

Wendy Burrows AUT researcher



Consent Form

4th August 2020

Project title: Adopting the Perceive, Recall, Plan and Perform System of Task Analysis (PRPP) Assessment into practice in Aotearoa New Zealand: Influences on clinical reasoning.

Project Supervisor: Professor Clare Hocking

Researcher: Wendy Burrows

- ☐ I have read or had read to me and I understand the participant information sheet dated dd mmmm yyyy.
- ☐ I have had time to ask questions and to have questions answered.
- ☐ I have had sufficient time to choose whether to take part in this study or not
- ☐ I understand that taking part in this study is voluntary (my choice) and that I may pull out from the study at any time up to two days after the video recording without this affecting me in any way.
- ☐ I understand that I can choose to have a copy or not of the video recording
Please select by ticking
- ☐ I would like to be given a copy of the video recording
- ☐ I do not want a copy of the video recording
- ☐ I understand that it is my choice whether the video recording is either used only by (name of practitioner) occupational therapist to help him/her review his/her actions and decisions from the occupational therapy session or whether I chose for it to be given to Wendy Burrows researcher at AUT. If I select only for (name of practitioner) Occupational therapist to use the video recording, then the video recording will be deleted one week after (name of practitioner) has talked with Wendy Burrows. If I choose and (name of practitioner) agrees to giving the video recording to Wendy Burrows, then the video will be kept in a locked office at AUT for a period of 6 years and then deleted.
Please select by ticking one or both circles
- ☐ I agree to (name of practitioner) using the video recording
- ☐ I agree to Wendy Burrows Researcher AUT being given the video recording
- ☐ I agree to take part in this research.

Participant's Signature :

Participant's Name :

Date:

Declaration by occupational therapy participant

I have given a verbal explanation of the research project to the participant and have answered the questions the participant has about it.

I believe that the participant understands the study and has given informed consent to participate

Signature :

Name:

Date:

Appendix S: Phase 2 Reflective Log

PRPP Assessment Reflective Log

Thank you agreeing to keep a reflective log. The aim is to capture your thoughts, decisions and actions related to the PRPP assessment processes with a specific client/tangata whaiora.

If you have chosen to audio record your responses, please use the questions below as a prompt. If you plan to type/write your reflections on the form, answer directly below each question.

This log is for client/ tangata whaiora: One ☐ Two ☐

The questions outlined below are only a prompt and you are encouraged to add additional ideas and information. The log is divided into sections, however, feel free to include further sections as needed to describe the assessment processes you used.

Before you used the PRPP assessment with this client/tangata whaiora

- At the outset of seeing this person, how did you identify the occupational performance issues to address? And what were these?
- What were all the assessment options available to you?
- What influenced your choice to use the PRPP assessment with this person?
(Consider influences relating to yourself as the therapist, the person, practice context, timeframes, resources, features of the PRPP assessment itself)
- If you selected to use other formal or informal assessments as well, what influenced this choice?
- Please comment on any advantages or barriers that you weighed up as you chose the PRPP assessment
- Please record how you explained the PRPP assessment process to the client/tangata whaiora/whanau (family)/significant other/s
- Please record details of the conversation you had with the client/tangata whaiora/ whanau (family)/ significant other/s to decide which tasks to use for the PRPP assessment...
- Please comment on your familiarity with the task/s selected, including any cultural considerations, and your response to using a familiar or unfamiliar task ...
- What did you consider when setting up the PRPP assessment, your choice of where to do it and any organising of resources you needed?

During the PRPP assessment

- Please talk me through setting up the assessment...
- Where did you position yourself, the person and other people that were present to begin the assessment? What did you consider?
- As the assessment progressed did you change the setup of the assessment or reposition yourself or the person or other people in any way? What prompted that? How did it work out?

- Please describe any support you gave to the client/tangata whaiora during the assessment.
(Why was it needed? Did the support you provided help? Did you consider doing something that you didn't action?)
- Please talk me through recording your observations.
(How did you do this? When? Where? How visible was this to the client/tangata whaiora? Were they involved in that at all?)
- Please comment on whether the assessment went to plan? And why or why not?
- If you scored the PRPP assessment, when and where did you do this? Please comment on observations and interpretations that influenced your scores *(think about those you were confident or unsure of)* ...
- If you consulted with anyone else as you weighed up assessment scores and/or results, please tell me about how that went ...

After the PRPP assessment

- Please comment on the sense you made of the assessment results
- Please describe sharing the PRPP assessment results with the client/tangata whaiora/ whanau (family)/ team members
- Please talk me through the next steps /actions you took after completing the PRPP assessment...
- What verbal or non-verbal feedback did you get from the person or their whanau or team members?
- Please comment on how using the PRPP assessment influenced goal setting / intervention planning or intervention stages of occupational therapy for this client/tangata whaiora?

Thank you for taking the time to complete this reflective log. Please can you email the written/typed or audio recording of the log to prppresearch@gmail.com and I will contact you to arrange a time for an interview to discuss further your thoughts, ideas and thinking you use with the PRPP assessment

Ngā mihi nui

Wendy

Wendy Burrows
Researcher

Appendix T: Phase 2 Interview Guide

Indicative Questions for the Semi Structured Interviews

Questions are numbered in topic themes with possible probes and follow up questions bulleted under each topic.

1. Tell me about choosing to do the PRPP assessment with this client/tangata whaiora?

- What did you consider?
- What influenced your choice to use the PRPP assessment with this person?

(Consider influences relating to yourself as the therapist, the person, practice context, timeframes, resources, features of the PRPP assessment itself) Please comment on any advantages or barriers that you weighed up as you chose the PRPP assessment

- Was there anything about the client/tangata whaiora's health condition or situation which influenced your choice?
- In what way did you view the PRPP assessment as suitable?
- What were all the assessment options available to you?
- Did you select other formal or informal assessments as well, what influenced this choice?

1. What did you anticipate would happen by doing the PRPP assessment with this client/tangata whaiora?

- What outcome/s were you aiming to achieve?
- How did you envisage your therapeutic plan might be influenced by using this assessment?

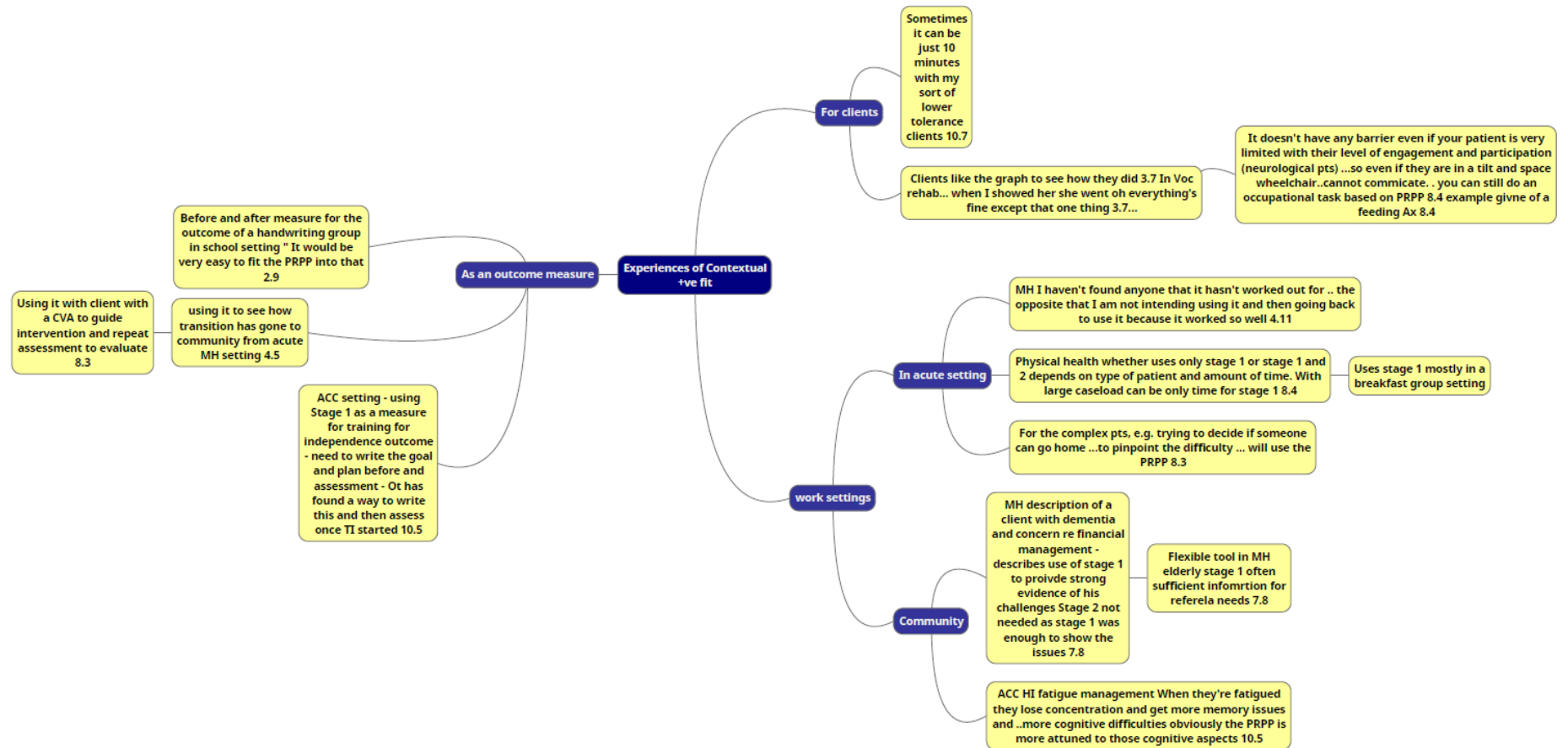
2. What was going on in your mind when you set up the PRPP assessment with this client/tangata whaiora?

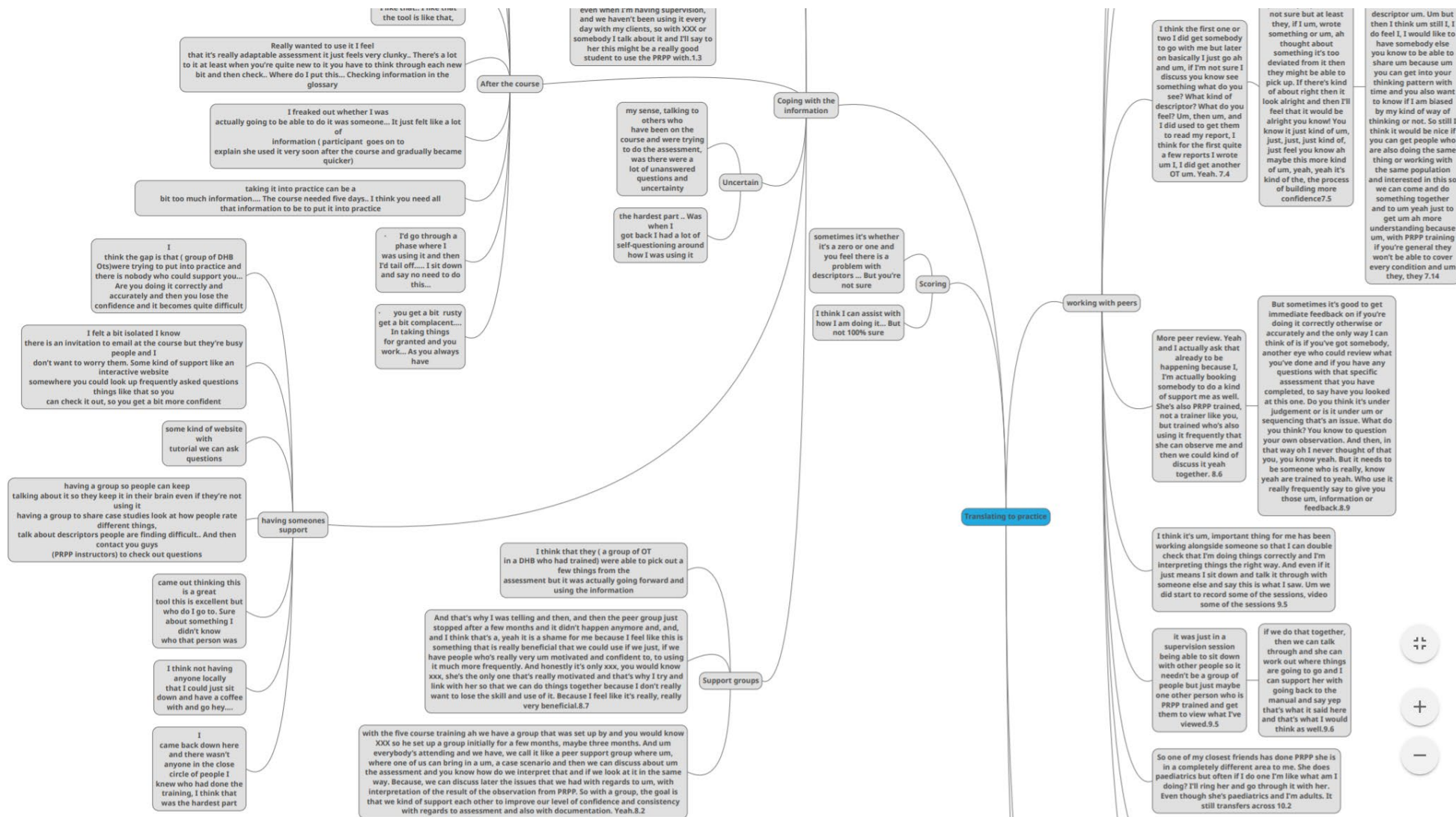
- Did you have any doubts or concerns?
- How confident were you using the assessment for this client/tangata whaiora?
- How did you explain the PRPP assessment process to the client/tangata whaiora/whanau (family)/significant other/s
- what conversation you had with the client/tangata whaiora/ whanau (family)/ significant other/s to decide which tasks to use for the PRPP assessment...
- How did you identify the occupational performance issues to address? And what were these?

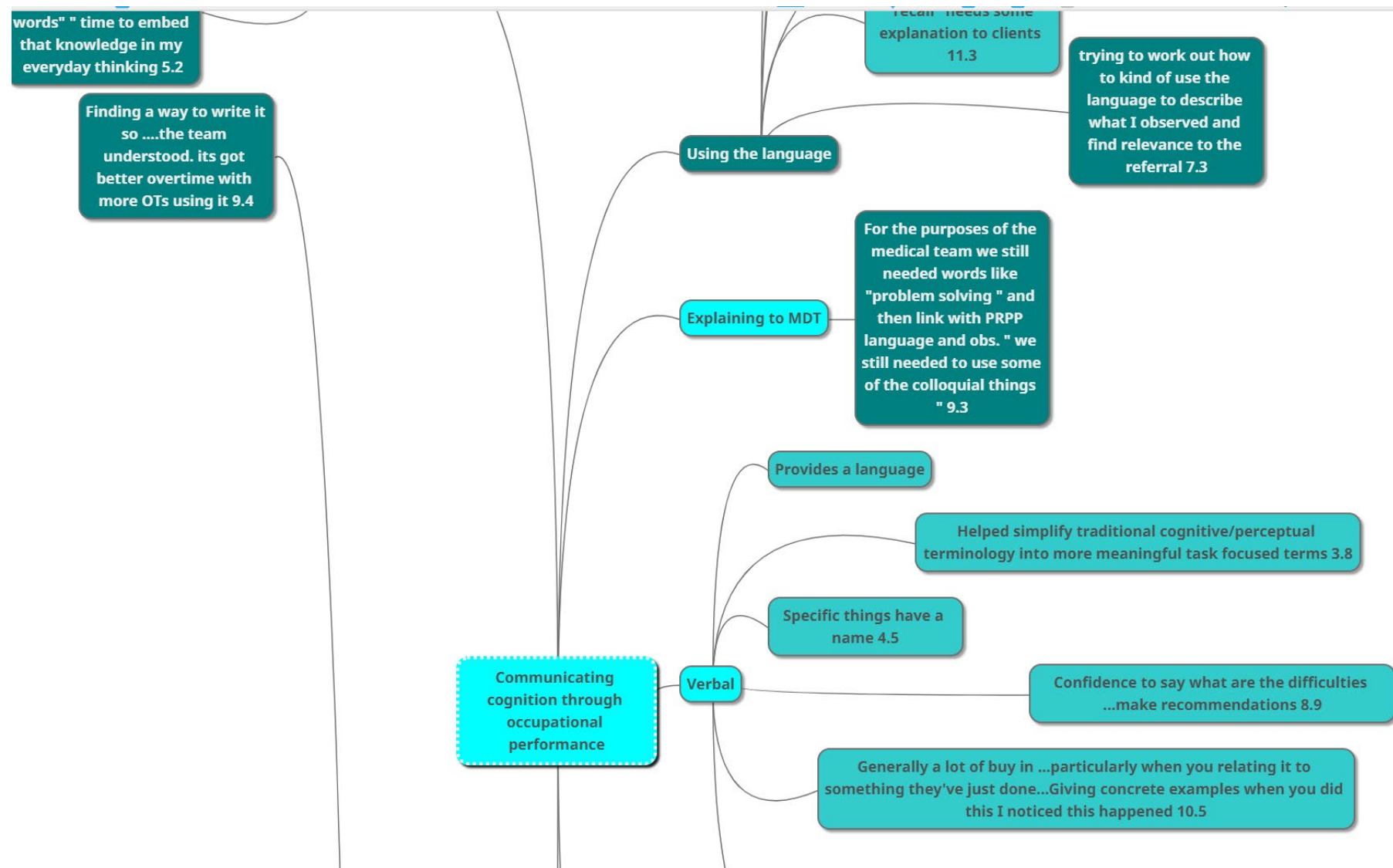
- Please comment on your familiarity with the task/s selected, including any cultural considerations, and your response to using a familiar or unfamiliar task ...
 - What did you consider when setting up the PRPP assessment, your choice of where to do it and any organising of resources you needed?
3. What things about this assessment did you feel totally comfortable with?
- Were there things you anticipated would go well?
 - Any surprises?
 - Where did you position yourself, the person and other people that were present to begin the assessment? What did you consider?
 - As the assessment progressed did you change the setup of the assessment or reposition yourself or the person or other people in any way? What prompted that? How did it work out?
 - During the assessment did anything occur that you hadn't expected? Or things your expected that did not occur? Please comment on whether the assessment went to plan? And why or why not?
4. Did anything hinder the assessment process with this client/tangata whaiora?
- What happened?
 - What were the challenges?
 - If you scored the PRPP assessment, when and where did you do this? Please comment on observations and interpretations that influenced your scores (*think about those you were confident or unsure of*) ...
5. What sense did you make of the assessment results for this client/tangata whaiora?
- Did the results tell you anything you hadn't expected?
 - Was anything clearer from the results?
6. Tell me about reporting the assessment results?
- How did you go about reporting?
 - To whom?
 - Is that what you usually do?
 - What did you consider when reporting?
7. On completion of the PRPP assessment, what were the next steps you took?
8. In what way did the PRPP assessment results influence goals that were set with the client/tangata whaiora?
- Can you give any examples?

- Please comment on how using the PRPP assessment influenced goal setting / intervention planning or intervention stages of occupational therapy for this client/tangata whaiora?
9. The first day of the PRPP assessment training includes content about the Occupational Performance Model Australia (OPM(A)). Can you outline for me what you remember about that model and how it influences your practice thinking generally?
- Can you recall how it influenced the choices you made for this client?
10. Is there anything else that you haven't talked about that you contemplated before, during or after the assessment process?

Appendix U: Examples of Phase 1 Mind Maps







Appendix V: Examples of Phase 2 Mind Maps

