

**OCCUPATIONAL THERAPY LEVEL II FIELDWORK:  
EFFECTIVENESS IN PREPARING STUDENTS  
FOR ENTRY-LEVEL PRACTICE  
IN THE REHAB SETTING**

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**A Dissertation  
Submitted to  
the Temple University Graduate Board**

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**In Partial Fulfillment  
of the Requirements for the Degree  
DOCTOR OF PHILOSOPHY**

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## ABSTRACT

Occupational therapy (OT) is a rehabilitation profession in which licensed therapists facilitate functional independence, to the greatest extent possible, of an individual with disabilities.

Education for OT is at the Master's level consisting of a two-year academic program followed by clinical Fieldwork II, a required 12-week internship under the mentorship of a licensed therapist with at least one year's experience. In light of the fact that clinical fieldwork sites differ in size and resources, and clinical instructors may have only one year's experience and no formal training in instruction, there is great variability in students' clinical fieldwork experiences.

The purpose of this study was to determine novice rehab OT's perceptions of four key factors in clinical education: First, skill areas in which they felt most prepared; second, areas perceived as obstacles in adjustment to entry-level practice; third, essential elements of an ideal clinical learning environment; and fourth, the need for credentialing clinical instructors. Participants were 1-3 years post rehab fieldwork with first job in rehab. An online survey (N=45) and audiotaped interviews (N=9) were utilized to collect data on the perceptions of new OT's on Fieldwork II experiences. Interviewees represented a convenience sample independent of survey participants. Most participants reported feeling prepared to perform basic clinical skills, communicate on interdisciplinary teams and seek mentorship in the workplace. Less proficiency was perceived in the areas of patient/family communication, and coping with reality shock (adjustment to real life practice). Over half of the participants felt that there should be some kind of mandatory credentialing for clinical instructors. There was consensus among OT's regarding the ideal Fieldwork II setting which included well-trained instructors, availability for onsite learning and a well-equipped clinical site.

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In memory of my dear parents, Sarah and Carl Shuster (z"l) who, because of the ravages of war were unable to pursue higher education, but whose wisdom far surpassed any advanced degree.

Rosalyn Shuster Lipsitt, M.H.L., OTR/L

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## CHAPTER 1 INTRODUCTION

### *Introduction*

Occupational therapy is a rehabilitation profession in which licensed therapists facilitate an individual's return to functional independence, to the greatest extent possible, whether the disability was incurred via injury, mental or physical illness, or from birth. The intervention of the occupational therapist (OT) is "functional activity". As a result of assessing an individual's assets, liabilities and goals, and interviewing the patient and/or his caregivers, and in conjunction with activity analysis, the OT, collaboratively with the client, sets goals and chooses therapeutic interventions based on the client's needs and interests. These interventions include functional activities relating to self-care, such as bathing and dressing, caring for others, household tasks, mobility at home and in the community, education, work and leisure. The goal of these interventions is the client's "...engagement in occupation to support participation in context or contexts" (AOTA, 2002, p. 609). The aforementioned quote reflects the foundation, domain and process of the OT profession.

The education and training for OT's is at the master's level for entry into practice. An OT program typically consists of two years of academics and six months of post academic fieldwork. This fieldwork consists of two, three-month, full-time internships at two different settings. The post-academic fieldwork is referred to as Fieldwork II. During the academic program itself, students experience one day per week, for 6 or 8 weeks, depending on the program, learning in a clinical setting, under a licensed OT. This is referred to as Fieldwork I. Requirements for both Level I and Level II Fieldwork

are established by the Accreditation Council for Occupational Therapy Education, the profession's national association which establishes the program essentials, and grants accreditation to qualified occupational therapy programs in the United States (AOTA, 2003). This study focused on post-academic clinical fieldwork, Fieldwork II.

The primary purpose of clinical Fieldwork II, according to the Accreditation Council Standards (2003), is to provide students the opportunity to apply, in the field, what they have learned in the academic setting. The goal is to develop satisfactory entry-level clinical skills under the supervision of a registered OT. Such an OT is one who has passed the national registration exam, is licensed by the state, and has at least one year of clinical experience. In addition, the clinical site is required to provide students with the opportunity to work with professionals in other disciplines, and to prepare students to work in a constantly changing health care service delivery system. Students' learning experiences during this phase of their education are vitally important, as the student, at the conclusion of these clinical rotations, is required to pass a Fieldwork II performance evaluation. Passing this evaluation is a prerequisite for taking the national registration exam, mandatory for licensure by the state.

Supervision of the Fieldwork II student, typically, is carried out by a licensed OT who has had at least one year of clinical experience (Accreditation Council for Occupational Therapy Education, 2003). In traditional settings, both the student and the clinical instructor are on site, during business hours, five days a week. In atypical, or non-traditional settings, there may be no OT on site. When this is the case, the Fieldwork II student may be supervised by a licensed and registered OT, a minimum of six hours a week, with the OT available by telephone during work hours.

The accreditation standards, as described, allow for a myriad of possible fieldwork experiences for OT students. Aside from the broad spectrum of practice areas a student may be exposed to, such as psychiatric or pediatric practice, students may have a wide range of supervisory experiences as well. Student “A”, for example, may be placed in a non-traditional site, such as adult day care or homeless shelter, with no OT on site. Student “B” may be in a traditional rehab clinic with an OT supervisor having only one year’s experience as a professional; student “C” may well be in an established school setting with a master clinician, with five or 10 years experience as a supervisor and a clinician. In addition to the above variations, it is not uncommon that some therapists may supervise two students at a time, or share supervision for one student. All of the above examples reflect the variability of Level II experiences.

What is the result of this complex training system? What is known from the research literature on students’ perceptions of the fieldwork experience, and reports from the academic fieldwork coordinators who assign students to clinical sites, troubleshoot potential problems, and review students’ evaluations of the fieldwork experience, is that there is a great variability in the quality and quantity of clinical instruction as well as great variability in the physical and human resources of clinical sites across the system.

### *Purpose and Significance*

The purpose of this study is to examine four key areas related to the effectiveness of Fieldwork II and novice OT’s perceived preparedness for practice. First, via survey and interview, to determine the skill areas in which they felt most prepared; second, to determine which areas remain as obstacles to entry-level practice; third, to explore novice

therapists' perceptions as to the essential elements of an ideal clinical learning environment; and fourth, whether or not credentialing should be mandatory for clinical instructors (CI's). Moreover, limiting the study to rehab OT's who had a Level II Fieldwork in rehab assists in attaining a more accurate picture of Fieldwork II effectiveness in this domain of practice.

Eliciting survey responses and interviewing novice therapists, who are 1-3 years out of their respective educational programs, will enable those in the educational arm of the profession to improve Fieldwork II education by identifying areas of didactic learning which need to be addressed. In addition, information gained from informants may contribute to improvements in clinical education, such as determining which clinical skills need to be more adequately addressed, as well as which characteristics of clinical sites are most conducive to learning. Improving clinical education will not only benefit Fieldwork II students, but will also ultimately serve to improve the care of clients entrusted to those in the profession, as is the profession's ethical imperative (American Occupational Therapy Association, 2000). The following questions were addressed by the study:

Based on the perceptions of novice rehab OT's:

1. For which areas of practice do they feel most prepared?
2. Which skill areas remain as obstacles in adjustment to entry-level practice?
3. What are the essential elements of an ideal clinical learning environment?
4. Should credentialing for clinical instructors be mandatory?

## CHAPTER 2 REVIEW OF THE LITERATURE

### *Scope of Literature Search*

In consideration of the fact that the purpose of fieldwork education is to "... prepare students to become competent, entry-level generalists who can function and thrive in a rapidly changing and dynamic health and human service delivery system" (Costa, 2004, p.3), it follows that a determination should be made as to whether clinical fieldwork does, indeed, prepare students for entry-level practice. A review of the literature was conducted to explore the scope, content and results of research related to the perspectives of novice occupational therapists on their preparation for the professional work environment.

A search of the Cumulative Index to Nursing & Allied Health Literature (CINAHL), Medline and ERIC data bases was conducted to review relevant studies and articles published between 1982 and 2006. The search yielded very few studies related to effectiveness of Fieldwork II as preparatory for entry-level practice, therefore, the search was expanded to include current literature in related fields of practice, namely, medicine and nursing, to determine relevant issues and their similarity to concerns about OT training. Recent studies of medical interns, residents, and novice nurses were found which revealed those novices' perspectives on the effectiveness of their clinical training.

Given that physicians and nurses outnumber occupational therapists, and that the medical profession has more academic and monetary resources to design and carry out research, it is not surprising that the majority of studies and articles focusing on students' perceptions of their clinical training reflect medical internship, residency or nursing

clinical rotation experiences. Despite this, less than thirty articles combined were found within the professional literature of medicine and nursing, which related to professionals' perspectives on their clinical training. Within these health professions, both positive and negative aspects of that training were revealed, some of which were common to all the new professionals, including OT's. It must be noted that although the articles chosen for review discuss professionals' perceptions of their entry-level skills, most participants do not associate or evaluate their professional skills directly with aspects of their clinical training.

#### *Common Challenges Among Health Care Disciplines*

An analysis and synthesis of studies in the health care literature, examining the perspectives of novice professionals as to their preparedness for practice, revealed variability in perceptions of competence related to clinical skills, both among and within the health professions. Additionally, it was noted that novice health care practitioners have several challenges in common. These challenges in addition to the clinical skills may be grouped under four domains or concerns. The first, *communication*, includes interdisciplinary, intradisciplinary, patient/family communication, which includes issues of death and dying, as well as management of subordinates. The second relates to *conflicts of values*, that is, having to make sense of academic learning versus "real life" practice. The third includes *time management and organizational issues*, such as adjustment to productivity demands. The fourth issue is coping with a *perceived lack of mentoring opportunities* in the workplace for new professionals. These concerns are significant across the healthcare disciplines, and will be specifically addressed within the

discussion of the literature of each profession. This review begins with physicians' perspectives.

*Novice Perspectives: The Medical Profession*

Much of the research on new medical practitioners focused on clinical skills and practice issues specific to physicians, such as managing orthopedic diagnoses, gynecological practice (Roberts, Starr, & DeWitt, 2002), urgent or critical care issues (Bowen & Ball, 2003), and pediatric training (Liebelt, Daniels, Farrell, & Myers, 1993) among others. Generally speaking, novice physicians responded positively regarding their field training and effectiveness with hands-on, clinical skills. However, in several studies where deficits in training were perceived, novice medical practitioners voiced concerns about two skill sets which were not medical, per se, but were essential. These two areas of expertise are distinct and fall into two categories: business systems and communication, with communication being one of the domains of concern of the novice health care professional as noted above.

The first area of concern, business systems, is specific to the physicians, and includes issues such as cost-effectiveness, office management (DeWitt, Robins, Curtis, & Burke, 2001; Roberts et al., 2002), and continuum of care (Plauth, Pantilat, Wachter, & Fenton, 2001). This business category bore no commonality with the other health care professions, and is not discussed further in this review. The second category, communication issues, was perceived as inadequately addressed, not only in medical training, but also in the field training of nurses and OT's.

As regards physicians, communication skills are essential, as medical professionals are expected to relate effectively with colleagues within and outside of their own

professions. In a needs assessment conducted for the purpose of improving medical education administered by Hannon (2000), of the 84 participants, 91 percent of the graduate doctors reported not having been prepared to facilitate teamwork and to chair team meetings, with only 21 percent of them rating “communication with professional colleagues” (p. 278) well covered during the clinical internship. Darer, Hwang, Pham, Bass and Anderson (2004) interviewed 1,000 physicians practicing in various specialties. Sixty-one percent reported that they had less than adequate training in interdisciplinary teamwork with non-physician providers. A similar finding is noted in the results of a survey of 389 practicing hospitalists, where specific communication skills were rated as to their importance in current practice, and how adequately they were taught. A lack was perceived in training related to communication with patients and families, referring physicians, ancillary staff and patients’ insurers, all of which were rated as highly important, but less than adequately taught (Plauth et al., 2001). The primary care residents examined in one study reported a desire for more training in out-patient practice and social skills (DeWitt et al., (2001). In a study by Prince, Van de Wiel, Van der Vleuten, Boshuizen, and Scherpbier (2004), utilizing four focus groups, many of the participants felt less than prepared for multidisciplinary teamwork and management skills, and some reported feeling uncomfortable communicating with senior nurses who were more knowledgeable than they.

A very specialized aspect of communication is that of end-of-life care and issues of death and dying, which involves families and caregivers as well as patients. Given the “geriatric imperative”, that is, that in the next 30 years the geriatric population will increase from 35 million to 71 million in the United States (Landefeld, 2003),

communication involving these issues is critical for all medical professionals. A survey of 1000 residents and faculty revealed that less than 20 percent of medical students and residents received formal end-of-life care education, and most felt unprepared (Sullivan, Lakoma, & Black, 2003). Similar concerns were expressed by 389 hospitalists in a national survey, some of whom spent less than one month training in a hospice setting and did not feel adequately knowledgeable regarding advanced directives (Plauth et al., 2001). Feeling unprepared to handle issues of bereavement and grief, and end-of-life care was expressed by participants in studies of medical residents and/or faculty, with more than half reporting insufficient education in these areas (Darer, Hwang, Pham, Bass & Anderson, 2004; Hannon, 2000; Sullivan et al., 2003).

The second common phenomenon among the medical novices is the experience of mandatory adjustment, or “reality shock”. The term “reality shock” is described as “...the reactions of new workers when they find themselves in a work situation for which they have spent several years preparing, and for which they thought they were going to be prepared, and then, suddenly, find they are not.” (Kramer, 1974, vii). New professionals encounter many unexpected circumstances for which they must adjust quickly.

Exacerbating this long-standing situation for new doctors are present-day restrictions imposed by the Taxpayer Relief Act and the Balanced Budget Act of 1997, which results in the streamlining of medical academic education and residency (Langdale et al., 2003) in order to reduce federal funding. The result of this streamlining has meant that some graduates may enter residency less prepared at a time when there are increased demands for patient care. This may explain some of the stressors experienced by novice physicians. The interns in Hannon’s (2000) study felt unprepared to cope with the level

of stress when having to answer difficult questions posed by patients' family members or having to break bad news, and having no time to deal with and process their own, personal feelings. Some found themselves alone on a ward with insufficient staff to supervise and advise them during critical situations. The sudden increase in workload also contributes to stress (Prince et al., 2004). New doctors also perceived the need for faculty to make a stronger link between academics and practice in order to avoid the response of one participant who stated, "...[I] learned by being thrown in at the deep end" (p. 329).

The third issue of concern involves time management. Interns participating in Hannon's (2000) study described medical "call" (being solely responsible for a group of patients) and "cover" (substituting for another doctor) extremely busy and sometimes "frightening" (p. 281) at first, for new physicians unaccustomed to juggling many patients at one time. Inability to manage time created fatigue and inability to take in new information and use the residency experience to increase learning. New house officers in the Netherlands expressed having to get used to not only diagnosing and managing patients, but also having to organize paperwork, order tests, dictate reports, make sufficient time for all their new duties, and yet, feeling less than adequate with their organizational skills (Prince et al., 2004). Despite the recognition of the problem, both in the United States and abroad, new duties are likely to be instituted which will add to the medical resident's day, as the Accreditation Council of Graduate Medical Education (ACGME) has, at the start of the millennium, incorporated an 80-hour workweek for residents in the United States. This is likely to increase fatigue and, subsequently, the time it takes to perform all tasks (Hoff, Pohl, & Bartfield, 2004).

Mentoring and supervision, the fourth common concern among the health professions, are key components in the clinical training of health care providers. An emphasis on support and sharing professional experiences is part of what is called a “learning organization” recommended by Hoff et al. (2004), adopted from the business world. “Culture and context...contribute to the variation in acquisition of competencies across residency programs” (p. 533). This statement is borne out by the responses of early career physicians as reported in the literature. Most newly-minted house officers in one focus-group study were unclear as to their role, and received little feedback and guidance from supervisors (Prince et al., 2004). In Hannon’s (2000) study, participants reported learning more from experience than any formal help they may have received, which was not abundant. Mentoring, which would include feedback, personal interest, support and encouragement are essentials as described by the residents.

Despite the need for increased mentorship and skilled supervision, this aspect of medical education has been found lacking for at least two reasons. First, the competencies for medical residents are not standardized, and therefore cannot be consistently incorporated into the curriculum (Kurshid, Bennett, Vicari, Lee, & Broquet, 2005; Langdale et al., 2003) resulting in inconsistent and variable supervision and clinical training. Second, as regards the practice area of geriatrics and end-of-life care, there is a lack of qualified faculty members to train and evaluate students (Kurshid et al., 2005; Landefeld, 2003; Sullivan et al., 2003). These concerns will only grow in importance as demands for more efficiency in patient care increase. In addition, limits in post-graduate training are being instituted by the ACGME, requiring graduate medical students to enter residency with fewer skills than students in the past (Langdale et al., 2003).

*Novice Perspectives: The Nursing Profession*

The experiences and perceptions of novice nurses are very important to the profession at this point in time, as the turnover rate for graduate nurses is 55-61 percent, a reality which is costly to the hospitals and organizations for which they work (Casey, Fink, Krugman & Propst, 2004). Although the literature on this specific topic is not abundant, the articles and studies reporting on the perceptions of novice nurses regarding clinical skills are similar. Although many nursing students felt that they would be competent after their clinicals (Pancia, 1991), they realized upon entering practice that they were not totally prepared. Ellerton and Gregor (2003) found that novice nurses had adequate basic skills, but took longer to perform them. Upon completing assessments, these nurses may not have been able to interpret their findings. Despite this, researchers have found that although new nurses may lack complete confidence and skill as they enter practice, they do report experiencing significant improvement over time (Casey et al., 2004; Gerrish, 2000). This may be why many of the novices do not mention specific clinical skills as being problematic. Ellerton and Gregor (2003), researching novice nurses three months into practice, reported that many rated themselves “seven” out of “ten” on a “readiness to practice” scale, despite not being completely skilled. This phenomenon is explained by Benner, Tanner, and Chesla (1996) who characterize this stage as “lightness of being” (p.52). This reflects a stage where the novice is adequate, but does not yet understand the nuance of practice, yet feels very capable.

As was observed of novice physicians, new nurses raise a concern about communication. In one survey 270 graduate nurses were surveyed in an effort to identify stressors as they transition into practice. Their responses were recorded at three, six and

twelve months post graduation. They reported that communicating with interns and residents proved to be difficult, but improved at the one-year mark (Casey et al., 2004). Second most difficult in their transition overall was “relationships with peers and preceptors” (p.307). Some examples of this are fear of asking questions, and not knowing how to handle power relationships, both of which were determined to be “developmental stumbling blocks” (Goh & Watt, 2003, p. 17) for new nurses. A similar theme is noted in a study by Thomka (2001), where communication with supervisors was a concern of 11 out of 16 of the respondents, as novice nurses reported having been criticized in front of patients or staff, and sometimes treated with resentment. Novice, college-prepared nurses in Australia reported having problems with established teams who were used to the old apprenticeship model (Clare, Longson, Glover, Schubert & Hofmeyer, 1996), and had difficulty adjusting to these college-prepared nurses as far as communicating effectively. New nurses also reported difficulty in managing ancillary personnel, or nursing staff (Casey et al., 2004; Clare et al., 1996; Gerrish, 2000), and assuming membership on an interdisciplinary team (Horsburgh, 1989; Pancia, 1991). A few had to assume a preceptor role as early as nine months into practice, and felt unprepared (Casey et al., 2004).

In addition to communication concerns related to peers, subordinates and professionals from other disciplines, interactions with patients and families are also difficult for many, as was the case in a qualitative study by Ellerton and Gregor (2003). These authors reported that novices felt they lacked expertise in the area of helpful and meaningful communication with patients and families concerning the plan of care. Related to plan of care is the issue of death and dying, a topic with which many new nurses were

uncomfortable. In the study by Casey et al. (2004), of nurses at 1-12 months post graduation, 37 percent of the subjects felt this discomfort with no improvement over time. According to Hopkinson (2001), novices report that there is little education on bereavement in school. One participant in Delaney's (2003) study reported that during clinical training, "If someone coded, you were never allowed to stay in the room." (p. 441). In her study of nurses, six months to three years into practice, Hopkinson's (2001) subjects reported being uncomfortable answering patients' and families' questions about death and dying, and were unsure how to respond when family members reacted in unusual or alarming ways upon hearing bad news. Some students, however, found that they were able to utilize what they learned about Kubler-Ross' model of grief, which they learned while in school, and found it helpful. In Gerrish's (2000) comparative study, novice nurses interviewed in 1998 felt better prepared for issues of death and dying compared to the 1985 cohort, due to better communication courses in school.

As was common among new physicians, novice nurses also experience "reality shock" (Kramer, 1974). Although close supervision and mentoring is beneficial in many respects, it may also be protective, insulating fieldwork students from some of the more demanding aspects of practice. Demands in recent times have increased, due to changes in the health care system beginning in the 1990's. These changes resulted in increases in the number of unqualified health care workers, the number of patients needing care, the number of dependent patients requiring more complex, technical care, and shorter lengths of stay. These demanding factors brought an increase in productivity demands, and a need for flexibility on the part of health care professionals (Gerrish, 2000).

Upon entering the profession, many nurses experience a clash of values, differences between beliefs they developed in school and what they observed in the workplace. This common phenomenon, referred to as cognitive dissonance (Meyer, 2005), reflects the "...incongruity between the rule-bound academic ideal...with the institution-driven clinical reality." (p. 76), and is similar to the reality shock described by Kramer (1974). This was expressed by the nurses in a study by Goh and Watt (2003), who felt that the basic physical care they were providing to patients was not enough, since it did not address the whole person as was taught in school. Some felt that in order to fit in with colleagues, they had to perform procedures the way it was done at the site, and not the way they were instructed in their academic program. Additionally, new nurses felt overwhelmed at the increased responsibility entrusted to them all at once, while at the same time, trying to fit in to the culture of the institution or unit (Casey et al., 2004; Clare et al., 1996; Delaney, 2003; Ellerton & Gregor, 2003; Gerrish, 2000; Goh & Watt, 2003; Pancia, 1991; Thomka, 2001). Facing and coping with these realities often result in fatigue, loss of confidence (Clare et al., 1996), and for some, a reason to leave the profession (Pancia, 1991; Thomka, 2001).

The time factor has proven to be a crucial one for novice nurses, as it was for new physicians. In Ellerton and Gregor's (2003) study, one new nurse reported that reviewing a patient's chart could take her three times longer than an experienced nurse. Extended time for reading charts was also noted by Casey et al., (2004), whose study examined the challenges and stresses of graduate nurses. Extra time was also needed to locate equipment and seek out superiors to ask questions, all of which usurped precious minutes from the workday. Most troubling to the novices was that these time constraints impeded

their ability to carry out meaningful, individualized care, as opposed to simply performing perfunctory tasks (Clare et al., 1996; Goh & Watt, 2003; Pancia, 1991). Some other issues related to time management were difficulty with prioritizing tasks in order to provide timely care, being disorganized, and difficulty establishing a routine (Casey et al., 2004; Gerrish, 2000; Goh & Watt, 2003). The nurses in Delaney's (2004) study were challenged by having to manage six or seven patients, among other concerns; however, they were able to resolve some of their issues after participating in an experimental 12-week long orientation program.

A key component in transitioning from academia into clinical practice is the opportunity for positive mentorship. Whether support professionals are titled "attendings", "preceptors", "senior staff", or "fieldwork supervisors", their role in orienting, training and providing feedback for the new professional is more vital today than in previous times. This occurs because of the realities of managed care, which requires increased productivity levels, as well as other demands. These new realities in the health care system are faced in countries around the world as well as in the United States. Gerrish (2000) reports increases in the amount of support given novice nurses in Great Britain; however, mentorship is still variable. This is due to the fact that the 1991 recommendations by the United Kingdom Central Council (UKCC) for Nursing, for four-month preceptorships for new nurses, are not requirements. In addition, there exist no credentialing requirements for nursing preceptors, which explains the variability in the quality of the preceptorship experience.

Good mentorship includes positive feedback, which assists in increasing confidence and facilitates adaptation to the new role (Delaney, 2003). In the study by Casey et al.

(2004), which investigated the most difficult aspects of role transition, relationships with peers and preceptors was found to be one of the six most prevalent themes to emerge from the data. For many nurses, the preceptorship was positive (Gerrish, 2000; Goh & Watt, 2003). For some, inconsistent mentorship and lack of positive support negatively affected their experience (Horsburgh, 1989). Trust was also an issue for some who feared “speaking out” (Casey et al., p. 307), or reporting poor treatment by preceptors for fear of retribution (Thomka, 2001). In this same study, reports of inconsistency were noted, as participants described some preceptors as “helpful”, and some having a “sink or swim” attitude (p. 17). Weber’s (2003) needs assessment of new nurses resulted in the facility instituting one-on-one mentorship, monthly. For many graduates, orientation and mentorships are variable, depending on the setting (Delaney, 2003; Ellerton, 2003).

It follows, then, that having no mentor or preceptor at all would be even more difficult. The graduate nurses in Horsburgh’s (1989) study reported that not having a preceptor impeded adjustment to the new professional role, for instance, having to rely on self-evaluation. For some new nurses who did not have the benefit of a post-training preceptorship, issues of death and dying were difficult, and those who were able to find an experienced nurse after whom they could model their own practices, did so (Hopkinson, 2001).

### *Novice Perspectives: The Occupational Therapy Profession*

The work experiences of novice OT’s are sparsely represented in the literature of the past 20 years. Of the 14 articles pertaining to new OT’s, only four report on new therapists’ perceptions of their clinical skill levels, with the remainder reporting on

difficulties with the four key issues described above. What little information there is on novices' perspectives on the effectiveness of their fieldwork as preparation for practice also includes the influence of fieldwork on practice preference.

Research on new OT's perceptions of their clinical skills reveals variability in clinical competence. In a comparative study of new nurses, psychiatrists and occupational therapists practicing in mental health in the United Kingdom (Holmshaw, 1999), OT's perceived their training to be too generic with not enough mental health focus. The training spoken of was not specified as academic or clinical. In addition, they did not feel prepared for the gradual shift from group, to one-on-one treatment, which they encountered early on in practice. As a result, a high turnover was seen in this area of practice. Cottrell's (1990) study of 95 OT's in mental health focused on self-ratings of their clinical skills. Some areas of weakness included use of OT frames of reference in practice, ability to use current research findings in practice, and providing OT input regarding the functional effects of psychotropic medications. One major difficulty with this study is that forty percent of the subjects reported having 1-5 years' experience; however, data analysis did not differentiate the novice group's responses specifically. Despite the fact that novice OT's were not studied exclusively, it is noteworthy that eighty percent of the respondents rated themselves as either good or excellent on 15 of the 21 tasks on the questionnaire. None of the respondents reported on the influence of their clinical fieldwork as contributing to their confidence and competency, but did report that basic, continuing and post professional education is essential in building confidence. In one Australian study, 144 novice OT's working in a myriad of settings reported feeling well-prepared in client management, documentation and ethical issues as reflected by the

high mean factor score on the clinical skills scale of the instrument used (Adamson, Hunt, Harris, & Hummel, 1998). Those in the aforementioned study felt only partially prepared in applying evaluative approaches, pursuing and reading professional literature, designing and writing research, and evaluating measurement instruments.

Fieldwork was, however, reported in the literature as a key factor in the practice preference of new graduates (Christie, Joyce, & Moeller, 1985). In this study of 131 OT fieldwork students and their supervisors, twenty-four percent indicated that fieldwork contributed to their becoming interested in varied areas of practice. Fifty-five percent responded that their preference for a particular clinical practice area was either formed or changed during fieldwork. This finding was echoed in Cottrell's (1990) study which revealed that mental health fieldwork was viewed three times more negatively than physical disabilities fieldwork, which deterred many entry-level OT's from choosing to practice in mental health.

The perceptions of school-based OT's are also represented in the literature as this practice area is the largest OT practice area today (Dunn & Cada, 1998). Brandenburger-Shasby (2005) performed a random sampling of twenty percent of the School System Special Interest Section of the American Occupational Therapy Association for their study of new therapists. Participants were asked how well prepared they felt for practice in pediatrics, based on their entry-level preparation alone. Eighty percent of the 450 respondents perceived themselves to be poorly prepared. The areas of practice participants felt least prepared for, and these include new therapists one to three years in practice, are: providing transitioning from early intervention to the pre-school community; evaluating for assistive technology; providing services in inclusion and

natural environments; and documenting present levels of performance to reflect the student's ability.

In most of the studies, little is revealed about the nature and influence of Level II fieldwork on the participants' experiences as new OT's. Some mention fieldwork as a source of learning, without specifics, and others delineate specific skills that were adequately taught, but do not relate them to fieldwork. All of these factors contribute to an incomplete picture as to the effectiveness of fieldwork. An example of this would be a study by Tryssenaar and Perkins (1999), where OT's specifically mention fieldwork as the chief source of their learning; however, no specific skills are enumerated. In contrast, new practitioners from different practice settings reported that their "course", not fieldwork specifically, adequately prepared them for ethical issues, client interventions and documentation (Adamson et al., 1998).

A select few studies, however, address the contribution of clinical fieldwork. In the Brandenburger-Shasby (2005) study, only 35 percent of the participants indicated that their Level II fieldwork contributed to their preparation. Since Atkinson and Steward (1997) found that fieldwork was most valued by OT's working in a practice area in which they had a Level II fieldwork, it would be valuable to know if any of the 35 percent in the Atkinson and Steward (1997) study of novice pediatric OT's actually had a Level II fieldwork in pediatrics. The importance of a match between the fieldwork practice area and the practice area of one's initial employment is illustrated by Bergson (1996), in her letter to the editor of the American Journal of Occupational Therapy. In this letter she describes being forced to take her first OT position, as a sole therapist, in a school system as remuneration for a tuition loan from the state. She describes her frustration and

feelings of ineptitude, as she had not experienced a Level II fieldwork in any pediatric setting whatsoever.

Regarding ability with communication, novice OT's have similar concerns to those of other new health professionals. Results from Adamson's (1998) survey of 144 new OT's in Australia indicated that they felt ill-prepared for communicating with professionals from other disciplines, and perceived that communicating with patients regarding issues of death and dying was covered less extensively in their training. Interdisciplinary communication and managing subordinates were also issues for new therapists both in the U.S. and abroad (Adamson et al., 1998; Atkinson & Steward, 1997; Hollis & Clark, 1993; Rugg, 1996). For some new OT's, eliciting clients' cooperation can be problematic (Rugg, 1996), as well as effectively communicating with family members (Atkinson & Steward, 1997). For OT's working in isolated rural settings, asking for help may be awkward due to decreased resources and time constraints (Steenbergen & Mackenzie, 2004).

Reality shock seems to be an issue for many new practitioners across the disciplines, including OT's. Having just come from a mentored relationship in clinical fieldwork, it is difficult for one to foresee the challenging realities of the workplace, and the responsibilities expected of the novice, such as acclimating to treating a large caseload (Rugg, 1997; Tryssenaar & Perkins, 1999). It has been reported in the literature that for some novices, office politics are unexpected and unforeseen, as well as clashes of values when new OT's encounter less than excellent patient care from colleagues (Rugg, 1996; Tressenaar, 1999; Tressenaar & Perkins 1999). Unprofessional ethics and attitudes are also unexpected. New therapists are surprised that those from other disciplines may be

territorial, and in some cases, not value the profession of OT (Tressenaar, 1999). New therapists may be unprepared for the subtlety and complexity of people's problems, dealing with the distress of caregivers (Holmshaw, 1999), and have difficulty with patients who have unusual needs (Atkinson & Steward, 1997). One new graduate reported feeling unprepared to handle all the administrative duties of her school-based practice, and to handle children with multiple diagnoses (Bergson, 1996).

Part of the reality shock experienced by young professionals is related to time and organizational skills. For many it is the first time they are expected to manage a full caseload of clients and perform the full gamut of administrative duties. In a study comparing the "expected" and "actual" experiences of new OT's, Rugg (1997) found statistically significant differences related to "finding time for non-treatment activities" and "finding time for all work-related responsibilities" (p.167). Time management was also a problem for 25 percent of the 144 respondents in the study by Adamson et al. (1998). Specific concerns about time management included organizational skills (Tryssenaar, 1999), planning travel time (Lee & Mackenzie, 2003), planning interventions to fit the length of treatment sessions, determining lengths of stay (Tryssenaar & Perkins, 2001), juggling a full case load, and in some cases, being asked to limit the number of clients seen (Bergson, 1996).

As was the case with the other health professionals, occupational therapists perceive the need for consistent mentoring as they begin their professional duties. Few of the studies reporting on OT's perceptions of their professional preparation mention specifically the influence or benefit of their fieldwork supervision; however, the fieldwork supervisor plays a pivotal role in clinical training (Christie et al., 1985), and

facilitates the student's development from novice to expert (Tryssenaar & Perkins, 2001). Despite the vital role of the fieldwork supervisor, at this point in time, there exists only continuing education courses for supervisors, but no official credentialing. This situation creates variability in clinical instruction, which may be why new OT's perceive a strong need for supervision and mentoring as they begin employment, a fact that was brought out in the literature.

The novice therapists in Rugg's (1996) study responded that they did not receive adequate supervision as often as was needed. In the Brandenburger-Shasby (2005) study of school-based OT's, 60 percent of the 450 respondents indicated that mentoring, as they began their first position, was important in their preparation. This is not surprising considering that only one-third of them had completed a Level II fieldwork in school-based practice. In Tryssenaar's (1999) case study of a new OT, in which she records all of the challenges and struggles of the participant in her case study, mention of the clinical supervisor is conspicuously absent, prompting the reader to wonder how the challenges she enumerates will be resolved. Tryssenaar and Perkins (2001) studied six therapists, three OT's and six physical therapists, through the final stages of school and through their first year of practice. Only one of these first-year clinicians had access to a supervisor for instructional meetings. New therapists, with no OT supervisor on site, perceive a great challenge, as having to wait for a return telephone call relaying an important response creates frustration and anxiety (Steenbergen & Mackenzie, 2004). Additionally, when complex cases present themselves, the OT, being a novice and alone, has no one to consult (Bergson, 1996). OT's practicing in rural settings may experience

low self-confidence and would benefit from the opportunity for debriefing to facilitate clinical reasoning (Lee & Mackenzie, 2003).

An examination of the professional literature regarding the effectiveness of clinical fieldwork from the novice's perspective has brought to light three essential points in considering the proposal for further research. First, research on this topic is not abundant across the healthcare professions. Second, within the existing research focusing on this issue, there is evidence that common issues, concerns and themes exist among the three health professions examined. Third, within the profession of OT, there exist only eight articles in the past two decades focusing on the novice perspective, with only six researching OT's exclusively.

Given the paucity of information on the question of whether clinical fieldwork is effective in preparing OT students for entry-level practice, and that there is some evidence of shared concerns among novice health care practitioners, it is evident that focused research on the effectiveness of Fieldwork II is warranted. The present research was conducted to study novice rehab OT's, one to three years in practice, who had a Fieldwork II experience in a rehab setting. Rehab practice settings include acute care, sub-acute, long-term care, neuro rehab or out-patient. The study was carried out in order to determine the effectiveness of Fieldwork II in preparing OT's for entry-level practice.

As was revealed in the literature, novice OT's shared five challenges with the other health care professionals. However, because studies of OT's were so few in number, and rehab OT's were not studied exclusively, this research was designed to explore whether this finding is valid as regards novice rehab OT's specifically. A depiction of the novices' perceptions regarding transition into entry-level practice, as described in the

literature, is illustrated below in a conceptual framework. This conceptual framework is a tool, in the form of a visual model, for the purpose of understanding how concepts relate to each other. The concepts in this model emerged from the literature and are depicted to illustrate perceived obstacles on the path from fieldwork to entry-level practice and are those the OT's shared with the other novice health care professionals.

Information from the literature was synthesized and depicted as five themes. The concept labeled "Clinical Skills" represents the carrying out of appropriate assessments, treatment planning and hands-on techniques of OT practice. "Communication A" in the framework represents the common difficulties in the area of patient/family communication such as death, dying, bereavement and the setting of personal boundaries. Challenges having to do with interdisciplinary communication involving professionals, ancillary personnel and agencies were grouped together and labeled "Communication B". "Reality Shock" is used to represent the mandatory adjustment of new professionals to the realities of the workplace such as inequities in the medical insurance system, encountering homelessness among patients, and keeping up with expected productivity levels. "Mentoring" represents the difficulty some new health care professionals have in acquiring mentors at their first employment setting. This framework served as a guide in examining which of the skill areas reported in the literature are perceived as obstacles for the novice rehab OT's in this study.

## CONCEPTUAL FRAMEWORK

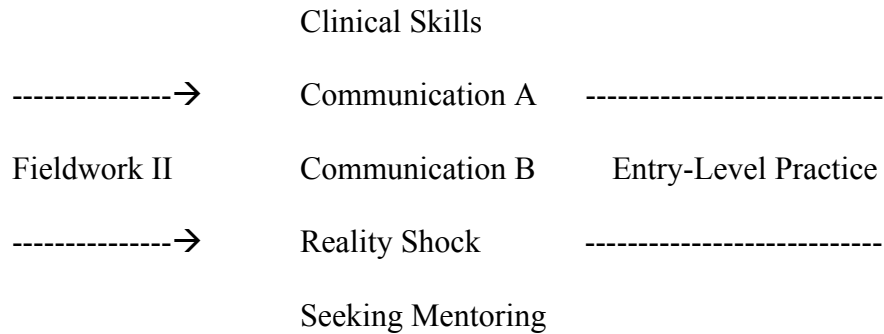


Figure 1. Challenges of Entry-Level Healthcare Professionals as Depicted in Literature

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### Key

Clinical Skills	Hands-on intervention & treatment planning
Communication A	Communication with family & patient
Communication B	Intra/interdisciplinary, ancillary personnel, agencies
Reality Shock	Adjustment to realities of the workplace, values conflicts

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## CHAPTER 3 METHODOLOGY

In consideration of the key objective of determining the effectiveness of Level II clinical fieldwork in preparing entry-level OT's, a mixed method design consisting of a structured questionnaire and semi-structured interview was utilized to achieve a greater understanding of the whole. The two methods were chosen for their ability to best examine the variable, "novice OT's perceived degree of preparedness for entry-level practice" as it relates to their Level II clinical fieldwork, and to support the intended outcome, "the effectiveness of rehab Level II Fieldwork". The mixed method reflects the philosophical framework of pragmatism as recommended by Greene (1994), and the elements of the tailored design method (TDM), as described by Dillman (2007), for the purpose of program evaluation. According to DePoy and Gitlin (2005), combining objectivist and naturalistic philosophical approaches allows for greater breadth and depth in health and human services inquiry.

The thirty-three question online survey was utilized as a tool for its ability to reach a greater number of potential participants and to yield a greater amount of quantifiable data. The one-to-one interviews allowed for describing the perceived experiences of novice OT's and the meanings derived from those experiences. Additionally, anecdotal data assisted in bringing meaning to the experience of being a novice therapist in transition to the work world and served to elaborate on the findings of the quantitative data. Combining the above data collection methods allowed for exploration of the topic from both a broad and specific perspective, and has the potential to benefit both the beneficiaries of the program, Level II FW students and their patients, as well as the

designated stakeholders, namely, the Commission on Education of AOTA, and OT clinical educators.

### *Instrumentation*

The instrumentation for this research consisted of an online web survey and a semi-structured interview. Because this study addresses specific issues related to a particular group within a population, novice OT's, a newly constructed instrument was needed. Health and human service professionals frequently require original measures to fit a particular study or research purpose (DePoy & Gitlin, 2005). The survey was a 33-item, self-administered, 2-part, web-based survey, utilizing a 4-point Likert scale (Appendix A).

The questions for the survey were constructed based on the five challenges faced by early career health professionals as delineated in the nursing, medicine and occupational therapy literature; namely, clinical skills, patient/family communication, interdisciplinary communication, reality shock and mentoring. Examples of questions relating to clinical skills asked about OT assessment and intervention. Eliciting clients' cooperation and communicating with clients from a different culture are issues related to patient/family communication. Preparation for membership on an interdisciplinary team was included in questions related to interdisciplinary communication. The construct of reality shock was operationalized in the survey as preparation for speaking about death and dying and adaptation to the "real world way of doing things". The questions on mentoring, whether by the fieldwork supervisor or another professional, addressed the challenge of being mentored in the work place as reported by many new therapists. Survey questions

are representative of the five areas of concern which the OT's shared with other new healthcare professionals as illustrated in the conceptual framework. In addition, areas of concern specifically to OT's as reported in the literature are also represented in the survey, such as issues related to supervisory skills of the clinical instructor, the influence of the fieldwork experience on practice preference and whether credentialing for clinical supervisors should be mandatory. Issues and corresponding survey items are illustrated in Table 1 below.

Table 1. The Nine Issues Addressed by Survey Items

<u>Issues of Novice OT's</u>	<u>Targeted Survey Items</u>
Communication A (family & patient)	11, 13, 17
Communication B (Inter/intradisciplinary, Ancillary personnel, agencies)	12, 14, 19, 20
Values Conflict/Reality Shock	9, 22, 23, 25
Time Management/Organizational	8, 10, 18, 24
Applying academic & Clinical Skills	1, 2, 3, 4, 5, 6, 7, 21
Mentoring	15, 16, 29
Credentialing	31
Supervisory Issues	26, 27, 28, 29, 30, 3, 33, 34
Practice Preference	21 a

The purpose of the interview questions was to elaborate, give depth, meaning and detail to the objective information of the survey. There were seven interview questions formulated to elicit responses which would answer the four research questions and elaborate on the responses from the survey. Of the four research questions, all but number three are addressed by both the survey and the interviews. Question three, “If you were to design the ideal Feldwork Level II experience, what would that look like?”, is a survey question exclusively. Table 2 below states the research questions, which of them is addressed by the survey and which by the interviews. Research question one is demographic in nature and does not appear in the table.

Table 2. Research Questions and Where They Are Addressed

	Survey	Interview
1. For which areas of practice do OT’s feel most prepared?	Yes	Q 2
2. Which skill areas remain as obstacles in adjustment to entry-level practice?	Yes	Q 4,5
3. What are the essential elements of an ideal clinical learning environment?	No	Q 3-6
4. Should credentialing for clinical instructors be mandatory?	Yes	Q 7

Validity of the instrument was addressed as follows: The survey was reviewed by two clinical experts and two academic experts in the field to establish face validity of content. In addition, at the conclusion of the Temple University IRB review, the instrument was piloted to three novice OT’s, those who fit the inclusion criteria for the study, but who

were not participants. Feedback from this group was used to refine the survey in order to ensure interpretability of items (Schwartz, 1999).

In addition to the survey, nine semi-structured interviews of volunteer participants who fit the inclusion criteria of the study were conducted to elaborate on therapists' perceptions of their fieldwork training, to include details of educational content and specific instructional methods and their effectiveness in preparing the OT's for practice (Appendix B). The interview questions were piloted to two novice OT's in order to modify and or clarify the questions.

Of the nine interviews, seven were conducted locally, audiotaped and transcribed verbatim. Two of the interviews were conducted via telephone with the researcher taking detailed notes as opposed to audiotaping as the participants were located in a distant section of the country. During the interviews, follow-up questions were posed, as needed, for clarification and elaboration. Member checking was conducted to ensure accuracy of the typed transcripts. These methods are in concert with current, accepted methodology in the field of social inquiry (Green, 1994).

### *Selection of Participants*

Participants in the study were recruited through purposeful sampling via professional networking. All of the therapists met the criteria of being 1 to 3 years post graduation, having had a Level II rehab fieldwork experience, and were first employed in a rehab setting. The domain of rehab for the purposes of this study includes the types of clinical sites to which students are typically assigned, namely, adult rehab, acute care, sub-acute, adult brain injury, long-term care and neurorehabilitation.

Participants for the online survey were recruited via the internet through a free online listserv sponsored by the American Occupational Therapy Association where the study and inclusion criteria were described. Anonymity was assured and a direct link to Survey Monkey was provided. A welcome screen provided details as to the purpose of the study, inclusion criteria, informed consent (Appendix C), and information on how to connect with the researcher should questions or concerns arise. Readers were informed that five survey participants would be chosen at random, from those who include an e-mail address, to receive a \$50.00 check.

Participants for the interviews were to be chosen at random from online participants who would voluntarily submit their e-mail addresses. However, it was decided that onsite interviews would be more effective; therefore, those who met the inclusion criteria were sought through professional networking from rehab facilities in the Philadelphia area. Two of the nine participants were interviewed from Dallas, Texas, over the telephone.

The purpose and procedures of the study were explained to participants by the researcher, as well as methods for insuring anonymity such as omitting all names and identifying information on the transcripts. All interviewees were given informed consent for both interviewing and audiotaping and were informed that five of them will be chosen at random to receive a check for \$50.00.

### *Data Analysis*

Descriptive statistics to summarize the data included frequency distribution, means and correlation analyses. Frequencies allow for observing the distribution of values for each question and how often each value occurs. Observed frequencies were converted to

percents which revealed what percentage of the whole group had a particular score on any given value. Means were calculated for each survey question and grouped from high to low in order to determine in which areas OT's felt most prepared, moderately prepared and least prepared. In addition, Pearson correlations were calculated to determine if any significant relationships exist among the variables including demographics.

The qualitative interviews were transcribed and analyzed using the responsive interviewing formal coding schema (Rubin & Rubin, 2005). Unlike the open coding used in grounded theory in which every line is read and coded based on its content, in responsive interviewing coding the researcher bases his coding on themes found in the literature. In this study, the challenges of novice health care professionals were gleaned from the research literature of the health sciences, analyzed for content and reduced to five constructs: clinical skills, patient/family communication, interdisciplinary communication, reality shock and mentoring. The constructs were operationalized with clear descriptions and examples to aid in the coding. The transcribed texts from the interviews were examined for the above five constructs. In addition, relevant concepts and themes which most closely related to the research questions were identified. The reason for applying this type of analysis was to discover whether novice rehab OT's specifically, identified the same issues as other health care professionals, in their transition from fieldwork student to entry-level therapist.

Interview data were verified via member checking (Patton, 2002). Trustworthiness was also addressed with one-tenth of the total interview data given to a qualified OT for coding. Percent agreement was calculated at .84. Qualitative material was also used to illuminate and elaborate on the quantitative findings of the web-based survey and similar

themes from an unpublished pilot study by the researcher (Lipsitt, 2003) were used to triangulate the current data.

## CHAPTER 4 DATA ANALYSIS/RESULTS

In light of the current findings in the literature, namely that studies of the effectiveness of clinical training of occupational therapists exclusively in preparing them for practice are few in number and most studies include several practice areas, this study was designed to determine the perspectives of new rehab OT's exclusively. The survey and interview questions were developed for the purpose of determining OT's perspectives regarding the effectiveness of their Level II Fieldwork, that is the clinical portion of their training. To that end, they were asked in which areas of practice they felt best prepared, what obstacles remained unaddressed, what they consider to be essential in an ideal learning environment, and lastly, whether clinical instructors should be credentialed.

Data collection for the online survey, which included demographic information, was conducted via Survey Monkey. Despite two separate postings in the rehab, geriatric and fieldwork nationwide listservs, the response rate was low (N=45). Data received from the Survey Monkey Excel spreadsheet were entered into SPSS. Means, standard deviations, frequencies, percentages and Pearson correlations were calculated for the survey responses for each question. Demographic information was to have been analyzed to determine if any relationships exist between the responses of participants whose Fieldwork II supervisor had one year or less experience in the field and those whose supervisors had more than one year experience prior to taking the student. However, due to the small response rate this was not examined.

Demographic data were collected for all interviewees (N=9), and are included in Tables 5-13, below. Interview data were verified via member checking (Patton, 2002).

Printed transcripts were coded utilizing the responsive interviewing formal coding schema approach (Rubin & Rubin, 2005) to identify relevant concepts and themes expressed across the interviews and which most closely relate to the research questions. An example of how transcripts were coded would be as follows: interviewees comments which included the word “support”, “mentorship”, or phrases such as “interaction with team leader”, or “someone to bounce ideas off” and “informal supervision” were coded as “seeking mentorship”.

Trustworthiness was also addressed with one-tenth of the total interview data given to a qualified OT for coding. Percent agreement was calculated at .84. Qualitative material was also triangulated with the quantitative findings of the web-based survey and with similar themes from an unpublished pilot study conducted by this researcher (Lipsitt, 2003).

This chapter reviews the findings of the study in four sections; first, demographic data for all participants; second, survey data as it addresses each of the nine practice issues enumerated in Table 1; third, analysis of quantitative data as they are rank ordered in thirds, illustrating high, moderate and low degrees of preparedness for practice. Correlations are included in the analysis. Section III also includes the qualitative interview responses relating to preparedness. The fourth section synthesizes the quantitative and qualitative data and how they combine to answer the research questions which appear in Table 2.

*Section I: Demographic Data*

The majority of participants were female, between the ages of 22-30 with 1-3 years in practice. Since OT is a female dominated profession, the large female response is representative of the field. Most of the survey participants had one year of experience with interviewees equally divided among one, two and three years. Inpatient rehab in the northeastern United States was the area of practice in which most were employed with the majority of participants having been trained in the northeast as well. The majority of their rehab supervisors were female. The ages of interviewees' fieldwork supervisors were almost equally divided between the ages of 22-30 and 31-41. The fieldwork supervisors of the survey participants were mostly 31-41. The majority of participants had fieldwork supervisors with four or more years of experience. The majority of participants were not their fieldwork supervisor's first student.

Table 3. Gender of Participants

Gender	N=45		N=9	
	Survey Frequency	Percent	Interview Frequency	Percent
Male	4	8.5	1	12.0
Female	41	91.5	8	88.0
Total	45	100.0	9	100.0

Table 4. Age of Participants

Age	N=45		N=9	
	Survey Frequency	Percent	Interview Frequency	Percent
22-30	29	64.4	8	88.9
31-41	9	20.0	1	11.1
42-51	5	11.1	0	0
52+	2	4.4	0	0
Total	45	100.0	9	100.0

Table 5. Region of OT Fieldwork Training

	N=45		N=9	
	Survey Frequency	Percent	Interview Frequency	Percent
Northeast	20	44.0	6	66.7
Midwest	10	22.2	1	11.1
South	1	2.2	0	0
West	2	4.4	1	11.1
Southwest	6	13.3	1	11.1
Southeast	6	13.3	0	0
Total	45	100.0	9	100.0

Table 6. Participants' Years in Practice

Years in Practice	N=45		N=9	
	Survey Frequency	Percent	Interview Frequency	Percent
1	19	42.2	3	33.3
2	13	28.9	3	33.3
3	13	28.9	3	33.3
Total	45	100.0	9	100.0

Table 7. Participants' Current Area of Clinical Practice

Area	N=45		N=45	
	Survey Frequency	Percent	Interview Frequency	Percent
Inpatient	19	42.2	9	100.0
Outpatient	5	11.1	0	0
Long Term Care	8	17.8	0	0
Assisted Living	1	2.2	0	0
Community	1	2.2	0	0
Other	11	24.4	0	0
Total	45	100.0	9	100.0

Table 8. Geographical Region of Participants' First Practice

Region	N=45		N=9	
	Survey Frequency	Percent	Interview Frequency	Percent
Northeast	25	55.6	7	77.0
Midwest	4	8.9	0	0
South	2	4.4	0	0
West	3	6.7	1	11.1
Southwest	3	6.7	1	11.1
Southeast	7	15.6	0	0
Missing	1	2.2	0	0
Total	45	100.0	9	100.0

Table 9. Gender of Clinical Instructors

Gender	N=45		N=9	
	Survey Frequency	Percent	Interview Frequency	Percent
Female	40	88.9	1	11.1
Male	5	11.1	8	88.9
Total	45	100.0	9	100.0

Table 10. Clinical Instructors' Years in Practice

Years in Practice	N=45		N=9	
	Survey Frequency	Percent	Interview Frequency	Percent
2	4	8.9	1	11.1
3	1	22.0	0	0
4+	40	88.0	8	88.9
Total	45	100.0	9	100.0

Table 11. Age of Clinical Instructors

Age	N=45		N=9	
	Survey Frequency	Percent	Interview Frequency	Percent
22-30	10	22.20	4	44.4
31-41	25	5.55	4	44.4
42-51	10	22.20	0	0
52+	0	0	1	11.1
Total	45	100.00	9	100.0

*Section II: Survey Data in Percents Relating to the Nine Practice Issues*

The first practice issue is applying academic and clinical skills. Practice issues include those in Table 1 and represent the difficulties of early-career health professionals as reported in the literature. OT clinical skills include treating patients with multiple diagnoses, hands-on interventions, using research and the literature, treatment planning and determining length of stay for the patient.

Results from both the interviews, to be presented in a subsequent section of this paper, and the survey, reveal a perceived confidence in clinical skills. Survey respondents, as recorded in Table 12 below, rated themselves as very well prepared

(61.4%). Almost a third (31.8% ) felt somewhat prepared in the area of hands-on clinical skills. Related to this is treatment planning, a skill in which 59.1% felt very well prepared. The majority of survey participants felt very well or somewhat prepared for treating patients with multiple diagnoses, evaluating and choosing appropriate assessments, determining length of stay and managing a full case load.

Table 12. Preparation For Clinical Skills (percents)

N=4	Multiple Diagnosis	Hands-on Skills	Using Research	Reading Literature	Treatment Planning	Length of Stay	Choosing/Using Assessments
Not at All	0.0	0.0	2.2	4.4	0.0	11.1	2.2
Not Very	2.2	6.7	35.6	28.9	6.7	13.3	17.8
Somewhat	57.8	31.1	48.9	42.2	35.6	42.2	48.9
Very Well	40.0	60.0	13.3	24.4	57.8	33.3	31.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

The second practice issue is patient/family communication, referred to as Communication A in Table 1, and refers to issues such as eliciting patients' cooperation, managing cultural differences, and discussing issues of death and dying. The majority of survey participants rated themselves as very well prepared to manage cultural issues and elicit patients' cooperation, however, regarding issues of death and dying, only 48 percent combined felt somewhat, or very well prepared.

Table 13. Preparation For Communication A: Patient/Family (Percent)

N=45	Cooperation	Culture	Death and Dying
Not at All	0.0	4.4	20.0
Not Very	2.2	8.9	31.1
Somewhat	44.4	46.7	33.3
Very Well	53.3	40.0	15.6
Total	100.0	100.0	100.0

The third practice issue which presents difficulty according to the literature is interdisciplinary and intradisciplinary communication. This refers to communication among professionals from different disciplines at team meetings, the OT's on the job supervisor, ancillary personnel such as nurses' aids and communication with insurance companies regarding coverage for the patient. Eighty percent of respondents felt very well prepared for participating in team meetings and 57.8 percent felt very well prepared for communicating with their supervisor. Those who felt somewhat or very well prepared to communicate with ancillary personnel made up over 90 percent. One aspect of the communication issue, communication with insurers was problematic with only 37.8 percent combined feeling somewhat or very well prepared.

Table 14. Preparation For Communication B: Intra/interdisciplinary Communication  
N=45 (Percent)

	Team Members	Supervisor	Non-OT's and Ancillary	Insurers
Not at All	0.0	0.0	2.2	33.3
Not Very	2.2	11.1	2.2	28.9
Somewhat	17.8	31.1	46.7	26.7
Very Well	80.0	57.8	48.9	11.1
Total	100.0	100.0	100.0	100.0

The fourth practice issue under investigation was values conflict/reality shock. This issue represents circumstances encountered for which novice OT's reported difficulty in the literature. It includes having to take on a Level II student, coping with observing

variations in practice by peers, experiencing office politics and having to adjust to new, “real world” ways of practicing OT.

The OT’s in this study who felt very well prepared to take on a Level II student represented only 28.9 percent of the participants and only 37.8 percent felt somewhat prepared. Most of the participants felt prepared to cope with seeing the variations in quality of care in the workplace with 33.3 percent strongly agreeing that they were prepared and 55.6 percent agreeing. With rank-ordering of the data, however, there was a low level of agreement about preparation for seeing the variations in practice. This will be discussed in the next section of this analysis. When asked about being prepared to handle office politics, 26.7 percent strongly agreed that they were prepared while 37.8 agreed. The majority (51.1 percent) did not feel that it was hard to adjust to the “real way” versus the “school way” of doing things on their first job with only 26.7 feeling that it was hard to adjust to this aspect of being a new OT.

**Table 15. Preparation for Taking On a Level II Student (Percent)**

N=45	Question 9
Not at All	13.3
Not Very	20.0
Somewhat	37.8
Very Well	28.9
Total	100.0

Table 16. Adequate Preparation For Adjustment to Reality of the Workplace (Percent)  
N=45

	Cope with variations in quality of care	Handle office politics	Adjust to “real world” way of doing things
Strongly Agree	33.3	26.7	11.1
Agree	55.6	37.8	26.7
Disagree	11.1	37.8	26.7
Strongly Disagree	0.0	4.4	11.1
Total	100.00	100.00	100.0

Challenges related to time management and organizational skills, the fourth practice issue addressed in this study, have been common to new healthcare professionals according to the literature. Questions relating to this issue in the survey asked about managing a full caseload, ability to prioritize tasks and establish a routine. The majority of respondents felt very well prepared in each of these areas. In response to the statement “My Fieldwork Level II did not prepare me with adequate organizational skills”, the majority disagreed (51.1 per cent) and 11.1 percent of respondents strongly disagreed. Tables 17 and 18 below, quantify the OT’s perceptions of preparedness with these tasks.

Table 17. Preparation For Time Management/Organization (Percent)

N=45	Full Caseload	Prioritizing	Establishing A Routine
Not At All	0.0	2.2	2.2
Not Very	4.4	2.2	6.7
Somewhat	28.9	31.1	35.6
Very Well	66.7	64.4	55.6
Total	100.0	100.0	100.0

Table 18. Responses to: “Fieldwork II Did Not Prepare Me With Organizational Skills”

N=45	(Percent)
Strongly Agree	11.1
Agree	26.7
Disagree	51.1
Strongly Disagree	11.1
Total	100.0

The sixth practice issue is the ability to self-advocate and seek mentoring at one’s first place of employment. Level II clinical Fieldwork is designed to teach students entry-level skills in order that they will have a foundation for more advanced learning. In order to facilitate new learning, it is important for new OT’s to have a good understanding of their learning style and how to seek out an appropriate mentor as they enter practice. Skillful fieldwork supervisors meet with the student frequently to assist them in becoming self-aware through the supervisory relationship.

Approximately one-third of the respondents in this study felt very well (35.6 percent) or somewhat prepared (46.7 percent) to seek a mentor. A majority (64.4 percent) were very well prepared in understanding their own learning styles. Issues related to mentorship are elaborated on more fully in Section III of this study through the responses of the nine interviewees.

Table 19: Preparation for Seeking Mentorship (Percent)

N=45	Advocating For Self And Seeking a Mentor	Understanding Your Mentoring Needs and Own Learning Style
Not At All	4.4	2.2
Not Very	13.3	8.9
Somewhat	46.7	24.4
Very Well	35.6	64.4
Total	100.0	100.0

The seventh practice issue concerns supervisory issues in Level II Fieldwork. Research in the literature reveals several factors which students perceive as being key to a positive learning experience. OT's report that onsite supervision is preferable and one-on-one time with the CI is very important. OT's concurred with other health professionals that a CI should have skill with giving feedback and should understand the student's learning style. In terms of a positive learning environment, having other professionals from whom to observe and learn is also important.

OT's in this study overwhelmingly agreed (88.9 per cent) that a supervisor should be onsite during the student's clinical training. The study also revealed that most (57.8 per cent) had one-on-one time with their CI's, that he or she was skilled in offering feedback (57.8 per cent), and was competent overall (55.6 per cent). Many respondents strongly agreed (46.7 per cent) or agreed (40 per cent) that their CI understood their learning style. Most of the participants strongly agreed (84.4 percent) that they had the opportunity to learn from more than one professional while on clinical fieldwork. Responses for this issue are recorded below in Table 20, and in Section III where interviewee data is reported.

Table 20. Supervisory Issues: Clinical Supervisor/Supervision (Percent)

N=45	Should Be Onsite	Had one-on-one	Skill With Feedback	Learned From More Than One	Understood Learning Style	Was Competent
Strongly Agree	88.9	57.8	57.8	84.4	46.7	55.6
Agree	11.1	31.1	26.7	15.6	40.0	35.6
Disagree	0.0	11.1	11.1	0.0	6.7	6.7
Strongly Disagree	0.0	10 0.0	4.4	0.0	6.7	2.2
Total	100.0	100.0	100.0	100.0	100.0	100.0

The eighth practice issue concerns the credentialing of CI's. The clinical instructor plays a key role in the training of the Level II Fieldwork student and sets the tone for the overall experience. Presently there exists a great variability in the skill levels of CI's in the field as is commonly known to the academic fieldwork coordinators who place students in, and interact with, professionals in rehab facilities across the country.

Perceptions of OT students as reported in the literature corroborate these facts. The OT's in this study were asked if credentialing for CI's should be mandatory. Almost a quarter of the respondents (24.4 per cent) strongly agreed and 37.8 per cent agreed that credentialing should be mandatory. One third of the participants (33.3 per cent), however, disagreed as noted in Table 21 below. This evidence plus the mixed responses from interviewees, as reported in Section III of this report, reflect that the evidence for or against credentialing by this cohort is inconclusive.

Table 21. Mandatory Credentialing of CI's (Percent)

N=45	
Strongly Agree	24.4
Agree	37.8
Disagree	33.3
Strongly Disagree	4.4
Total	100.0

Influence of Fieldwork II on practice preference is the ninth and final practice issue. Respondents in the present study were in agreement with reports of their peers in the literature. The Fieldwork II experience has a strong influence on practice preference as is reflected in Table 22 below. Almost half of survey respondents (48.9 percent) strongly agreed that fieldwork influenced their practice preference with 37.8 percent agreeing. Several of the interviewees concurred that fieldwork influenced their practice preference as is stated in Section III.

Table 22. Level II Fieldwork: Influence on Practice Preference (percent)

N=45	
Strongly Agree	48.9
Agree	37.8
Disagree	11.1
Strongly Disagree	2.2
Total	100.0

*Section III: Rank-Order, Qualitative Responses and Correlations*

The descriptive statistics reported above describe OT’s perceptions of several issues: preparedness for entry-level practice skills, communication, values conflicts, time management, mentoring, supervision, credentialing and practice preference. The following section further elucidates the above responses of new OT’s via rank ordering of the data. The nine practice issues have been collapsed into the four tables below and include the individual survey questions. The practice issues are included in the tables as follows: Preparation for Applying Clinical Skills, Preparation for Communication Issues, Characteristics of the Fieldwork Site, and Preparation for Issues Relating to Reality Shock. The levels of agreement, along with data from the interviews for three of the four research questions will be analyzed first: 1) For which areas of practice do OT’s feel most prepared? 2) Which skill areas remain as obstacles in adjustment to entry-level practice? 3) Should credentialing for clinical instructors be mandatory? The fourth question, “What are the essential elements of an ideal clinical learning environment?” is addressed at the end of this chapter, as it was asked to interviewees only.

Response choices on the survey were on a scale of 1-4, from “very well prepared” to “not at all prepared”. Some questions offered the response choices of “strongly agree” to “strongly disagree”. The means and standard deviation values were calculated for each of the 33 items via SPSS. The items were then rank-ordered in thirds. The questions’

responses with the highest mean scores, 3.51-3.88, represent the areas of practice for which the participants felt most prepared or statements with which they strongly agreed. The responses ranked from 3.33-3.46 reflect those for which the OT's felt moderately prepared, or statements with which they somewhat agreed, and the lowest group of means, those falling below 3.33 represent skills for which the new therapists felt least prepared or statements with which they strongly disagreed.

In examining the areas in which OT's felt most prepared for practice, the analysis begins with the survey participants' perceptions of their preparedness to apply academic and clinical skills (Table 23 below), the first of the four areas of preparedness. The OT's in the study felt most prepared in self-awareness of their learning styles, planning interventions, using their hands-on clinical skills, and eliciting patients' cooperation. Although these are important skills as a clinician, it is equally important to be able to integrate these processes into the organizational system in which one works. This would be reflected in their organizational skills: the ability to plan interventions to fit into the length of the treatment session, prioritizing tasks and managing a full caseload, both of which survey respondents felt prepared.

A moderate response was reported for treating patients with multiple diagnoses" and "able to establish a routine as a new OT". Skills that the new OT's felt least prepared for were related to reading and utilizing the professional literature, the basics of which are learned in the academic segment of training, choosing appropriate assessments and determining the patient's length of stay. Despite these few areas of deficiency, most respondents strongly disagreed with the statement, "Fieldwork *did not* prepare me with adequate organizational skills".

Table 23. Preparation For Applying Academic and Clinical Skills N=45

Question number	Mean	Standard Deviation
High		
2. Hands-on clinical skills	3.58	.657
6. Plan intervention for length treatment session	3.51	.626
8. Managing a full caseload	3.62	.576
10. Prioritizing tasks	3.58	.657
11. Elicit patients' cooperation	3.51	.549
12. Understand your learning style	3.51	.757
Moderate		
1. Treating patients with multiple diagnoses	3.38	.535
18. Able to establish a routine as new OT	3.44	.725
Low		
3. Using current research findings in practice	2.73	.720
4. Reading the professional literature	2.87	.842
5. Choosing appropriate assessments	3.09	.763
7. Determining length of stay	2.98	.965
25. Fieldwork <i>did not</i> prepare me with adequate organizational skills	1.66	.522

Interviewees also felt well-prepared for specific clinical skills. When asked, “In what ways did your Level II fieldwork experience prepare you for entry-level practice?” each of the nine participants enumerated two or more clinical skills.

**Mike: I learned how to do transfers, biomechanical interventions and a lot of ADL [activities of daily living such as bathing]. I learned handling techniques...and how to treat more than one patient at a time.**

**Lisa: The planning and multitasking. You know, thinking about three different treatment plans in one hour, five minutes before they**

**start. Strategies to organize myself. Without the experience of fieldwork I wouldn't have known what to do.**

**Josse: I got a good idea of the basics which are important to rehab: strength training, endurance, family training, tub transfers, emphasis on balance and cognition, serial casting and coma stim [stimulation].**

Respondents to the survey reported feeling less prepared for utilizing the professional literature, understanding assessments and planning for lengths of stay. Although interviewees did not mention those areas specifically, those areas may be ones that clinical educators need to address more consistently. When interviewees were asked what they didn't feel prepared for upon entering practice, several of the interviewees commented on unexpected productivity levels.

**Sandy: One of the things [you have to get used to] in the skilled nursing facility is having to meet a productivity level of 90%. But they really mean 120%. When I first spoke to them before being hired, they said 85%, then the very first day, she said 90%. They kept changing it. I told them that I could meet the high per cent if I didn't have to do documentation and eat lunch. They just tell you to dovetail patients and do more groups. It's really hard to see 13 patients a day.**

**Amanda: That [productivity] was something I really struggled with when I first became a therapist because as a student you don't have to worry about billable hours...To go from being able to take my time and really be able to test everything I wanted to test...to where I had to worry about my hours and my productivity to make it through the day, it was hard because I couldn't do everything I wanted to do with the patient.**

**Mike: Before [in my first job] in the skilled nursing facility people didn't go home [as soon as they do in rehab]. Where I was before, it was a 'get the minutes' kind of company [be sure to bill for the maximum amount of time]. Here it's not like that.**

**Cindy: Being pressured to see two patients at once you sometimes can't give them what's best for them at the time, or what they need. But what can you do? And I think that all therapists are faced with that dilemma.**

**Josse: Another unexpected thing was how much this rehab center emphasizes patient satisfaction to such a degree. It's about getting patients' needs met, at mealtimes or having enough pillows, but to such a degree it was unexpected. [Also] how they deal with week-end work and missed minutes is more intense here than at fieldwork. You have to work six Saturdays and three Sundays in a seven month period.**

The above data may appear to reveal a discrepancy between survey participants' positive perceived level of preparedness for managing a full case load and establishing a routine and interviewees' perceptions of being ill-prepared to meet productivity demands of entry-level practice. There may be a few possible reasons for this. First, the survey did not ask specifically about productivity level. Second, the survey respondents may not be remembering accurately or may be motivated by social desirability issues. As regards interviewees, several of them had a Level II fieldwork in a setting such as sub-acute rehab where patients have a longer stay and then took a first position in an acute care setting where patients have a very short length of stay and where OT's may have a larger

caseload. This case load-length of stay discrepancy may account for these differences in responses.

Both groups of participants in this study seem to be communicating that they are proficient in basic clinical skills as a result of effective training in their rehab fieldwork experience. Productivity issues seem to be separate from overall preparedness in clinical skills and seem to be a function of the specific practice setting.

The second of the four areas of preparedness is related to communication issues (Table 24, below). Communication issues for OT's involves patient/family and interdisciplinary communication. High survey scores are revealed for survey participants regarding their perceived preparation for being a member of an interdisciplinary team. This skill includes reporting about patients at team meetings and planning co-treatments with professionals from other disciplines. The respondents felt moderately prepared for communicating effectively with non-OT's, such as nursing assistants and their supervisor from their first job. Low scores appeared for issues of "communication with clients from different cultures", "talking about issues of death and dying", and "interacting with insurance companies", a task faced from time to time when OT's may need to defend their request for additional treatment sessions for the patient to third-party payers.

Table 24. Preparation For Communication Issues: Interdisciplinary and Patient/Family  
N=45

High=strong preparation/agreement      Moderate=moderate preparation/agreement			
Low=low degree of preparation/agreement			
Question Number		Mean	Standard Deviation
High			
12.	Being member of an interdisciplinary team	3.78	.471
Moderate			
14.	Communicating effectively with supervisor from your first job	3.47	.694
19.	Communicating effectively with non-OT's	3.42	.657
Low			
20.	Interacting with insurance companies	2.16	1.02
13.	Communication with clients from different cultures	3.22	.795
17.	Talking about issues of death and dying	2.44	.990

Interviewees were asked to describe experiences for which they felt prepared as a result of fieldwork. Many of the responses echoed those of survey participants' confidence with interdisciplinary communication.

**Marge: I had great rapport with staff and doctors [at fieldwork]. I learned how to deal with the interdisciplinary approach...using the different services the hospital provided, like interpreters.**

**Cindy: We worked very closely together [with the physical therapists]. I would kind of look to them for help with mobility and with transfers... and we did co-treats.**

Interviewees confirmed having interdisciplinary experience at fieldwork.

**Cindy: Yes...If it was a tough patient, we'd put our heads together and see what we could come up with. [I learned] how to interact with others: PT.'s, nurses and doctors and be assertive when I need to be and make sure I'm advocating for the patient and everything like that.**

**Anne: [I learned] how to work with other professionals and learned what their specialties are...and how to “refer out” was a big thing.**

Unlike their peers in the other medical professions, the OT’s in this study were mostly confident in their abilities to interact with professionals in other disciplines and were satisfied with this aspect of their fieldwork training.

Interviewees did not volunteer much information about ancillary personnel, however, two participants would have liked more experience in fieldwork with rehab aids and assistants:

**Josse: Here at [XYZ Hospital] there are more rehab aids and I didn’t feel ready for that. I needed to know more how to utilize aids. The aids at fieldwork helped the PT’s. I would have liked to know what things you could ask them to do...how to communicate with them.**

**Marge: I think I would have enjoyed a little bit more interaction with a COTA [Certified Occupational Therapy Assistant]. We did have two COTA’s and I don’t think I had enough interaction with them.**

Communication with clients from different cultures is a reality in the workplace today, especially for OT’s working in large cities. This was one of the aspects of practice which survey respondents felt least comfortable despite the fact that every OT academic program includes this topic in its curriculum. It would seem, then, that based on the fact that cultural differences are presented in the academic curriculum, at least to some extent, students are able to have an intellectual understanding of cultural differences, be they

racial, ethnic or socioeconomic, however, when confronted by cultural differences in “real time”, it may be difficult to anticipate one’s reaction.

Interviewees described some of the differences in values and culture they encountered which differed from their own and to which the new OT’s had to adjust. Values conflicts were expressed as follows:

**Amanda: [Yes.] Just people who want to take care of their family member [rather than have the OT enable their independence with self-care] and that’s just the way it is and you can’t get away from that. As for me, I’m a very independent person and would want to do everything for myself. I may want a patient to put socks on, or to get dressed, and they’ll say, ‘No, my family’s going to do that for me.’ [Then I say], ‘But that’s why you’re in rehab, so you can do it for yourself.’**

Different cultural issues emerged for the new OT’s:

**Sandy: Mostly what I learned about culture was in school [as opposed to fieldwork]. With the Hispanic culture, I’ve found that I have to tell the families to ‘back off’ a bit. I don’t remember where I learned that.**

**Lisa: Here the culture is much different. Maybe because this is near the city, and my fieldwork wasn’t. In my fieldwork, we had one Spanish-speaking person over the three months I was there. Here, there’s a new Spanish-speaking patient every week.**

Regarding cultural issues, participants in the study feel less prepared as they encounter patients whose culture differs from their own. Interviewees offered examples of differences related to ethnic culture and socioeconomic status specifically, and the need for the process of clinical reasoning in decision making in unfamiliar circumstances.

The issue of communication with patients and families related to death and dying proved to be a difficult area for the new OT's. Survey respondents echoed the concerns of new medical, nursing and OT practitioners from previous studies in the literature who expressed that this issue, as well as issues of bereavement had been covered less in training. In this current survey only 6.3 percent felt very well prepared with 32.6 percent being somewhat prepared for issues of death and dying. When interviewees were asked, "For what experiences did you *not* feel prepared as a new OT?" two responded with issues related to this:

**Marge: I mean there's lots of things you can't be prepared for til you have experience with it, of course. I don't know...death. It was hard to deal with that. In long term acute care we saw it more often than not.**

One therapist spoke about her experience having to talk about death and dying with a family.

**Marge: Yes. Dealing with [death] with them and dealing with your own personal feelings about it, and taking it personally. There was one woman [at my fieldwork site] who passed away and she had no family ...and that kind of got to me. A lot of our patients at [my fieldwork site] didn't have families. Dealing with intense families [here, in practice] was especially difficult. [Some are] overbearing and interfere...you're not doing enough for their loved one, their friend, or whatever it is.**

For one new OT, the issue of death was the critical experience she recalled from her fieldwork:

**Sandy: In long term care [a critical experience] was experiencing death and how to deal with the family and also my own personal issues. It was an impactful experience because two or three months before that I had**

**lost my grandfather and I had to come to terms with my ideas about death and dying. The experience with the patient taught me how to deal with the family and be respectful of them.**

When asked if there was anything about fieldwork that helped her with this area she responded in the negative:

**Sandy: Not really...What we learned in school was helpful and the fact that I experienced death in my own family helped. Also, I've had a little more life and work experience than some of the younger OT's in school.**

The quantitative and qualitative data point to the fact that novice OT's feel less prepared for issues related to death and dying. Curricula of OT academic programs include the topic of death and dying as well as didactic information about pervasive feelings of loss experienced by patients adjusting to mental and physical disabilities. However, new OT's are reporting that experiences in this area are diverse and learning how to communicate in this area has been through direct experience, in context.

Another area of concern related to interdisciplinary communication which revealed itself as a concern to the OT's but not encountered in the medical and nursing literature, was OT's facing the realities of the medical insurance system. Survey participants felt least prepared for this type of communication. In the medical reimbursement system in the United States, rules and regulations change frequently and specialized documentation is needed to ensure the desired results. When asked what she didn't feel prepared for in her new role, Sandy, one of the interviewees, responded:

**You have to learn the Medicare system and how to be an advocate for the patient. Sometimes it becomes a question of ethics [documenting in such a way that Medicare will allow extended coverage]. This was unexpected. In that system you really sell your soul to the devil. It's really sink or swim in your first job.**

Alexis had a similar perspective.

**[Sometimes the patient has achieved independence] but the insurance is still paying for days, so they keep him here. [Sometimes] the opposite happens where the patient has not plateaued and is not independent [but has no more insurance] and they 'boot him out'. I was really shielded from that as a student, and I think that my supervisor fought really hard for my patient when I was a student, and I wasn't involved in that process. So when I had to come into my own as a therapist and do it for myself, it was kind of shocking for me to realize how much of a game it is. 'Cause it's all about documenting everything in just the right way and sometimes being just a little bit sneaky with your documentation to make sure the patient gets what he needs.**

Regarding preparation for communication with health insurers, the interviewees are in consort with the survey respondents. Although the basics of treatment documentation are covered in the academic programs such as accepted abbreviations, the writing of progress notes and the like, specifics regarding documentation for insurance reimbursement have been reserved for the clinical portion of training. Because of the complexities of the health care system in the U. S. at present, reimbursement specifics change frequently making this a difficult skill to teach both in the classroom and in the field. This reality is reflected in the survey and interview responses of this study.

The third factor contributing to preparedness relates to the characteristics of the fieldwork site and includes supervision and the physical environment (Table 25, below).

Table 25. Characteristics of the Fieldwork Site: Supervision and Physical Environment  
N=45

Question Number	Mean	Standard Deviation
High		
27. An OT supervisor, on-site is important for the student	3.88	.317
30. I had the opportunity to learn from more than one health professional	3.84	.366
Moderate		
21a. My Level II fieldwork influenced my practice preference	3.33	.769
28. Supervisor dedicated one on one time for me	3.46	.694
29. Supervisor had adequate skill giving constructive feedback	3.37	.860
33. Supervisor was competent in preparing me for entry-level practice	3.44	.724
Low		
24. Physical resources at Level II site were adequate for my learning	3.02	.753
31. Supervisor understood my learning style	3.26	.863
32. There should be mandatory credentialing for supervisors	2.82	1.007

Survey respondents had a high level of agreement regarding the importance of an on-site OT supervisor and that they had the opportunity to learn from more than one health professional. There was a moderate level of agreement that fieldwork influenced OT's practice preference. Moderate responses were elicited by three statements describing

supervisor characteristics: dedication of one-on-one time, skill in giving feedback, and overall competency. Lowest levels of agreement were found in response to whether the supervisor understood the student's learning style. Low agreement was also seen regarding the adequacy of the physical resources of the training site and whether credentialing should be mandatory for CI's.

Interviewees had similar responses and elaborated on their experiences. When asked to describe their Fieldwork II learning environment, four of the nine interviewees stated that they had learned from more than one professional at their fieldwork site and related it as a positive experience. This view is corroborated in a pilot study examining students' sources of learning in the clinical environment (Lipsitt, 2003). The following reflects the strong positive influence of learning from interviewees in the current study.

**Lisa: when I went there [fieldwork], I had treatment sessions with the PT and here I do the same thing. That helped me learn what PT does in the clinic and how we can work together.**

**Cindy: [At my Fieldwork II] it was a teaching hospital...it's geared toward students and learning. [It's geared to] the ideal of having your CI and other therapists to help out with things...between my CI, the PT's, the fieldwork coordinators, the other OT's, I felt like I could go to anyone with questions. They were very knowledgeable and helpful.**

**Anne: The transdisciplinary approach helped. The way it was set up...I could get support from the therapists on the other floor...just being able to say, "Hey, I'm having trouble", or "What do you think about this." We could bounce ideas back and forth.**

**Mike: I learned handling techniques and ortho by observing in the gym. Also, how to treat more than one patient at a time.**

**Sandy: It was a small environment and I got to interact with other professionals.**

Moderate levels of agreement were seen in survey participants' responses to questions regarding whether fieldwork influenced their practice preference, and whether their fieldwork supervisors dedicated one-on-one time to them, gave constructive feedback and were competent in preparing them for entry level practice. With regard to the influence of Fieldwork II on choice of practice area, respondents in this study echoed those of their peers in the literature. There were strong statements among interviewees that fieldwork did, indeed, influence their choice of area of practice. Three of the nine interviewees commented on the issue in the context of answering one of these questions, "How did your Fieldwork II prepare you for your first job?" and "Can you describe a critical incident from fieldwork?" Interviewees concurred with survey respondents.

**Sandy: I was planning to go into pediatrics, but experiencing the death of that patient with the family changed me, I decided to go to work in a SNF (skilled nursing facility). It changed where I wanted my career to go.**

**Cindy: I had my first Fieldwork II at a school, and I loved it and said, 'I just have to get through [my rehab fieldwork]' thinking that I would always want to work with children. But here I am! If I had to pick my own fieldwork, I couldn't have picked a better place for me.**

**Berni: [Working with the amputee patient] really opened my eyes to the therapeutic process. I saw the psychosocial aspect of life-changing events. The whole thing made me want to continue to broaden my experience and work in rehab.**

As regards supervisor characteristics, there was a moderate level of agreement to statements in the survey regarding the three characteristics mentioned most often in the literature as being important to students; one-on-one time, skill with constructive feedback, and competence in preparing the student for entry-level practice. Pilot study interviewees mentioned these characteristics as well (Lipsitt, 2003) when describing the attributes of an effective instructor. Interviewees in the current study concurred with survey respondents on the above factors, elaborating on what competence “looks like” and offering additional characteristics as well.

**Interviewer: “What would you include in an ideal Fieldwork II learning experience?”**

**Lisa: Having a good supervisor is essential. A structured time to meet [one-on-one] is important, daily or weekly. If something comes up in the morning, you know you’ll have time in the afternoon to ask about it. You shouldn’t be left stranded.**

**Berni: the student should have a supervisor who is easy to approach and to question even though for the OT it would be a simple question. My supervisor had a good strategy. She would say, ‘I don’t know. Why don’t you look it up tonight and let me know tomorrow.’**

**Josse: The student and the supervisor should meet regularly, 100%, every day, and talk about each patient every day. I don’t care if you [the supervisor]**

**are there extra time—that’s the only way to do it. The supervisor should be asking the right questions. Here [at my job] I meet with my supervisor more than I had to at my fieldwork.**

**Mike: For fieldwork, you just need a good CI, a good teacher. The CI really needs to be ‘up for it’ [taking a student].**

When asked to describe ways that Fieldwork II prepared them for entry-level practice, the interviewees described the importance of close supervision and guidance by the CI’s.

**Sandy: I’d have to say my supervisor really prepared me. She taught me treatment methods...documentation skills, how to set goals. She helped me develop my thought processes...She let me be hands-on early on. She would encourage me to go in there and build rapport. She knew how to give the ‘just-right’ challenge. She allowed me to excel and she set a good example with everything she did.**

**Cindy: I got a calendar with all my meetings...inservices ...weekly meetings with the CI...[when I would be] picking up one patient...eventually a full case load...the way it was done was perfect for me and she [the CI] was always there, and she was always sure that I was comfortable...she was always there to bounce back ideas and stuff.**

**Amanda: [My supervisor] was really helpful. He was there for me when I needed him to be but he also wasn’t breathing down my neck...he was always just out in the hallway if I needed to ask him a question. But he wasn’t there the whole time. So I thought that was really perfect. He also wouldn’t answer all my questions for me, he would make me do a lot of that work on my own which was also helpful.**

In contrast, data from three of the interviewees illustrates how a negative experience with clinical supervisor may affect the student's learning in fieldwork.

**Lisa: My Level II [fieldwork] was during the three months of the summer so my supervisor was on vacation. There were a few Mondays and Fridays, then she took a whole week off. So getting bounced around to different therapists...I couldn't get angry because people can't give up what they're going to do, but that was hard. I was working all of a sudden with another person, then another person, then another person. When she was on vacation, I really felt out of place...I really think consistency is important.**

Anne's supervisor required her to do detailed treatment plans each night throughout her entire twelve weeks at the site, a task which is not required in a real job situation.

**Anne: I had a supervisor who was really hard and I was stressed my entire fieldwork, all 12 weeks. I picked up her case load rather quickly, more quickly than most, I think. When I compared myself to my roommates, I saw that I had much more work. I did treatment plans every night for every patient. That was 8-10 treatment plans a night, and during the time I didn't see it as beneficial and then by the end it seemed repetitive because by that time I had written so many treatment plans...I was pretty proficient at it. So I would say that by the last two weeks it wasn't very helpful, it just added to the stress.**

**Mike: We had a rocky relationship. Actually, she's not an OT anymore. She had some personal problems. I had a lot of self-directed learning [at fieldwork]. It was a 'tough love' type of site. I learned valuable skills. I learned good work habits, like doing paper work over lunch.**

Given the moderate level of agreement regarding supervisor characteristics and the varied responses of the interviewees, it is evident that fieldwork supervisor competence is variable at this point in time and that it is apropos that the national organization is beginning to create a program for voluntary credentialing.

Regarding the physical characteristics of the training site, the data reflects a low level of agreement with the survey statement, “Physical resources at my Level II site were adequate for my learning.” For occupational therapy students, a good instructor is essential, but at the same time, the quality of the physical resources cannot be underestimated. This is due to the fact that occupational therapy stresses rehabilitation training in the context of the living environment. Patients are instructed in modified methods of every-day activities of daily living such as self-care, cooking and other functional tasks related to home, school or work. Rehab sites which do not have quality simulated living environments and adaptive devices would not be an adequate training environment. This view was corroborated by fieldwork students in a pilot study (Lipsitt, 2003) where they enumerated valuable assets of their learning environment such as a greenhouse, gift shop and an ATM machine.

Interviewees in the current study were asked directly to describe the physical settings of their fieldwork sites. Key responses are as follows which describe the variability of their fieldwork sites:

**Anne: There was a clinic with two aides to help you out. There’s an ADL [activities of daily living] suite which is a full functioning apartment, with a full bathroom, bedroom kitchen, washer and dryer.**

Two of the interviewees spoke about the physical environment at their fieldwork.

**Amanda:** [It wasn't big]. They had weights and basic things but not a lot of crafty things or a lot of cool new stuff that's out there, either. It was really ADL focused. ...it was hard to do crafts or other things.

**Berni:** There was a room with a big table in it with equipment on it, like a hand bike. There was a mat where we practiced transfers...and a cooking area. ...it was a VA [Veteran's Administration Hospital] and there were more areas you could branch out to.

The issue of credentialing of fieldwork supervisors is included in this discussion of the characteristics of the fieldwork site. Due to the variability in supervisory skills as reported by OT students and acknowledged by OT academic fieldwork coordinators, the issue of credentialing has come to the forefront of discussion within the profession and was included in the survey. Despite the variability in students' experiences with CI's, there was a low level of agreement in the survey to the statement, "There should be mandatory credentialing for supervisors." Most of the nine interviewees favored some form of training, but were unsure about credentialing specifically despite the fact that three of the nine interviewees reported some difficulties with supervisory issues.

Comments representative of the interviewee cohort are as follows:

**Sandy:** I, personally, had two wonderful CI's, but I have heard horror stories. I've heard that some OT's just take a student to help with the OT's case load...So, I think it would be wise to let the OT's know what students need to get out of it [Fieldwork II].

**Lisa:** From a student's point of view, I think it's a good idea. looking at it as an OT, I feel that any OT should be able to

**handle having a student. We are trained to be OT's and should be able to pass this on to other people whether credentialed or not.**

**Cindy: I actually don't think they need to be credentialed. I think that licensed and having one year experience... well, maybe one year's not...maybe it would help. I had a very positive experience [with supervisors], but maybe for some people it would benefit them to teach them how to structure [the fieldwork] and how to give feedback, and setting goals. Actually, maybe if it's based on that, [yes].**

**Amanda: I don't think I know enough to say if it's important, but I think we should have some sort of training at your job or somewhere else because I've seen it here where therapists are unsure of what the expectations are and it puts them and their student...it's negative for both of them. 'Cause the supervisor's unsure of what their role's supposed to be and how to guide the student along.**

**Berni: Actually, I went to a course on supervision. There was good information. It was helpful. I think something like this for all supervisors would help to standardize the fieldwork experience for students.**

This data reflects the fact that overall, these participants do not feel strongly about credentialing of supervisors. This may be explained by the fact that the supervisory process is a very individual one. Students who had positive supervisory relationships do not have the perspective to judge how the situation might be otherwise and, therefore, do not perceive a need for credentialing.

The fourth and final area of preparation relates to preparedness for issues relating to reality shock (Table 26, below). Survey respondents were in consort with their peers in

the literature regarding a lack of preparedness to take on a student in their own field, while they themselves were still novices. A low level of agreement was also seen in response to preparedness to cope with seeing the variations in quality of care by others, self-advocacy and seeking a mentor, and the ability to handle office politics. These were challenges also faced by other new health care professionals. The new OT's, however, unlike their peers did not agree with the statement, "It was hard to adjust to the 'real way' of doing things versus the 'school way'." This suggests that the new OT's were able to differentiate between learning via classroom simulations, case studies and the like, and learning situated in the field. It reflects a cognitive flexibility in learning through various sources.

Table 26. Preparation For Issues Relating to Reality Shock N=45

Question number	Standard Deviation		
	High	Moderate	Low
9. Taking on a Level II student		2.82	1.007
15. Advocating for yourself and seeking a mentor as a new OT.		3.13	.815
22. Prepared to cope with seeing the variations in quality of care by others		3.22	.636
23. Prepared to handle office politics		2.86	.868
26. It was hard to adjust to the "real way" of doing things versus the "school way"		2.37	.833

High=strong preparation/agreement Moderate=moderate preparation/agreement

Low=low degree of preparation/low level of agreement

In addition to the survey data, interviewees contributed their experiences related to some of the issues noted above. When asked to describe an experience at their first job for which the interviewees did not feel prepared, only Lisa spoke about being assigned a

Level I (once a week onsite) fieldwork student. None of the interviewees had been assigned a Fieldwork II student at the time of their interview.

**Lisa: I [had a] Level I student I wasn't prepared for. I learned what to do with her from my boss, not from what I learned in school. I didn't feel prepared from school to have a Level I. Not that it is very difficult but just...[coming up with] different ideas...and how to critique, and different things like that.**

The fact that this new OT did not feel prepared to supervise a student for a once-a-week fieldwork assignment, allows for the assumption that she would not be adequately prepared to assume a supervisory role for a full-time Fieldwork Level II student who would be with her daily for three months. Preparation for the teaching role, in the present system, according to the OT's is not adequate .

Variability in practice is not uncommon in the clinical setting given the various educational institutions and experiences of individuals. Survey respondents felt least prepared for this. The interviewees were asked to speak about anything they were surprised about upon entering practice. As was the case with the survey respondents, the interviewees were surprised about the variability in practice among OT's and other health professionals.

**Josse: I don't feel that rehab nursing is up to par here. I don't see them putting in the same amount of effort that we do...They may say, 'Oh, I'll get to that.' I've seen impatience and annoyance at every-day kinds of things, like patient needs, pain situations. We had a patient who expressed his frustration at having to wait two hours for medication. He discharged himself. We were upset because we were working so hard to get him functional.**

Marge commented about two situations she encountered on her first job.

**Marge:** On my first job, we had a therapist who wasn't really carrying her weight. She was pregnant and she was asking other people to do some of her duties. Do you just deal with it there or do you go to your supervisor? My choice was to go to the supervisor because it got to be too much and actually got to be a safety issue at one point. But knowing when to do that, how to do that, how to balance and manage that is a bit difficult. That's something you don't really learn on fieldwork. [another surprising thing] was [sometimes] trying to understand why certain interventions were done [by another therapist]. I've never had trouble going up and asking [why something was done]. If I understand it, then I won't be so judgmental about it...But seeing that everybody doesn't do it your way was a little hard to take.

Amanda also reported an incident.

**Amanda:** There was a therapist who worked here who was probably committing fraud [which I wasn't witness to]. But I had one issue with her and I went to my boss and nothing was done. [What happened was] I had a morbidly obese patient who I always kind of talked about at lunch time...She was a dependent, 2-person transfer. And I would always try to problem-solve things to do with her. So that therapist went up to her room one day without telling me and started chatting with her and then came back and said, 'Oh, Amanda, she's so big!' And just commenting on her weight and everything and [saying], 'By the way, here's some ideas of what you can do with her, when her ideas were totally inappropriate for anything...and for me, the only reason she went up there...I've talked about other patients before... but she'd never gone up to see *them* before. I interpreted that as, 'Oh, this woman's a freak show, so I want to go and see how big she is!' She has said other inappropriate things about other patients before. I had a lot of values issues with her. I just chose to ignore her.

Acquiring mentoring seems to be an issue among the survey respondents, however, two interviewees reported positive experiences in this area. Anne, an interviewee, is still on her first job after graduation, however, she was recently transferred to another floor of the same institution. She expressed the importance of having good mentoring and is grateful for the support available at her workplace.

**Anne: When I came to this floor, I could get support from the the therapists on the other floor. Just being able to say, ‘Hey, I’m having trouble’, or ‘What do you think about this?’ We could bounce ideas back and forth.**

Josse is also grateful for good mentorship at her work site.

**Josse: One thing about this place is that there are better working relationships than I had at Fieldwork II. The OT’s there didn’t consult with other OT’s but here you’re expected to go to your team leaders. There’s really good mentorship.**

Amanda and Marge do not have the mentorship that they would like at their respective work sites. When asked, “Is there anything you want to say about transitioning from student to OT?” They replied as follows:

**Amanda: For me the most difficult thing is, the whole time you’re a student you have this nice person with you, willing to help you out and answer your questions. When you’re a therapist, you have people, but not like you used to. I think for me that was hard ‘cause I was so used to being like, ‘[supervisor’s name]! What’s this?’ or, ‘Is this O.K.?’ I like a lot of feedback. So it was hard to go from having a lot of feedback to not having any.**

**Marge: As far as my first job went, we were kind of thrown to the wolves. I learned a lot from my physical therapy partners that I had and some from the OT's I worked with and very little from my supervisor. They were there if we needed them, but they didn't really seek us out.**

The issue of mentorship is an important one as novice professionals need to continually develop and learn from the very beginning as they enter the health care practice arena. The survey data reveals a lack in the new OT's ability to seek mentorship. The mixed responses of the interviewees reveals the importance of mentorship in the workplace and that mentorship is inconsistent at rehab clinical sites at this point in time, according to the participants in this study.

The issue of preparation for office politics, for which survey respondents did not feel especially prepared was relevant, as well to interviewees. Encountering workplace politics was a new and difficult phenomenon for some.

**Marge: Of course [when you're a student] they want to be careful what they say around you. They're trying to be professional. But when you [as an official employee] are in that setting the professionalism goes out the door. It was a little difficult in my first job.**

**Cindy: Yeah there's always talk about people and the boss And maybe about a therapist who did something and it Wasn't quite...[I saw] just a little.**

**Amanda: I was shielded from all the politics of everything when I was a student. I was purely there to treat patients...**

**and then as a therapist, you're exposed to everything...all of the politics and drama of working somewhere, so I think I was kind of shocked about that because I love rehab but there's a lot of drama. Sometimes therapists get blamed for wanting to hold onto patients.**

In addition to the issues enumerated in Table 26 above, interviewees described three additional realities in today's health care environment. None of these were mentioned in the literature, but proved to be impactful for the new OT's; namely, the phenomenon of homelessness, the realities of the current health insurance system over and above the documentation issues as mentioned previously, and lastly, the issue of establishing emotional boundaries with patients.

For some OT's working in their first professional position, this was their first intimate exposure to those who are homeless. Encountering the phenomenon of homelessness was impactful for new OT's. For some, the mix of people which included those who were homeless, was a challenge.

**Anne: You get a mix of people...When you see people [here] your own age [who are homeless], you're kind of amazed especially when, like I come from a family where people have a college education and here I meet people who dropped out of grade school, or they didn't complete high school. So you have to change your thinking about what kind of approach you're going to take, how are they going to return to their life.**

**Cindy: We had homeless people we had to get to Shelters or place them in skilled facilities. Yeah, those things were initially shocking. Actually, now that I think back, I had one guy who was real agitated and he was really unpleasant...I found out that he was homeless, fell off a park bench and got a spinal cord injury. I was just, like, 'My God!'**

**And where was he going to go? He had no family, nothing. We had responsibility for this guy all of a sudden and he wanted to have nothing to do with us...And [another time] this [homeless] guy was leaving, he said his daughter was home, but his daughter wasn't home, so they didn't know where to drop him off.**

**Anne: Absolutely. You get a mix of people...What's so interesting about this floor is that you'll be walking down and see a patient that was homeless...no discharge plan whatsoever, and you're working your butt off getting him independent, even though their goal is to return back to the streets.**

In addition to encountering individuals who are homeless, interviewees also found the workings of the health insurance system unexpectedly problematic and troublesome. The following comments elaborate on this point as well as augment what was said by interviewees related to communication in the section on communication issues. The following comments describe some of the values conflicts experienced.

**Cindy: [taking several seconds to answer]. Insurance... if it stops. If someone wasn't covered, they had to kick them out. And other people it seemed like they could stay forever. Some of them wouldn't be able to get out-patient [therapy] so they said, 'Let's keep him for four weeks instead of three weeks.'...At first it was shocking, unbelievable and why we keep some people longer than we need to, while other people need us... because of insurance coverage issues.**

Comments related to the insurance system emerged in two contexts. The first was the section on communication and included the complexities of documentation. The second, the reality shock of seeing the fundamental workings of the system itself, to the extent

that some individuals are given limited care due to coverage issues and others denied care altogether due to lack of coverage. These realities impact on the idealism of new OT's.

The last issue related to reality shock mentioned by the interviewees was the reality of having to set emotional boundaries when encountering difficult behaviors or responding to inappropriate patient communication. These comments were offered when asked about critical incidents at fieldwork.

**Marge: Here's the one that sticks out in my mind. My supervisor had a middle-aged stroke patient. He was one of my first patients and we got to know each other really well over the several weeks he was there. He played that whole line of him being a male and me being a female. Sometimes he'd make inappropriate comments. It got to the point [where] my supervisor had to point this out to me where I was treating him more as a friend than a therapist. The line became very fuzzy and I had to step back. I let it go a little bit "beyond" and it wasn't benefiting him...or myself. I had to revamp my whole approach. One of the reasons I became a therapist is because of being [able to be so] personal, but then trying to find that line and not to cross that, is so hard. You get so close with your patients...they become family-like.**

Marge also commented on communicating about death with a patient's family.

**Dealing with it [the death] with them and dealing with your own personal feelings about it, and taking it personally. There was one woman who passed away and she had no family...and that kind of got to me.**

Josse related her response to her patient who was told that she, the patient may have ALS (a terminal neurological disease).

**In being supportive of her and dealing with psychosocial issues, I became very close with her. The neuropsychologist was there to help and came to me and said, ‘This must be hard for you.’ I was shocked at how close I became with her and other patients, and how *their* bad news became *my* bad news.**

Anne described her reactions to experiencing patients’ extreme behaviors on the brain injury floor prior to her learning, in time, to set internal emotional boundaries.

**I would say I wasn’t prepared for the behavioral outbursts. On my very first day, I had a patient in leather restraints, which we virtually never use on this floor. I had a patient that bit his roommate and drew blood...Also, the sexual inappropriateness and how to handle that. It was very overwhelming coming to the brain injury world from the stroke world. I don’t think you can be prepared for that. I think that it’s something you learn with time, and I was mentored.**

A search of the literature revealed the reality shock issues which are common to all the novice health care practitioners studied. These were used to formulate several of the survey questions. Interviewees contributed the additional challenges of interfacing with patients who were homeless, being confronted with limits of the health insurance system and creating emotional boundaries in order to allow for effective treatment of patients. For the participants in this study, these appear to be additional concerns not adequately addressed in fieldwork.

In addition to ranked data, Pearson correlations were calculated (Table 27). Two positive moderate correlations were found. The age of the CI shows a moderate positive correlation with dedicating one-on-one time with the student and with competence in preparing the student for entry-level practice. These were significant at the .01 level (2-tailed test). The supervisors’ years in practice was moderately correlated at the .05 level

with his or her understanding of the student’s learning style and correlated at the .01 level with his or her competency in preparing students for entry-level practice. It would seem that years in practice as an OT may not only translate into clinical competence but also in ability to discern students’ needs such as quality time with the supervisor and teaching to the student’s learning style. The majority of the survey respondents, 88.9 percent reported that their supervisors had been in practice for four or more years and ranged in age from 31-41.

Table 27. Statistically Significant Correlations Related to Supervisor Competency N=45

Survey Question	Age of Supervisor	Supervisor Years in Practice
27. Pearson Sig. (2-tailed)  An OT supervisor, on site is important for a Level II student.	.147 .337	.365* .014
28. Pearson Sig. (2-tailed)  My supervisor consistently dedicated one-on-one time for me.	.428** .003	- .100 .512
31. Pearson Sig. (2-tailed)  My supervisor understood my learning style.	.223 .142	.331* .026
33. Pearson Sig. (2-tailed)  My Level II supervisor was competent in preparing me for entry-level practice.	.394** .007	.480** .001

\*Correlation is significant at the .05 level.

\*\*Correlation is significant at the .01 level.

#### *Section IV: Synthesis of Data as Response to Research Questions*

The combined quantitative and qualitative data provide insight into the issues particular to novice OT's perceptions of their rehab Level II Fieldwork experiences. The nine practice issues were collapsed into four categories and represented in Tables 23-26. The data in each table in conjunction with the interviews inform three of the four research questions: for which areas of practice do OT's feel most prepared upon entering the work place, which skill areas do they see as obstacles to a smooth transition, what are the essential elements of an ideal learning environment and whether CI's should be credentialed. Table 28 summarizes the areas OT's felt most and least prepared for.

The answer to the first research question under consideration, "For which areas do the novice OT's feel most prepared?" the answer is found in the rank-ordered levels of agreement to specific questions. Regarding preparation for applying academic and clinical skills, the data reflects that the OT's feel most prepared for hands-on clinical skills, planning interventions to fit the length of the treatment session, prioritizing tasks, eliciting patients' cooperation and understanding their own learning styles. They also feel mostly prepared, but to a more moderate degree for treating patients with multiple diagnoses and establishing a routine as a new OT. Survey participants felt adequately prepared with organizational skills. This is evidenced by the fact that there was a low level of agreement to the statement, "Fieldwork *did not* prepare me with adequate organizational skills." Interviewees were asked to enumerate how their Level II Fieldwork prepared them for practice. They, too, concurred with the survey participants about hands-on clinical skills naming specific ones such as biomechanics and activities of daily living.

One discrepancy was found between the responses of the two groups. Survey participants felt very prepared to manage a full caseload and establish a routine. However, several of the interviewees felt ill-prepared for the productivity levels expected at their first job. Since both groups perceive themselves to be most prepared for clinical skills and all the interviewees reported treating a full caseload by the end of their fieldwork, it is the opinion of the researcher that this discrepancy may be explained in two ways. First, productivity levels are individual for each facility. Second, tasks included in the calculation of productivity levels most likely include tasks over and above treatment of patients. These may include documentation, attendance at meetings, inservices, organizing supplies or program planning.

The second area for which the participants felt most prepared was interdisciplinary communication and communication with their supervisors from their first jobs. Both the survey participants and the interviewees felt competent in this area coming into their first employment situation. Interviewees described feeling competent at team meetings where they interfaced with physicians nurses and other health professionals as well as successfully co-treating patients with PT's.

The second research question is "Which skill areas are obstacles in adjustment to entry-level practice?" Obstacles include deficits in preparation in the areas of clinical skills, communication and realities of the workplace, referred to as "reality shock". In the area of academic and clinical skills, the lowest responses were associated with four skills: reading the professional literature, using current research findings in practice, choosing appropriate assessments, and determining lengths of stay. With regard to reading and applying research, it is noteworthy that in recent years leaders in the

profession have been stressing the importance of evidence-based practice in an effort to raise the status of OT among the health professions, however, not all OT's are proficient in accessing and utilizing research. The reason for this may be that at this point in time there is variability among academic programs in their use of research in the curriculum. In addition not all rehab facilities have consistent, established inservice programming and mentoring in this area.

The OT's in this study also felt ill-prepared for interacting with insurance companies, communication with clients from different cultures and talking about issues of death and dying with patients and their families. Interviewees as well as survey participants had difficulty when faced with having to intercede with insurance companies on behalf of a patient. Learning the specifics of effective documentation in order to continue treatment was a challenge reported by interviewees. When OT's have student status during fieldwork, very often their supervisor will handle communication with the insurance companies and students may not be exposed to some of these tasks.

Communication with clients from different cultures is often a new experience for novice OT's depending on where they had their fieldwork. For OT's working in the inner city for the first time, it may be challenging to encounter a large number of foreign language speakers or an ethnically diverse patient population. Survey participants in particular did not feel prepared for this area of practice. Only one of the interviewees mentioned having to adjust to the Spanish speaking population she encounters in her workplace. Interviewees were not asked specifically about communication with those from other cultures, but responses to this issue came about when they were asked if there was anything they did not feel prepared for as a new OT. They offered examples from

practice where they encountered individuals of different ethnic and socioeconomic groups and the challenges involved.

Speaking to patients and families about issues of death and dying may be challenging at any point in one's career as a health professional. Both survey participants and interviewees noted their difficulty with this task. This type of communication many times has the effect of therapists needing to set emotional boundaries in order to remain effective in the workplace, an issue associated with the realities of the workplace which is the next topic of discussion.

The third area in which the participants felt least prepared relates to the realities of the workplace, referred to in this study as "reality shock". In this category survey participants felt least prepared to take on a Level II student, and seeking a mentor in the workplace. Interviewees as well as survey participants felt least prepared to cope with the variations in quality of care by others, and office politics. Regarding mentorship, responses of interviewees were mixed which reflects the variation and non-standardization of policies regarding new OT's at the clinical sites. During the course of the interviews three other areas related to reality shock emerged: the need to set emotional boundaries with patients to maintain professionalism, the shock of encountering homelessness and its challenges for discharge planning and the inequities of the current health insurance system.

Table 28 summarizes specifically which areas entry-level therapists felt prepared for as a result of their Level II Fieldwork clinical training.

Table 28. Preparation For Practice Acquired in Level II Fieldwork

Skills	Most Prepared	More Preparation Needed	Inconclusive
<b>Clinical Skills</b>			
Hands-on clinical skills	X		
Interdisciplinary communication	X		
Communication with supervisor	X		
Choosing assessments		X	
Determining length of stay		X	
Reading & Utilizing Research		X	
<b>Communication</b>			
With insurance companies		X	
Diverse cultures		X	
Issues of death and dying		X	
<b>Reality Shock</b>			
Assigned a Level II student		X	
Observing variations in care		X	
Handle office politics		X	
Setting emotional boundaries		X	
Encountering homelessness		X	
Observing insurance inequities		X	
Ability to seek mentoring			X

Table 29. Ideal Level II Learning Experience (N=9) Interviewees

Characteristic	Number of Interviewees Specifying
Varied Population on Site	7
Well-Equipped	6
Take on Patients gradually	5
Structured Program	4
Structured Orientation	3
Opportunity to Rotate	3
Inservice Education	3
Interdisciplinary Approach	3

Table 30. Supervisor Characteristics (N=9) Interviewees

Characteristic	Number of Interviewees Specifying
Good Teaching Skills	9
Approachable/Tolerant/Patient	7
Good Communication Skills	6
Dedicated	5

The data analyzed and summarized above and illustrated in Table 30 offer the answers to the first two research questions regarding which areas novice OT's felt most and least prepared for upon entering professional practice.

As was mentioned previously, responses to the third query as to whether clinical educators should be credentialed were varied and the evidence is inconclusive. What was evident however, relates to the fourth research question about what constitutes an ideal learning environment. Here, the key role the supervisor was stressed by the interviewees as they described how a positive or negative experience with the supervisor may affect training as well as practice preference. A well-equipped site is also essential for the most effective training of OT's, as evidenced by the testimony of the interviewees and participants of the pilot study (Lipsitt, 2003). Tables 29 and 30 illustrate interviewees' perspectives on the ideal clinical learning environment and supervisor traits.

Interviewees were not asked specifically about supervisor traits, however, this data emerged in the context of the discussion regarding the physical learning environment.

## CHAPTER 5

### DISCUSSION

#### *Revised Framework and Addressing Challenges*

For the past seven decades, occupational therapy students have had the requirement of fieldwork training for the purpose of allowing them to apply, under the supervision of a mentor, what they have learned in their academic program. In light of the paucity of research in this area, this study was designed to determine the effectiveness of Level II rehab fieldwork in preparing students for entry-level practice in the rehab setting. A conceptual framework was constructed based on common challenges among medical, nursing and occupational therapy students as reported in the professional literature of the past twenty years (Figure 1). Data analysis of the study at hand yielded differences between the experiences of OT's and their medical counterparts physicians and nurses. The revised framework, below, was constructed to reflect the challenges of the OT's in the study (Figure 2). The discussion which follows examines how the findings of the study informed the construction of a revised framework, which reflects the challenges of novice OT's specifically, as perceived by the participants. Recommendations for addressing these challenges will be presented. The limitations of this study will be noted as well as possible foci for further research.

Survey and interview data reveal that for this cohort, FWII clinical hands on skills training was effective. The 45 survey participants and nine interviewees felt adequately prepared in their hands-on skills and were better prepared, based on their self-reports, than the new nurses, physicians and OT's in previous studies. This development may be due to the fact that in the earlier years of this decade, all OT programs were required to

be upgraded to the post baccalaureate level. In light of this positive finding, the factor of clinical skills was eliminated from the revised framework. One adjunctive skill which supports clinical skills is utilization of the professional literature. Survey respondents felt less prepared in this area. Research and utilizing the literature is an emerging skill as academic programs move into advanced master's and clinical doctorate programs. Improvements in this area may be seen in the future with increased instruction and direction on the clinical side, however, time constraints in today's workplace are an issue. Creative solutions such as "Lunch and Learn" journal clubs in the workplace may be worthwhile.

Communication A, representing communication between the OT, patients and families is an ongoing issue for new therapists. The reason for this is that OT's work very closely on a psychological as well as a physical level when treating patients. OT's try to promote functioning through meaningful activities, ones that are very individual and personal to each patient. Therefore, it is not unusual for personal issues such as death and dying to arise from time to time depending on the patient's diagnosis. Patients may have existential questions about their circumstances. This is an area where individual therapists need to develop their own perspectives on spirituality. This is not to suggest that they embark upon pastoral counseling, but rather, working through spiritual issues, such as determining one's own beliefs and priorities in life will assist the new OT in gaining confidence in serving as a sounding board or referring the patient to a counselor or clergy. In addition, it may assist the therapist in dealing with her own response to the patient's emotions. Fieldwork supervisors may also recommend readings on death and

bereavement to assist the student, as well as articles on spirituality and palliative care in occupational therapy practice.

Communication B, interdisciplinary and intradisciplinary communication is an area in which OT's in this study felt prepared. In this area of expertise, they differed from some other medically related professions as reflected in the literature. The culture of the OT profession values flexibility and teamwork, values which are implicitly taught on the academic as well as the clinical side of OT education. An offshoot of the communication issue which was revealed to be somewhat problematic was documentation of services to ensure reimbursement for services. Although students are introduced to documentation during their academic program, most of what they will need to know is acquired during fieldwork. An effective method to assist with this skill would be increased one-on-one training, a dedicated block of time with the fieldwork supervisor, for this explicit purpose. Additionally, a module on documentation for new OT's as part of their orientation to the workplace may also be effective. This might include an instruction manual with practice exercises and guidelines, designed for the specific facility has the potential to advance the learning of the new OT. Because documentation remains an issue, Communication B was retained in the revised framework.

OT's were in consort with their peers in nursing and medicine with the issue of reality shock as they deemed high productivity levels a shock. However, for OT's, the reasons for this surprise may be different. Despite the fact that each of the OT's interviewed in this study reported that by the end of their fieldwork they were treating a full case load of patients, upon entering practice, they were surprised by the high productivity levels. This may be due to a fieldwork in long term care, where there is a slower pace and smaller

caseload in contrast to accepting a position in an adult physical rehabilitation hospital which is faster paced, may include responsibilities for group therapy and a higher caseload. Criteria for caseload are individual to each facility and should be addressed during an organized orientation. In addition, new therapists might be allowed to take on a full caseload gradually during the first few weeks of employment as they adjust to the new pace and environment. Also helpful would be trained mentors who would provide strategies on time management and appropriate interventions which accommodate time constraints.

Aside from high productivity levels, additional areas of reality shock emerged in this study which were not prevalent for other early career health care professionals. These include homelessness, insurance inequities, boundary setting, encountering different cultures, variations in care and varying availability to obtain mentoring. All of these were specifically mentioned by interviewees in this study and are included in the revised framework. These issues would be best addressed on both the academic and clinical side of education.

Courses in Healthcare Systems need to include information on the realities of these systems in practice as well as the current rules and regulations in order that students may be better prepared to manage complexities as they arise in the work place. Modules on culture, prevalent in all OT curricula need to address poverty and homelessness, in addition to information on ethnic diversity among patients. The issue of treating individuals who are homeless is particularly problematic for OT's who are trained to direct intervention planning based on the patient's home environment including physical and social supports. Not having a specific home environment in mind may leave a new

therapist in a quandary about identifying appropriate functional activities to address. It may be helpful for seasoned OT's to guest lecture in academic programs in order to offer their personal experiences in this area and to present case studies as part of new therapists' exposure to this phenomenon in our society. The next issue to be included in the revised framework, variations in care, may be observed in rehab practice. The offering of case studies reflecting this as part of the study of the occupational therapy code of ethics, while in the academic program, may prove to be beneficial.

While the above issues relate to both the academic and clinical aspect of education, one key factor in the training of new OT's is specific to the clinical side, namely, mentorship. The inconsistency in the availability of skilled mentors in the workplace has been reported in the medical, nursing and OT literature. Mentoring support for participants in this study is variable and is a factor which has been retained in the revised conceptual framework.

The skilled mentor has the potential to serve as a bridge between the fieldwork experience and entry-level practice and as such may contribute to a shortened adjustment period for the new practitioner. This would serve to increase productivity for the facility and decrease stress for the OT. Forehand (2008) suggests that the mentoring relationship should be one "...characterized by guidance, modeling, collaboration, collegiality, clear communication, and mutual enrichment of experiences...[versus] rigidly hierarchical" (p. 749). These characteristics reflect that both the art and science of practice are needed to be an effective mentor, and therefore, it is reasonable to suggest that appropriate individuals in the workplace be singled out for special training to be mentors for new OT's. A structured orientation program which would include extended mentorship for

two or three months would also assist in the transition of new therapists into the profession.

### REVISED CONCEPTUAL FRAMEWORK

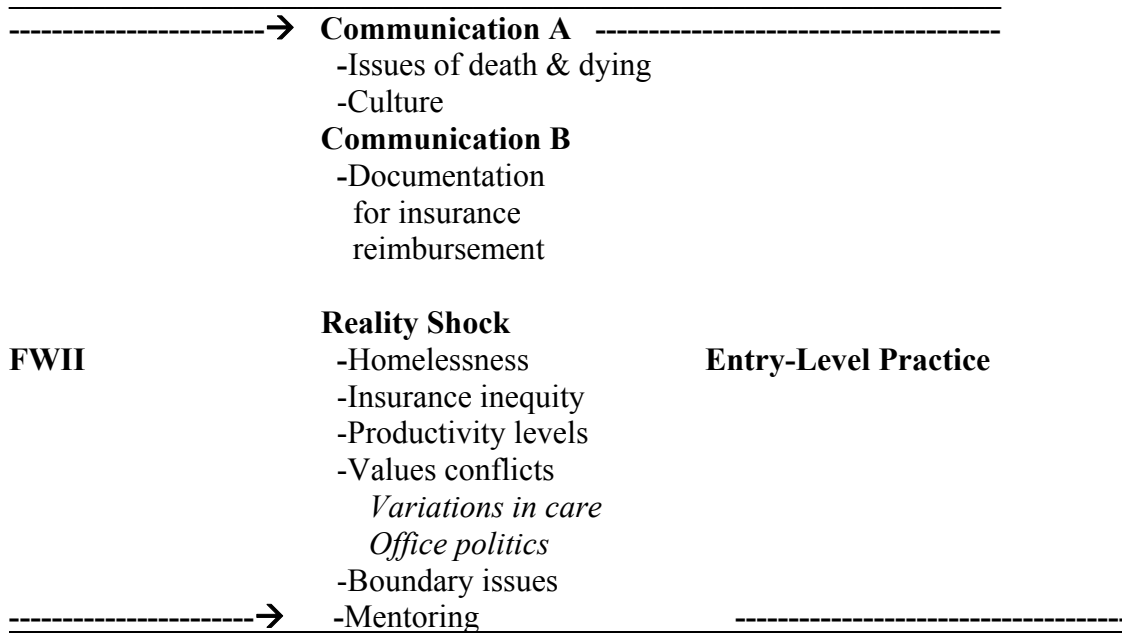


Figure 2: Challenges of Entry-Level OT's

#### *Limitations of the Study and Future Research*

The future of occupational therapy depends on the quality of the profession's educational system including clinical training. In order to properly determine effectiveness of rehab clinical educators and training sites, it would be advantageous to expand the size and geographical area of the study as this research was limited to the northeast U.S. Given the small cohort, transferability of results from this study is limited to participants with 1-3 years experience in the field of rehab and who work at sites

similar to those described in the study. With a higher response rate there would be less concern about responders' tendency to answer positively to questions regarding their training, or may be influenced by social desirability. Given that participants were 1-3 years post fieldwork, recall bias may be an issue as well. It is also difficult to determine whether the perceptions of the OT's as to the adequacy of their training indeed reflects their actual performance.

Limitations notwithstanding, the current study informs the profession as to several challenges faced by new OT's in a particular cohort, as they transition into professional practice. Results suggest a need for more intense instruction in specific areas of study on both the academic and clinical side. In addition, structured orientation and mentorship in the workplace appear to be variable among training sites, suggesting a need to focus on improving and standardizing this aspect of clinical training. The findings of this study may serve as an impetus for further inquiry. Future research examining whether similar challenges exist in other OT practice domains would assist in validating current findings. The issues related to the concept of "reality shock" require further elucidation as they speak to the complexity of practice, the interactions of individuals and the systems in which they work. In addition, research designed to further understand all of the concepts in the revised framework and how they interrelate, would be particularly informative. Research in the profession whether clinical or related to education is a core value and contributes to the improvement of OT education. It supports the profession's vision for the future which includes evidence-based practice in all areas. By improving OT education through research, therapists contribute to the ongoing development and perpetuation of the profession.

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**APPENDIX A**  
**ONLINE SURVEY AND RESULTS**



**OT Level II Fieldwork: Effectiveness in Preparing Students for Entry-Level Practice in the Rehab Setting**

**Results expressed in per cents.**

**Section I:** Directions

Choose the response which best describes your experience. With your first employment setting in mind, how well would you say your Level II rehab fieldwork prepared you for:

	very well prepared	somewhat prepared	not very prepared	not at all prepared
1. Treating patients with multiple diagnoses.	40.9	56.8	2.3	0
2. Hands-on clinical skills.	61.4	31.8	6.8	0
3. Using current research findings in practice.	13.6	50	34.1	2.3
4. Reading the professional literature.	25.0	40.9	29.5	4.5
5. Evaluating and choosing appropriate assessments.	31.8	50	15.9	2.3
6. Planning interventions to fit the length of the treatment session.	59.1	34.1	6.8	0
7. Determining “length of stay” for the patient.	34.1	43.2	13.6	9.1
8. Managing a full case load.	68.2	27.3	4.5	0
9. Taking on a Level II student.	30.2	37.2	18.6	14.0
10. Prioritizing tasks.	65.9	29.5	2.3	2.3
11. Eliciting clients’ cooperation.	54.5	43.2	2.3	0
12. Being a member of an interdisciplinary team.	79.5	18.2	2.3	0
13. Communicating with clients from a different culture.	40.9	45.5	9.1	4.5

**OT Level II Rehab Fieldwork: Effectiveness in Preparing Students for Entry Level Practice in the Rehab Setting**

With your first employment practice setting in mind, how well would you say your Level II rehab fieldwork prepared you for:

	very well prepared	somewhat prepared	not very prepared	not at all prepared
14. Communicating effectively with the clinical supervisor from your first job.	59.1	29.5	11.4	0
15. Advocating for yourself and seeking a mentor as a new OT.	36.4	47.7	13.6	2.3
16. Understanding your own learning style and mentorship needs.	67.4	25.6	4.7	2.3
17. Feeling comfortable talking to patients about issues of death and dying.	16.3	32.6	32.6	18.6
18. Being able to establish a routine as a new OT.	56.8	34.1	6.8	2.3
19. Communicating effectively with non-OT's and ancillary personnel.	45.5	50.0	2.3	2.3
20. Interacting with health insurance companies.	11.4	27.3	31.8	29.5
21. With your first employment practice setting in mind, how well would you say your Level II rehab FW prepared you for hands-on clinical skills?	52.3	40.9	6.8	0

**Section 2:** Directions (Results expressed in per cents)

Indicate to what extent you agree or disagree with the following statements about your Level II Fieldwork.

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	strongly agree	agree	disagree	strongly disagree
21. My level II fieldwork influenced my practice preference.	50.0	40.5	9.5	0.0
22. I felt prepared to cope, as a new OT, with seeing the variations in the quality of care given by different OT's in my setting.	37.2	51.2	11.6	0.0
23. My Level II fieldwork prepared me to handle office politics in my first position as an OT.	25.6	37.2	32.6	4.7
24. My Level II fieldwork did not prepare me with adequate organizational skills as an entry-level OT.	25.6	53.5	18.6	2.3
25. After my Level II, it was hard to adjust to the difference between the "school-way and the "real world" way of doing things.	11.9	28.6	47.6	11.9
26. An OT supervisor, on site is important for a Level II student.	88.4	11.6	0.0	0.0
27. My Level II supervisor consistently dedicated "one-on-one" time for me.	58.1	30.2	11.6	0.0
28. My Level II supervisor had adequate skill in giving constructive feedback.	62.8	23.3	9.3	4.7
29. I had the opportunity to learn from more than one health professional while on FWII.	83.7	16.3	0.0	0.0
30. My supervisor understood my learning style.	48.8	39.5	7.0	4.7

Indicate to what extent you agree or disagree with the following statements about your Level II Fieldwork.

	Strongly agree	Agree	Disagree	Strongly disagree
31. There should be mandatory credentialing or certification requirements for all Level II Fieldwork student supervisors.	27.9	34.9	32.6	4.7
32. My Level II supervisor was competent in preparing me for entry-level practice.	58.1	34.9	4.7	2.3
33. The physical, non-human resources at my Level II site were adequate for my learning.	35.0	53.0	18.6	2.3

**APPENDIX B**  
**INTERVIEW QUESTIONS**

## **Interview Questions**

### **OT Level II Rehab Fieldwork: Effectiveness in Preparing Students for Entry-Level Practice in the Rehab Setting**

#### Interview Questions

1. Describe your rehab Level II setting and compare it to the setting of your first job.
2. In what ways did your Level II FW experience prepare you for entry-level practice?
3. Describe a critical incident, a defining moment, during your FWII.
4. Describe some experiences which were not helpful in preparing you for your first practice setting.
5. From your perspective, were there experiences as a new OT for which you did not feel prepared?
6. If you were to design the ideal FW Level II experience, what would that look like?
7. Do you feel that credentialing for clinical instructors should be mandatory?

**APPENDIX C**

**E-MAIL MESSAGE TO AOTA LISTSERV AND SPECIAL INTEREST  
SECTIONS**

## E-Mail Message to AOTA Listserv and Special Interest Sections

Dear Colleagues:

Please consider the following personal commitment: “I will volunteer 10-15 minutes of my time to contribute to my profession and the improvement of OT fieldwork education.”

I am seeking novice therapists (1-3 years post graduation), currently working full-time in a rehab setting, who have had one Level II rotation in rehab, to participate in a short, web-based survey, 33 questions, which is part of my doctoral research entitled:

**“Occupational Therapy Level II Rehab Fieldwork: Effectiveness in Preparing Students for Entry-Level Practice in the Rehab Setting”**. This survey is being conducted in order to understand the past clinical training experiences of current novice rehab therapists, and how their Level II rehab fieldwork contributed positively to, or impaired their transition to entry-level clinical practice. This information will be used to improve the experience of future students and to determine the need for credentialing of future clinical instructors.

Participation in this survey is voluntary and confidential. All information and any reports emanating from the study will eliminate any identifying information. You have the right to withdraw from the study at any time, without any repercussions and you may contact me at any time to answer questions, or request research results at the conclusion of the study (Rosalyn Lipsitt, 610-331-3664). When you contact the researcher, [rlipsitt@temple.edu](mailto:rlipsitt@temple.edu), you will be sent the web address of the survey and will be eligible to be one of five participants chosen at random to receive a \$50.00 check. Those of you who volunteer to be interviewed, may do so by providing your e-mail address and will also be eligible to be one of five participants chosen at random to receive a \$50.00 check.

Your response to the survey constitutes your consent to participate. Interviewees will be given informed consents in person for both interviewing and audiotaping. Thank-you so much for your time.

**APPENDIX D**  
**INFORMED CONSENTS**

## **Informed Consents**

### **Informed Consent For Audiotaping by the Researcher**

This audio-taped interview is being conducted as part of a doctoral research study at Temple University for the purpose of improving the rehab Level II experiences of future students. Understanding the past clinical training experience of current novice rehab therapists, and how their Level II rehab fieldwork contributed positively to , or impaired their transition to clinical practice, will assist those in the profession in designing effective instructional methods and positive learning environments.

Participation in this interview is voluntary, and will involve ½ hour-45 minutes. You have the right to withdraw from the study, at any time, without any repercussions. All information audio-taped by the researcher and transcribed is confidential, and any reports emanating from the study will eliminate any identifying information. No names of schools, participants, instructors or students will be revealed. You may contact the researcher at any time to answer questions or request research results at the conclusion of the study.

Your signature below constitutes your willingness to be audio-taped during the interview.

\_\_\_\_\_  
Participant

\_\_\_\_\_  
Date

Rosalyn S. Lipsitt, MHL, OTR/L  
(610) 331-3664  
[rlipsitt@temple.edu](mailto:rlipsitt@temple.edu)

### **Informed Consent for Interview**

This interview is being conducted as part of a doctoral research study at Temple University for the purpose of improving the rehab Level II experiences of future students. Understanding the past clinical training experience of current novice rehab therapists, and how their Level II rehab fieldwork contributed positively to, or impaired their transition to clinical practice, will assist those in the profession in designing effective instructional methods and positive learning environments.

Participation in this interview is voluntary, and will involve ½ hour-45 minutes. You have the right to withdraw from the study, at any time, without any repercussions. All information transcribed by the researcher is confidential, and any reports emanating from the study will eliminate any identifying information. No names of schools, participants, instructors or students will be revealed. You may contact the researcher at any time to answer questions or request research results at the conclusion of the study.

Your signature below constitutes your willingness to be interviewed.

Participant\_\_\_\_\_

Date\_\_\_\_\_

Rosalyn S. Lipsitt, MHL, OTR/L  
(610) 331-3664  
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