DEVELOPING PROFESSIONAL IDENTITY IN OCCUPATIONAL THERAPY: A PHENOMENOLOGICAL STUDY OF NEWLY QUALIFIED STAFF AND THEIR EXPERIENCES IN THE PRECEPTORSHIP PERIOD.

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A thesis submitted in partial fulfilment of the requirement of Staffordshire University for the Degree of Doctorate in Professional Studies.

December 2016

Acknowledgements

I would like to express my thanks to the following individuals and organisations for their invaluable help and support in the completion of this thesis.

Firstly I would like to thank the faculty at Staffordshire University, especially my supervisory team Dr Peter Kevern and Dr Ed Tolhurst for their patience and support.

I would like to thank South Staffordshire and Shropshire Healthcare Foundation NHS Trust for their financial support and the time to complete this study. Particular thanks go to Debbie Moores, Allied Health Professionals Lead, and the occupational therapy team for older people and my own team the Telford and Wrekin Memory Service, who have been incredibly supportive through-out.

I would particularly like to thank the participants of this study, for their time, and their thoughts, both which they gave generously.

I thank my parents Malcolm and Nancy Thompson for their endless proof reading.

Lastly, but definitely not least, I thank my husband Jon and my children Beth, Jack, and Mia, for their love and support, and for pretending to be interested when I talked to them about phenomenology.

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Abstract

The overall aim of this research is to explore the experiences of newly qualified occupational therapy staff, with reference to professional identity and the role of the preceptorship year in developing this.

Using a phenomenological methodology, based on the work of Van Manen (1990), seven newly qualified staff were interviewed using a grand tour question. The subsequent transcripts were analysed using thematic analysis that included *a priori* coding, as well as codes that emerged from a detailed reading of the data.

The findings and recommendations are presented as answers to the two research questions which are:
How do newly qualified staff, who have recently been through preceptorship, experience the preceptorship process?
In what ways is the preceptorship process perceived as having any influence on the development of professional identity?

The findings indicate that preceptorship is perceived to be important in the development of professional identity as part of a continuum, and that the preceptorship period offers an unrivalled time of reflexivity and growth and puts a large emphasis on role modelling.
Recommendations include action points specifically developed for the Trust where the research was conducted. They may be useful for other organisations who are providing preceptorship programmes. These recommendations include choice and training for the preceptors. The recommendations also highlight that professional identity is the responsibility of every individual member of the profession.

Key Words: occupational therapy, professional identity, preceptorship, phenomenology.

Introduction

The aim of this introductory chapter is to place the research in context in terms of its focus, both personal and political, and outline the importance of such a study.

1.0 Research focus

The title of the research, designed to intentionally consider the content and methodology of the study, is

Developing professional identity in occupational therapy: a phenomenological study of newly qualified staff and their experiences in the preceptorship period.

The overall aim of the research is to explore the experiences of newly qualified occupational therapy (OT) staff with reference to professional identity and the role of the preceptorship year in developing this. The research questions are:

How do newly qualified staff, who have recently been through preceptorship, experience the preceptorship process?

In what ways is the preceptorship process perceived as having any influence on the development of professional identity?

The audience for the research is fourfold. Firstly, the occupational therapy managers and senior clinical staff within the National Health Service (NHS) Trust in which the research has been completed. Secondly, other senior staff from other disciplines within the Trust, as it is envisaged that the information gleaned can cross disciplinary boundaries and have relevance for other staff groups. Thirdly, newly qualified occupational therapists in the hope that they not only benefit from the outcome of the study, but that they also benefit from the process of research, which will in turn help move the profession of occupational therapy forward. The final audience is the academic community, and, as such, I have an academic duty to ensure that the findings of the study are disseminated so that they are available to others whose research focus is in a similar or related field.

This study uses a phenomenological framework and is based on Van Manen's (1990) work *Researching the Lived Experience.* In order to avoid Paley's Rhetoric trap, I must be clear

that generalisability is not a goal of this research (Paley 2005). Paley claims that phenomenology research, specifically in nursing, claims not to generalise and then does just that. Findings from this research then must be treated as the experiences of seven people. Themes that have arisen from the data and findings or recommendations conceived from them are done, in the full knowledge that it is information that may be useful but it cannot, and should not, be globalised. However, it is conceivable that, although the research may not be generalised, other Trusts and other occupational therapists may find the information gained during the research both interesting and useful in their own working environments.

Throughout the research, there is a reflexive thread that verifies my personal engagement with the research, and although this is acknowledged in terms of bias, its inclusion is important in demonstrating the authentic connection between the research data and the researcher. *Reflexive statements are printed in a different font so as to make them clear to the reader.*

1.1 Personal context

Phenomenological research always requires the personal engagement of the researcher with her data (Van Manen 1990). For me this engagement started many years ago with my decision to become an occupational therapist. I qualified and started work as an occupational therapist in 1994, and since then I have worked in a number of contexts within the NHS though primarily in adult mental health and more latterly in services for older people's mental health. *It is within my current role, working in the memory service team that I attended a national conference and heard a nurse telling the conference that the occupational therapist on their (memory service) team was "morphing into a nurse". It was this one perturbing sentence that highlighted that the issue of identity was still a potential problem within occupational therapy, and one that could warrant further investigation.* Van Manen (1984) states that you cannot have a research question until you have determined a personal interest, and so with my personal interest declared I could now move on to engage in the research process.

1.2 Political context

There are two distinct political themes guiding the NHS at the time of writing, one of austerity and one of quality. *Agenda For Change* (Department of Health (DOH) 2005a) and the financial austerity of the time has created a backdrop where occupational therapists are in danger of being reduced in number and re-graded which has implications for supervision, mentorship, preceptorship, the development of the profession, and general learning. Documents that follow *Agenda For Change,* such as the *National Quality Commission Skill Mix* document (National Quality Board 2013) and Department of Health papers, *High Quality Work Force* (DOH, 2008) and *Closing The Gap* (DOH 2014b,) also deal with these issues and there is a risk that traditional occupational therapy roles, along with those of other health professions, will in future be carried out by unqualified, and cheaper staff.

The issue of quality is one that is raised in the *Francis Report* (Francis 2013). The repercussions of its 290 recommendations will be felt in the NHS for years to come, however, its impact on patient dignity and safety must be positive. It leaves in its wake a thread, that moves through the subsequent policies, of transparency, candour, patient centeredness, professionalism and responsibility (DOH 2013b, National Advisory Group on the safety of patients in England. 2013, NHS England 2014, DOH 2014a). This political climate means it is more important than ever to be able to articulate as a profession, who we are, what we do, our unique skills and the added value of our profession; the ability to do this is intrinsically linked to professional identity (Morley, Rennison 2011).

1.3 Definition of terms

The key terms of preceptorship and professional identity that are used in this research are defined below. I acknowledge that each term has a number of definitions assigned to it in the literature. The definitions below reflect how the terms are used in this piece of research.

1.3.1 A definition of preceptorship

The Department of Health (2010) *Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals* states that preceptorship should be considered

as a transition phase for newly registered practitioners while continuing their professional development, building their confidence and further developing their competence to practice. This definition is developed in the *Preceptorship Handbook for Occupational Therapists* by Morley (2012) who defines preceptorship as:

> *"a structured development process. It includes observed practice and feedback against agreed standards, to support newly qualified practitioners to build their professional identity and competence in order to facilitate their successful adaptation into the workplace" (p5).*

1.3.2 A definition of professional identity

The following definition from Adams and Hean *et al*. (2006) is a useful generic definition of professional identity that is neither too simplistic nor too complex.

> *"Professional identity concerns group interactions in the workplace and relates to how people compare and differentiate themselves from other professional groups. It develops over time and involves gaining insight into professional practices and the development of the talents and values of the profession. It is the attitudes, values, knowledge, beliefs and skills that are shared within a professional group and relates to the professional role being undertaken by the individual" (p56).*

Creek's 2003 definition of *Occupational Therapy as a Complex Profession* is now considered as a seminal piece of work in defining what occupational therapy as a profession does. I link this to Mosey's earlier work, *A Monistic or a Pluralistic Approach to Professional Identity* (Mosey 1985) as I consider them to be inextricably linked. Together I use them as the definition of professional identity in occupational therapy within this research, and as such, they are discussed in more detail throughout. Creek's work, highly compatible with Mosey's work, includes: professional values and beliefs, roles and ethics, knowledge and core concepts, domain of concern, the occupational therapy process, treatment and assessment tools, skills and evidence-based practice. As a definition of professional identity, it is wanting in terms of the developmental aspect of identity and the importance of socialisation. It does however clearly identify the attitudes, values, knowledge, beliefs and skills of occupational therapy.

This research has been conducted in order to fulfil in part the requirements for a Doctorate in Professional Studies at Staffordshire University. This course has been completed part-time over a five-year period. The thesis is structured in a traditional way with a background chapter, a literature review, methodology, two analysis and discussion chapters and a conclusions chapter.

Background

2.0 Introduction:

In order to present a background to support this research there are a number of areas that need to be discussed. The thesis deals with three substantial topic areas, that of occupational therapy, professional identity and preceptorship, and various aspects of these areas will be addressed.

Professional identity is, and should be, a complex construct (Mosey 1985) that takes in the values and beliefs of a profession, the language of a profession, education, environment, socialisation, exclusivity, roles and personal meaning and feeling. It is not static and is ever evolving and developing (Ohlen, Segesten 1998, Larson, Brady *et al.* 2013). Therefore within this chapter, I consider identity formation, our identities at work and the impact of positive identities and relate these to occupational therapy. This chapter will take some of the commonalities of the different theories and present them as a working definition of professional identity formation and presentation in order to give clarity to the analysis of data and provide useful discussion.

The chapter will end with a conclusion that provides, not only a summary of the chapter, but also offers to delimit the previously agreed definitions.

2.1 Occupational therapy: placing the profession in context

In order to understand some of the potential issues that the profession of occupational therapy has with its own professional identity it would be first wise to consider, not only a definition of occupational therapy, but how the profession came to be and some of the questions it asks itself around its own professional status. I will then go on to outline how the profession considers the issue of identity in the people that it cares for and end with a synopsis of the ongoing discussions about professional identity that have taken place within the professions own literature.

2.1.1 A definition:

> *"Occupational therapy provides practical support to enable people to facilitate recovery and overcome any*

> *barriers that prevent them from doing the activities (occupations) that matter to them. This helps to increase people's independence and satisfaction in all aspects of life. "Occupation" refers to practical and purposeful activities that allow people to live independently and have a sense of identity. This could be essential day-to-day tasks such as self-care, work or leisure" (College of Occupational Therapists (COT) 2011 accessed 16/9/16).*

Occupational therapy as a profession has its roots in America after the First World War, stemming from a movement to encourage rehabilitation in injured soldiers and from moral treatment in psychiatry.[1] The founding fathers of occupational therapy came from diverse backgrounds. A psychiatrist, a nurse, a physician, a social worker and an architect, they worked together in order to focus on the needs of their patients and create a therapy that was to evolve into modern day occupational therapy. Wilcock (1993) describes the human need for purposeful occupations as being innate and this core theme of the concept of the importance of activity is the one epistemological given of the profession. William Rush Dunton was the psychiatrist and published a number of books about his new *Reconstruction Therapy* (Dunton 2012b). Originally published in 1918 his book contained a credo for occupation, made up of four statements that can be considered as a guideline for good mental and physical health.

- *That occupation is as necessary to life as food and drink.*
- *That every human being should have both physical and mental occupation.*
- *That all should have occupations which they enjoy, or hobbies. These are more necessary when the vocation is dull or distasteful. Every individual should have at least two hobbies, one outdoor and one indoor. A greater number will create wider interests and a broader intelligence.*

[1] Moral treatment, a therapeutic and preventive philosophy for managing mental disorders, which was popular in the early 19th century, based on William Tuke's retreat model. Treatment consisted of removing the afflicted from their homes and placing them in a surrogate "family" of 250 members or less, often under the guidance of a physician. It emphasised religious morals, benevolence and "clean living". Patients were accorded humane and kindly care, and were required to perform useful tasks in the hospital. Emphasizing religious doctrine and benevolent guidance in activities of daily living; it was a form of psychotherapy as opposed to somatic treatments such as bloodletting and purging (Medical Dictionary 2014).

- *That sick minds, sick bodies, sick souls, may be healed through occupation (Dunton 2012b inside cover).*

This credo was a simple list of the four main beliefs of the emerging profession of occupational therapy and although the first credo is the one most often quoted, the others reflect the need for occupation for health (Dunton 2012b). The present day College of Occupational Therapists maintains this theme defining the professions beliefs as:

> *"Occupational therapists view people as occupational beings . . . People are intrinsically active and creative and need to engage in a balanced range of activities in order to maintain health and well-being"(COT 2015 p1).*

This definition, a simplified version of what amounts to a two-page definition in the document, captures the core belief of the profession in the importance of activity. Dunton's book *Occupational Therapy for Nurses* (Dunton 2012a) gives further clues to the developmental issues of the profession, as it stems from other professional groups doing occupation with their patients. It is from this point that the epistemological and professional issues with occupational therapy germinate.

2.2 Epistemological issues within occupational therapy.

Occupational therapy has struggled since its inception to marry together the different epistemological positions held by its founders, and Hagedorn (2001) refers to this as a built-in philosophical inconsistency. The epistemology of the profession is recognised as being complex (Mackey 2013) and even viewed by some as being in crisis (Grant 2013). The profession's complex epistemological positioning arises because its knowledge base has its background in other disciplines; this eclectic mix has led to a profession that can give no simple philosophical statement and is torn between pragmatism and structuralism (Wilcock 2000, Creek 2010). Mitchell (2013) recognises that the knowledge used by occupational therapists in their daily work comes itself from different knowledge paradigms, that some knowledge, for example, is scientific, e.g. anatomy and physiology, whereas some knowledge is less absolute, such as some of the psychological techniques used. It is because of this eclectic mix of knowledge that Blaire and Robertson (2005)

insists that from an ontological position the profession must accept multiple realities, and the same could be said of the profession's epistemology. It is highly dependent on whom the therapist is working with, what their aims, are what treatment techniques they are using and in what setting the therapy is taking place.

This complexity has led to significant debates in the literature particularly around the use of language, with Wilcock (1999) and Sawsaa and Ribchester (2013) stating the importance of language to the profession and Creek (2003) producing a list of profession specific words that could help move occupational therapy forward, not only in terms of its epistemology but also of its professional status.

2.3 Professional issues within occupational therapy.

There is a fundamental question of whether occupational therapy can even be considered as a profession. Beck and Young (2005) define professions using four conditions.[2] From these conditions, they conclude that roles similar to occupational therapy, e.g. teaching, cannot claim full professional status and can only be seen as semi-professional. This view is one that is echoed by Richardson (2001), and both authors raise the same objection, that a profession such as occupational therapy does not have the level of autonomy needed in order to be classed as a full profession.

The problem with autonomy, however, is not just an issue for occupational therapy; as well-established professions such as medical doctors also have their autonomy threatened. Rosenthal (2002) quotes Starr stating that it possible to have one aspect of autonomy taken away and yet retain it in other aspects. Starr (1982) names five dimensions of autonomy as being political, economic, social, cultural and technical. Occupational therapy's inclusion with the wider group of Allied Health Professionals (AHP's) at national and local levels may well have affected their autonomy, however it is

[2] 1) Collective collegiate autonomy over training, competence and conditions of work. 2) Defining the boundaries of their own knowledge base, and educational curriculum. 3) Having a developed code of ethical practice through which members are held to account for their actions. 4) Training that involves knowledge and socialisation into the values of the profession and the standards expected by its members regarding integrity, judgement and loyalty.

uncertain without further research as to whether this grouping actually improves all the Allied Health Professionals autonomy, certainly in the political and economic dimensions, or if it detracts from the individual professions that make up the group. Rosenthal, states that a precondition of professional autonomy is that it is a multidimensional phenomenon, and it would, therefore, be difficult to prove that occupational therapy has no autonomy in any of Starr's dimensions. As this lack of autonomy is the only aspect that stands in the way of professional status, according to Beck and Young, and Richardson, it would then be unreasonable to deny the status on the grounds that autonomy may be compromised, but otherwise retained in some dimensions.

Questioning the understanding of the term professional, Dent and Whitehead (2002a) claim that in modern times a blurring of boundaries has resulted in a deconstruction of society's understanding of what it means to be a professional. This blurring of boundaries happens not just in the business world that Dent and Whitehead examine but also in the National Health Service where generic roles and new ways of working are becoming a standard way of working (DOH 2005a). This blurring of roles can go on to have a significant impact on professional boundaries and professional identity (Clarke, Martin *et al*. 2014).

2.4 Vocational identity

Lent's (2005) social cognitive career theory describes the formation of vocational identity as being like a dynamic, moving jigsaw, that has multiple pieces that must fit to make an ever-changing picture. His theory tries, and succeeds, to amalgamate the concepts from trait theories, such as Holland's (1985) vocational identity theory (Spokane, Cruza-Guet 2005) and development theories like those of Savickas (2005). His comprehensive theory posits that not only do individuals have roles, interests and values but that these inform the choices they make with regards to vocation, and that these, in turn, are impacted by the individual's self-efficacy, outcome expectations and personal goals. Lent is specific when he states that choosing a career path is not a single or a static act. It is Holland that reminds career counsellors not to ignore individuals' expressed interests as they are often a good indicator of future career choice (Reardon, Lenz 1999). This was certainly the case for me when at the age of 14; I said I wanted to become an occupational therapist.

Using Lent's terminology, at this age I expressed a primary choice (that of being an occupational therapist), I then went ahead and performed actions to aid me to reach my goal (choosing specific GCSE and A levels and arranging the right work experience) and my performance at these different tasks allowed me to develop my self-efficacy (my belief in my capabilities) in order to further pursue my goal.

Lent's (2005) social cognitive theory unlike Holland's (1985) trait theory, does not attempt to predict which career would suit us best in terms of job title. It does consider a more encompassing view of the different elements that make up our career and our relationship to our job. They put much greater emphasis on the environment a person works in and also about how that person interacts with the environment. It accepts that our professional and personal identities are in main socially constructed but also that our individual personalities also play a part in our career choices and our performance in them. This mix of the social and the cognitive factors provide a more comprehensive and less unilateral career theory.

2.5 How the profession of occupational therapy considers identity.

The profession of occupational therapy, although diverse, is clear about how it views the identity of the people it works with. They are known by different names (patients, clients, service users) and whilst this naming issue reflects a dimension of identity, it is not an issue that affects how occupational therapists view the wider identity of these people.

The ontology of the profession is rooted in the values that define people as occupational and axiological beings (Drolet 2014). These beliefs, a core part of the professions' identity, demand that occupational therapists consider that people within the world experience it differently and prescribe meaning to objects, people, places and events, dependent on a large number of variables that include a number of socially defined concepts. Occupational therapy places value on people's roles, habits and routines and Caza and Wilson (2009) state that our work role is one of the primary ways people identify themselves. Occupational therapy as a profession works with people with a number of different illness's and disabilities. This sometimes means that the work role is not the

primary role in their life. However, occupational therapy recognises the many different roles people play in life and how these may be used to define the patient, including the sick role (Parsons 2012), and other more positive roles, such as parent, student, volunteer (Jones, Blaire *et al*. 1998).

Importantly occupational therapy also believes that not only do we as a profession view people in this way, but that patients themselves put value on their life roles and use these roles in order to help define and give meaning to the self and their life. These roles may include diagnostic labels that become part of the patient's identity and often these diagnostic labels carry with them a cultural understanding so that others may know what to expect from someone who is defined as schizophrenic, as having Alzheimer's or epilepsy. In some occupational therapy models (for example Mosey's Psychosocial Dysfunction) being aware of your self-identity is regarded as a skill (Hagedorn 2001). The philosopher Michel Foucault, when asked to describe himself, stated that he did not need to know who he was, as he felt that the whole point of his life and his work was to become someone that he was not in the beginning *(*Martin, Gutman *et al.* 1998). Foucault here manages to capture the idea that our self-identity is, and indeed should be, ever changing. Dent and Whitehead (2002b) go on to say that our self-identity is a never-ending process, one that is not fixed and does not have an end point.

It is of note that Foucault was being asked to define himself by his occupational role, is he a philosopher, a historian, or a structuralist? Parsons put great emphasis on the importance of roles in society, viewing them as being essential to holding society together (Sherman, Wood 1979). As an occupational therapist, roles are seen as vital to an individual's perception of self, identity, relationships and to their overall health (Hagedorn 2001). Parsons wider sociological theories and especially his work on roles have been influential in occupational therapy, and so functionalism as a whole is regarded as almost implicit within the profession (Jones, Blaire *et al*. 1998). Whilst Parsons has been criticised, (Kaspersen 2000) his views on religion, the family, roles (particularly the sick role) have had an undeniable impact on the profession of my choice.

2.5.1 A professional view of professional identity.

It has already been stated that occupational therapy is a complex and diverse profession. As a result of its mixed epistemological and theoretical base it has to acknowledge the existence of multiple realities and no absolutes (Duncan, Nicol 2004), this is despite the fact that some of the aspects of the profession are based in scientific positivism and use absolute truths, such as anatomy and physiology (Mitchell 2013).

As an occupational therapist, I can, therefore, view the issue of identity through this lens. Identity (professional) can be said to be socially constructed (Jenkins 2014), and dependent on being viewed by others (Billington, Hockey *et al.* 1998). Identity is therefore not fixed and is changeable; indeed Jenkins describes it as a process that is never finished. Billington also describes role identity as having pre-determined cultural scripts. Therefore although we may make conscious choices to go into one profession over another (Lent 2005) we have little conscious control over how that role is then perceived by society, as the cultural script is already in place and evolves and changes slowly over time. Identity then is socially defined and changeable, but deeply rooted in our values and beliefs. The importance's we ascribe to those professional values are culturally scripted and central to our own sense of professional identity.

2.5.2 The problem with identity in occupational therapy

The issue with identity in occupational therapy is deep rooted and has at various points been a subject of major debate in the profession's journals, for example in the late nineties and the early noughties there were significant debates held about the role of the occupational therapist in community mental health teams in the *British Journal of Occupational Therapy* (Harries 1998, Taylor, Rubin 1999, Hughes 2001). In part it goes back to the beginnings of the profession with its different epistemological beliefs struggling to weld themselves into one conceptual ontology (Cusick 2001).

The role of the occupational therapist developed alongside the National Health Service and splits into working within different aspects of health care. The issue here for occupational therapy is that the core skills of the job remain constant, but the day to day practicalities of the job can be very different depending on the client group that you as a

therapist work with. For example, I work in memory services and do a lot of assessment work around people's cognition. I have set up groups and individually delivered advice and treatment around cognitive stimulation and been involved in assistive technology and basic problem solving in terms of risk assessment and independent living.[3] However, when I worked with the paediatric service my job role involved assessment of movement and stability in children with dyspraxia. The treatment was mostly based around fun and games in order to improve function and hand-eye coordination and groups were craft based. Both roles require assessment skills, problem-solving, and therapeutic use of self and group work skills; however, the context in which these skills are used is very different. I never asked a seven year old to make a cup of tea, similarly I never asked an 80 year old to get on all fours and try and stop me from pushing her over. Although these differences may seem obvious, they create a problem in terms of professional identity as people outside of the profession do not then have a clear concept of what the job entails. Even my father-in-law, for example, confessed that although he 'knew' what occupational therapy was, he did not understand how that fitted into working with people with dementia. This was because his 'knowledge' of occupational therapy was from the occupational therapist who dealt with his mother after she had had a fall. They provided a raised toilet seat and some grab rails and put in a stair lift, and had given information and advice about falls prevention. This did not in my father-in-law's eyes match up to what I did for a job. Therefore this wide-ranging variety in client group and settings can lead to confusion, from outside the profession as to what occupational therapy actually is.

Alongside this is the debate around generic working within the NHS, certainly within mental health, partly driven by models of delivery and partly by financial constraints, the debate of specialist versus generic work has raged on in professional journals for a number of years. Occupational therapists work as part of a multi-disciplinary team and all

[3] Cognitive stimulation therapy is a treatment for people with cognition problems that asks them to increase their mental, physical and social activity in order to stimulate cognition (Spector *et al*. 2006). Assistive technology is the use of technology to aid independent living at home, for example door sensors or GPS tracking devices. This technology allows people to remain in their own home.

members of the team are at times required to do jobs that are specific to no profession, but regardless still need doing (in my own team the role of duty worker would fit this description).[4] However, occupational therapy has at times been concerned that specialist skills would be lost to generic work (COT 2006). This again could lead to confusion about our professional identity from outside the profession. Those looking in, the other members of the team, could not see the specialist skills and therefore could not either use them or respect them because for a time they were not there (Baxter, Brumfitt 2008).

The debates held in professional journals about generic working led to a fight back from occupational therapy and a reclaiming of our core skills, particularly in mental health (Craik 1998, Craik, Chackfield *et al.* 1998). It does, from a reflexive perspective, 'feel' as an occupational therapist that our identity is stronger now that it has ever been, but there are still issues around professional identity that give cause for concern. The issue of working in isolation is one of these concerns. Within the NHS, there has been a move towards community-based services rather than inpatient services. This has been happening in mental health gradually over a period of twenty years, since the *National Health Service and Community Care Act* (DOH 1990) was introduced. As occupational therapists this has meant we have moved away from the traditional occupational therapy department into often being the lone therapist in a multi-disciplinary community team. This move has led to less daily contact with other members of our profession, the department morning meeting being replaced with a monthly business and development meeting. This, in turn, means less regulation of staff. In the traditional department, all occupational therapy staff would follow the one model, use one set of paperwork, have regular supervision, discuss changes, seek advice, and discuss professional issues on a daily basis, and would see and hear how their colleagues worked. This ability to learn from one another had benefits for newly qualified staff, especially in the development of their own concept of what it means to be an occupational therapist. You learnt from good and bad alike and developed your sense of professionalism from those you admired and avoided the pitfalls of those you did not (Stockhausen, Sturt 2005, Morley 2007b, Smith,

[4] The role of duty worker is a generic one. A qualified member of the team, on a rota basis, sits in the office and is responsible for ensuring the lone working policy is effectively carried out, referrals are triaged and any phone calls are dealt with.

Morley 2013). The move to being a lone therapist within a team essentially means that that level of support does not exist in the same way that it used to. Preceptorship appears to have been developed in recognition of this and in a way tries to replace the occupational therapy department in measuring a new recruits progress, competence, confidence and commitment to the profession.

2.6 The formulation of identity

There are many theories on the formulation of identities, all of which have their own merits. Erikson (in Stevens 2008) leads the way in terms of developmental theories of identity, expanding on Piaget's work. However, despite his work being well respected, and indeed it is at the root of a number of professional assessment tools I use in the workplace, it is not essentially relevant to the formulation of professional identities. I also struggle from a critical aspect to separate the man from his theory, and find myself unsure of how much his theory can be given credence when his personal life choices were so potentially damaging to the development of his own children.

Our identity is complex and intricate and has many layers. I consider Goffman's (1959) view of identity to be one that fits in with some of my own concepts. Goffman feels that Identity can be explained in terms of a performance, that we present ourselves to the world, depending on the audience. He has been criticised in terms of lack of authenticity and reflexivity (Elliot 2008). However at no point does Goffman claim that our performed selves are not our real selves, they are just an aspect of us, which we present at that time (Lawler 2014). So the criticism, of lack of authenticity, may well not be valid and be an overreaction to the metaphor of theatre that Goffman uses. It is Gidden's (1991) view of identity that specifically contains the concepts of reflexivity. I would argue that in order to perform and plan for how we present to people, as Goffman postulates, then we must be able to be reflexive in order to place our self in the correct context.

Therefore formulation of identity is also in some part reliant on individual reflexivity and self-awareness. To constantly monitor ourselves and our lifestyle choices, to review our idea of self and where we fit into society is part of what Giddens sees as being a reflexive

self (Scott, Wilson 2011). We have an image of our self, and what we might be, a possible self (Kornadt, Rothermund 2012). This difference in ideal and actual self is linked to the need to think good things about yourself, essential to our self-esteem (Higgins 1996). At times maintaining slightly unrealistic ideals about yourself can even be good for self-esteem (Wilson, Dunn 2004). However the need to have an idea of your true self goes back at least as far as Aristotle (Schlegel, Hicks *et al*. 2009). In occupational therapy, this concept is seen in terms of having realistic goals (Kusznir, Scott 1999).

To find our self-identity is something that we are all individually responsible for on an on-going basis. This reflexive project is one that should see the individual considering themselves over time and space (Giddens 1991). After a period of change, it is recognised that reskilling can be a helpful way of regaining our self-identity (Giddens 1991). Our concept of self is linked with the society at large and so our reskilling may be linked to our social construction of self (Giarmo 1997). Therefore a different job, moving house, a new set of friends could all be viewed as reskilling. In order to cope with the constantly changing world we live in we have to be reflexive.

Abraham Maslow promotes a positive psychology that has its focus is on a healthy mind rather than an unwell one (Maslow 2014). Within this, he discusses the subject of self-identity and importantly he recognises it as a journey that is taken throughout the whole of an individual's life. He names his theory as *The Psychology of Being*, i.e. being ourselves in the moment, with the concept of *becoming* relating to the striving for self-actualisation. Maslow's theories are often overlooked by clinical psychologists because they do not relate to a damaged mind. However he recognises that striving to *become* is a normal part of identity development. This can give psychological credence to the sociological identity theories that talk about self-actualisation and that identity development over time, such as Giddens (1991) and Lawler (2014).

Maslow's work also allows for a wider translation of Ann Wilcock's (1999) work on *Being Doing and Becoming*. Wilcock is well renown in occupational therapy and has written widely around the areas of occupational science and occupational and health. Although she does not specifically write about professional identity, her work strikes at the core of

occupational therapists beliefs about the link between occupational and people's well-being. In her role as a researcher and as an occupational therapy educator in Australia she has been influential in the identity formation not just of her students but of occupational therapists across the globe (Kosma *et al.* 2013). Wilcock (1999) writes in terms of how occupational therapists view their clients, paying only lip service to how these concepts may relate to professional identity. However, Maslow's focus on normal health and well-being allows us to relate these concepts to the professional as well as the patient. Other writers, who also borrow this terminology, are also dealing with the identity of subsections of the population that are not regarded as ill, such as punks, indigenous people, occupational therapy students and bereaved families (Widdecombe, Wooffitt 1990, Martin 2003, Forhan 2010, Rensburg 2011). The concepts of *doing, being* and *becoming* are therefore valid concepts with which to discuss the identity of newly qualified occupational therapists and it is terminology that will be used in chapter six, in order to analyse the data around professional identity.

Identity is embedded in social context and socially constructed. I consider that the concepts of cultural scripts (Billington, Hockey *et al*. 1998), the off the peg identities produced by certain roles (e.g. doctor, lawyer) are related to Goffman's (1959) concepts of performance as well as Holland's (1985) concepts of stereotypes. Without social context, how would we know how to perform? It is expressed clearly in the literature that the concept of identity is viewed as socially constructed (Savickas 2005, Abreu 2006, Whitcombe 2013). Dent and Whitehead (2002a) understand identity in terms of a social web, and that as part of that people have prior associations with a set of norms around what it means to be, for example, a doctor. Here occupational therapy will reflexively struggle; being such a diverse profession means that many will only have a prior association with one aspect of the profession, as has already been discussed. This concept of prior associations is fundamental to the development of professional identity, as it is found that students have already preformed ideas of what it means to be a member of their chosen profession (Weaver, Peters *et al*. 2011, Larson, Brady *et al.* 2013, Sabanciogullare, Dogan 2014). Sutherland and Howard *et al*. (2010) discusses how prior knowledge helps students fit into the values and beliefs of a profession.

2.7 Key contributions from occupational therapy writers about professional identity.

Further to the initial definition made within the introduction, it is necessary to further explore concepts of professional identity that already exist within occupational therapy. There are two authors whose contribution about professional identity is not only key to the subject but have also been dominant in their conceptualisation of the professional's identity.

Ann Cronin Mosey, a professor of occupational therapy at New York University was already a respected author before she was asked to present the prestigious Eleanor Clarke Slagle Lecture to the American Occupational Therapy Association in 1985. She had written books about not only occupational therapy practice and theory, but also about the configuration of the profession (Mosey 1981). Mosey's (1985) paper, a result of a review of the available literature at the time was a continuation of this and outlines a pluralistic approach to professional identity. She argues that by focusing on only one aspect of identity we as a profession do not allow for the complexity and fullness of our professional epistemology, ontology and philosophy, or acknowledge the wide scope of our practice. She reasons that by distinguishing a number of components of professional identity we can offer a robust account of ourselves as a professional group. Mosey lists these components of professional identity as being:

philosophical assumptions about the individual,
environment and goals,
code of ethics,
body of knowledge (theory),
domain of concern i.e. routine task behaviour, occupational roles, life task/skills and occupational performance areas,
aspects of practice (occupational therapy process),
legitimate tools,
linking structure (frame of reference practice),
empirical research.

In a contemporaneous publication Katz (1985) questions Mosey, but not in a way that dismisses her thesis. Katz queries the importance put on various components and not

their inclusion in the list. Therefore Mosey's work stands still as the definitive list of the components of professional identity in occupational therapy. It is not until 2003 that Jennifer Creek begins to put flesh on the bones of Mosey's work. Creek (2003) herself does not describe her work as being about professional identity, but more about trying to describe occupational therapy. An ethnographic piece of research it sets out to construct a shared reality of occupational therapy. What she does, however, is provide discussion and substance to Mosey's framework that clarifies that it was not only correct but that it has also stood the test of time. Creek, like Mosey, is a prolific and well respected author in occupational therapy and was commissioned by the College of Occupational Therapists specifically to define the parameters of the profession. She then went on to use this knowledge in the strategy document *Recovering Ordinary Lives* (COT 2006).

Creek's (2003) concepts of what makes occupational therapy a complex intervention defines a number of the same components that Mosey described initially in 1985. She presents the complete list as being:
professional experience,
professional values and beliefs about people, health and occupation,
roles, responsibilities and duties,
concepts and domain of concern,
occupational therapy process, goals and desired outcomes,
legitimate tools which comprise of assessment, treatment and outcome,
theory, including frame of reference and models,
skills, professional thinking and client centred practice,
evidence-based practice, audit and continuing professional development (CPD),
external influences.

Within this conceptual framework, there are things missing that are picked up by contemporary identity theory, namely the concept of developing over time, and the concepts of pre socialisation and socialisation within the profession. Bearing these two omissions in mind it will be Mosey (1985) and Creek's (2003) work that is used to form the *a priori* codes that will allow for analysis of data in chapter six. Therefore within occupational therapy, professional identity is seen rightly as a complex social construction

of self that is linked to the philosophy of the profession and ethical and moral issues (Mosey 1985, Dige 2009). There is general agreement between authors about the different components of professional identity (Katz 1985, Mosey 1985, Morley, Rennison 2011). Other definitions focus on different components of professional identity such as confidence and competence (Holland, Middleton *et al*. 2012a, 2012b,) but do not give an overall theoretical view of professional identity. Mosey's (1985) pluralistic model, and Creek's (2003) additions and enhancements, therefore, provide a robust understanding of professional identity within occupational therapy that allows for growth and change.

2.8 Positive identities

We have an inherent need to form a positive identity (Dutton, Morgan Roberts *et al*. 2009) and if linked to professional identity, this is seen as instrumental to the effectiveness of the profession or organisation (Morgan Roberts, Dutton *et al*. 2009). A positive Identity is defined by Kreiner and Sheep (2009) as being one that is competent, resilient, authentic, transcendental and holistically integrated. It has to be resilient and adaptive as in order for a positive identity to endure it has to be able to cope with change. Positive identities in the workplace should be aligned to who we are, who we want to be, and who we need to be (Corley, Harrison 2009). It is, therefore, important that the identities we create as professions are strong and durable, also that they are positive rather than neutral or negative if others are to be engaged with them in a positive way (LeBaron, Glenn *et al.* 2009).

It is recognised that a positive identity has a number of attributes including being cognitively and emotionally inspirational, generative, in terms of resources and well-being, authentic and flexible (Glynn, Walsh 2009). A positive identity should also allow for growth and enable the development of positive relationships, which will in turn feed back into the identity. It should be dynamic, satisfying and robust (Ragins 2009, Caza, Wilson 2009). Positive identity and effective teamwork are linked in terms of expertise recognition. Whereby expertise is inherently thought of as positive, and is thought to be the reflected best self (MacPhail, Roloff *et al*. 2009) and that by recognising and valuing expertise in others, a team can work with each other effectively. I would argue that in order for others to recognise expertise, the individual needs to recognise it and claim it.

This is confirmed in Ragins (2009) statement that positive identity is about self-cognition and self-affirmation. Positive professional identity should, therefore, answer the question of what it means to be who I am, and why it matters that I am who I am (Morgan Roberts, Dutton *et al. 2009)*.

Greyson Perry (2014a, 2014b) a famous artist, considers that our identities are our greatest artwork; he acknowledges how they change and develop over time. It would seem odd then to create art that does not reflect the best of us to the rest of society, and having a positive identity is a statement of this. To present ourselves in a way that is seen by others to be positive is a skill that is needed on an individual and on a group level. Perry often refers to how ourselves are reflected in others, and therefore this positive identity needs to be recognised and conferred on us by others, not just ourselves. Occupational therapy has a number of issues in terms of reflecting a positive identity. It needs to battle not only on its own merits as a profession, but as a group of professionals (Allied Health Professionals) and also as part of a wider organisation of, in my case the NHS, or a private health company. The point Greyson Perry makes, which is also made by other theorists (Billington, Hockey *et al.* 1998, Lawler 2014) is that the identity of either self or organisation is reflected in how others define it, and that the identity is often conferred whether liked or not by the individual or organisation involved. Therefore a positive identity is not just the artwork we create but it is dependent on the views of the art critics who agree or disagree with the identity that is projected.

The National Health Service itself has had an identity crisis in recent years, in terms of its brand. Following the *Francis Report* (2013) public trust in the NHS has had to be restored and at national levels the NHS has worked hard at this with a number of white papers and documents designed to restore trust in the brand of the NHS (DOH 2013a, National Advisory Group on the safety of patients in England. 2013, NHS England 2014). There are ongoing political issues that threaten this branding, such as putting services out to tender and non-NHS companies providing some services, threats to funding and research as well as ongoing stories in the press about persistent bad care, but other initiatives such as the Berwick report (National Advisory Group on the Safety of Patients in England 2013) and the NHS constitution (DOH 2013a) seek to combat these. Within this climate,

occupational therapy needs a positive identity in order to effectively market its service to its existing employers and perhaps expand into areas, currently defined as role emerging, such as private care homes or schools. A positive identity enables a positive marketing strategy and pre-knowledge of a profession will also enable effective recruitment (Adams, Hean *et al.* 2006, Morley, Rennison 2011).

2.8.1 Identity as a solution

The benefits of having a strong professional identity are well documented in the literature and reflect the benefits of the preceptorship process designed, amongst other things, to support it. They include more confident and competent staff (Holland, Middleton *et al*. 2012a), increased retention (Wright 2001), decreased likelihood of stress and burnout (Edwards, Dirette 2010), a clarity in the definition of roles and core skills (Von Zweck 2008) and more effective teamwork (Wakefield, Boggis *et al.* 2006, Hallin, Kiessling *et al.* 2009) and a clear articulation of the profession as a whole (Molyneux 2001, Russells 2014). The work of Crossley and Vivekananda-Schmidt (2009) regards having a professional identity as a prerequisite for accepting the responsibilities and obligations of a profession. These benefits are linked to the quality of work done by the profession. There is evidence to show that if team members know what the other members do, they can work together more effectively as a team, without overlapping of roles and that this leads to a better patient experience (Rodger, Mickan *et al*.2005, Wakefield, Bogis *et al.* 2006).

Another positive aspect of a profession having a positive identity is in the recruitment of students. Adams and Hean *et al.* (2006) discuss how students entering into the medical professions have a pre-formed idea of what it means to do that particular job. If the profession of occupational therapy has a weak identity then it may be difficult for students to have any ideas about the profession before they enter for study, and if this is the case they may not enter the profession at all. Sutherland and Howard *et al.* (2010) discuss this in terms of students having a prior knowledge of the discipline and this has already been highlighted as an issue in occupational therapy. A weak identity could, if not addressed lead to a very limited amount of people having any prior knowledge. The benefits then of a positive and strong identity could be an increase in recruitment to the

educational establishments of the profession, thereby taking a step to ensuring the profession's longevity.

2.9 Preceptorship as a process,

Preceptorship is a process which helps newly qualified staff develop their confidence, skills, competence and sense of professional self in the first year after qualification. It is defined in the *Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals* (DOH 2010) as:

> *"a transition phase for newly registered practitioners while continuing their professional development, building their confidence and further developing their competence to practice."(p10)*

This definition is further developed in the *Preceptorship Handbook for Occupational Therapists* by Morley (2012) who defines preceptorship as:

> *"a structured development process, including observed practice and feedback against agreed standards, to support newly qualified practitioners to build their professional identity and competence in order to facilitate their successful adaptation into the workplace.[5]" (p5)*

2.9.1 Role of preceptorship

The Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals (DOH 2010) focuses on the benefits of preceptorship to both staff and the employer, these are listed as being for the newly qualified worker; increased confidence, professional socialisation into the work environment, job satisfaction, feeling valued and taking personal responsibility for commitment and knowledge. For the employer; enhanced quality of patient care and experience, better recruitment and retention, reduced absence and sickness, and the ability to identify staff that may need support. Prior to her 2012 handbook Morley (2007b) emphasises the need in the preceptorship process to work with experienced staff in order to learn skills and knowledge from them.

[5] The Trust has specific paperwork and policies around preceptorship. The preceptee receives regular clinical supervision and at four points during the first year has to perform a formal knowledge and skills framework (KSF) (NHS Scotland ND) review in order to look at skills and competencies required for the role and identify areas for development and training needs. (Anon 2014a, 2014b)

The need to work with role models has also been linked to the development of professional identity, with Clarke and Martin *et al.* (2014) claiming that you cannot develop professional identity without having a good role model to learn from. Morley's (2012) definition of preceptorship includes that it is there in part to support the ongoing development of professional identity in newly qualified staff.

The teaching of professional identity is carried out at undergraduate level (Ikiugu, Rosso 2003) but it is not clear whether this is consistently continued during the preceptorship year. There are however clear links between the preceptorship year and the concepts of lifelong learning. Mary Morley (2007a, 2009a, 2009b) has written extensively about preceptorship and its role in the transition of students to qualified staff and within this includes requirements for continuing professional development. She links the practice of this to existing learning cycles; in particular Kolb's learning cycle which demands a reflective approach to learning. Morley's (2012) *Preceptorship Handbook For Occupational Therapists* is the culmination of her previous research about preceptorship which used a variety of methods to collect data from small groups of practitioners. Preceptorship was piloted throughout 25 NHS Trusts in London, so although the groups of practitioners interviewed were small they were well spread throughout the capital. It is also of note that all the Trusts piloted were mental health Trusts, and from this Morley's work was generalised across the areas that occupational therapists work in, with no other work around how preceptorship could be effective in acute hospital Trusts. However, Morley's insights were written as preceptorship was being developed for the profession and the role of the preceptor in the continuing development of professional identity has not been evaluated locally, or in the literature since 2009. If as the current evidence suggests professional identity plays a key role in the retention of staff and effective team working then it can be argued that the preceptorship year should continue to encourage the growth of professional identity.

The Trust has a preceptorship course for new staff which consists of a monthly meeting over the first six months. However due to the different start dates of staff and communication issues, it is unknown how effective these can be, for example, the person on preceptorship with me, despite being in post two months received the email after the

first two sessions had taken place. It is of note as well that these preceptorship groups are multi-disciplinary, and as a result of the makeup of the Trust, spaces are predominately taken by nurses in their preceptorship year.

2.9.2 Communities of practice as a way of developing professional socialisation within preceptorship.

It is possible that the concept of communities of practice could be applied to the existing preceptorship courses that run within the Trust in order to address some of the imbalances. Communities of practice have been used in health care since the 1990's (Li *et al.* 2009) and although originally perceived as a way of social learning are also regarded as being an essential aspect of identity development (Wenger 2000). Communities of practice are defined as being:

> *"groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis" (Wenger et al. 2002 p4).*

They are designed to enhance knowledge and increase the link between theory and practice, in the place where practice happens (Li *et al.* 2009). They are widely accepted to have many positive characteristics for the staff that are involved in them. This includes a heightened sense of ownership and responsibility, a reduction in social isolation, a critical approach to learning and therapeutic reasoning, an informal sharing of information, an exchange of competence and experience, identity building, continuing professional development, empowerment, maintaining professional networks and knowledge creation (Li *et al.* 2009, Hoffman *et al.* 2011, Lev-On 2015, Thomas, Judd 2015). It is recognised that the group may focus on different functions dependent on the needs of, the experience, and the maturity of the group. Li *et al.* (2009) found that community of practice groups shared four main areas of focus including social interaction, knowledge sharing, knowledge creation and identity building; however, emphasis changed in order to meet the requirements of the group. Turner and Knight (2015) also state that committing to a group can reinforce identity and articulation.

Using the community of practice as a way of focusing on identity development, Davis (2006) regards it as a responsibility that is equally shared between the individual and the group. Davis sees the group as an embodiment of a larger concept, i.e. the profession (page 2) and in doing so gives the profession the responsibility of socialising its new members. This makes clear the link between the community of practice and social theories of learning. Because of this social learning, Davies is clear that communities of practice have a fundamental role in professional socialisation.

Wenger (1998, 2000) defines identity in terms of knowledge. Knowing, learning and sharing knowledge are a part of belonging, and knowledge is integral to professional identity. He concedes that identities may not always be strong or healthy but regards them as a combination of our competence and experience. Wenger also regards context as important, describing our identities as needing a 'social home', where our competence is recognised and our potential is encouraged and expanded. He recognises trajectory, multi-membership and fractals, as a way of defining our identity over time, space, boundaries, social and environmental levels. However, always the concept of identity is brought back to the sense of belonging to a community whether that is local, global, organisational or family.

2.9.3 Preceptorship as a solution.

One of the questions this research seeks to answer is: In what ways is the preceptorship process perceived as having any influence on the development of professional identity? By asking this question we can try to determine if preceptorship can be a solution to the long-standing issues of identity in the profession of occupational therapy. In order to do this preceptorship needs to deal somehow with the issues that have contributed to the profession's problems with identity in the first place. These issues have been previously identified in this work as being ones of epistemology, scope of work, generic working versus specific use of occupational therapy core skills, working in isolation, community working and supervision and regulation of staff.

Preceptorship does not deal directly with the issues raised by the mixed epistemology of the profession, however given that these issues are historic and arise because of how the profession was founded it could be argued that these issues will never be sufficiently

allayed and that they actually are an integral part of our identity. The dualism of a health and social care background is in some ways what makes the profession unique, and perhaps as a profession we need to move away from using this mixed bag of a starting kit as an excuse for our identity issues and towards embracing it as part of our professional identity.

Preceptorship may also struggle to deal with the scope of the profession's work. It cannot make a paediatric occupational therapist and a head-injuries occupational therapist do the same thing on a daily basis, but it can look at common core skills and competencies that each professional should have regardless of the client group and the setting that they work in. This issue of the scope and variety of the job and its impact on professional identity is considerable and preceptorship does not begin to deal with this issue in terms of professional identity as viewed from outside the profession.

Preceptorship should deal with the issue of generic working. It matches skills and competencies to the Knowledge Skills Framework (KSF) framework (NHS Scotland ND) and these are specific to each job (DOH 2005a).[6] This, therefore, should allow for a discussion around the role of the occupational therapist and the balance of specialist versus generic work that is done by individuals. Part of the potential problem with this is that it may be dependent on the skills and knowledge of the preceptor as to how this discussion is done, or if it is done at all. *I, for example, am half way through being a preceptor for the third time, but I have not had, or been offered, or even seen any training around preceptorship, how to carry out the process, how to be a preceptor and what the expectations and scope of the role are.* It may be that this lack of training is common throughout the Trust and could be one that affects the quality of preceptorship and how it then impacts on the preceptees' perception of the process.

[6] The KSF is a very wide framework as it has to cover all of the roles and functions of the different staff groups in the NHS. It is made up of 30 dimensions. Dimensions are broad competence statements which set out the main areas of knowledge and skills and how these should be applied to meet the demands of your work in the NHS (NHS Scotland ND).

Where preceptorship should have an impact is in the area of working in isolation. Many occupational therapists including newly qualified staff work as lone professionals within a team, and their supervision comes from people who work in a different team, or sometimes a different organisation. Preceptorship could for the first year be the way of introducing newly qualified staff to ideas of occupational therapy practice and theory that will influence the way they work and the way they develop in terms of their career pathway and professional identity. Although, this could be somewhat dependent on the preceptor and their skills and knowledge. This again raises the issues of training but also the selection of preceptors. I was chosen to be a preceptor because I had a band five occupational therapist come to work in the team I am in, not because I had any special skills or knowledge, or because I am good at my job, it was a simple matter of geography that put me into the role of preceptor. If this is true throughout the Trust then it may be that not all preceptors have the experience or skills needed for the role and this surely would limit the impact of the preceptorship process.

So although preceptorship itself may not have all the answers to the professions' issues with identity it certainly can impact on some of them. Preceptorship, therefore, should be the beginning of the solution, by enabling newly qualified occupational therapists to explore their competencies and core skills and what it means to be an occupational therapist in a supportive and safe environment.

2.10 Conclusion

In conclusion, this chapter has uncovered the reasons why occupational therapy struggles with concepts of professional identity. It considers the role of the preceptorship process and how this may be useful, and also considers the concepts of identity formation, careers theory and positive identities and how these various theories may be used by the profession to consider the issue of professional identity as we move forward.

This chapter outlines the importance of having a positive professional identity and how this can lead to more effective teamwork and increased recruitment; it also considers the benefits to the preceptorship process. There are issues that are raised however such as the training and selection of preceptors and that preceptorship itself may not fully be able

to meet the needs of the profession when it comes to how people outside the profession view it.

It also raises the issue of epistemology in the profession of occupational therapy and suggests that a different view of our eclectic past may be helpful. The hotchpotch of professions and epistemologies that go into the makeup of the profession are often seen as the underlying cause of our issues with identity (Creek 2010, Grant 2013), whereas this chapter claims that these differing doctrines make the profession unique and should be celebrated as part of our complex identity rather than denounced as too complex to be of use.

Literature review

3.0 Introduction.

A structured literature review was conducted. Using guidance from the text S*ix Steps to a Literature Review* (Machi, McEvoy 2012) I would like to consider the ethical considerations of engaging in a literature review. As in the rest of the research process, an ethical approach can help ensure a rigorous method and answer questions of reliability and validity. Ethically the issues of plagiarism must be avoided and Machi and McEvoy (2012) go on to be clear that the author has a responsibility to report an accurate unbiased account of the literature and importantly not to use the literature out of context or misrepresent it. Part of this ethical consideration must also be around transparency of method and therefore the beginning of this review will start with a statement of the search terms and engines used as well as the inclusion and exclusion criteria applied to documents. This enabled a methodical approach to surveying the available literature to be applied. The search engines were chosen to reflect the health professional aspect of the literature as this is central to the research questions. Therefore Ingenta Connect (which incorporates the British, American and Australian Journals of Occupational Therapy) was chosen, CINAHL Plus (a leading health search engine) and ProQuest Nursing & Allied Health Source (which includes nursing and allied health professions literature). These three search engines generated a large amount of material, but also soon duplicated results. Two other search engines were trialled, these being Google Scholar and JSTOR, however, the first was not focused enough and therefore the results were unwieldy and not useful, and the later yielded no useful results returning zero hits for most of the search terms. Both search engines were therefore not used in the final literature search. The reference lists of the retained literature were also searched so as to identify further beneficial texts.

The search terms used were:
occupational therapy AND preceptorship,
occupational therapy AND professional Identity,
occupational therapy AND professionalism,
preceptorship AND professional identity,

preceptorship AND professionalism,
professional identity AND professionalism.

The search terms used were intended to find information regarding the specific issues that will be analysed by the research. By searching occupational therapy I began to limit the literature to be profession specific, although it still found hits that have other relevant professions in the articles, the word preceptorship is used in a specific way in occupational therapy that is not the same as in nursing, and this will be discussed later in the literature review. Professional identity is the main issue to be discussed within the overall research. However, as this is such a widely defined term I also chose to search the term professionalism as well, as I considered that this may give some insight into the aspects of identity that form the definition of professional identity. In the search engines used, the terms occupational therapy, preceptorship and professional identity on their own produced too many results to be useful and the Boolean terms were used in order to manage the data and allow for a thorough, methodical search of the literature.

The inclusion criteria were that articles must be in English, from professional, academic or peer-reviewed journals and be either research or experience pieces. They should also be written since 2000. Mary Morley wrote about developing a preceptorship programme in 2007 (Morley 2007b) and so searching back as far as 2000 should highlight any early work that was done around preceptorship. Exclusion criteria are, obviously articles that do not meet the inclusion criteria, as well as anything that did not have direct relevance to the research questions. I also excluded articles that dealt with private practice and those that were primarily about student education, although work related to the transition from student to qualified member of staff was included.

The accompanying table of hits and reduction diagram show how the literature was searched and refined to give a total of 92 hits that were included in the final literature review.

Table 1: Table of hits

		Database 1 Ingenta connect	Database 2 CINAHL plus	Database 3 ProQuest nursing and allied health source
Search term: all searches limited to date (2000 to present) and to academic journal		Hits	Hits	Hits
1	Occupational therapy and preceptorship	1	14,703	127
2	Occupational therapy and professional identity	30	40	2,636
3	Occupational therapy and professionalism	383	65	634
4	Preceptorship and professional identity	1	614	221
5	Preceptorship and professionalism	23	29	223
6	Professional identity and professionalism	2,104	87	1,426
Total number of hits screened		2,542	15,538	5,267

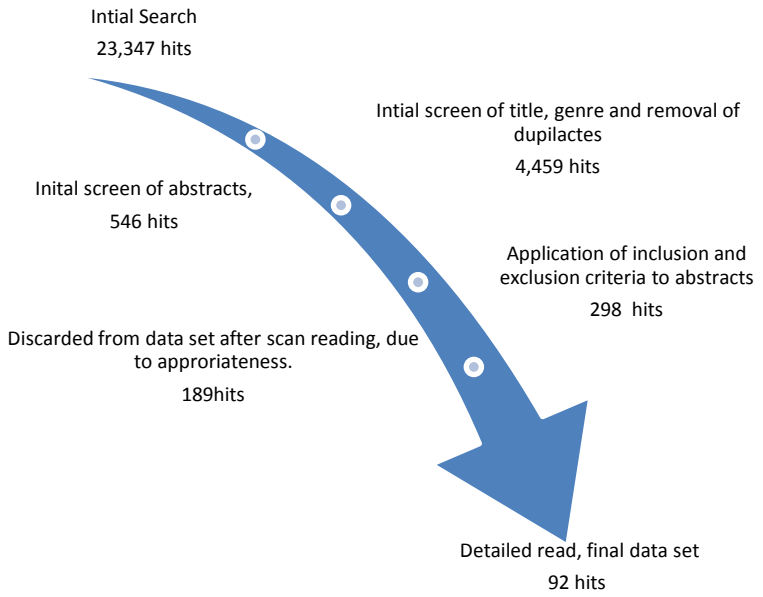

Figure 1: Reduction of data

The literature review was conducted using the schema introduced by Machi and McEnvoy (2012), this includes guidance regarding selecting the topic, searching the literature, developing the argument, surveying and critiquing the literature and finally writing the review. The topic, selected and refined at the thesis proposal stage, is that of occupational therapy, professional identity and preceptorship. The searching of the literature is outlined above and the remainder of the literature review will cover the surveying and critiquing of the literature and presenting the argument.

The literature review will cover three main areas. These are preceptorship, professionalism and professional identity. Within each area of the literature review there are five subthemes that have been identified. These have been identified by a system of mapping core ideas (Machi, McEnvoy 2012 p52).[7] This, in turn, will emphasise the gap in the literature that this research aims to fill.

[7] I coded each piece of literature in terms of its main theme (preceptorship, professionalism or identity); I then listed each piece of literature within a main theme and pulled out the main thread of that article. I subsequently made a map of these ideas linking ones that were the same or related until they were reduced to the core idea. I repeated this process for each main theme, which gave a total of fifteen core ideas to be discussed in the literature review.

Table 2: Themes from literature review

Preceptorship	1) The need to give recognition to the process, from management as well as participants. 2) Time to complete the process. 3) The skills and experience of the preceptor. 4) The expected learning element, related to the KSF. 5) The supportive and reflective element.
Professionalism	1) Professionalism is described by clear values attitudes and knowledge and behaviour. 2) Being able to articulate and understand these values is vital to understanding your own role and to teamwork in general. 3) Clarity of role is essential to socialisation within a professional group. 4) Concepts of professionalism are not static and develop over time and can be regarded like a contract by more experienced staff. 5) Outside drivers impact on concepts of professionalism.
Professional Identity	1) Professional identity has a practical component to it that includes knowledge and skills, confidence and competence. 2) There is a philosophical component to professional identity that includes reflexivity, language and perception of self. 3) There are organisational issues that impact on professional identity. 4) That defining your role helps define your professional identity, knowing who you are and what you do is important and is linked with professional socialisation. 5) There are reported benefits to having a strong/positive professional identity.

3.1 Preceptorship.

My perception of the writing about preceptorship is that it is less prevalent in later occupational therapy literature, with its peak being around 2007-2009 when Mary Morley was writing articles about the development of the preceptorship programme and her preceptorship manual (Morley 2012). During the process of completing the literature review it was noted that often literature referring to nursing discussed preceptorship in a different way to literature in occupational therapy and teaching. Nursing literature used the term preceptorship to refer to the process of mentoring student nurses. This changes post 2010 when the national guidance for preceptorship, *The Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals* from the Department of Health was released (DOH 2010). This guidance expressly describes preceptorship as a process that supports newly qualified staff, and the literature in nursing then changes to reflect this.

For example, Myrick and Yonge (2001, 2004) writing in the early part of the noughties use the term to describe the support of students as does Harbottle (2006). The terminology moves to its new use in later writing, such as Muir and Ooms *et al*. (2013) and, Harrison-White and Simons (2013), who both use the term to discuss support for newly qualified staff. An ongoing issue for nursing writing may be that the term is not used in the new way definitively across the globe. For example, Al-Hussami and Saleh *et al.* (2011), although writing in 2011 and therefore post the new definition within nursing, are writing about a programme in Jordan. There is a possibility that the authors had started their research using the term in its previous usage and had either chosen not to update, or had not seen the update prior to publishing, or that the update being a Department of Health document does not have relevance abroad and therefore the term is used differently across the nursing world.

This is not the case in occupational therapy writing where the term is used consistently throughout the main national journals, (British, American, Canadian, Australian and Scandinavian). A number of reasons for this can be proposed; that the term preceptorship has been used in occupational therapy to describe support for qualified staff for a longer time. That it has never been used to describe the student process (which itself has had a

number of different titles over the years but never preceptorship). That authors from one country often publish in another country's journal (from example Hazel Mackey's (2006, 2014) work is published in the Australian Journal of Occupational Therapy, despite the research being carried out in Stoke on Trent and Stafford in the UK). It may also reflect the smaller community of occupational therapy, as opposed to that of nursing, and the need for the profession to project a recognisable international identity. There are a number of issues raised by the literature on preceptorship and these are detailed in table two and discussed below.

3.1.1 The need to give recognition to the process, from management as well as participants.

There is an element of preceptorship that the literature makes clear is essential, and that is that, as a process, its import is recognised, not only by the individual preceptors and preceptees but also by the management and by the organisation itself. Myrick and Yonge's (2001) study discussed preceptorship in reference to student nurses, however they make a point that is as valid for NHS establishments as it for higher education. That is, that the establishment not only needs to develop and support assessments for the preceptee, but they also need to commit to supporting the preceptor. They discuss the need for relevant experience, regular meetings, and careful scrutiny. This was written prior to any formal preceptorship work, completed by occupational therapist Mary Morley and places its focus on the environment or climate that preceptorship should take place in. Myrick and Yonge (2001) note how important it is for staff to accept the role of preceptor or preceptee, and that others in the work environment need to accept the process and role too in order for it to be successful.

Lee and Tzeng *et al.* (2009) take a different approach to encouraging management and organisations to accept the responsibilities of preceptorship. They focus on the effects that preceptorship had on turnover, cost and quality. Although their aim was not to raise the import of preceptorship in terms of support for staff, they were driven by low retention rates of newly qualified nurses in the United States. Their findings recommend preceptorship as a way that organisations can increase retention, control costs and improve quality but they again emphasise the need for organisational support for

preceptors in order for the programme to be effective. Fagerberg (2004) again discussing nursing staff, advocates that the support required in order to retain staff, should be viewed as a political issue.

That organisations need to recognise the process of preceptorship, are findings that are reiterated in the literature from different professional groups. Harbottle (2006) evaluated radiotherapy preceptorship and Hobbs (2012) considered the process in midwifery and Maringer and Jensen (2014) for occupational therapists. All have a common thread that the climate, environment, workplace or organisation needs to be supportive of the process and of the participants, and that this can be done effectively by considering a formal framework for preceptorship, that values the process, the relationship and the effort involved. Harbottle sums it up:

> *"if preceptorship is to be successful then everyone needs to support the process and ensure that there is time to effectively carry it out. There needs to be recognition from the management as to its importance but also from all the staff that are going to be involved" (P 52).*

3.1.2 Time to complete the process of preceptorship.

The above quote from Harbottle (2006) envelops one of the components seen as important to preceptorship that is time to carry out the process. Harbottle's qualitative study used a focus group to interview radiographers about their experiences of the preceptorship process and one of the major themes developed is time. This had two sub-components, one being the length of time that the preceptorship program should run for. In Harbottle's (2006) study, the time frame varied from 3-6 months to 12-18months. The Department of Health *Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals* (DOH 2010) mentions a period of preceptorship but does not strictly define a timeframe, only stating that some required skills and attitudes may take as long as two years to develop. In occupational therapy, it is standard that preceptorship lasts for a year.

The other factor of time themed in Harbottle's (2006) study is the time that the process demands from the practitioners that are engaged with it. In Harbottle's study this was seen as a resource issue, one of short staffing, and of needing to roster people on

together to enable meetings. This is a concept also developed in Foster and Ashwin's (2014) paper. They establish that their preceptorship programme initially allocated newly qualified midwifery staff 75 hours of supernumerary time, although this time was not wholly received by all of the ten participants in the study, the time that was rostered was seen as valuable by most, making them feel respected and supported as they had time to learn and reflect. Also acknowledging time as a factor, Marks-Maran and Ooms *et al.* (2013) found that nursing staff felt that making time to meet up was difficult. This was mainly to do with a conflict of role between being a part of the preceptorship process, as a preceptor, and having a clinical role as well, this is despite preceptors stating that it was given high priority. Ohrling and Hallberg (2001) also acknowledge this issue, though with a different lens, claiming that the preceptorship process (that of mentoring student nurses at this point) is energy demanding for all involved. Using preceptorship in its post 2010 meaning, Panzavecchia and Pearce (2014) establish in their qualitative study that nursing preceptors (of newly qualified staff) found lack of time to be a barrier in delivering a successful preceptorship programme with one participant claiming that:

> *"no time or acknowledgement is given to the role" (p1123).*

The fact that these studies ranging over nearly 15 years are still acknowledging that time is a factor is worrying. Especially when authors such as Smith and Morley (2013), writing just generally about time-consuming professional development issues in occupational therapy (including KSF, supervision and CPD) discuss them in terms of being, required, fundamental, legal, and a responsibility.

3.1.3 The skills and experience of the preceptor.

The majority of the literature around preceptorship contains a clear message that its locus is the preceptor. Myrick and Yonge (2001) claim that the learning environment is key and that a large component of the environment is about nursing staff. In particular, they highlight the relationship between the preceptor and other staff in the learning environment. Myrick and Yonge's (2004) paper expands on this claiming that the success of the whole process depends on the knowledge, experience and behaviour of the preceptor and the relationship she has with the preceptee. These findings are

consolidated by Muir and her colleagues in a study that considered midwifery preceptorship from the viewpoint of the preceptee and the preceptor (Marks-Maran and Ooms *et al.* 2013, Muir and Ooms *et al.* 2013). From both points of view, the role of the preceptor was seen as pivotal, with preceptees placing high value on the skills and knowledge of the preceptor, and the preceptors recognising the importance of their personal skills in the professional development of the preceptee. The work of Mary Morley in developing and reviewing preceptorship in occupational therapy is much blunter in its statement that new starters need to spend more time with experienced practitioners (Morley 2007b, Smith, Morley 2013). There is general agreement with this idea, that the role of preceptor needs to be undertaken by an experienced member of staff (Harrison-White, Simons 2013, Kumaran, Carney 2014, Foster, Ashwin 2014). Kumaran and Carney (2014) also claim that the role of nursing preceptor is very stressful, and there is also some consensus that just because a member of staff is experienced does not mean that they know how to be a preceptor. As a result of this, there are a number of papers that identify the need for staff training in order to perform the role of preceptor successfully (Al-Hussami, Saleh *et al*. 2011, Harrison-White, Simons 2013, Maringer, Jensen 2014)

3.1.4 The expected learning element, related to the KSF.

There is a direct link made between preceptorship and the Knowledge Skills Framework (KSF) (NHS Scotland ND), not only in the Department of Health paper, *Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals* (DOH, 2010) but made earlier in 2007 by Mary Morley in her paper *Building Reflective Practice Through Preceptorship* (Morley 2007a). At this early stage in the development of preceptorship in occupational therapy, Morley clearly views that the KSF framework is a document that will support the process of preceptorship and indeed designed the preceptorship process to 'dovetail' into the KSF (P42). Also in 2007 she uncovered that often newly qualified staff lacked structure in their supervision and support, something the relatively new KSF, introduced in 2004/2005 had not at that point in time managed to put in place (Morley, Rugg *et al*. 2007). Therefore preceptorship was viewed as a way to add this needed structure. When evaluating the process Morley (2009b) identified that the structure had indeed been helpful and that linking the preceptorship work to the KSF

competencies gave occupational therapy staff a view of *"achievement's not weaknesses"* (p388). The concept of linking preceptorship to a formal record of competencies is also seen in teaching (Sutherland, Howard *et al*. 2010), midwifery (McCusker 2013, Foster, Ashwin 2014) and nursing (Muir, Ooms *et al*. 2013). These links, and their development over the years are still neatly summarised by Morley, who right at the beginning of developing preceptorship claimed, of newly qualified staff that, it would *"facilitate their development as experienced practitioners"* (Morley 2007a p42).

3.1.5 The supportive and reflective element of preceptorship.

The literature highlights the importance of the supportive and reflective element of preceptorship, and places importance on this element rather than the element of learning skills or meeting the KSF guidelines. Morley (2006) quotes Tryssenaar and Perkins (2001) when she begins to discuss preceptorship in terms of being a coping strategy that helps newly qualified staff make the transition from being a student to being a professional. Morley (2006) views preceptorship as being a period of time where more experienced members of staff can help to *"boost the confidence"* (p233) of newer staff, and preceptorship is viewed very much as a way of enhancing the already existing support structures of supervision and CPD. She also quotes Wright (2001) stating that newly qualified staff are looking for ways to feel confident in their role and may feel stressed and therefore may require more support.

The need for preceptorship to be supportive is echoed in Harbottle's work with radiotherapy staff (Harbottle 2006). Harbottle learned that one of the groups she studied really valued the reflective and supportive element of preceptorship, whereas the other group focused more on the learning of skills. This difference in focus was due to how preceptorship had been defined at the outset of the study. However, the group who did value the supportive and reflective element found that the preceptorship process motivated them to be reflective (p48.) This need to feel supported continues to be a theme in the literature, as Phillips and Tapping *et al.* (2013) found that health visitors, who took part in a mixed methods study that reviewed a pilot of a preceptorship programme, valued preceptorship for a number of reasons that included, feeling supported at work, managing stress levels and being able to take any issue to the

preceptor. In the preceptorship programme for midwifery staff that Foster and Ashwin (2014) reviewed there were actual *reflect and learn* sessions. These were viewed by the participants as not only helpful in terms of reflection but also in terms of support. One participant found that the helpful component of the session was that:

> *"you realised that other people felt the same and had good days and bad days" (p154).*

After these papers that espouse the importance of the supportive and reflective element of preceptorship, it is disheartening then to read Kumaran and Carney (2014) finding that student nurses did not feel supported in their transition from student to qualified member of staff and that somehow the preceptorship period was not facilitated well and left the participants in the study feeling that all protection and support was suddenly withdrawn (p608). This difference in how this initial year was supported may be due to the study being carried out in Ireland where preceptorship may be different, and despite being written in 2014 the article still talks about preceptorship for student nurses. This article itself may be evidence for the need for a full preceptorship programme during the first year of being qualified in order to offer a continued level of support whilst staff gain confidence and skills.

It is worth at this point making the link between support and emotional resilience. Ashby and Ryan *et al.* (2013) discuss professional resilience as being the same conceptually as emotional resilience. Resilience is a concept linked to coping, reducing stress and decreasing burnout. Studies list factors in resilience as being: support, humour, and boundaries, work-life balance, time management and self-care (Gupta, Patterson *et al.* 2012, Scanlan, Still 2013, Poulsen, Meredith *et al.* 2014). The benefits of preceptorship list decreased sickness and reduced turnover for staff (DOH 2010, Morley 2012) and therefore preceptorship should be a time where emotional and/or professional resilience is encouraged, supported and developed and coping strategies consolidated. However Scanlan and Pepin *et al*. (2015) showed that professional resilience was an unmet educational priority even though it was considered essential. Their study of occupational therapy education in Australia and New Zealand does raise the question of whether preceptorship is consolidating strategies for resilience or if it is responsible for teaching them. If preceptorship is indeed responsible for teaching resilience, then the supportive

element of the process becomes much more essential to the individuals involved and the development of their emotional coping strategies.

3.2 Professionalism.

Most noticeable in the literature about professionalism in health care is its increasing prevalence in more up to date literature. Of the 33 articles relating specifically to professionalism eight of these were written in the last two years. Indeed it is claimed that the very future of the health care professions relies on the social and moral understanding of professionalism (Sullivan 2000). There are a number of themes that run through the surveyed literature on professionalism. These are outlined in table two and discussed in turn below.

3.2.1 Professionalism is described by clear values attitudes and knowledge and behaviour.

There are 18 articles that begin to shape how the concept of professionalism is understood in practical and concrete terms. They discuss values, attitudes, knowledge and behaviour that are classed as professional and thereby make up professionalism. The main issue with this is that the list of values and behaviours and knowledge that makes up professionalism is seemingly endless and this imprecise bubble of terms is forever changing shape.

It is understandable that the skills and knowledge would be different depending on what sort of professional you are, for example as an occupational therapist I have a different knowledge and skills set than you would expect an accountant or a lawyer to have, however some of the values and behaviours and attitudes may well be expected to be the same (for example, treating people with respect, being on time). It is Aguilar and Stupans *et al.* (2013) who try to specifically define professional behaviours and attitudes in Australian occupational therapists. However, although their study produced some agreed upon terms (seven behaviours and 61 values) I perceived it to be unwieldy. Seven named professional behaviours is a manageable amount to describe and evaluate and even measure yourself against, but 61 values is too large a number to be useful in defining the professions' attitudes to professionalism. The study used a Delphi technique to produce

the terms; however, I would deliberate whether there was a sufficient agreement on terms in order to make it useful. It does, however, provide the profession with a complex list of values that occupational therapists consider as being professional.[8]

Halldorsdottir and Karlsdottir (2011) considered the aspects of professionalism in midwifery and included competence and knowledge in their five aspects. Ashby and Ryan *et al.* (2013) in their study of occupational therapists discussed the need for knowledge to be central to a profession and although their study focusses on professional resilience and touches on issues of identity it does highlight that all their participants identified that central to occupational therapy, central to professional resilience, is the use of core occupational theory knowledge and occupational perspectives of health. This core knowledge appears to be vital to professionalism so it is initially confusing to see Baxter and Brumfitt (2008) encouraging staff to share knowledge. Their argument for this is that in understanding, not only your own professional knowledge, but that of your colleagues you can encourage smooth and effective team working.

Having knowledge of your professional role is highlighted as being important to professionalism by a number of authors including Wilding and Whiteford (2008), Rodger and Mickan *et al.* (2005) and also Sims (2011). Wilding and Whiteford's (2008) main focus was on language used by occupational therapists to express their daily work and role with patients, whereas Sims (2011), and Roger and Mickan *et al.* (2005), both focused on knowledge of your professional role (in nursing and allied health staff respectively) and concluded that surety of role is essential to an individual's professionalism. When Crossley and Vivekananda-Schmidt (2009), sent out a questionnaire to health and social care students about professional self-identity, one of the themes they asked the students about was that of teamwork. They found that professional identity was a prerequisite for accepting the responsibilities and obligations of a profession. The notion that one can accept the responsibilities of a profession does correspond with the findings of Robinson and Tanchuk *et al.* (2012) that professionalism developed over time and became like a

[8] Aguilar and Stupans *et al.* (2013) define the Delphi technique as a multistage data collection method that aims to gather individual perspectives and obtain a collective agreement on a topic.

contract and that when people developed their knowledge and skills they became, or accepted the role of professional.

The appearance that knowledge is central to professionalism is also developed by Kelly and Courts (2007) who asked newly qualified nurses to fill out a professional concept scale, all of them had highly valued their clinical experience as students and felt that this experience was essential to their self-concept. This experience would not have only been about learning how to do the practical tasks of nursing but would have also modelled professional behaviour and values and Clarke and Martin *et al.* (2015) also link having professional role models to professional identity in occupational therapy.

3.2.2 Being able to articulate and understand these values is vital to understanding your own role and to teamwork in general.

There is a potential circular trap whereby you can only articulate your role if you understand it and only understand your role if you can communicate it effectively to others. The literature addresses this issue in two different ways. Firstly to consider the philosophical importance of language used by professions often in terms of discourse analysis, and secondly to study the practical implications of being able to communicate effectively with the focus being in teamwork.

Observing the subtle differences, Wilding and Whiteford's (2008) study considered that language could be empowering for occupational therapy professionals. Their work was completed after Jennifer Creek's seminal work on developing a professional language in occupational therapy (Creek 1998, Creek 2003), and provides a continuum for this line of research. In their study, they substitute the word function for occupation and claim the phrase 'experts in doing'. These simple changes made the staff involved in the study feel like they were being 'more like an occupational therapist' (p185), because they used the word occupation, and also they found using the word expert was empowering and made them feel on a par with other team members whom they had viewed as experts (p184). It is Morley and Rennison (2011) that link the idea of using language to market the profession of occupational therapy restating Bannigan's (2000) claim that we need to *'communicate passionately' (p463)*. Maclean and Breckenridge (2015) understand the use

of language further, not just in terms of its import and everyday meaning but that it also should inform future theoretical development.

A newly qualified occupational therapist Russells (2014) summed up the second way of looking at the practical implications of being able to articulate your professional role stating:

> *"as my knowledge and understanding of different professional roles increased this enabled me to communicate more effectively" (p33).*

She was not just referring to the role of the occupational therapist, but to understanding all roles within the team. Russells' experience is echoed time and time again in research papers that cross professional boundaries: occupational therapy, medicine, social work, dentistry, and teaching. Sims (2011), found that language affected communication is the simplest of ways; people used their job title to define their role. Like Sims (2011), Wakefield and Boggis *et al*. (2006) studied joint education programmes in their research, they found that there was a need for team members to recognise each other's skills in order for a fully collaborative approach to care to happen and the Rodger and Mickan *et al.* (2005) study also confirmed this. Hallin and Kiessling's *et al.* (2009) study also focussed on an inter professional education and confirmed that all the students involved in their study (616) found that working as a team gave clarity to their own role, as well as increasing communication within the team. There was a voice of dissent in the Wakefield and Boggis *et al.* (2006) study that claimed that in being educated in a multidisciplinary way you might lose your role (p150). However, the Wakefield study, and the other studies, does not find this overall. Indeed Fossey's (2001) work on interdisciplinary teamwork, found that shared education and professional development could only improve dialogue and understanding of the occupational therapy role amongst the interdisciplinary team.

Recognition of professionalism was viewed as important in the Ross and Turner *et al*. (2009) study of dental nurses, finding that an acceptance of professional status was important in the workplace. In her 2001 study of interdisciplinary teams, Molyneux (2001) discovered that not only was communication essential to teamwork, but that the

personal qualities of staff and their commitment to the job were also essential. The personal qualities described encompassed competence, being a team player and a lack of professional jealousy, with one participant stating that you have to be:

> *"secure in your professional knowledge, and then you can afford to move boundaries" (p31).*

This comment alone encapsulates the importance of being able to articulate and value your own professional role within a team setting and also links to the next theme of clarity of role.

3.2.3 Clarity of role is essential to socialisation within a professional group.

Judith Macintosh (2003) begins her research into nursing identity with a definition of socialisation; one that she adapts from a number of sources.[9] Macintosh claims that despite the fact that professional socialisation begins in nursing education that there is still ground to be covered once staff are qualified as they battle the stress of being newly qualified nurses. This view is compounded by Feltham (2014) as in her study she identified that the part of the preceptorship role that was valued was socialisation into the workplace as a qualified midwife. With a more complex view of professional socialisation Alidina (2013) states that it is the process of becoming a professional nurse that socialises one into a profession, rather than the process of socialisation that makes you a professional. Crossley and Vivekananda-Schmidt (2009) concur with this stating that you need a professional identity before you can accept the responsibilities and obligations of the profession and Elcin and Odabasi *et al.*(2006) state that professionalism as a subject should be taught as part of pre-registration medical courses as early as possible. This is a different perspective from other writers who claim that often students are already socialised to the profession that they are due to study, before they even start their course, through a process of auto stereotyping (Hind, Norman *et al.* 2003, Adams, Hean *et al.* 2006, Weaver, Peters *et al.* 2011, Larson, Brady *et al.* 2013). Although these two views are somewhat opposing, there is a general agreement that having a positive strong role model aids the development of professional identity which in turn means that

[9] Macintosh (2003) defines socialisation as the process whereby individuals acquire and integrate into their lives the expected knowledge, behaviour, skills, attitudes, roles, and norms deemed appropriate and acceptable to their chosen profession.

people develop a clear concept of role within the professional group adding to their assimilation and socialisation into the group. Clarke and Martin *et al.* (2014) go as far as to claim that you cannot develop a professional identity if you have no professional role model and Ohlen and Segesten (1998) agree. Pratt and Rockmann *et al*. (2006) followed a number of medics over a six-year period and found that role modelling was essential to socialisation and constructing an identity as a medic. Turner and Knight (2015) also find role modelling an essential component for learning within communities of practice.

Socialisation into the profession of occupational therapy was found to be essential in order for therapists to maintain their professional resilience (Ashby and Ryan *et al.* 2013). The process is seen as both formal and informal, being responsible for validating professional practice, sharing problem-solving and coping strategies as well as maintaining professional identity. In their study of 270 teachers, Sutherland and Howard *et al.* (2010) discuss socialisation in terms of 'finding the teachers voice' and the concept of merging the personal and professional is presented. This is also discussed by Johnson and Cowin *et al.* (2012) who clearly state that nurses should develop their concept of self and not just rely on socialisation in order to become a professional, and this is also reflected in Wright's (2001) article. Wright found that as individuals became more senior in their profession so their professional identity became entwined with their personal identity, so that being an occupational therapist becomes part of who you are as a person.

It is Clouder (2003) that joins the self and the professional through the use of Erving Goffman's (1959) theory of self. She interviewed 12 occupational therapy students over a three year period (the whole of their undergraduate education) and found that:

> *"those who wish to join the profession need to adapt accordingly to gain membership" and that "professional socialisation is a process through which individuals are socially constructed and largely shaped into conformity" (p220).*

She also finds that our professional positions and roles fluctuate over the period of time we have been in the profession and that this is influenced by continued socialisation

throughout an individual's career. To quote Clouder (2003) again *"professionalisation is a complex process" (p220).* The literature suggests that socialisation is vital to professional identity and that developing professional knowledge and skills are a part of this. Being able to define ourselves as an individual and as a professional is also key, but that having a role model to guide, teach and lead by example not only influences role and professional identity but is an essential prerequisite to becoming socialised into the profession.

3.2.4 Concepts of professionalism are not static and develop over time and can be regarded like a contract by more experienced staff.

In their study, Robinson and Tanchuk *et al.* (2012) asked questions of university faculty and occupational therapy students about concepts of professionalism and compared the answers from both groups. The qualitative study raised interesting ideas about how professionalism was perceived but most remarkably showed a development in the concepts of professionalism over time. The occupational therapy students were uncertain about what constituted professionalism and unclear about when professional behaviour was expected. They had indistinct concepts of boundaries, whereas experienced staff were able to describe professionalism as being "*like a contract"* (p280). This recognition of professionalism being developed over time and therefore being a fluid concept is also reinforced by Sims (2011) who finds that professionalism is not a static concept and also by Aguilar and Stupans *et al.* (2012) who found after interviewing occupational therapy staff that no one concept of professionalism was found. Kinn and Aas (2009) concur with their findings stating that experienced staff felt more able to assertively express their specialist contribution to the team.

The idea of having one concept of professionalism is however perhaps a false one, as it is clear from earlier attempts at a definition, that professionalism is an issue that can be described as multifaceted. It may be that in Aguliar and Stupans' *et al.* (2012) study that interviewees' experiences of professionalism reflected different facets of professionalism rather than different concepts of professionalism. MacIntosh (2003) describes how her nursing subjects "grappled" with the idea of what professionalism means. Like the Robinson and Tanchuk *et al.* (2012) study that suggests the concepts become clearer over

time, Tryssenaar and Perkins' (2001) study also suggests that successful adaptation to being a professional occurs over time. In order for that to happen the concept must become better understood and have more clarity for the individual. This development of the concept for the individual could happen via the learning of professional socialisation and transitions such as described by Maxwell and Brigham *et al.* (2011).[10]

All the studies discussed here focussed on a qualitative approach to data gathering with most using semi-structured interview techniques to ask participants their views, this is with the exception of Sims (2011) who also used a survey in her study of nurses, though found her survey response rate to be very low. Perhaps even this is an indicator of the complexity of the concept of professionalism that people are happy to talk about it in a face to face interview situation but unable to express their views adequately in a written survey.

There does seem to be juxtaposition in terms of the fluidity of the concept of professionalism, and the perceived boundaries of professionalism talked about in the Robinson and Tanchuk *et al.* (2012) study. These boundaries were seen as much more 'real' in terms of rules by the students in the study, but the 'experts' were much more comfortable with the concept of fluid flowing boundaries, and this freedom of professional expression appears to come with experience.

3.2.5 Outside drivers impact on concepts of Professionalism.

When Lambert and Radford *et al.* (2014) sought to answer the question of whether occupational therapy could flourish in the 21st century they based their answer on literature that had been presented at the World Federation of Occupational Therapy conference. What they posit is that occupational therapy as a profession, and occupational therapists as individuals have to rise to the challenge and prove their worth. Tancock (2014) agrees stating that raising the profile of the occupational therapy profession is the responsibility of the individuals and not that of the College of

[10] These transitions include preceptorship, environmental issues and support via communities of practice.

Occupational Therapists. Lambert and Radford's *et al.* (2014) paper calls for a change in the type of research the profession engages in, a review of the service and interventions we provide and an evaluation of our values and behaviour. In short, if we as a profession want to survive the health economy of today we need to analyse ourselves and prove our worth in the current climate of 21st-century health economics. It needs to be stated however that not all writers agree that occupational therapy needs to engage in an increase in quantitative research, and that notable authors, state that qualitative research has an essential place in the ongoing development of the profession (Morley, Smith *et al*. 2011, Cusick 2001).

The economy is not the only aspect of our environment that forces professions to consider their status, values and beliefs and re-evaluate them. Fagerberg and Kihlgren (2001) establish that the nature of the work impacted on nurse identity and that those who had more paper or task orientated jobs had a different sense of identity to those that were involved only in direct patient care. They ask a, perhaps, tongue in cheek question at the end of their paper; does this mean when a ward changes its system the nurses will quit their jobs? Given that this paper is written in 2001 and many systems have changed in nursing and subsequent nursing papers discuss recruitment and retention issues it is possible that they were indeed predicting the future.

Further issues that impact on professionalism are the place of work. In her study of midwives, Hobbs (2012) found that staff struggled if they chose to work in a community setting rather than hospital-based teams, and that they felt marginalised because of this. Hobbs also notes that the culture of a profession influences the next generation and sometimes causes conflict. She discusses this in terms of old school versus new school midwifery and searches for the common values between the distinct cultures. Happily, she is able to find a common professional value, that of being "with the woman" that gives the profession a sense of balance in a time of change.

Taking a wider view of professions, Clouston and Whitcombe (2008) argue that, for occupational therapy, the juxtaposition of the professions ontology in a medically dominated work environment causes ongoing threats to the profession's sense of

coherence and consistency. These threats relate to the core assumptions, roles and definitions of the professions knowledge and skill base and need to be consistently challenged in order to maintain professional stability. It is clear, from the literature, that what professionalism means and how it is perceived from within, and outside of a profession, changes over time as environmental, cultural and political changes shape the concept of what it means to be professional.

3.3 Professional Identity.

48 papers were reviewed that outlined concepts of identity. They either explicitly discussed identity as a concept or they remarked upon professional identity as part of a wider subject area (preceptorship or professionalism), resulting in my view that the issue of professional identity is central and pervasive in concepts of professionalism and issues around preceptorship. Professional identity is a theme that is discussed at length in the literature remarkably though with no firm constructs or definitions at its root, possibly due to its well-known nebulous nature. The issues and themes raised in the literature around professional identity are detailed in table two and discussed below.

3.3.1 Professional identity has a practical component to it that includes knowledge and skills, confidence and competence.

The literature as a whole considers that there is a practical side of professional identity citing knowledge, skills, confidence and competence as all being factors that make up professional identity.

For newly qualified nursing staff this has proved an issue as McIntosh (2003) identified that professional identity has a basis in the level of experience the individual has, and that often new starters found significant dissonance between the expectations they have of the job and role and the reality. McIntosh's results are verified by a number of other studies that claim new starters have negative feelings due to feeling un-experienced. Tryssenaar and Perkins (2001) describe this as a constant stress, with most recently Pillen, and Beijaard *et al.* (2013) noting negative emotions in teaching staff where the expectations of the job did not meet the reality. However, Tryssenaar and Perkins (2001) are positive that individuals can successfully adapt to their roles, and that as newly

qualified occupational therapy staff gain experience their stress levels decrease and their confidence enables an assimilation of a professional identity. This is a view supported by Stockhausen and Sturt (2005) in their review of nursing staff.

This period where staff are gaining experience is a difficult time and Holland and Middleton *et al*. (2012b) link it to difficulties with gaining confidence and competence. They report on a newly qualified occupational therapist who lost confidence in this time, as she felt that the identity she gained as a student was lost in the workplace, which was not as supportive 'post student' life.[11] Maggie's story in their paper shows that she acknowledged that she had a lack of experience and that, when she went out of her way to develop her skills her confidence and competence increased, in turn affecting her perception of professional identity. Their other paper considers carefully how people gain the experience needed to develop confidence. They identify that spending time with someone with skills, and observing them, and then doing the task, as well as taking all opportunities to practice were important in the development of confidence (Holland, Middleton *et al*. 2012a).

Mackey (2014) considers that it is the reflection on knowledge and skills that help embed a professional identity in occupational therapy. Whilst acknowledging that personal experiences and perceptions influence identity, Sims (2011) is clear that professional knowledge is a key component of professional identity. One of his respondents described having "knowledge that you can't forget" (p269). Whitcombe (2013) advocates the use of problem-based learning to help student occupational therapists begin to develop skills that lead to professional identity and Morley (2009a) would agree describing knowledge giving as initially a responsibility of the university. She goes on to then describe being able to develop this knowledge into practical skills as being vital to the development of professional identity. To illustrate her point she describes a situation where a newly

[11] This sadly is a situation that does not seem to have changed for a number of years given that Cottrell (1990) was developing her own questionnaires to ask occupational therapists about their perceived competence, and then relating this to confidence and identity. By 2007, when Kelly and Courts (2007) asked newly qualified nurses about their professional self-concept, specific measures had been developed for the purpose of asking about issues such as self-concept using scales that specifically ask about knowing and skill.

qualified occupational therapist was not able to consolidate any of her skills due to the generic nature of her new team.

3.3.2 There is a philosophical component to professional identity that includes reflexivity, language and perception of self.

Fortune (2000) asks the question: is everything you do in practice according to philosophy? She states clearly that in order to be professional you need to be grounded in the philosophy of the profession. Such is the conviction that there is a strong philosophical component to professional identity that Ikiugu and Rosso (2003) claim that it is the lack of philosophy that has caused a problem with professional identity in occupational therapy. Claiming that this epistemological crisis comes from a conflict in the language used by the profession, Grant (2013) is in agreement with other studies that claim that the use of professional language is key to professional identity (Mackey 2006, Wilding, Whiteford 2008, Bleach 2014). It is O' Conner (2008) that discusses teacher's professional identity in terms of professional philosophy and personal beliefs and makes significant links between identity and philosophy and morals, emotions and reflexivity. She concludes that teacher's identities have philosophical and axiological dimensions (p126). This view is also established for occupational therapists by Drolet (2014). This sense of a profession having value or worth is also reflected in the work of Sabanciogullare and Dogan (2013) who explored the perceptions of 63 nurses and asked about what it really means to *be* a nurse. Also by Stone and Ellers *et al.* (2002) who reviewed clinicians who were also teachers and how they found an image of themselves within this dual role, and had a feeling of wanting to give back to the profession (p184). This axiological view of professional identity continues in the work of Hazel Mackey (2006, 2013). She finds that through reflection and reflexivity occupational therapists worked to produce a truth, however, the concept of professional identity was one that was not static and changed over time as people's knowledge and skills increased. This is echoed in Beijaard and Verloop's *et al.* (2000) work with teaching staff as they also found that teachers perceptions of themselves as teachers, changed over time and how they defined themselves became related to different areas of expertise. For example, in the beginning, staff measured themselves in terms of expertise around their subject area, and later in expertise around pedagogical experience. The Beijaard study also found that teaching

staff felt well able to articulate their identity (p761), something that occupational therapists have been criticised for (Wilding, Whiteford 2008, Ashby, Ryan *et al*. 2013).

There is a definite need for self-reflection to become a part of how professional identity is developed and maintained, and this is advocated strongly by Abreu (2006) who shares experiences from her own professional journey, as an occupational therapist, specifically to:

> *"help others reflect on the development of their identities" (p599).*

Her strong feelings are also replicated in the work of Mackay (2006) for occupational therapists and for teaching staff in the work of Bleach (2014) and in nursing in Johnson and Cowin *et al.* (2012) who state that there is a need for a:

> *"greater focus on developing the individuals understanding of the self and their own identity formation, and that this would be more helpful in professional identity formation" (p564).*

It is Dige (2009) who considers the ethics of professional identity in occupational therapy, and in doing so not only raises the ethical issues of values, morals, and principals but claims that:

> *"philosophical reflection…leads to a stronger professional identity and a much needed emphasis on the client orientated perspective" (p97).*

3.3.3 There are organisational issues that impact on professional identity.

The organisational issues that impact on professional identity are understandably some of the same issues that I stated had an impact on professionalism. The main concern in the literature includes the resource issues of being able to match newly qualified staff with experienced staff in order for them to have a role modelling approach to developing professional identity (Fagerberg 2004, Smith, Morley 2013). Fagerberg (2004) also highlights the impact of the work environment on staff nurses self-esteem. This is regarded by Fagerberg as being an issue that should be dealt with at an organisational level, as it is an issue caused by the workplace. Fagerberg goes on to state that adequate support for staff in the workplace is essential in professional and personal development

and that identity development is then aided by staff being able to conceptualise what it means to be a nurse (Fagerberg, Kihlgren 2001, Fagerberg 2004).

A majority of the studies considered in this literature review have used qualitative data to investigate issues of professional identity. Using quantitative methodology, Vasile and Albu (2011) assessed the correlation between different personality types, stress levels, and professional identity. They used three different measurement instruments on 67 people and found that work environment had a large impact on people's amount of stress. Clarke and Martin's *et al.* (2015) study that used the different methodology of hermeneutic phenomenology identified that work environment has an impact on professional identity for occupational therapists. In contrast to Morley's (2012) work, stating people needed a role model, those students who had completed a role emerging placement often identified very strongly with the core philosophies of the profession, perhaps because they had to articulate themselves them as students.[12]

3.3.4 That defining your role helps define your professional identity, knowing who you are and what you do is important and is linked with professional socialisation.

The views of Crossley and Vivekananda-Schmidt (2009) have already been introduced, that is, that you cannot take on the roles and responsibilities of a profession until you have a professional identity. They advocate the use of role modelling in order to facilitate the socialisation process. It is Beijaard and Verloop *et al.* (2000) who move this concept on and state that the role model should not only be an experienced member of teaching staff (which is Smith and Morley's 2013 proposition for occupational therapists) but someone whom the individual views as being good at their job.[13]

[12] A role emerging placement is a placement in an environment where occupational therapy is not already established in the work force.

[13] At the beginning of this process when I was beginning to establish ideas for research, I completed some reflexive writing about professional identity of occupational therapists. This included a list of the characteristics of staff I had worked with that I perceived as 'good' or 'bad' at their jobs. Clearly then Beijaard and Verloop's *et al.* (2000) findings do not only relate to teachers as I had gone through this process myself, both unconsciously throughout my career and then consciously in my preparation for this piece of research.

Having the confidence to express who you are and what you do it something that the literature identifies is currently difficult for nursing staff with both Crawford *et al.* (2008) and Willets and Clarke (2014) claiming that nurses are struggling to present themselves to the outside world. This struggle to know who you are is strongly related to role modelling and professional socialisation as Ohlen and Segesten (1998), Macintosh (2003), Santasier and Plack (2007), Machin and Machin *et al.* (2012), and Clarke and Martin *et al.* (2014) all related the idea of 'feeling like a nurse/therapist' to role modelling and professional identity. Consequently having a positive role model can be related to professional identity, as can being able to articulate your professional role to others. Toal-Sullivan (2006) is one of a number of authors who identify that being able to define your role leads to more effective team working and increased confidence in the professional role (Wakefield, Boggis *et al.* 2006, Machin, Machin *et al.* 2012, Bodell, Levins 2012).

This definition of role is often perceived to start before qualification, and in some cases before formal education, with the process of professional socialisation often starting before a choice of career is made (Adams, Hean *et al.* 2006, Sutherland, Howard *et al*. 2010, Weaver, Peters *et al*. 2011). The socialisation and role modelling process continue throughout the under-graduate courses with Stockhausen and Sturt's (2005) findings suggesting that nursing students develop confidence and knowledge and become nurses during this time (p8). It is important to note that this process never ends and that professional identity is not a static concept and develops, throughout the duration of a professional's career (Pillen, Beijaard, Brok 2013).

3.3.5 There are reported benefits to having a strong positive professional identity.

Other than the benefits already reported above, that of effective team working, inter-professional working, reflexivity, reduced stress for newly qualified staff and increased confidence there are a number of other reported benefits to having a strong and positive professional identity.

The benefits of professional identity are highlighted in a number of research projects. Hercelinskyj and Cruickshank *et al.* (2014) focus on the issue of recruitment and retention. Their qualitative study considered mental health nurses in Australia and found

that role ambiguity, conflict and stress, damaged professional identity. They discussed that staff that were supported and confident in their role had a greater capacity to work through stress. Their overall findings were that an authentic concept of professional identity must be developed nationally in order to combat serious national recruitment and retention issues. This echoes the work done by Wright (2001), which also focused on recruitment and retention in occupational therapy and also uncovered that there is a need for a clearer professional identity, and more support in the workplace aided that.

Identifying that a strong professional identity was important in resilience, Ashby and Ryan *et al*. (2013), linked this not only to recruitment and retention issues in occupational therapy, but the ability to maintain a profession specific focus when working in isolation from other therapist's and not being drawn into generic work modes. Sabanciogullare and Dogan (2014) discuss comparable issues and link professional identity to increased job satisfaction and decreased burnout levels in nursing staff. A parallel issue was considered through a quantitative methodology by Edwards and Dirette (2010) who used the professional identity questionnaire to link a lack of professional identity to burnout in occupational therapy. All the articles mentioned place value on the support given to staff through supervision, role modelling, and other avenues as being essential to how staff develop identity. Morley (2009a) places importance on preceptorship to help develop professional identity, though Pillen, Beijaard and Brok (2013) view professional identity in teaching as a tool to help professional development and learning.

Only one article (Molleman, Rink 2015) discussed possible negative attributes of having a strong professional identity. This is an extended literature review that was used to consolidate a whole concept of professional identity for medical students. They identify the positives of a strong identity as being better communication and collaboration within your own speciality, high motivation to contribute to care, and a willingness to collaborate with other specialities. The highlighted negatives paradoxically are related to the positives: feeling lost in the team and isolated in your role, a blurring of boundaries, and the rise of new specialities in care as well as technological developments. The benefits of a strong professional identity need to be in balance and the identity needs to

be positive, as well as strong, in order to avoid the negative connotations of strong identity, including how a profession is perceived from the outside.

3.4 Conclusions.

The literature base that discusses issues of preceptorship, professionalism and professional identity is vast and the limits that were put in place in the search engines were needed to allow a comprehensive but genuinely representative review of the literature. Although the concepts of professional identity and professionalism appear at first to be similar, the review of the literature revealed some discreet differences in theoretical thought and therefore the separate searches for these terms yielded a wealth of literature that would be missed if only one term had been used. A number of the core ideas that developed throughout the review of the main themes were similar: environmental impacts, the importance of knowing your role, philosophical and practical considerations and issues of socialisation.

Missing from the literature is a contemporary review of an occupational therapy preceptorship programme, that appraises the impact of preceptorship on the awareness of professional identity constructs in newly qualified staff. This research aims to fill that gap by asking the following questions:

How do newly qualified staff, who have recently been through preceptorship, experience the preceptorship process?

In what ways is the preceptorship process perceived as having any influence on the development of professional identity?

The overall aim of the research is to explore the experiences of newly qualified occupational therapy staff with reference to professional identity and the role of the preceptorship year in developing this.

Methodology

4.0 Research title.

The title of the research, designed to intentionally consider the content and methodology of the study, is:

Developing professional identity in occupational therapy: a phenomenological study of newly qualified staff and their experiences in the preceptorship period.

The overall aim of research has been to explore the experiences of newly qualified occupational therapy staff with reference to professional identity and the role of the preceptorship year in developing this. The research questions are:

How do newly qualified staff, who have recently been through preceptorship, experience the preceptorship process?

In what ways is the preceptorship process perceived as having any influence on the development of professional identity?

4.1. A phenomenological framework.

To study such a complex profession as occupational therapy I chose a phenomenological framework. Phenomenology seeks to explain how we experience what we do, and is concerned with the experience rather the search for absolute truth and is intrinsically linked to self (Fulford, Thornton *et al.* 2006, Howell 2013,). Phenomenology gives insight into how I as a researcher have sought to understand the truth about professional identity in occupational therapy.

4.1.1 Hermeneutic phenomenology and Heidegger.

Previously when studying phenomenology, I have favoured the hermeneutic phenomenology of Heidegger given his relevance to health care and indeed occupational therapy (McConnell-Henry, Chapman *et al.* 2009a). Heidegger determined that the search for truth (as in a definitive conclusion) was not in itself important but that the search for the lived experience was (Fulford, Thornton *et al.* 2006).

Being and Time is Heidegger's most prominent theoretical work (Heidegger 2010) however its direct application to research is made difficult due to its dense writing style,

and I have often relied on a secondary commentary of Heidegger's work in order to unlock the methodological implications of his theory. Therefore if I had proceeded to apply Heidegger as my main theorist in this research process, I would have had to utilise the work of secondary commentators such as Gallagher (2012), Lewis and Staehler (2010), and Inwood (1997). However whilst the use of secondary commentators is helpful the original text should not be neglected, as otherwise essential insights may be either misconstrued or missed altogether, and therefore I used the original work of another theorist.

4.1.2. Hermeneutic phenomenology and Van Manen.

I have drawn on the work of Max Van Manen (1990, 2002, and 2014). Van Manen has the same epistemological grounding as Heidegger; he is particularly interested in the lived experience rather than the absolute truth. He also observes that phenomenological engagement is always personal engagement, (p156), echoing Heidegger's statement that to fully remove yourself from the research would be impossible (McConnell-Henry, Chapman *et al.* 2009b). *Researching The Lived Experience* is Van Manen's (1990) main body of work and in contrast to Heidegger's oeuvre is written in order to be a practical guide to research rather than a purely theoretical work. He, therefore, manages, from an epistemological standpoint, to stay true to Heidegger's hermeneutic phenomenology, whilst producing work that is also focussed on method.

Van Manen's (1990) work is written from a pedagogical stance and although I have not researched pedagogy, Van Manen does state his work is relevant to nursing and other such professions (p1). Preceptorship is referred to as using adult learning methods within the preceptorship policy of the Trust (Anon. 2014a, 2016), and pedagogy is strongly associated with continuing professional development (Morley 2007a), Making Van Manen's work appropriate for this research.

The use of Phenomenology in this research, allows the previously discussed complex epistemology of occupational therapy to be reduced to the individuals understanding of what about the profession is important to them. Each individual is influenced by a number of factors that have shaped their experiences within the preceptorship year and a

phenomenological approach has allowed individuals to determine and examine these factors. There is also a strong precedent for the use of Van Manen's methodology within the field of occupational therapy. Finlay (1999, 2004, 2009,2011), herself a well-respected author in the field of occupational therapy, has written specifically around research and phenomenology and made good use of Van Manen's work.

That the concept of phenomenology involves personal engagement is also discussed by other authors. McConnell-Henry and Chapman *et al.* (2009a) describe hermeneutic phenomenology as researching real people in real situations. I would add to this that the research is carried out *by* real people, on real people in real situations, and that it is this that is the heart of the epistemology of hermeneutic phenomenology. Hermeneutic phenomenology then, regardless of the theorist, holds the epistemological position that it is the individual's experience that is important, rather than a definitive truth. Also held is the position that the researcher cannot be separated fully from the research. This then requires that the researcher is aware of themselves, and how they then interpret the lived experiences of others.

4.2 Positionality.

I am an occupational therapist working with the NHS, and I have researched other occupational therapists working in the same NHS Trust as myself, and therefore under Adler and Adler's (1987) description of fieldwork membership roles, I consider myself as an opportunistic complete member researcher.

In their seminal work, *Membership Roles in Field Research*, Adler and Adler (1987) define a continuum of different fieldwork roles that researchers take on; these include peripheral member research, active member research, complete member (opportunistic) research and complete member (convert) research. Opportunistic complete member research includes sharing a world view with the members of the group that is being researched as well having a genuine commitment to the group. The research role is mainly overt; however, Adler and Adler (1987) recognise that researchers in this position often have to create a research role or space for themselves. The role of 'researcher' may well change their position, status and condition of pre-existing relationships within the

group, and that the researcher, or indeed the group itself, may find that this feels unnatural. In short, there will be a period of transformation for the researcher, in terms of their ongoing relationship to the group. I was able to negotiate with my employer for space and time in order to 'be' a researcher during the data collection process. This allowed me to fully consider the issues of bias that the context of phenomenological engagement by its very nature includes and give them full attention in the process of data analysis (Hellawell 2006).

4.2.1 Defining an 'insider'.

This position as an insider is one that is complex to define with Luttrell (2010) suggesting that it should be a multifactorial definition that includes race, gender, culture, class, sexual orientation, as well as membership to a particular group (p.368). Using these parameters I could still define myself as a complete member, as not only have I been a qualified occupational therapist for more than twenty-two years, I have spent twenty of these years working within the NHS Trust that I am currently employed in, under its various different configurations over the years. Demographically I am a member of a group of professionals who are traditionally white middle-class women, as am I (Higgs *et al.* 2011, Peters 2013). In this study, however, I interviewed newly qualified occupational therapists, and in this respect, there are deviations from the group norm. I am not newly qualified, I am in my forties, married with three children and I work part-time.

These discrepancies between myself and the aspect of the group I have researched required me to be aware of the potential complex difficulties of insider research which include an inherent bias of the topic, and a failure to ask critical questions (Denzin, Lincoln 2005), role conflict, role confusion and loyalty tugs (Dwyer, Buckle 2009) and not assuming shared meaning (Hellawell 2006). There are other criticisms of insider research. Knight (2002) is critical of the perceived privilege that insider research carries; stating that it is not superior to outsider research and he states that there is a danger that the participant (insider) researcher can become confused about their role. This is a criticism that echoed my own initial concerns, that as a novice researcher the boundaries between being a therapist and being a researcher would be difficult to manage, and I put in

place a number of strategies to address this. For example, I booked all but one of the interview appointments on a day that I was otherwise not at work, and allowed time to transcribe the data before returning to work. I met all interview participants in a place of their choosing to try and balance the relationship bias. By not interviewing people I was directly managing or supervising, I again tried to maintain the balance between 'researcher' and 'therapist'. Luttrell (2010) also acknowledges this difficulty by asking the question of how does being a researcher impact on your identity? With this in mind, throughout the research process, I privately reflected on some of the intentional and unintentional impacts on myself and my family and work colleagues of my change in position as well as the process as a whole.

There are also benefits to being a complete member researcher. The benefits are ease of access to my population, (Denzin, Lincoln 2005) being able to ask meaningful questions (Knight 2002) and having complete acceptance from the population (Dwyer, Buckle 2009). Methodologically insider research is often used in qualitative research (Flick 2009). Dwyer and Buckle (2009) even suggest that either hermeneutic phenomenology or action research are the only reasonable methodologies to use in terms of insider research. They argue that the use of quantitative methods is unrealistic as the researcher cannot be truly objective as they already have preconceived ideas about the subject or people they are researching. This would make the position of unbiased objectivity not only an unrealistic expectation but nigh on impossible to achieve.

Considering myself to be a complete member in the research field and therefore an insider allowed me to use this positioning to guide me towards a suitable methodology, hermeneutic phenomenology, and also allowed for me to research peoples' experience whilst recognising my own prejudices and my own bias as it is an inherently reflexive approach (Hellawell 2006).

4.2.2 Personal and professional issues which have an impact on the research.

This topic of professional identity is one that offers a research opportunity that is relevant to my profession and to my specific workplace, it is not party-politically motivated, and as

the literature reveals, has been under discussion for at least the last thirty years, and with its potential to influence the future, in terms of selling or marketing the profession, it is a topic that will continue to provoke debate.

The personal issues that drove this research are mainly around being proud of my profession and wanting to be certain of its progression. I am proud of my profession, proud of being an occupational therapist, proud of the position that it gives me within the multi-disciplinary team and I take pride in doing my job properly. The other driver, that of wanting to ensure the progression of occupational therapy, is purely around valuing the profession and wanting to be an occupational therapist in the NHS for the rest of my working life, and therefore needing to take some personal responsibility in order to secure the future and growth of the profession. The issue of professional identity was raised at a conference I attended in September 2013. During the question and answer session, a nurse spoke about how the occupational therapist on her team was "morphing into a dementia nurse". This raises the issue of professional identity as one that is still highly relevant in occupational therapy and it is also one that provoked a strong personal emotional response. Interestingly when I discussed this with my therapy colleagues it promoted a similar emotional response. On discussion with an occupational therapy manager it was identified as an issue within the NHS Trust I work for, as she stated that that less experienced staff were struggling to maintain their role and professional boundaries, which she saw as part and parcel of professional identity. This was seen as a problem as it resulted in the member of staff engaging in a generic role, and was being seen just as an extra pair of hands on the ward rather than an occupational therapist with unique skills to contribute towards the care of patients.

In the profession of occupational therapy as a whole, the concept of professional identity underpins a number of issues that are on the current agenda, and are potentially ongoing issues, such as marketing the profession and making the evidence base of the profession more robust and promoting the profession on a political level (Mason, 2006, COT, 2014). In terms of the professional code of conduct, as a qualified occupational therapist I have a responsibility to work with students, section 5.5 states:

> *"You have a professional responsibility to provide regular practice education opportunities for occupational therapy students where possible and to promote a learning culture within the workplace" (COT 2015 p31).*

I consider that morally this responsibility should also extend to newly qualified staff. The topic, then, has an ongoing relevance to the profession as a whole and not just to the NHS Trust I work in.

4.3 Ethical responsibilities.

The British Educational Research Association (BERA) has ethical guidelines for educational research. Alongside this, many professional bodies, including occupational therapy have their own codes of conduct which cover ethical behaviour in research (COT 2015 section six pages 33-34, BERA 2011). I registered my research with the NHS Trust using the *Integrated Research Application System* (IRAS 2014) which is linked to the NHS National Research Ethics Service (NHS Research Authority 2014) and did the same with the university receiving ethical approval from both organisations. The *Research Governance Framework* (DOH 2005b) outlines researcher responsibilities to the wider research community and my duty has been to complete the project from the beginning in a way that is ethically and morally sound. This responsibility was put to me in layman's terms by my supervisor as having 'an academic debt to pay'.

4.3.1 An acknowledgement of bias.

Part of that academic debt is the acknowledgement of bias (Creswell 2014). The *Research Governance Framework* produced by the National Research Ethics Service (DOH 2005b) contains specific ethical guidance for the NHS. This document makes it absolutely clear that the researcher's first responsibility is to the dignity, rights, safety and well-being of the participants. The framework includes guidelines about informed consent, openness, honesty and accountability, and the right to withdraw, privacy and disclosure.

There are specific ethical issues that relate to my position as an insider researcher. I excluded from the research sample anyone whom I currently manage, and anyone for whom I have been the preceptor, as this could have influenced the data, at collection or

analysis stage. I was also clear, prior to (in the written information) and at the beginning of the interview, that any disclosures that amount to a breach of the *Professional Code of Conduct* (COT, 2015) would be reported to an occupational therapy manager within the Trust. I also acknowledged bias. Previously I have identified that these biases include my own education, my knowledge of other occupational therapists, my personal relationships with other senior occupational therapists, and my experience of working in different areas of the NHS Trust over a twenty year period, as well as my own professional identity as an occupational therapist. Participants in the research will have had their own bias in reference to me, either from their personal relationship with me, or knowledge of my work or even gossip within the workplace. It is important that each of these issues has been analysed in terms of their effects on the research process and how they affected my analysis of the data and that they are sufficiently acknowledged within the academic arena.

4.3.2 Ethics ensuring rigour.

Ethically driven research should begin to reduce threats to research validity, and in doing so promote the rigour of the research piece (Maxwell 2010). There are a number of techniques I have used in order to address the specific areas of validity and reliability. These have been primarily in three stages of research, the selection of participants, the analysis of data and the writing up of results.

Firstly there is a requirement to be honest about the inclusion criteria used to select participants and this is made clear in this chapter and also in the participant information leaflet (see appendix three). Therefore if future research were to attempt to replicate this study, the participant group is clearly defined. During the collection of data, it was essential that the participants were aware of their right to withdraw from the study at any time and that they were assured of anonymity and confidentiality. It was also required that they understand any circumstances that might lead to a breach of confidentiality. It is also important that data has been stored correctly, none of the participants have been identified by name or work place and participant numbers have been used on all stored material. No raw data has been made available to anyone within

the Trust. In the process of analysing the data, I offered the participants a verbatim transcript of the interview in order for them to confirm it is a factually accurate account. This act of respondent validation directly answers any concerns about the validity of the data, and by using verbatim transcripts as opposed to summaries of interviews the transparency of the data is increased. The technique of thematic analysis has been used on the data, and then discussed in supervision in order to address reliability concerns. The data has been collected on a password protected digital recorder and then transcribed onto a password protected computer and memory stick. Once the data was secured on the computer it was deleted from the digital recorder. The computer and memory stick belong to the researcher, not to the workplace.

The writing up of conclusions is an area that contains hidden validity threats, and it is only by approaching the data from an ethical standpoint that these threats can be effectively dealt with. It has been important to acknowledge reflexive and personal reflections within this process, and therefore throughout the writing up of the data there are a number of reflexive statements to aid the process of ethical transparency.

4.4 The research audience.

This research is specifically directed towards a number of recipients, firstly, the occupational therapy managers and senior clinical staff within the NHS Trust in which the research has been completed. Secondly, it is directed towards non occupational therapy senior staff within the Trust as some of the information gleaned crosses disciplinary boundaries and may have relevance for other staff groups. Thirdly it is directed towards the newly qualified occupational therapists in the hope that they not only benefit from the outcome of the study but that they may also benefit from the process of research which will in turn help move the profession of occupational therapy forward. Lastly, the research findings are aimed at the wider national academic community, as findings will be disseminated in order to consider whether they are useful to other geographical areas and workplaces.

4.5 Research design.

The research has taken place within the NHS Trust that I work for. Within the Trust there is a policy in place that states that all newly qualified staff will go through the preceptorship process (Anon. 2014a). This process requires the newly qualified member of staff to fill out the preceptorship *Knowledge Skills Framework* (KSF) paperwork used by the Trust (Anon 2014b) in conjunction with their preceptor in order to document their development and competence over the first year post qualification. However, the process also requires an element of role modelling and learning through supervision and mentorship as well as working towards pay scale goals.

4.5.1. Purposive sampling.

I received a list of the band five occupational therapists in the Trust from the secretary of the lead Allied Health Professional (AHP), who sourced it from ESR (electronic Staff record). The list contained 35 names, two of which I immediately removed as I was, or had been their preceptor. Professional management approval for these staff to partake in research was gained prior to research beginning and this allowed staff to take part with permission from the Trust without it being based on the individual (see appendix one). The sample size was small, as not all staff were either eligible or agreeable to being involved. However this is not considered an issue in a phenomenological study as a small number of in- depth interviews are preferable to large-scale data that is not as rich in content, a recommended sample size is five (Smith, Flowers *et al.* 2009). I interviewed seven members of staff.

In order to recruit participants, I sent an initial email from my NHS email account to introduce myself and state they would be receiving an invitation to be involved in research from a university email account. The initial email was sent as a group email but blind copied so that recipients would not be able to identify each other. It was sent from my work account initially due to the amount of unsolicited emails staff receive and so I considered that to introduce the university email may improve the response rate to the invitation email. I followed this up with an email from the university email address, also sent as a blind copy, this included the invitation, the information sheet and consent forms (see appendix two). This email asked them to let me know if they were eligible and willing

to be part of the study, and also if they did not meet the eligibility criteria or just did not want to would they still let me know. All replies were responded to individually with a message of thanks, with people positively responding being told I would be in touch shortly. I then sent out a second personalised email to the people who had not responded, this also included the information pack again. I did not resend the email to the staff on maternity leave.

Table 3: Responses after the second email

Responses After second email:	Total 33
Declined	2
Does not meet criteria	10
Agreement	7
Other reason (declined)	6 (4 leaving the trust, 2 maternity leave)
No response	8

Deliberately missing from the write up of the interview data is demographic information regarding the participants. This is in order to help preserve the confidentially of the interview participants, for the same reason dates of data collection are not included within the thesis.

4.5.2 The interview.

At the start of the interview, participants were asked to confirm their understanding of the consent issues, other information regarding the participants was asked, including gender, age at the point of preceptorship and if they had any prior career before commencing occupational therapy education. None of the seven participants refused to give this information. The purpose of the last question, about prior careers, was to allow Holland's Trait Theory (Holland 1985) to be applied to mature students. There was no inducement to be involved with the study, and as no vulnerable groups are involved, there are no conflicts of interest.

Following the collection of this data, the Holland (1985) codes were dismissed as not being a relevant concept within the parameters of this research. Holland's codes are

Realistic, Investigative, Artistic, Social, Enterprising and Conventional (RIASEC). The code for occupational therapy is SRE (social, realistic and enterprising). It is of note that when I did the vocational test myself I came out with the code SEA (social, enterprising and artistic). The codes are initially dated 1985 and in this code index occupational therapy is listed as a low qualified job. Current discussions in the United States are around whether there should be a PhD entry level for the profession and American Occupational Therapy Association are moving towards this by 2025 (AOTA 2011). The most up to date list of codes come from a 1996 revision of the codes, displaying codes for over 2000 jobs (Chronical Career Library 2015). The code for occupational therapist, does not differentiate between different types of health care, the 1996 code list has 19 codes for qualified nursing, and one for occupational therapy.[14] As a result of these considerations the Holland (1985) codes were not deemed relevant and therefore not included in the analysis of the data.

Participants were invited to take part in a recorded interview that lasted approximately an hour and was held at a time and place to suit the participants. Van Manen (1990) promotes a semi-structured interview in order to gather data. However, I found a less structured approach allowed me to ask a grand tour question and then build on ideas from the content of the interview taking place and previous interviews held. The grand tour interview question designed to elicit experiences was:

> *I'm interested in all of your thoughts about your experiences in the whole of the preceptorship process and also how it helped you to develop your professional identity as an occupational therapist. From the time you started until you finished that first year, anything that you want to talk about, anything that stands out for you or that you see as being important or interesting is of value to me. What were your experiences during this process?*

[14] Hollands (1985) codes were formulated in America in the 1970's, where mental health occupational therapists would have been a rarity rather than the norm, his updated codes do not appear to take into account the changing face of healthcare either in the States or the UK, for example the move towards community care, the surge in evidence based practice and the move away from industrial therapy have all changed the context of the role of occupational therapist.

4.5.3 Data analysis.

The interviews were then transcribed. I completed this process myself so as to immerse myself in the raw data (Phillips, Pugh 2010). This data was then kept in anonymised form on a password protected computer, with the original recording being deleted as soon as the interview data was securely stored. In order to analyse the interview data I used a thematic coding technique. Van Manen (1990) supports this process of theming and coding data to analyse interviews, however, it is unclear in his writing as to how exactly the process is carried out. I, therefore, utilised the work of Guest and MacQueen *et al.* (2012) whose book *Applied Thematic Analysis* is congruent with Van Manen's work but also a helpful 'how to' guide for a novice researcher. Thematic analysis is described by Braun and Clarke (2006) as a stand-alone research technique and Guest and MacQueen *et al.* (2012) claim it as an inductive analysis technique for qualitative data.

Thematic analysis is used in two distinct ways in the analysis of this data. In order to answer the first question, that of the experiences of preceptorship I read and re-read the data allowing the codes and then themes to emerge from what was in the text. Figure two demonstrates how codes were created. The data was read through and then read through twice more in order for initial codes to be created. Each time a new data set was added the other data was re-read. The emerging codes were then grouped into themes, the definitions and make-up of which can be seen in appendix three. Also included in the appendices is a full transcript, alongside screen shots of the Nvivo process of coding so that the process has transparency and can be reviewed (appendix four).

For the second question, that of how preceptorship was perceived to impact on professional identity, I used *a priori* coding. That is that I had a pre-existing concept of what I considered to be professional identity, i.e. the work of Mosey (1985) and Creek (2003), and coded the data accordingly, looking for text that supported the codes. The codes were taken from the headings used in their definitions of professional identity, for example, knowledge and skills and CPD. The full code book can be seen in appendix three. I also, from other reading added the codes reflexivity and socialisation in order to provide a robust coding of professional identity. This dual approach to coding and analysis allowed for the research questions to be dealt with in the most appropriate way.

4.6 Presentation of findings.

The findings are presented in two analysis and discussion chapters, one to answer each research question. Any quotes used from the data that are of six words or less are embedded in the text, longer quotes are presented as separate from the main body of the text. The use of parenthesis will be used to indicate the subject a participant is talking about if it is not clear from the exert of text and ellipses will be used to remove speech, this will be done only to clean up the text and improve the reading experience and not to change the meaning of the original text. Throughout the text participants of the research are referred to by number, e.g. P1, P2 etc.

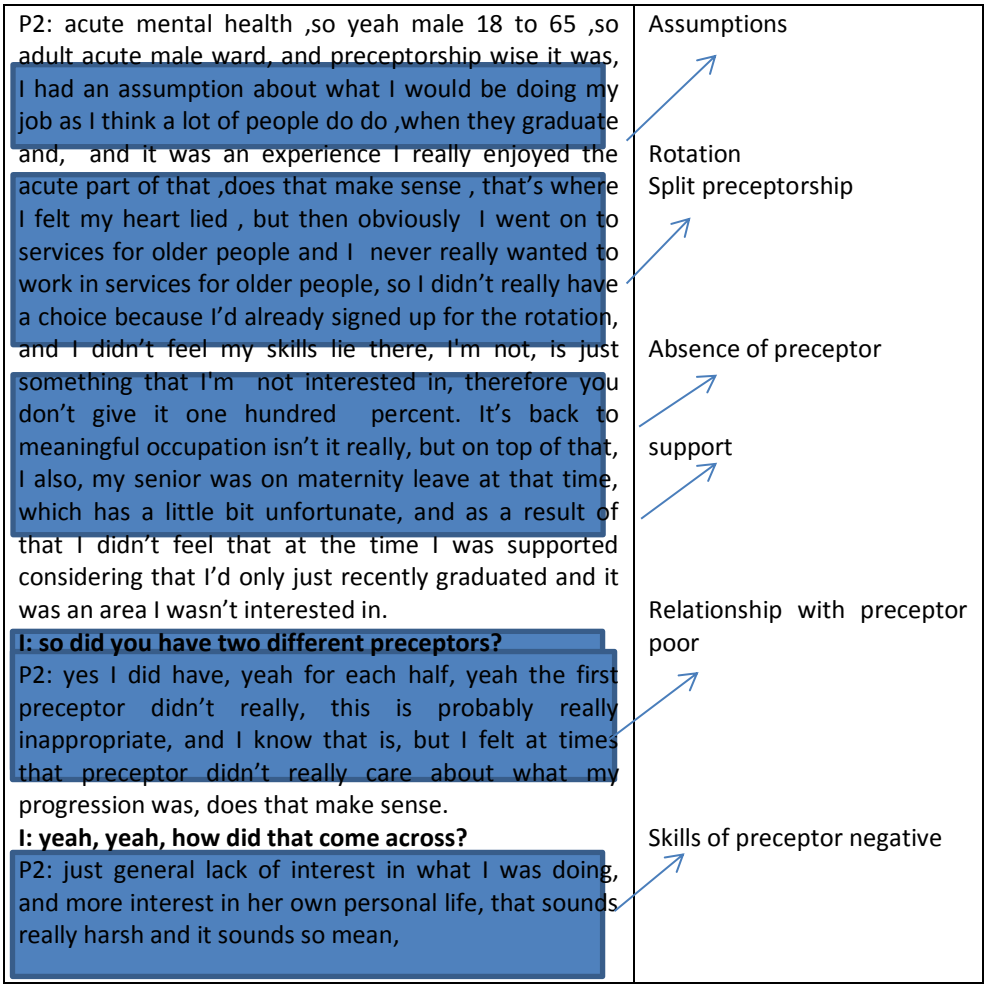

Figure 2: Example of how text was turned into code

Within the findings there are statements made from a reflexive perspective. These are acknowledged within the text by the use of a different font, and are the interpretations of the researcher. The positionality of the researcher makes these statements difficult to avoid entirely although the intention has been to keep them to a minimum.

The first analysis and discussion chapter uses the headings taken from the six themes that emerged in the initial analysis of the data; however, the subheadings do not directly use the codes from within these themes as they could make the reading of the analysis unwieldy. Instead the subheadings are related to the codes, they are grouped together in order to make sub-themes and therefore subheadings. This avoids unnecessary repetition of data and allows the discussion of smaller pieces of data to flow within the wider discussion.

The headings for the second analysis and discussion chapter, that answers the second research question is taken from a number of *a priori* codes created to collate the data for the second question. Within the second analysis and discussion chapter, I also utilise Ann Wilcock's (1999) work on *Being Doing and Becoming*. It has already been identified that there are other writers who also borrow this terminology to discuss concepts relating to identity, (Widdecombe, Wooffitt 1990, Martin 2003, Forhan 2010, Rensburg 2011, Maslow 2014) and the concepts therefore of *Doing, Being and Becoming* are therefore valid concepts with which to discuss the identity of newly qualified occupational therapist. It is worth noting that within this second analysis and discussion chapter that the interpretive aspect of the research becomes clear as I make a number of interpretations from the data that do not come directly from the participants themselves. I also use writing in a reflexive way to enable the analysis of the data, using the process of writing as a tool that allows me to engage in the process of finding the results (Frank N.D).

4.7 Conclusions.

The research adds to the literature about the development of professional identity and preceptorship in occupational therapy. It has answered questions about how newly qualified occupational therapy staff are supported by a specific Trust in the development of their professional identity and provides feedback and guidance to the Trust about the

effectiveness of the preceptorship programme in this context. Mary Morley, who developed preceptorship nationally for occupational therapy, called for further research around the effectiveness of preceptorship (Morley, Rugg *et al*. 2007) and although she has continued to research this subject herself (Morley 2009b) this piece of research adds to the knowledge base she has been developing.

The research will be disseminated at local and national level. The results will also be prepared for publication in order to ensure that the results and process of the research can be critiqued within the academic arena.

Analysis and Discussion: How do newly qualified staff, who have recently been through preceptorship, experience the preceptorship process?

5.0 Introduction

In order to answer the above question, the data was read and emerging codes developed and then grouped into themes. This process of thematic analysis is described in more detail in the methodology chapter, and a full list of codes, and the themes they fit into can be found in table six, appendix three. The data produced a number of themes which describe and explore the ways in which the newly qualified staff who were interviewed experienced the preceptorship process.

The themes that were developed from the coding of the participants' experience are: the influence of the preceptor, the process, the support they are, or are not offered, the organisation and organisational structures. They also experienced the preceptorship period as a journey and one that they can claim ownership over (see figure three).[15]

The purpose of this chapter is, therefore, to expand on these themes. The chapter will do this by discussing each theme in turn and using the data within these themes to answer the research question as robustly as possible. It is important to note for the purpose of discussion that the themes are not dealt with in any specific order. No one theme is regarded as being more or less important that the others, rather, that together they represent the gestalt of how preceptorship is perceived by the people who were interviewed within this research. For this reason, the analysis and discussion are not separated and are presented together in order to make the links to the data transparent and reflexive.

[15] I understand ownership in this context to mean that preceptorship is a process that the individual feels a sense of control over and also that it is an individual experience belonging to that person and that they have the right to use it and define it as their own.

Figure 3: Themes developed from the codes.

The presentation of the data is discussed in the methodology section under section 4.6. The themes will be discussed in this chapter, with subheadings developed from the codes that make up the themes.

5.1 Theme: The Preceptor

The preceptor theme is defined as any discussions around the skills and attributes of the preceptor and the relationship with the preceptor. It includes the codes that are listed in table six, that are taken directly from the data. Within this theme, a total number of 78 references were coded from all seven interviews.

5.1.1 The skills of the preceptor

The skills of the preceptor were described as being: knowing someone's learning styles (P3), articulation, knowledge, professionalism (P7), supportive, experienced (p6) approachable (p1) experience in the job, having *"a few years under their belt"* (p4).

It is evident from the data that the participants had expectations of what preceptorship, or their preceptors in particular would be like. P4 describes it clearly:

> *"I think actually that there is this expectation that the preceptor, you are going into the post thinking my*

> *preceptor is my preceptor on high, and you think they know everything."*

P2 also discussed the expectation stating that:

> *"I had this idea of what it should be, and that 'senior – junior' role would be"*

However these expectations were not reported as being matched in reality. P2 was clearly disappointed and upset that her assumptions of support were perceived as not being met:

> *"Expecting all these things and it just not materialising, that was the hardest part"*

However even the more optimistic expectations of P4; thinking the preceptor would know everything turned out to not be true as she goes on to state that:

> *"It (preceptorship) can be a really new experience for them, it was for mine"*

Some, however, felt that their preceptors did have experience within the preceptorship role, P1 for example states that her preceptor: *"had experience of using preceptorship".* P6 does not state this in terms of the experience in the role but does feel that her preceptor was experienced, as when she was asked directly, whether the preceptor had enough experience to complete the preceptorship process she answered: *"yes definitely".*

Of the seven people interviewed for this research, two reported negative experiences and at least one had a preceptor that had been brand new to preceptorship. Three had had more than one preceptor, and it is these participants who report the negative experiences. Those with the negative experiences however raise interesting points about the ability of the preceptors, and perhaps also about choice. P2 states:

> *"It was kind of like this is your preceptorship you're lumped with it"*

If I think about this reflexively as an insider researcher, the reason I feel this statement relates to choice is because of my own experience in the Trust. A band five rotation post was created in the team I work for and after the recruitment process had been completed and a newly qualified occupational therapist appointed, I was then told that I would

have to do preceptorship with her. It was assumed that this was going to happen and that I would be happy to do this, even though at the time I had not heard of preceptorship, or had any concept of what was involved. Although I feel that I have been able to embrace preceptorship, I have to wonder if this lack of choice plays a part in the negative experiences reported and described by P2 and P7. P2 discussed how her preceptor was close to retirement and P7 how his initial preceptor then went on long-term leave.

P7 is interesting as he discusses an initially negative experience and then a later positive one which leads him to remark about the disparity of his experience. And indeed he opened up the interview by making this point:

> *"mentors do need to be . . . similarly skilled within being a mentor for preceptorship, there is a real inconsistency I feel"*

And this is highlighted across the whole set of participants that there was not a consistent level of either professional or personal skills throughout the preceptorship process, and that even when a preceptor was perceived as skilled in terms of being an occupational therapist this did not mean that they were skilled at being a preceptor, for example, it has already been stated that P4 recognised that preceptorship was new to her preceptor, but she also had the experience where another member of staff had to tell her preceptor what was acceptable in terms of workload:

> *"one of the OT's there actually said "oh my god why are you doing that it's such a waste of your time" . . . and I know she then spoke to my preceptor and the demands reduced."*

This leaves me as a researcher with the sense that some of the experience of the preceptorship process at least is dependent upon the preceptor and their level of experience, level of skill, and level of commitment to the process. P2, with her difficult experiences reflects:

> *"if I had a preceptor like I had the band seven in services for older people, that experience (preceptorship) would have been very very different".*

We can perhaps, therefore, learn more about the importance of a 'good' preceptor by listening to the experiences of those who report having had a 'bad' one. That the preceptors should choose to do the role and therefore be engaged in the process, that they should have a sufficient level of experience in order to perform in the role, that they should have a base level of training that allows them to have knowledge about what is expected from the preceptee within the process. These three points together, choice, experience and training could go some way to addressing the concerns raised about the inconsistency in the process by P7.

5.1.2 The relationship with the preceptor

All seven of the participants raised matters relating to the relationship between themselves and their preceptor, however only three of the seven made comments that could be viewed as recounting a negative or poor relationship with their preceptor.

The participant who made the most negative comments about the relationship between herself and her preceptor is also the only participant to talk about the absence of a preceptor. These negative comments made by P2 appear to be concomitant as she relates her preceptorship experience as being mostly difficult and unsupported. P2 reports her experiences as being extremely negative stating:

> *"I felt at times that my preceptor didn't really care about what my progression was", and that there was "just a general lack of interest in what I was doing"*

She was not the only participant to voice negative comments. P7 also reported a negative relationship with his initial preceptor describing a situation where he had to make compromises in order to ensure the relationship did not dissolve; he considers that his ability to do this was related to his status as a mature preceptee:

> *"I'm mid-40's; I've got enough about me to know".*

This study is too small to say definitively whether the age or maturity of the preceptee has any bearing on how they as individuals handle potentially difficult workplace relationships but it was considered by P7 and by P3, in a different context, to be a factor.

Participants commented on positive aspects of their relationships with preceptor's far more than negative aspects. P1 describes a close, supportive relationship, P4 talks about building a good rapport, and P7 about his later preceptor being motivating. As well as the relationship though, the participants highly valued the skills of the preceptor. It is clear from this research that a key way in which participants experience the preceptorship process is through the person of the preceptor, and that their influence on the process is powerful especially when it is experienced in a negative way.[16] The influence on people's professional identity is more subtle but appears to take the form of role modelling. Even when the preceptor has been experienced negatively it is seen by the participants as a lesson in how not to do things, for example P2, refers to her own experience of being a preceptor as:

> *"knowing that as a band five you to need to have that kind of caring supervision . . . it makes a massive difference"*

This role modelling is seen in the quotes from participants that reflect their admiration for their preceptors. P1 talks about being able to contact her preceptor outside supervision and ask questions about anything. P6 describes how her preceptor was keen for her to learn and challenge herself. These personal qualities are the aspects of the preceptor themselves that are difficult to quantify but appear to be essential, mainly because when those qualities are missing they are remarked upon as being far more important than when they are present. So the reports from P2 in particular talk about a preceptor who was experienced as being uninterested, uncaring, unsupportive, and unprofessional and not offering opportunities to help her expand her knowledge or skills. These qualities are perhaps not ones that can be taught, and could be seen to highlight the need for choice in the role of preceptor and that perhaps staff should not automatically become preceptors, even if they are in a management role.

[16] Experience throughout this chapter is taken to mean the individuals engagement with the process, how they have observed and learnt from the process, the impression it leaves them with and how they confront and contend with the process.

5.1.3 Protection as a function of preceptorship.

Another aspect of the preceptorship relationship that was mentioned was that of protection. This was mentioned primarily by P2 who had felt a lack of it and had struggled at times to cope with the demands of the workplace as a new member of staff and felt that part of that preceptor role should have been one of protection for junior staff, she states:

> *"you need someone protecting you so you have boundaries" and "I didn't have any senior to protect me"*

P6 felt that her supervisor was at times overprotective and that this took her away from doing her job, the example she gives for this overprotection is weekly supervision, feeling that this was not always necessary and it took her away from the ward. P4 also recognises that preceptorship has a protective element stating that it is:

> *"protective of the preceptee as well . . . and your well-being really"*

This element of the preceptorship process is not highlighted in the same way by other participants but its inclusion, especially coming from someone who felt it was absent, is important. The teaching of how to protect yourself from workplace pressures is not something that is done explicitly in occupational therapy, or any other aspect of the NHS and staff burnout is one of the areas that preceptorship is designed to help address (Edwards, Dirette 2010, Morley 2012). I am not suggesting that we assume that those who did not mention it did so because protection was not an issue. However the concept of protection could warrant further consideration. This is an area that is an important part of preceptorship, the learning of boundaries, how to say no, how to manage demands and yet in this research it is almost hidden, perhaps because it is not easy to put into words.

The issue of protection of staff is related to that of emotional or professional resilience. The concept is discussed in the literature review and is seen as being essential to learn how to deal with stress and avoid burnout (Edwards, Dirette 2012, Ashby, Ryan *et al*. 2013).

5.1.4 Outcomes and implications of the preceptor theme.

The literature review clearly highlighted that the skills and confidence of the preceptor were paramount to the preceptorship experience (Myrick, Yonge 2001, Smith, Morley 2013, Marks-Maran, Ooms *et al.* 2013, Foster, Ashwin 2014) and this research would support that with staff discussing positive and negative aspects of their preceptors' skill levels and their relationship with the preceptors. One participant expressly asks if there is any training for preceptors, having had both positive and negative experiences. This participant (P7) started by expressing the concern that:

> *"the mentor or the people you are working alongside need to be consistently trained in actually how to get the most or for you to get the most out of your preceptorship"*

This one comment raises an immediate issue for the Trust in terms of what training is made available for the people taking on the role of preceptor. At the time of writing, there is no specific training available for those expected to take on the role. This is not currently a role that you sign up to, apply for, train for, or get accredited to do. It is a role taken on if a new band five member of staff starts work in your service/team. The implication of this, one made clear in this research, is that the Trust then has no consistency in the way that preceptorship is delivered and no control over the experience or commitment of the staff who take on the role.

A recommendation to the Trust then is clear, deliver training for staff who wish to be preceptors, place newly qualified staff with trained preceptors, advocate yearly updates and a clear consistent approach to the delivery of the preceptorship programme. By committing to a training programme, and by asking staff to actively sign up for it, preceptorship will become a responsibility that staff are committed to delivering rather than something they are *'lumped with'* (P2), either because of their grading, job title or where the band five post happens to be. As a profession occupational therapists are expected to be accredited in order to take students and perhaps preceptorship could be included in this. However the APPLE (COT 2015a) accreditation for students is national,

but preceptorship is very much run by local guidelines and standards, for example P6, had worked in a Trust that did not provide preceptorship at all.[17]

The need for quality and consistency is highlighted in this research due not to the minority of negative experiences, but the severity of these negative experiences. That is, that staff who have trained for three years and come into the profession ready to grow, have considered that this growth is stunted because of a negative preceptorship experience. Both participants who discussed negative experiences are still in post partly because they were able to gain support from elsewhere.

5.2 Theme: Support

The theme of support is defined as: Discussion of the formal and informal support available in the preceptorship period including positive and negative issues as well as the concern of being a lone OT. It included four codes that are listed in table six and encompassed 51 comments from all seven participants.

5.2.1 The 'lone OT'

The concept of the 'lone OT' is one that needs to be raised at the beginning of this theme as it could be considered to be paramount to the reason why preceptorship support is so important.[18] Occupational therapy staff often work as a lone practitioner within a multidisciplinary team and therefore often the preceptor is not someone whom the preceptee directly works with on a day to day basis. P3 describes this as being challenging stating that:

> *"it was difficult as well being the only OT, and not in a team of OTs, because there is no one to sort of say, am I doing this right?"*

[17] Apple accreditation is a national scheme run through the College of Occupational Therapists that ensures the standards and education of student placement educators. The Accreditation of Practice placement educators scheme, revalidates professionals, via a portfolio every five years to ensure they meet current standards COT(2015).

[18] I understand the phrase 'lone OT' to mean an occupational therapist working as the only occupational therapist in a team (whether community or inpatient), they may not have another occupational therapist in the same location.

P5 sees this way of working as something that is quite normal now stating that:

> *"you don't have the luxury really of having a band six working alongside you when you start any more, maybe you did years ago but you don't now"*

This is echoed throughout the discussion on support. The participants, from the start, have been in posts where their supervision is from outside of the team, from an occupational therapist working on a different ward and with whom they are not directly working with. P5 sums it up by claiming that:

> *"I used to work quite independently from the start really".*

It is within this context that we consider the discussion around both formal and informal support.

5.2.2 Formal support

Formal support is considered to be that given in a way organised by the supervision structures within the Trust. Participants discussed both positive and negative aspects of formal support, however with 25 comments being made about positive aspects of support and only five about the negative aspects it was clear that overall the formal support was considered favourably by the participants. Aspects of formal support included supervision, preceptorship meetings, preceptorship groups and support from ward managers. It was viewed by the participants as important to support confidence, clinical interventions, developmental goal setting and recognition of skills.

Two participants talked specifically about preceptorship groups, one (P4) having a positive experience with them, feeling that they gave an opportunity for the preceptors and preceptees to get together. Also that it added the opportunity for peer support and allowed the process to have some uniformity, as preceptors would also meet to discuss factors around the practical administration of preceptorship.[19] P5, however, reports a different experience only finding out about the preceptorship group nine months into her time as a preceptee and then also finding it to be aimed primarily at nursing staff.

[19] It is noteworthy that these groups, described as being so useful by P4, no longer run in this format within the Trust.

There were some aspects of formal support that were felt to be less that positive. P2 was very vocal about what she perceived to be a complete lack of formal support, partly due to the perceived skills/personality of the preceptor and partly due to people being on leave. P7 immediately raised in his research interview the issue of lack of consistency in the way preceptorship as a process was delivered formally. Therefore formal support was received by the participants generally in a positive light, but they raised issues of consistency and quality and also appropriateness for preceptorship groups.

One participant (P6) goes on to mention a desire for the formal support of preceptorship to continue in her next post. The interview was coming to an end when she was asked if there was anything she wanted to add she said:

> *"not really I think when I go to my new job I'm certainly not gonna be as well supported as I have been in this Trust and that's a bit daunting and especially as I'll be a band six and I'll have you know to be helping to support other people in a role that I haven't done before perhaps if they could bring preceptorship into that it would be quite nice.*
> ***I: (both laugh) so preceptorship for being a band six, that's not a bad idea actually. It's an interesting idea as you move up you need a whole set of new skills on top of what you've already got.***
> *P6: yeah a different set sort of support isn't it. It would be nice to have some support for supporting others if that makes sense".*

This concept of having preceptorship type of support as staff move up into different grades, or into new posts is one that Mary Morley is already considering. In a private conversation, she termed it as "preceptorship plus" and is certainly an idea that warrants further consideration and research.

5.2.3 Informal support

Six of the participants talked about the importance of informal support structures. P2 had described these as particularly relevant as she considered the formal support aspect to be missing for a substantial amount of her preceptorship time. Participants talked about this support coming from two different groups of people; other occupational therapists (also

band five or newly qualified) and also other members of the multi-disciplinary team. Both groups were considered to be important in providing day to day support in the workplace with phrases such as “good rapport”, “good working relationship” and “very supportive” being used by the participants to describe the support they received. When staff talked about getting support from other occupational therapy staff they talked about people that they did not directly work with. Three of the participants spoke specifically about getting peer support from other newly qualified band five staff. P4 had met these colleagues through a formal support group but the relationships had developed to become an informal support network as well. There was not much negative commentary about the concept of informal support other than its transient nature. P2 discussed having good informal support with another band five but that this level of support she felt was lost when the member of staff moved to a different town because of the rotation post. P5 felt that working on a ward limited the informal support you could get from other occupational therapy staff, as she was unable to leave the ward as she was the only occupational therapist. The comments highlight the importance of support, not only from within the team that you are working with but from within the occupational therapy community as well.

5.2.4 Conclusions and implications of the support theme.

The implications of the theme of support are around the consistency of formal support and the opportunities to build informal support networks within the occupational therapy community. The first issue is one that could be considered as a training need for potential preceptors and this issue has already been discussed. The other issue potentially links to concepts of social learning and identity formation (Jenkins 2014), that by socialising with others from the same disciplinary group the newly qualified occupational therapists could not only gain support networks but also begin to develop skills and identity.

The Trust in the past (not currently) has run preceptorship groups which could be described as community of practice groups.[20] It is unclear why these groups do not still happen with the Trust, in this format, however, communities of practice can often fail when motivation is low, then people do not attend groups or take part in discussions and then the group becomes ineffective. Other potential problems that may lead to the failure of a group are issues with leadership. There needs to be respect for boundaries and a compliance with social norms within the group, and if there is no clear leadership or hierarchy this could be a potential sticking point. These issues may have contributed to the cessation of groups within the Trust. However, it is clear from the participants who did have a chance to attend occupational therapy specific preceptorship groups that they were valued and helped staff form formal and informal support networks.

If community of practice groups were to restart within the Trust a number of considerations would have to be made firstly around the responsibilities to organise and run a group, and permission for people to attend a group. Perhaps more fundamentally to consider the membership of the group. It may be unpopular to state that groups should be occupational therapy specific, when within the Trust we are linked with other AHP staff, however, one could argue that if a community of practice is to be effective and allow staff to consider professional issues and define its own learning boundaries then to be an AHP group may well be too wide a remit. Groups that consider this type of learning may link to professional standards and codes of conducts but also evidence-based professional development as well. There would need to be an element of self-regulation within the group regardless of its actual leadership structure that ensured its standards. This self-regulation may be carried out in a more understanding and sophisticated manner if a group is self-regulating the learning of one profession rather than those of a number of professional groups (Davies 2006).

[20] Communities of practice are defined in section 2.9.2. The Trust currently run sessions for all newly qualified staff. These are eight education sessions that are linked to KSF standards (NHS Scotland ND). They do not include the preceptor.

5.3 Theme: The Organisation

The theme of organisation refers to: matters concerning the organisation itself and how preceptorship was managed including teamwork and views of occupational therapy. The organisation refers to the NHS Trust in which the research was conducted. It includes 12 different codes, listed in table six, with all seven participants contributing to the theme in 136 different comments.

5.3.1 The preceptorship process

The preceptorship process itself has been generally well received by the participants. Although the documentation will be discussed separately in a different theme it is a part of how the process is delivered in the Trust. For two of the participants the fact that the Trust offered preceptorship was seen as advantageous. P4 asked about it in her initial job interviews as it was a process she had become aware of as a student, she found that often places could only give vague answers to how preceptorship was offered or supported. P6 had previously worked in a Trust that did not offer preceptorship at all, and so although she had already been qualified for a year she voluntarily went through the preceptorship process in this Trust. The process itself was described by the participants as structured, supportive, guidance, an induction, improving patient care, and as being a framework for your first year. There were some negative comments about the process including negative comments about the documentation and that the process was perceived as being there so you had to *"prove yourself"(*p5).

There was some discrepancy around who was involved in the preceptorship process with some people having just their preceptor involved and other people having other senior managers also involved in the process, most notably a ward manager (p1). This inconsistency could be dealt with by the Trust by linking it to future training given on preceptorship.

5.3.2 Views of occupational therapy

> *"I was very privileged in the first team that I worked with that they had a really fantastic understanding and appreciation of the OT role"(P4)*

As an experienced occupational therapist, who has worked within the same team for ten years, this sentence struck me as odd. I wondered why working with people who understood your role would be considered a privilege. Then I read through some of the views of occupational therapy that were not so positive and understood that there was still a sense from the occupational therapy staff within the Trust of having to battle some of the perceived negative qualities of occupational therapy, and also some of the past outdated views of the service. Within these negative views though there were some that stuck out, and my positionality as an insider researcher allowed me to put them into context.

A number of years ago there was a significant incident which resulted in one ward being closed and a number of staff facing criminal charges. P3 talks about starting her preceptorship year on this ward within a 12 month time period of the ward reopening. She states:

> *"OT wasn't very well received . . . I remember trying very very hard to get OT accepted . . . your colleagues already think that you're quite rubbish and you are going to be rubbish and not add any value . . . OTs were rubbish and the last OT did bugger all"*

These views are extreme and do not appear to be reflected in what the other participants have to say. They are most likely so extreme because of the serious nature of the incidents the ward had recently been through. P3 goes on to discuss how she was able to bring about change stating:

> *"by the time I left, it actually went on the risk register that there wasn't going to be an OT on there"*

The other negative views voiced were mainly about the misconception of what occupational therapists do. P2 talks about how there was a historical view of occupational therapy that was still held at times, that the service was seen as separate and one where: *"OTs just fiddle around with clay".* Whereas P4 was approached by a non-clinical member of staff and asked if she would be doing face painting as it was Easter.

However, overall the participants interviewed were far more able to talk about other staff as having a positive view of occupational therapy. P6 discussed how she did not feel the need to have to explain her role, especially to medical staff as the consultant psychiatrist was understanding of the role and she considered him *"pro OT".* She also then considers that this one team member having a positive view of the role had cascaded to other members of staff, and as a result she often had junior doctors shadowing her for the day as well as having appreciative comments from the nursing staff. The data implies that this positive concept of occupational therapy from other staff is something that occupational therapy staff do not expect and that it is not the norm, as the phrases *"I was privileged"* (P4) or *"I was lucky"* (P3) demonstrate, and this could be an area where future research is required.

5.3.3 Teamwork within the Trust.

The organisation does appear to be good at teamwork with the participants being able to directly state that they felt that their role was appreciated, and that they had support from team members, (specifically naming ward managers, nursing staff, consultants, healthcare support workers, AHP assistants and other occupational therapists).

There was recognition of the problem of generic work versus specific occupational therapy work. And although this debate is one that essentially started off this whole research project (with myself, as a researcher, hearing at a conference that an occupational therapist had "morphed into another nurse") it is not an issue that is the main focus of this research. It was mentioned specifically by P5, who when asked if there was a difference between her role as an occupational therapist and the role of the nurses on the team said:

> *"not hugely it's a very generic role . . . we do get referrals for OT specific things but that feels like that is a bit of a luxury service because of your case load and generic work . . . take priority"*

This raises a specific issue about the development of occupational therapists. P5 was talking about her current role and she is in her fourth-year post qualification, but as a Trust, we do place our preceptorship therapists into roles which have a strong generic

element of work. Although this research is small, the staff who worked in adult mental health teams appeared to have the most difficulty defining their role as different from their nursing colleagues, with the staff who worked in dementia care or forensic care finding it easier. It would be a gross generalisation to say that this was always the case but the issue of generic versus role specific work has a vast literature base that surrounds it, and therefore must be worthy of thought and consideration when placing newly qualified staff into teams.

5.3.4 Rotations and split preceptorships

Of the seven participants interviewed all of them had been appointed to rotational posts however only five of them spoke about rotational posts in the research interviews.[21] Of these five, two had been in a split preceptorship post, meaning that they were in a rotational post and that half way through their preceptorship year they moved onto the next rotation and onto a different preceptor. The rotation itself raised interesting issues in terms of confidence and skill with P4 recognising that after a year in post she felt that she knew what she was doing and that there was then a time of adjustment when moving onto the next post, of wondering if you could do the job, and that there was the need to acknowledge that you had transferable skills.

The two participants who had a split preceptorship experience did not describe this in a positive way. Although p5 is not negative about her experience of split preceptorship, she is not positive either describing it as: “okay”. However, she is not positive about any of the preceptorship process regarding it as a repetition of university and believes that demonstrating continuing professional development is more important. I cannot say that if her experience of preceptorship had been uninterrupted that she would regard it more favourably, however, I cannot help but wonder if this might be the case.

[21] A rotational post is a substantive post that moves around a number of different teams in the organisation. In the Trust these normally have four teams on the rotation and staff move on a set date every year. For example the team I work with have a rotational band five occupational therapist who can work on older adults functional inpatient ward, community dementia team, community adult mental health and crisis team. They rotate on the 1st January. This date has recently been reviewed in light of discussion following this piece of research and from 2017 the rotation will start in September.

P2 does regard the split preceptorship as a negative point. She spent six months on the adult acute wards followed by six months in services for older people. Part of the reason she felt that the experience was poor was because she rotated into an area that she did not want to work in, however, her experience of the preceptor in that area was regarded as better than her experience of the preceptor in the first post. Again it is hard to definitively state that the split preceptorship post played a part in P2's perceived difficult experience. The split preceptorship post, therefore, cannot be regarded as intrinsically negative, however neither can this research support it as a positive experience.

5.3.5 Training offered in the preceptorship year.

The issue of training is raised separately because of a particular comment made by P3. She felt that people in their preceptorship year had been denied training because they were in their preceptorship year and that for this reason, some staff had left the employment of the Trust. She views the training of staff as essential if:

"occupational therapy is going to maintain its unique role"

She views training as an important issue that demonstrates an investment in staff. Although her concerns around training are genuine they are not backed up by the experience of other participants in the study. Four other participants (1, 4, 5, and 6) spoke about the training they had received in their preceptorship year. These staff mainly spoke about completing occupational therapy specific courses, mainly the Allen's and the MOCA training.[22] P1 felt that this training had helped her develop her skills as an occupational therapist and P4 recognised that there was a need to consider relevant training. P6 describes her preceptor as:

"keen for me to look for training"

Although this research does not support the concerns of P3 there are still issues here to be considered. That occupational therapy specific training given in that first year was

[22] Allen's and MOCA are both occupational therapy models that include assessment and treatment of people with various mental health problems and are both used within the Trust (Allen, 2000, Sherwood *et al*. 2015).

perceived as supporting the development of skills in the profession. The staff who had received training during this time had found it useful in developing skills as well as helping: *"get the foundations really robust"* P4.

5.3.6 Conclusions and implications from the organisation theme.

There are a number of implications raised by this theme that are all organisational considerations regarding how preceptorship is managed and delivered throughout the Trust.

Firstly there is a perceived inconsistency in how preceptorship is delivered including who is involved in the process. This may well mean that either the existing policy needs to be clearer or that training is required.

That training in the preceptorship year should be occupational therapy specific and should enhance, not detract from, the essential embedding in of professional skills.

Best practice for the Trust could include recommendations to not spilt the preceptorship year, either that the preceptees do not rotate during this time, or that they keep the same preceptor, this may mean that rotation times have to be changed to fit in with the recruitment of newly qualified staff.[23]

This best practice could also include that newly qualified staff are placed in teams where the occupational therapy role is respected and recognised and forms the majority of the workload. Teams, where generic working is given more priority than occupational therapy work, would only have staff that are more experienced and more secure in their role and identity.

How occupational therapy is perceived by other staff and the reasons why this is may be an area for further research.

[23] This has already been actioned within the Trust

5.4 Theme: Structure

The structure theme relates to the formal structures involved in the preceptorship process including documentation and criteria for the process. It is themed separately from the organisation theme as documentation alone was a large aspect of what was discussed by interview participants. Although the documentation is specific to the Trust it is related to the Knowledge Skills Framework (KSF) (NHS Scotland ND) which is a national initiative within the National Health Service and therefore is not controlled specifically by the Trust. Six of the participants discussed topics that fell within this theme and there are 68 items of data.

5.4.1 Documentation

Five of the participants specifically commented on the documentation used by the Trust to support the preceptorship process.[24] These were viewed in a somewhat negative manner by the participants with P3 in particular, finding the paperwork: *"phenomenally difficult"*. P5, who generally had not found the process appropriate, felt the paperwork did not do the job it was supposed to. She felt that filling out the paperwork did not prove that an individual was competent in their skills. Others reported that the documentation could be 'tick boxy' (P7, P6, P4) and the other criticism was that it could be seen as being generic and not occupational therapy specific (P1). However underlying these negative views expressed by the participants, the data actually infers that the documentation was not in itself poorly written, but that the guidelines around its use and the consistency with how it was used were a significant issue. P4 actually refers to there being no in-depth guidelines around the paperwork, whereas P7 who had two different preceptors appeared to be clear that it was about how the paperwork was used that impacted on its usefulness. He states:

> *"you know it would be ticked off whoever I had, but the second person allowed me to really develop further and get some value out of it"*

[24] It is worth noting thought that the Trust is in the process of changing the way it conducts its appraisals going from using the 'KSF' documentation to using performance and development conversations (PDC) (Anon 2015). Currently the information around this does not include preceptorship but this may well change in the future.

This is echoed again by P4 who claims that the paperwork can be a tick box exercise: *"if you let it be"* and P1 who felt that she had the opportunity to: *"rejig and edit"* the paperwork to make it more occupational therapy specific.

There were also comments made about the documentation that portrayed it as an essential part of the structure of the whole process of:

> *"demonstrating your skills and your skill development over that initial year" (P4)*

It was also seen as allowing people to be clear about what their aims for the next few months were (P5). P7 regards the documentation as a framework for your first year and as a *"tool that guides future . . . professional skills"* but follows it up with the caveat that it is *"crucial in the right hands".*

The documentation is, in essence, a place to collect evidence to show that you meet the standards expected from a newly qualified member of staff, and that you develop throughout the first year of work in areas of professional skill, behaviour and knowledge. This also raised the issue of consistency, with participants talking about not being sure of what evidence to put in, or how much evidence to put in. P1 wanted: *"more clarity"* as to how much evidence to include, P4 felt that some aspects were: *"overzealously evidenced"* and that even the preceptors did not have clear guidelines about what to include. P4 also cited the use of the preceptorship groups as an effective way of monitoring this as preceptees would share what they were doing and how they were evidencing their learning with each other.

5.4.2 Continuing professional development.

The issue of continuing professional development (CPD) also links with the issue of training and general skill development. P3 states that:

> *"you just have to be prepared to keep refreshing your skills"*

It is P5 that raises the issue of continuing professional development specifically because she did not view the preceptorship process as being useful. She views preceptorship as

being a continuation of what has been done at university and felt that a focus on CPD was:

> *"more useful because it was developing you, whereas the preceptorship felt like it was like proving yourself, like just confirming to them that you know what you're saying you know"*

She finishes stating that:

> *"CPD should be something that is emphasised more than preceptorship".*

Continuing professional development does seem to have a part to play in the structure of the preceptorship process as highlighted by what the participants say about training. P4, however, considers that preceptorship should focus on the "foundations" and that after preceptorship is the time to spend time in the library and shadowing people. This would support the idea that any training completed in the preceptorship year should be occupational therapy specific and therefore support the fundamental skills of the profession.

5.4.3 How could preceptorship be better?

The consistency of how the preceptorship process is implemented within the Trust is raised throughout the discussion in this chapter. That there is no consistency or clarity in how the documentation is used, the amount of evidence that is expected and how the preceptors approach the process is raised in the data. These issues around the structure of how preceptorship is delivered could again be addressed by a robust training plan and also ongoing support for the preceptees and preceptors, so that they have a forum to discuss issues and concerns. P5 felt that the documentation did not prove that someone was competent and as a result of this felt that being seen to clinically demonstrate skills in practice would supersede the need for written evidence. Although this indeed would be the case, the fact that many occupational therapists do not work directly with their preceptors could make this difficult. However, there is no reason why using the current documentation, that seeing a preceptee perform a specific task, would not be classed as evidence to meet specific criteria.

P6 felt that more would be gained if the documentation was less specific and *"more of a vague outline"* that allowed more "leeway". She felt that a conversation, similar to having supervision may be more helpful. Again, under the current system this could happen and may well suit some people, however, it could still be regarded as inconsistent. The new format of appraisal within the Trust, the performance and development conversation PDC (Anon 2015), is in the format of a structured conversation.

5.4.4 Conclusions and implications from the theme: Structure.

The implications that arise from this discussion under the theme of structure have already been raised in other places. Namely, that training needs to be given to preceptors in how to deliver the preceptorship process and that this should include how to administer the paperwork. Also, that training given in the first year should be focussed around occupational therapy specific courses. Furthermore, that support systems for preceptees and possibly preceptors should be reinstated, possibly in the form of communities of practice groups.

5.5 Theme: A Journey.

The journey theme considers topics of discussion that show how the participants reflect on the concept of developing over time. It deliberately does not include the code of skills as although the participants reported that these had developed (clinical skills especially) that this was something that they had to take a much more active role in. The code of skills is therefore considered under the theme of ownership instead. All seven participants discussed subjects that fit into the codes that group together to form the theme 'journey' and there are 116 references in the data to this theme. It was clear that the journey started even before people started their occupational therapy education and continued after the preceptorship year, and was, therefore, part of a continuum (see figure four).

5.5.1. Before and during university: starting the journey.

The Journey towards becoming an occupational therapist starts before formal education has commenced at university. This would be congruent with theories in the literature about pre-formed ideas and socialisation (Billington, Hockey *et al.* 1998, Jenkins 2014).

Four of the participants described meeting either an occupational therapist or someone with a close connection to an occupational therapist which helped them make the initial decision to enter into the profession.

This journey, towards becoming an occupational therapist, appears to really start in earnest in university with P4 describing it as such when she recalls a conversation with one of her lecturers at the end of her course. He helped her reflect on the changes she had made and describes her transformation as an *'immense journey'*, a statement that resonated with P4. It is P5 that claims a specific aspect of the university course helped her develop, talking about practice placements P5 states:

> *"I always got more from my practice placements that I did from Uni and I'm that kind of learner, if you show me something and I do it I will remember it ".*

The preparation received at University for working life was viewed differently by different participants within the data. However, it did appear to prepare people for working in a challenging organisation such as the NHS. P2 sums this up by stating:

> *"The training . . . says to you . . . that change can be positive and negative . . . that it's a flexible thing . . . and you know that's reflective of everything in life isn't it really".*

It was the view of one participant that what the individual takes out of university is dependent on the student. P7 claims that some students left unprepared for working life. P3 recognised that the journey was always meant to continue though saying that by the time you leave university, *"you don't really own anything"* going on to discuss how after university you begin to do things in real life and that helps with the development of skills and confidence .

5.5.2 The 'real world'.

The concept of working in the real world and trying things out on real people was an issue voiced by the participants as being one that gave confidence but also provoked some anxiety. For some doing the job helped them: *"immerse themselves in their OT identity"* (P7) and for others, it was recognised as a learning curve (P4 and P5).

P5 initially sees working as a newly qualified occupational therapist as an extension of being at university, and this view is somewhat supported by other participants who also talk about being in "Uni-mode". P5 reports this as a negative, feeling that the preceptorship year was an extension, and at times a repetition of university and that she felt as if she needed to prove herself all over again. Whereas other people viewed it in a less negative light, they did report how being in student mode meant that they did an amount of work at home that potentially should have been acknowledged as part of their working day. P1, P3, and P4 all reported working on their preceptorship at home and that this was seen as acceptable because they were still in 'student' or 'Uni' mode.

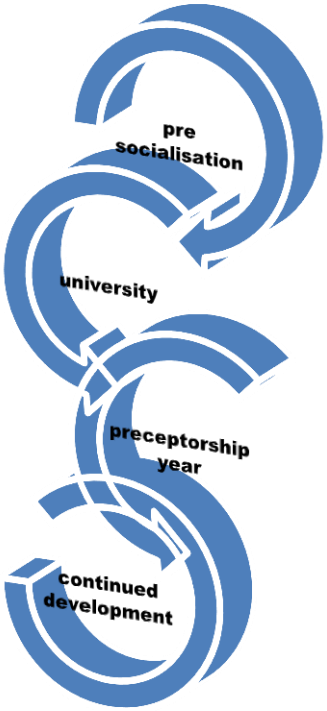

Figure 4: Preceptorship as part of a journey of development.

The 'real world' was considered anxiety provoking in the sense that these were real people and if interventions did not work then it meant that you had got it wrong (P3), however there was also a feeling of growth described by the participants, that they learnt from those around them (P5) and that they had the ability to reflect on their development (P1), as well as the realisation that the: *"learning is gonna be forever"* (P7).

5.5.3 Confidence.

Five of the participants discussed how the feeling of starting work as a newly qualified occupational therapist was quite a daunting experience, which supports this research's claim that the process of becoming an occupational therapist is one the continues after university. P3 describes feeling: *"terrified"* when she first started and P5 reports experiencing that first year as being: *"overwhelming".* This is also a word that P4 used to describe the time in that first year; she compares becoming a qualified occupational therapist to the time when you have first passed your driving test stating:

> *"oh my god, somebody has let me see patients and I'm on my own".*

P1 and P6 use the word daunting to describe the preceptorship process itself feeling that the concept of having to sit down and review yourself was: "*quite scary"* (P6).

During this preceptorship period though, six of the participants referred to how they felt that their confidence had grown. Only one (P5) felt that had nothing to do with the preceptorship process and felt that just doing the job would have made her confidence grow regardless. However, the other participants felt that there were aspects of the preceptorship process that contributed to their individual growth in confidence. P1 and P7 felt that becoming immersed in occupational therapy and gaining knowledge of what could be offered in terms of assessment and intervention and thereby having ownership of the role, meant that their confidence developed during the preceptorship year. P6 felt that setting goals and realising that you had achieved them on reflection, within the process had helped build confidence. She specifically found feedback from the preceptor helpful, she states that:

> *"They think you are doing better than what you think you are and that builds your confidence".*

P4 felt that the paperwork and the supervision structure within the preceptorship year had helped her to identify areas in which she had confidence, and acknowledge how this had developed, so that even when it came to moving on to her next rotational post she was able to be: *"aware that your skills are transferable".*

It is P1 that relates that her confidence was also associated with a sense of achievement. She acknowledged that her confidence had developed as she became more comfortable with her role, and she then questioned herself less. She reports at the end of the preceptorship process that it had made her:

> *"Realise how much she had come on . . . and what I had learnt. It felt good after all that work".*

Others also reported a sense of achievement P3 states:

> *"Wow, I've done all this, that's amazing . . . but you can't help but grow when you are challenged".*

P4 when asked *"when you got to the end of that preceptorship year did it feel like yeah I can do this?"* replied with a very definite:

> *"Yes I did, I very much felt like that"*

The journey of preceptorship, therefore, is only one part of a larger journey. A journey that, in its entirety, starts when occupational therapy is chosen as a career and ends when the individual chooses to no longer define themselves as an occupational therapist.

5.5.4 Conclusions and implications of the journey theme.

The journey of development starts at a point in time where the profession of occupational therapy as a whole has a duty to promote itself. That is before people have signed up for education, at the stage of preformed ideas. In this research, four of the seven participants described talking to occupational therapists about their jobs before signing up to become a member of the profession. This implies that it is the responsibility of each individual occupational therapist to promote themselves and the profession whenever possible as it would appear that by individuals endorsing occupational therapy as a career, others have been attracted into the profession.

It is also clear that there are some areas of preceptorship that could be considered as essential to the journey and continued growth of the individual. The participants defined these as being, reflective practice, goal setting, appropriate training, role modelling and

mentorship, all of which are recognised in the literature as the being benefits of the preceptorship process and preceptorship relationship (Department of Health 2010, Morley 2012). Therefore although the process has some critics within the interview participants it would appear overall that in terms of a journey of development the preceptorship process was viewed as having value.

5.6 Theme: Ownership.

Although the theme of ownership is written about last in this chapter it is one which underlies the whole preceptorship process in many ways. All seven participants discussed issues that are grouped together under this theme which includes 11 codes and 170 references. The concept of ownership within this theme covers issues of identity and professionalism as well as personal traits and personal learning.

5.6.1 Identity and professionalism.

A significant component of this theme is about identity and professionalism. This is not surprising given that the participants were asked to discuss how the preceptorship year had impacted upon the development of their professional identity. However, only four of the seven participants directly discussed identity in very specific terms. Other issues around identity came out in the discussion of role and how the job is defined and described by the participants and this will be discussed separately in section 5.6.3.

There are two issues raised about identity that fit with the literature on this subject and therefore this research validates what is already written. The first issue is that of development of identity over time (Giddens 1991, Dent, Whitehead 2002b). P3 thinks that:

> *"you don't come out of Uni with a professional identity do you".*

Within the course of her interview, she then describes a process of learning and confidence building and supervision that leads her to an end point of wanting to fight for the unique role of the occupational therapist. P7 also recognises that the development of identity takes time feeling that it was only after a number of months doing the job that he

became *"immersed"* in his identity as an occupational therapist. It is P7 that is also explicit about the problem of identity in occupational therapy describing it as a:

> *"long-term, not crisis, but a long-term banging the drum to ensure that OT is . . . appreciated and their role is really well defined".*

The other issue of identity is linked to that of development and relates to how novice occupational therapists see their professional identity as being separate to their personal identity. The literature claims that this changes over time as identities merge and become less separate over the years (Robinson, Tanchuk *et al*. 2012) this is made clear by two of the participants in particular. P4 claims that:

> *"There is a personal me and a professional me"*

She finds that there are aspects of herself that she curbs in her professional life in order to fit her professional identity (such as being on time, being less scatty) however recognises that identity is part of an overall process of growth. P6 describes how being an occupational therapist is part of her working identity and considers this to be different to her home identity. Although she goes on to consider that there may be an overlap as she uses some of her work skills in her personal life as well.

Both these issues relate to the development of professional identity over time and this also links this theme of ownership with the journey theme. P4 states that along her journey her tutor had recognised the:

> *"development of my professional identity and the ownership of actually the roles and responsibilities (of occupational therapy)".*

This statement makes a strong link between the development of identity and the ownership of the role of occupational therapist and would, therefore, link clarity of role with professional identity.

The concept of professionalism as being separate to, but linked to professional identity is one that is spoken of in depth by only one participant. P4 links this is some ways to her young age:

> *"when you haven't had a lot of life experience there are scenarios that can be quite challenging, which challenge your ability to remain professional".*

In particular she relates this to a patient disclosing sexual abuse; however what is also clear is that P4 regards professionalism as a skill, something that is developed along with confidence and experience, but also possibly something that is learnt, and conversely taught. She states:

> *"that sense of being in a professional role . . . it's a different version of you isn't it" and "that professional you know persona . . . I think for most people it does become part of your identity".*

These comments suggest that there is an ability to be professional (a skill) and a professional persona (an identity) linking the development of skills to the development of identity formation. This concept is discussed more fully below as the next section debates skills and other personal traits that may impact on identity formation.

5.6.2 Personal traits and skills.

The codes in this theme look at the personal traits of the participants. Only one participant talked about gender and it is, therefore, unreasonable to draw any wider conclusions from this one person's perspective. It may be though that this is an area that could be of further research interest within the profession of occupational therapy.

Three of the participants made specific reference to their personal traits that they think allowed them to continue in their post in difficult circumstances. P2 and P3 both discussed the concept of resilience with P2 actually using that word. Both describe challenging experiences in different ways. P2 reported difficulties in terms of the lack of support she felt she had, and P3 had worked on a ward that at the start of her preceptorship year she had perceived to be hostile towards occupational therapy and herself. Both consider the resilience to come from life experience, P2 from her upbringing and P3 from previous work experience. P3, who had started her occupational therapy education when she was 29 and had previously worked as a healthcare assistant considers this experience as essential to the post she started in, although not for all posts.

P7 echoes the concept of life experience being useful during preceptorship when he discusses dealing with the relationship between himself and his preceptor and stating:

> *"I've got enough about me to know that you could completely upset somebody".*

This statement echoes back to the concepts of resilience discussed earlier, issues of coping strategies and self-care. It was not just resilience however that was regarded as being important but also a sense of passion about the job, and although this came across subjectively in all interviews it was P2 and P3 that made it quantifiable by making simple statements such as: *"I love my job"* (P3) and: *"I completely believe in occupational therapy"* (P2). P2 makes it very clear when she says: *"I'm so passionate about OT".*

Also important is how the participants describe the development of skills during their preceptorship year. The development of skill, unlike the development of confidence, seemed to require more active participation, whereas confidence was discussed under the theme of journey and appeared to develop over time, with one participant not linking it to preceptorship at all (P5). The development of skill is seen as a concrete and definable entity. P3 states:

> *"I don't remember feeling very skilled at the start",*

Whereas P2, who describes, in general, a difficult time is clearly able to list what she sees as her skills which include, assessment, communication, problem-solving and developing rapport. P1 felt that she was given opportunities to develop her occupational therapy skills within her preceptorship year via the specific training she was encouraged to attend, including specific occupational therapy models (Allen (2000) and the MOCA, Sherwood *et al*. 2015). P5 thought that preceptorship should be about being able to demonstrate skill rather than knowledge, feeling that anyone could look something up on the internet but that skill should be shown practically, she lists communication and approach to people as being skills. P5 links this to learning styles; she particularly states that she learns by doing. P5 was not the only one to identify learning styles as being important in the preceptorship year, with two other participants also talking about the importance of learning styles. P3 links it directly to learning skills when she talks about learning by watching other skilled members of staff and learning how to do things by seeing them

done in practice, whereas P7 feels that everyone should take responsibility for their learning and that this includes transferring the skills you have from one learning environment (doing a degree) to another learning environment (preceptorship). The concept of transferable skills is one that is mentioned as well in terms of clinical skills. When the participants talked about moving rotation posts they talk about transferable skills (P2, P4). The preceptorship year then would appear to need to be adaptable to peoples' specific learning styles, develop existing skills as well as teach new ones, in order for people to develop the skills required to perform the role.

5.6.3 Developing roles and defining occupational therapy.

The answers of the participants when asked to describe their job, or their role, summed up the difficulties that the profession has in defining what it does. All seven participants discussed how they described their jobs to people inside and outside of the health service. All seven felt that their explanations were dependent on whom they were talking to and where. For example how they described their job to friends in the pub was very different that how they talked to medical and nursing staff about their roles. P1 clarifies this by talking about the type of language she uses when describing her role, feeling that she uses a lot more *"basic"* language if talking to friends or patients than she would to ward staff. P6 felt she always had to give an explanation to people outside of work because when she said she was an occupational therapist: "*nobody's ever heard of it".* P3 and P4 both described family members who no matter how often they tried could not get a concept of what they did fixed in their minds, both saw this as being something that was peculiar to that family member and described how it had become a source of amusement within the family.

P3 also describes a scenario that again is supported in the literature about preformed ideas (Sutherland, Howard 2010, Sabanciogullare, Dogan 2010) and this is something that P7 also comments on. P3 states:

> *"I don't know whether we always make it very easy for ourselves because we do cover so much. It's almost like being a jack of all trades but almost we master all of those as well, we have to, so it's not master of none".*

She goes on to say:

> *"it makes it difficult for people, I saw an OT when I had braces on my foot, oh ok. It's massively difficult yeah because we are everywhere aren't we".*

P7 describes this misunderstanding of the role within his own job saying that:

> *"a few people were sort of unsure as why I couldn't measure for a hoist".*

He raises an interesting point though as part of his explanation of the role of occupational therapy was about being holistic (a word used by all of the participants) he then queries whether this should mean that we as individual occupational therapists should be able to do everything, for example, work in a dementia community team and also measure for hoists. His argument being that if we work holistically we should be able to assess and treat holistically as well. He does talk himself out of this view point recognising that an individual cannot be an expert in all things. Indeed we cannot be master of all.

Other than the word holistic, the participants had generally developed a spiel of some sort in order to describe occupational therapy to others. P1 stated that she had learnt this as a student. These spiels generally include words like functioning, daily skills, enable, independent, quality of life, and well-being. Words like meaningful occupation were saved for when talking to other professionals. Defining the role was not a particularly easy task for the participants, but describing the difference between themselves and their colleagues raised other issues. P5 found this difficult because her current role was within a community mental health team and she saw the role as very generic where other participants considered the differences to be subtle and possibly unmeasurable, for example compassionate and empathetic (P2) good guys and bad guys (P6) the way you think (P5), and having an OT focus (P4). Some of the differences were more concrete in terms of assessments used (P4) goal setting (P1) and rehabilitation (P4).

The data expresses that there was a need not only to be able to articulate what the role of the occupational therapist was but that this was also essential in order to protect the profession. P4 states:

> *"you've got to be both an advocate for occupational therapy and also its defender at times"*

and P3 concurs stating that:

> *"if we are going to maintain our unique role . . . we need to continually fight the we are valuable, you do need us and we can offer you something fabulous to your service".*

Therefore being able to articulate the role of the occupational therapist becomes not just about clarity and identity but potentially about the survival of the profession as a whole.

5.6.4 Outcomes and Implications of the Theme: Ownership.

There are a number of implications arising from the above discussion. There are some areas that may benefit from further research including, if there any issues regarding gender for occupational therapists practising within the profession, and ongoing issues around the articulation of the role of the therapist and language used.

In terms of points of potential development as to how the Trust administers its preceptorship program, it may be that newly qualified staff would benefit from being in a team where the role of the occupational therapist is already well defined and that teams, where the role is generic, should be avoided for newly qualified staff. This would help staff build up the confidence to articulate their role and develop specific occupational therapy skills. As part of this confidence building it may be beneficial for the current documentation to focus on the learning styles of the preceptee information about this could be included in the training. This is currently the focus of another piece of research that is being explored within the Trust (Guest 2016). This is a point that is also highlighted in the implications for the theme of Organisation.

This discussion validates what is written in existing literature. Namely, that professional identity develops over time and then becomes blended with personal identity. That the development of skills is linked to professional identity and that also being able to articulate the role is part of professional identity (Mackey 2014). Also in the literature, and raised by the participants, is that being able to articulate the role of the occupational

therapist is essential to marketing the profession and securing its future (Morley, Rennison 2011).

5.7 Conclusions from the analysis and discussion of the first research question.

The above discussion seeks to consider the answer to the first research question, being: *How do newly qualified occupational therapists experience the preceptorship process?*

The data had been coded and themed using thematic analysis and the separate themes have been discussed above. Following this, there are a number of key learning points that emerge and from them, considerations of best practice for the occupational therapy service in the Trust. These are presented below, and it is expected that the recommendations will cause debate within the service as to how to move forward with the delivery of preceptorship to occupational therapy staff.

5.7.1 Key learning points.

The learning points are developed from the above discussion and are a summary of the key issues that arise from the analysis and discussion of the data when answering the first research question. Clear within the data is that Preceptorship is part of a continuum that moves people forward from student to a qualified member of staff and from qualified to a competent occupational therapist.

Within the research, participants discussed both positive and negative aspects of their preceptor's skill levels and their relationship with the preceptors. The data supports existing literature which clearly highlights that the skills and confidence of the preceptor were paramount to the preceptorship experience (Myrick, Yonge 2001, Smith, Morley 2013, Marks-Maran, Ooms *et al*. 2013, Foster, Ashwin 2014), with 58 coded statements talking specifically about the relationship or skills of the preceptor.

The data clearly showed that there is a perceived inconsistency in how preceptorship is delivered. This included comments about the preceptor's knowledge, skill, experience and commitment to the process. It also included statements about the use of the paperwork, the amount of evidence that is expected and how the preceptors approach

the process. The research data actually infers that the documentation was not in itself poorly written, but that the guidelines around its use were a significant issue. The qualities of the preceptor listed by the participants (articulation, knowledge, professionalism, supportive, experienced, approachable,) include qualities that cannot be taught. This highlights the need for staff who wish to be engaged in preceptorship to choose the role of preceptor. The preceptor's influence on individual professional identity is described as subtle but takes the form of role modelling and that even when the preceptor has been experienced negatively it is seen by the participants as a lesson in how not to do things. Following on from this the data highlights a potential need for training for preceptors.

The data clarified that there is an issue around the need for formal support as staff often do not work directly alongside other qualified occupational therapists. Formal support was perceived by the participants generally in a positive light, but issues were also raised of consistency and quality and also appropriateness for preceptorship groups that are multi-disciplinary. It is also clear that there are some areas of preceptorship that could be considered as essential to the journey and continued growth of the individual. The participants defined these as being, reflective practice, goal setting, appropriate training, role modelling and mentorship, all of which are recognised in the literature as being the benefits of the preceptorship process and preceptorship relationship (DOH 2010, Morley 2012). The literature is very clear that clarity of role is essential to professional identity, as in order for occupational therapists to work successfully as part of a team they need to understand their own role in order to perform well within the framework of the team (Rodger, Mickan 2005, Baxter, Brumfitt 2008). However, the data shows that this is an area that some of the participants found difficult. At least one of the participants (P5) worked within a team where she could not define her role as being any different to that of her nursing colleagues and others struggled to articulate their role.

The data also raised the question of training within the preceptorship year. One participant (P3) felt very strongly that staff were not offered training in this time. The data does not support that with other participants talking explicitly about occupational therapy specific training. Staff who had received occupational therapy specific training

during the preceptorship year had found it useful in developing skills as well as helping: *"get the foundations really robust"* P4.

The participants also discussed the issue of split preceptorship posts. Although not regarded as fundamentally negative, this research cannot endorse it as being a positive experience for the participants.

5.7.2 Recommendations based on analysis of findings

The above findings lead to a number of considerations for the Trust. It is worth at this point reiterating Paley's point (Paley 2005) that the data collected offers a small insight into the thoughts of these participants. The recommendations are therefore offered as practical outcomes of the research that the Trust can debate in terms of their usefulness and application.

The first recommendation is around the preceptors. It is clear that some sort of training should be offered, and that this should be training that preceptors choose to do and sign up for. That is, that staff should make an active choice about becoming a preceptor. This training should include information about the use of the paperwork.

For the preceptees, continuity and support should be considered. This would include minimising any disruption in the preceptorship period. Therefore as best practice, newly qualified staff in the preceptorship year should not rotate posts until preceptorship is complete. And if preceptorship is split for some reason, the same preceptor should be retained if possible; if not a formal handover should be considered. Other support in the form of supportive groups or communities of practice should be reinstated in order to support newly qualified occupational therapy staff, and also new preceptors.

For the Trust, it would be difficult, but beneficial, if the placement of newly qualified staff was in appropriate teams that give priority to occupational therapy specific work rather than generic working. Related to this, any training given in the preceptorship year should be occupational therapy specific and aim to increase professional knowledge and skills.

5.7.3 Conclusions

This research substantiates existing literature about the benefits of preceptorship and the development of professional identity (DOH 2010, Morley 2012) and also offers some practical guidelines that could be useful to the Trust and interesting to other organisations delivering a preceptorship process. It is clear that the heart of the process is in the relationship between the preceptor and the preceptee and relevant support and training could enhance this relationship.

Whilst this chapter uses the data obtained by the participants of the study to answer the first research question, it does not address the second, namely*: In what ways is the preceptorship process perceived as having any influence on the development of professional identity?* In order to answer this question, the next chapter will attempt to draw together the literature and the data to present a model of professional identity and then consider the role preceptorship has in its development.

Analysis and Discussion: In what ways is the preceptorship process perceived as having any influence on the development of professional identity?

6.0 introduction

The purpose of this chapter is to answer the second research question, that is: *In what ways is the preceptorship process perceived as having any influence on the development of professional identity?*

In order to do this, I first revisit the definitions of professional identity most relevant to occupational therapy, Mosey (1985) and Creek's (2003) work. Then by using *a priori* codes developed from their work I seek to find an understanding of professional identity in the interview data sets, in an attempt to robustly analyse and discuss the individual phenomenological experiences. A list of these codes can be found in Table seven, Appendix three. Following this, I return to the question of how preceptorship impacts on the identified components of professional identity and utilise the work of Ann Wilcock's (1999) article on *Doing Being and Becoming* in order to discuss this. The use of these three authors gives a professional credence to this work. Between them they have helped shape modern day occupational therapy by introducing models of practice, occupational science and national strategy. They are not without critique however, Kosma *et al.* (2013) find that Wilcock's whole body of work is underutilised in occupational therapy and they consider the complex and non-linear way in which her ideas have developed as being responsible for this. Creek was criticized for suggesting that occupational therapy intervention, being client led, could not be standardised (Duncan *et al.* 2007) and even that defining occupational therapy as complex was in itself meaningless (Lambert *et al.* 2007). Critique of Mosey's (1985) lecture; however seems to be lost in the mists of time, as she is referenced heavily by other authors. Indeed she was speaking at time when the global culture of occupational therapy was ready to not only hear her words but employ them (French *et al.* 1985). This chapter therefore, by bringing their work together, seeks to find practical answers to the research question by applying the theoretical work of some of the professions most respected authors.

6.1 The traditional definition of occupational therapy identity.

In the background chapter, Mosey's (1985) concept of professional identity in occupational therapy was introduced as the seminal work of the identity of the profession (Mosey 1985). Following its publication there have been no significant changes to its structure and it remains unchallenged as the definitive model of identity for occupational therapy. Jennifer Creek's (2003) work served to enhance it. Although Creek herself, unlike Mosey, does not refer to professional identity in the title of her conceptual framework, it is clear from the content of her framework that this is one way in which it can be understood. Indeed the similarity of Creek's (2003) description of occupational therapy to Mosey's (1985) definition of professional identity only accentuates this; it is for this reason that I make the deliberate choice to link the two pieces of work together. It is Mosey that specifically draws attention to the lack of commonality in the language used by the profession, but Creek acts on this at a later date in her own writing and through the College of Occupational Therapists (COT 2006, Creek 2010).

It is Creek (2003) that recognises the importance of professional experience as a component of professional identity and this is identified more forcefully in the work of Robinson and Tanchuk *et al*. (2012). These two frameworks (Mosey 1985 and Creek 2003) taken together provide a widely understood concept of professional identity in occupational therapy. However, it could be argued that they are not comprehensive as they do not fully account for how people enter the profession, how individuals learn the knowledge and skills and values, or how this develops.

The two bodies of work between them describe what Mosey (1985) calls a pluralistic approach to professional identity. They include; professional experience (Creek 2003 only) and philosophical assumptions, that include professional values and beliefs about people health and occupation. They include the code of ethics, role and responsibilities as well as knowledge and skills. They both include domain of concern, tools of assessment, treatment and outcome, and models and frames of reference. Mosey refers to aspects of practice, which Creek translates as the occupational therapy process and both include research, though Mosey expands on this to include evidence-based practice, continuing professional development and audit. Finally, Mosey specifically identifies an issue with

the lack of common language, whereas Creek recognises external influences that impact upon the profession. It is these headings that have formed the basis of the *a priori* codes that are used in the analysis of the data, though from additional reading I also added the codes reflexivity and socialisation in order to provide a robust coding of professional identity (Giddens 1991, Ashby, Ryan *et al*. 2013).

6.2 The definition of occupational therapy professional identity as derived from the participant data.

This study interviewed seven newly qualified members of staff and can therefore in no way develop an exhaustive definition of professional identity. It certainly cannot replace the existing frameworks. It can present the data as it relates to professional identity and the components of professional identity that were discussed by the participants as being important to them, and figure five does this. As can be seen, it does not reflect the complexity of the components listed in either Moseys (1985) or Creeks (2003) framework, and as it is developed from newly qualified staff it would not be expected to, however, it does cover the essential structures. One of the difficulties in theorising about identity issues is the difficulty of defining and articulating the term identity itself (Lawler 2014, Jenkins 2014) This poor articulation of identity issues is reflected in the data.

The data has been collated into areas that reflect my understanding of identity. The participants themselves may have not considered, at the time of talking, that the issue was related directly to identity (an example of this may be around CPD or training, I have linked this to identity because of my knowledge of Creek (2003) and Mosey's (1985) work, however, the participant may have understood it simply as a discussion around training). Although I have not changed the meaning of the data, I am aware that there is a possibility of bias in the way I have then grouped data and that this needs to be acknowledged.

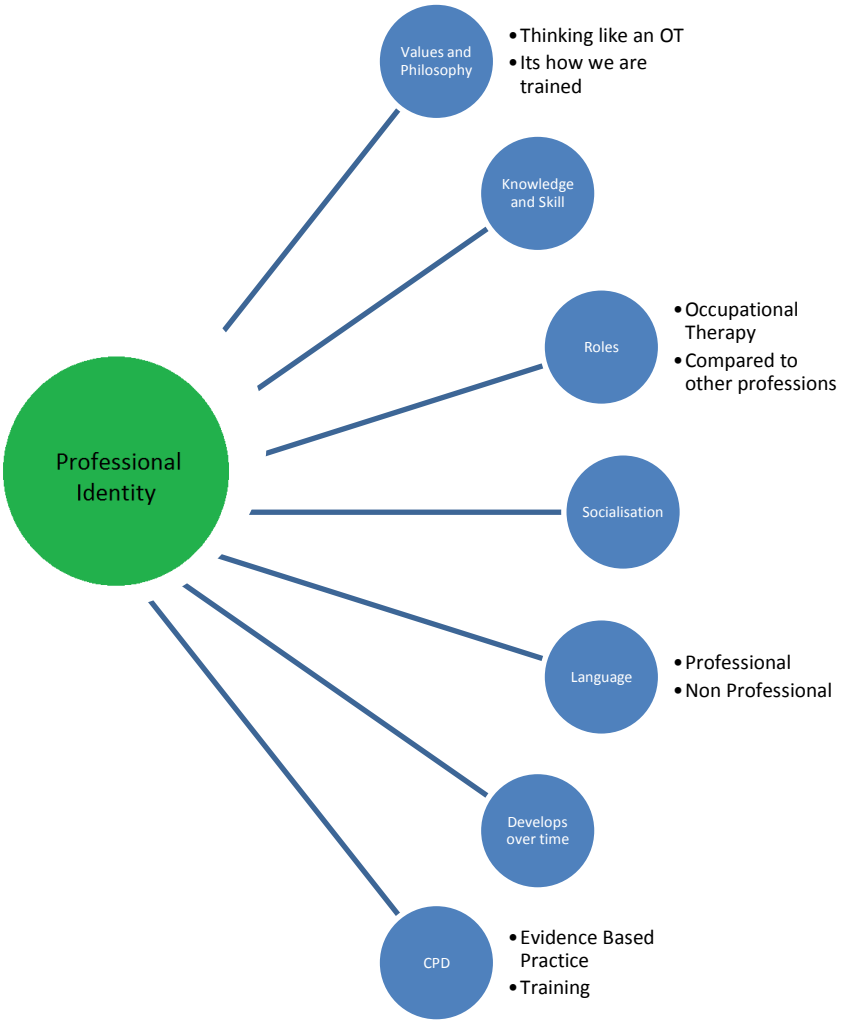

Figure 5: Professional identity components recognised in the research data.

6.3 Relating the definition to theory.

In order to consider how these issues, discussed by the participants relate to the theory of identity formation they will each be considered in reference to relevant theory. As the purpose of this chapter is to answer how preceptorship helps the process of identity formation this section aims to provide an overview of the theory rather than an exhaustive understanding of the complexity of identity theory. The question of how preceptorship impacts on these facets of identity is dealt with later in this chapter.

6.3.1 Role

The issue of role was discussed by the participants when asked about their professional identity. P3, in particular, went into lots of detail about particular clinical aspects of her

role. However, all seven of the participants talked about their job role in relation to what they did with clients (for example: goal setting, functional assessment, writing reports, multidisciplinary work, doing activities, taking people home, problem-solving, and running groups). The way they talked about the role, was in terms of specific tasks that they as occupational therapists carried out. In terms of identity theory, there are two reasons why occupational therapists talking about their role (as in what they do) is important. The first is to do with the definition of the role itself, and the second do to with how the role is defined when compared to other similar but different roles (in this case nursing).

The first issue is highlighted by Sims (2011) in that often people begin to define their identity through their job title; this is an issue for occupational therapy and is discussed further in section 6.4, where I consider if the title occupational therapist is understood by those outside of the profession. Bannigan (2000) feels that the articulation of our role is the key to getting people to understand what we do, however, articulation of our role is also an issue that the profession struggles with and will be considered under the section 6.3.4 where we consider the impact of language.

The concept of role being important is not one that is new to either social science or occupational therapy. The profession was grown out of the need to help people be able to perform roles that they, through injury or ill health, had stopped being able to do. The role of work in terms of how it benefits individuals and society is well written about in the social sciences with Marx, Weber, Durkheim and Parsons amongst those who have specifically theorised about work (Giddens 2009). However, it is not the sociology of work which is of concern here but how people identify with their work role. It is not surprising that occupational therapists choose to define themselves first and foremost by the roles they perform; this is reflective of how we initially approach our clients. What is useful here is the word ‘perform’. Giddens (1991) writes in terms of social actors and Goffman (1959) takes this one step further and has a whole analogy of identity based around the theatre, how we perform in terms of front of house, backstage etc. The term actors, and the analogy of theatre may be off-putting as it suggests that our identities are somehow staged or not real, but what it does allow for is the concept that we can show different aspects of ourselves to different people and choose to behave differently in different

situations. For myself, this is reminiscent of a childhood favourite, Worzel Gummidge (1979) who has a different head for different circumstances. Although this is a simplistic way of considering the concept of social actors it helps make sense of why in the data, the participants felt that their work selves and their home selves were different and P4 actually uses the phrase: *"occupational therapy hat"* when talking about switching from work mode to home mode. To be a social actor, or change heads then is not to be unreal, or non-authentic, it is recognition of the fact that our identities are socially defined and that there is a social script to be followed in certain roles and situations (Billington, Hockey *et al*. 1998, Jenkins 2014).

The literature is very clear that clarity of role is essential to professional identity, as in order for occupational therapists to perform well within the framework of the team they need to understand their own role (Baxter, Brumfitt 2008). However, the data shows that this is an area that some of the participants found difficult. At least one of the participants (P5) worked within a team where she could not define her role as being any different to that of her nursing colleagues and others struggled to articulate their role. The lack of ability to separate yourself from others is a potential problem in identity formation. If we accept that identity is socially defined (Lawler 2014), then we must also accept that part of the way we define ourselves is within a social context. We need to compare and contrast ourselves with others in order to define which group we sit in (Jackson 2002 in Lawler 2012). It is the differences and similarities that enable us to have a shared professional identity. If therefore a member of staff cannot identify differences between her role as an occupational therapist and the role of a nurse then she will struggle to define herself as either. Other participants were able to differentiate their roles and also recognise that their team members had also done so. P7 discussed how the identity of occupational therapy *"came across"* within services and P4, felt her role within her current team was the "*most defined"* of all the roles she had held, putting this down to being in a department that linked the occupational therapy staff to specific wards. It is also P4 who describes a scenario where the ward manager explains the importance of occupational therapy, and how it could be beneficial to not only the patients but to the team as well. Within the data, the participants attempted to separate themselves from

their nursing colleagues both practically and philosophically. Practically they talked about the time they had to spend with patients (P3) and the fact that they got to do things with people (taking them off the ward, P6) and philosophically they talked about the way they were trained to: *"think like an OT"* (P5).

6.3.2 Knowledge and skill

If it is accepted that occupational therapy is a profession and that as part of this, it has its own knowledge base (see section 2.3) then the knowledge and skills discussed by the participants must be seen as indicators of a professional identity. The descriptions of knowledge and skills included occupational therapy assessment, risk assessments, biopsychosocial models, problem-solving, activities of daily living , being holistic, being task based, supporting people to be independent and the use of therapeutic goals (P2, P3, P4,P6,P7). Tajfel (1982) advocated that being a member of a group was enough to claim identity from it, however, the issue of knowledge and skills would suggest that membership of the group alone is not enough to give professional identity. The knowledge and skills that a professional group have are what creates the semblance and substance needed for professional identity (Lawler 2014). It is Jackson (2002), in Lawler (2014) that considers the need for sameness. Where in the discussion of role we discussed the need to be different from other groups, the concept of sameness is what helps define a group, or profession, and the knowledge and skills of the group allow sameness. P7 acknowledges this when he states that:

> *"As (my) knowledge and skills have grown (I am) more immersed in the fuller range of how we can work alongside people".*

6.3.3 Philosophy

Having a shared philosophy is part of what makes occupational therapy a profession (Beck, Young 2005). Giddens (1991) considers the concept of a shared framework of reality as essential to identity. Although Giddens talks about self-identity rather than professional identity his thoughts about the phenomenology of identity are relevant. He considers that it is basic human nature to know what you are doing and why you are doing it, and that this is reflexive awareness. The philosophy of the profession fills this need in terms of our professional identity.

Within the data collected from the research interviews, it is difficult to gain a sense of what the philosophy of occupational therapy is. It is clear that there is an underlying concept that is shared by the participants. Small words such as “we” and “us” are used to group myself and other non- present therapists together, indicating an understanding of a shared reality. Other words were used to try and express the complexity of the philosophical assumptions of the profession; subtle, holistic, unique, creative, compassionate, emphatic, autonomous and complex, being examples of these words. Furthermore, there was the expression that once you had been trained as an occupational therapist this then became your way of viewing the world, for example, P5 states:

> *“I'm always working in an OT focussed way . . . that’s how OT’s think”.*

And this is confirmed by P3 who when talking about nursing staff says:

> *“they haven’t been trained to look at things in the way that OT’s have, you know”.*

So although the philosophy of the profession is difficult to articulate, especially when not asked to do so directly, it is there in the narrative of the research interviews, an underlying shared reflexive experience of what it means to be an occupational therapist.

6.3.4 Language

The sociology of language can be discussed and viewed through a number of sociological lenses. However, it is the use of the narrative in building identity that I find useful in terms of explaining the data. Lawler (2014) considers that the narratives we tell support the formation of our identities and reflexively I can certainly relate to this. If I talk about my own career I would talk about how long I have been qualified and the client groups I have worked with and the different experiences I have had, and this narrative does not just tell the listener about me but establishes my own held ideology about ‘who I am’.

Within the data, the narrative of language can be clearly seen, but the way language is used is also discussed. That is, there is a change in the nomenclature professionals use

when talking about the profession (COT 2006). This change is one that has been debated in occupational therapy as a profession. It is most clearly pronounced by P1 who talks about using a more basic language when she talks to patients and a more medical language when she talks to other professionals. P7 also states that how he defines the profession:

"depends on who you are talking to"

P7 makes the distinction between his personal and professional life, when he considers how his language changes, whereas P1 was talking about the difference between talking to patients and doctors. Five of the participants make comments about how difficult it is to articulate the role, with P5 feeling that it was most difficult when she was newly qualified, despite having just spent three years in formal education.

Creek in *Recovering Ordinary Lives* (COT 2006) suggests that if we want to be seen as professional we should use a more professional language and that this will elevate our professional status. This in itself is not a problem and makes sense, however, when we talk to our patients we use a more everyday language. At the present time there is a sense from within the profession that this is a problem, however, it is one that is recognised and action is being taken by the College of Occupational Therapists (2016). If we reconsider the notion of social actors and particular Goffman's (1959) work this issue becomes a non-issue, we change ourselves and adapt our presentation dependent on our audience, and this must include the language we use. Goffman's (1959) work gives us permission to be able to effectively talk to our patients in layman's terms and use a professional script when conversing with our colleagues without feeling guilty or that it is in some way wrong. I myself would see this ability to be bilingual, as it were, as a strength of the profession. However, as a profession, occupational therapists are still working towards being comfortable as well as confident in this ability to be effectively bi-lingual.

6.3.5 Socialisation

Although the interview participants discussed the concepts raised by the term socialisation they did so without use of that particular word or the terminology associated

with it. No-one for example, used the phrases pre-formed ideas or social scripts, although both those concepts were indicated within the interviews. We have already discussed how identity is socially formed and although the terminology is missing the concept of the social formation of identity is present within the data.

Initially, it is seen when the participants discuss how they started their education in occupational therapy. Four of the seven participants had met and talked with occupational therapists prior to starting their education, and those that had not had researched the profession. The decision to start the degree to be an occupational therapist, rather than to do speech and language therapy or teaching (some of the alternatives thought about by the participants P2, P4) indicates a conscious decision to join a specific professional group. This is often acknowledged in identity theory as being linked to preformed ideas and social scripts by Billington, Hockey *et al*. (1998), who are also clear that identity, without any social context, is meaningless.

The concept of socialisation within the professional group through university education is also raised by the participants. P3 talks about the support she received from a tutor to help her visualise being a qualified occupational therapist, and going on to state that: *"your training has prepared you well".* P7 debates his unusual status at university when he did not know if he wanted to work in physical or mental health. This statement alone indicates subgroups within the profession; however, as this research only interviewed staff working in mental health settings, the concepts of subgroups cannot be explored any further within this study.

Elsewhere in the data, the participants mention the level of both formal and informal support that they receive throughout the preceptorship period, relating the first specifically to role modelling and the second to more social support. P7 indicates how role modelling from a preceptor worked for him when he states that the preceptor had really shown him how to gain value from the process. He relates this to the preceptor's skill, knowledge and values. It was apparent from his tone that this person had engendered respect. P2 talks specifically about the importance of informal social support describing meeting people who shared her value base. Others describe its importance in

terms of rapport with the team, good working relationships and peer supervision. P4 used to meet for coffee with other newly qualified staff and claims: *"you can't undervalue those relationships".*

The concepts of socialisation are therefore recounted throughout the data and are present at all points in the journey of becoming an occupational therapist. They are indicated in the codes and themes used in the previous chapter and the *a priori* themes used in this chapter and it is a generally pervasive underlying part of identity formation.

6.3.6 Develops over time

That professional identity develops for an individual over a period of time is made clear within the literature. Robinson and Tanchuk *et al*. (2012) interviewed students and experienced faculty members. Although their study was specifically about professionalism rather than professional identity, they define professionalism as the behaviour that comes from the components of professional identity (they list knowledge, skills and attitudes as part of this). In this study P4 relates professionalism to identity and recognises the developmental aspect of this stating that:

> *"it (professionalism) becomes part of your identity more so than anything"*

Robinson and Tanchuk *et al.* (2012) find that students only have a rudimentary understanding of these concepts and that over time this develops until the experienced staff use phrases such as 'professionalism being like a marriage contract', 'something that you can't turn off' or 'something that is a piece of you', this is opposed to students that debate the need to be professional at different times. This shift in thinking shows the clear development of professionalism as a concept and its internalisation or assimilation into personal identity. Cook and Gilmer *et al.* (2003), quoted in Sims (2011), describe professional identity of nurses as being a developmental process that evolves throughout a professional career. Cook and Gilmer *et al.* (2003) do note that students have limited understanding of professional identity prior to being a student and this is an issue that I shall return to later in this chapter.

This process of development is one that is clear within the data from the participants. There is specific acknowledgement that you do not come out of university with a clear concept of a professional identity, and sometimes not even fully prepared for the world of work (P3 and P7). There is as well very clear evidence that the participants in some cases had not yet reached the stage described by Robinson and Tanchuk *et al.* (2012). More than one participant described having a different work and personal identity (P4 and P6). It is P7 that captures the feeling of ongoing development when he expresses:

> *"it's about identity and initially feeling yeah I'm an OT, and then realising learning is gonna be forever"*

There were numerous references made to still maintaining parts of a student identity (by all participants but P7).This leads to a need to acknowledge here that as the identity of 'occupational therapist' grows and gets stronger, so must the identity of 'student', in turn get weaker. This cross over between these two identities is supported within the data under the specific code 'Uni-mode'. This code related to the times where the participants did things (normally working at home) that they felt was still like being a student. The fact that they identified it as a separate way of *being* indicates that this is beginning to no longer be part of normal life and that this identity is beginning to fade. Therefore although the concept of identity developing over time is one that is recognised in the data, it is not something that can happen entirely within the preceptorship year. The preceptorship year can help this development but only as part of that larger continuum of development already discussed and presented in figure four.

6.3.7 Continuing professional development.

I have already noted that P7 made a comment about learning being forever, and the concept of continuing professional development (CPD) is a formal recognition of that. The issue of training and CPD is linked to that of knowledge, as it is in effect, the upkeep of professional knowledge and as such a responsibility of the profession, and individual professional (Beck, Young 2005). Continuing professional development also reflects the fact that identity is an active process and that individuals need to work at establishing an identity (Jenkins 2014), which is a concept shared by Giddens (1991) when he claims that identity should not be passive. Participants in the interviews described a number of

learning and training opportunities, most of which were profession specific, such as Allen's and MOCA training (Allen, 2000, Sherwood *et al*. 2015). This process of training can be seen as a parallel to the process of *becoming* (Martin, Gutman *et al.* 1998, Wilcock 1999, Jenkins 2014).

It was P5 who was most vocal about CPD, feeling that it was much more important than preceptorship. She had viewed preceptorship as generally a repetition of university placements and felt she was being asked to prove herself unnecessarily. However, she did value training and CPD in general as a way of developing skills and knowledge and of keeping up to date with new research and evidence. She talks about needing to make time for this development and so recognises that it is an active process. Her concerns being that if you do not make time to develop you could end up:

> *"doing what you were doing, when you first qualified 20 years down the line, and you've never looked at anything else"*

P5 also talks about the busy working day and not having time to "stop and think". She does not make a link between this statement of how working life is for her now (three years after preceptorship) and the time given over to the preceptorship process in that initial year.

There is also one other consideration worth making before I move on to think about preceptorship. That is, given that we have created a working model of professional identity, is that identity positive?

6.4 Does occupational therapy have a positive identity?

The concept of positive identities is raised within the background and literature review chapters, with it being posited that not only should professional identities be strong, but in order to avoid negative connotations, they should also be positive. By being positive they bring about a number of advantages (see 2.8. and 3.3.5). These advantages include being able to market the profession successfully (Bannigan 2000, Morley, Rennison 2011), recruitment and retention (Adams, Hean *et al.* 2006) and professional resilience (Ashby, Ryan *et al.* 2013). However it is also clear that a positive identity is formed not just when the individual, or in this case profession, thinks positively about itself, but when it is

viewed by those outside of the profession as positive (Lawler 2014). It is from this viewpoint that we must query whether occupational therapy does indeed have a positive identity?

The data is clear that the participants think positively about themselves and their role as occupational therapists. Participants describe themselves as being the good guys, being empathetic, being holistic, understanding, compassionate and hardworking, all of which are positive traits. However, the data also showed that therapists did not expect to have their role understood and that when it was it was seen as a *"privilege"* (P4), suggesting a maybe less than positive identity. There appears almost an expectation that people would get it wrong, when this was family it was seen as a source of amusement but when it was either professional or support staff it was seen with a sense of despair. P6 says that *"nobody's ever heard of it"* when talking about describing occupational therapy to people outside of a professional context, and herein lies a difficulty, if we, as a profession, cannot be socially defined then how can our professional identity be positive? There is some indication that within the context of the National Health Service and specifically with the Trust that the occupational therapy identity is more positive and more widely understood, with a number of participants talking about how their teams or individual team leaders respected and valued the role of the occupational therapist (P2, P3, P4, P6 and P7). Morley and Rennison (2011) discuss the need for every individual occupational therapist to take responsibility for the personal selling of the profession, and the participant data would support that, with P3 for example, discussing a situation where at the start of her time on the ward the profession was viewed negatively, to the point where she left that the lack of occupational therapist on the ward was viewed negatively. This shift in viewpoint does indicate that individual professionals can make an impact on how the profession is viewed from the outside. Another issue also realised by P3 is how the diversity of the profession can lead to confusion around the role. She goes on to describe someone knowing about an occupational therapist that had helped with mums broken hip, not knowing what she as an occupational therapist working in dementia care did. She acknowledges this difficulty stating:

"We don't make it easy for ourselves do we?"

This diversity may be a key issue in terms of the positive identity of occupational therapy in the wider social context. However, if we take Lawler's (2014) point of view that Identity is socially produced and that the truth of identity lies between people, is it enough that the Trust and the wider organisation of the NHS respect our professional identity as positive? Or do we need to reach a wider audience? The College of Occupational Therapists are currently asking their members, via Facebook, to consider how to sell themselves to the wider public, via a short simple professional definition (COT 2016). This would suggest that the NHS respecting our professional identity is not enough for it to be considered as totally positive and that this is an area where there is still work to be done by the profession as a whole, and the individuals that claim membership of it.

6.5 How does this working definition of professional identity compare to the traditional theoretical models of occupational therapy professional identity.

The traditional definition's presented in the first part of this chapter (Mosey 1985, Creek 2003) are theoretical models designed to encompass the complexity of a profession that has a multifaceted epistemological base and works across the vast sectors of healthcare that the National Health Service and private practice provide in the United Kingdom. What this research offers is a working definition taken from a small group of newly qualified staff all working with the same Trust with clients with a variety of mental health issues. The participants had been working between one and five years, and had completed their preceptorship year within the Trust. The research can therefore only offer a small scale working definition of occupational therapy professional identity which it presents in section 6.2. Given the limitations of this study, the definition is surprisingly similar to the literature. Whereas it is not as in depth, or fully formed it does identify some of the same areas as well as adding the concept of socialisation and developing over time (which Creek (2003) hints at in terms of professional experience). It does confirm a multifactorial approach to professional identity and takes into consideration; role, knowledge and skills, philosophy, and continuing professional development and language. This working definition firstly identifies that newly qualified staff do have a professional identity, even if it is not fully formed or robust, but it does also highlight a number of risks to the positivity of professional identity. These risks include generic working, articulation of the role, and possible subgroups, or re-grouping of occupational therapy (with AHP's).

It is with these risks in mind, that we need to consider how preceptorship can influence the development of a professional identity.

6.6 *Doing, Being And Becoming:* The impact of preceptorship on identity

The second part of question two looks at the ways in which preceptorship impacts on the development of professional identity, so now, having defined what the participants mean by professional identity the way preceptorship influences this can be analysed.

The Preceptorship Handbook For Occupational Therapists (Morley 2012) specifically states that preceptorship supports newly qualified practitioners to build their professional identity (Page 5) and as such it is not an unreasonable assumption that preceptorship should, therefore, impact on the ways that professional identity is developed. The *Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals* (DOH 2010) falls short of specifically highlighting professional identity development as an aim of preceptorship, however it does discuss a number of factors that fall within the above umbrella of professional identity such as values, roles, attitudes and socialisation.

Ann Wilcock (1999) writes about *Doing Being and Becoming* and discusses occupation and health in these terms. However, she also relates these concepts to the wider development of the profession. This wider view is one that is also supported by other writers including psychologist Abraham Maslow (2014). Taking Wilcock's lead I relate these concepts to the development of professional identity and discuss how during the preceptorship year these three concepts, *doing being* and *becoming* enable the continued development of a professional identity.

6.6.1 *Doing*: organisational issues

As an occupational therapist *doing* is central to human nature, our profession is founded on the belief that people *do* (Wilcock 1999). Occupational therapists believe that people engage in the purposeful *doing* of tasks and occupations and that this leads to mental and physical well-being. Wilcock (1999) goes on to acknowledge that what people *do* creates and shapes societies in which we live. That what we *do*, is part of our identity is therefore

not surprising. Preceptorship enables the *doing* of the role of occupational therapist in a number of different ways. The data specifically comments on informal and formal support, a structure, documentation, and training. All these areas are ways in which the preceptorship process within the Trust supports the newly qualified therapist in the *doing* of their role.

The documentation forms a large part of the way that the Trust supports preceptorship (Anon 2014b). Based on the KSF core dimensions (NHS Scotland ND) the paperwork identifies skills and competencies that the newly qualified member of staff needs to achieve in order to progress within their career. The documentation enables the preceptor and preceptee to set goals and review them formally on a three monthly basis within the preceptorship year. The paperwork is met with mixed reviews by the participants, P4 describes it as: *"tick boxy"* and others agree that it can be a tick box exercise (P5, 6, 7) whereas P1 found it: "quite generic" and at the extreme P3 found it *"phenomenally difficult".* The comments about the paperwork were not all negative however with P7, feeling that when it had been used effectively it was:

> *"a tool that guides future . . . professional skills"*

P5 and P6 discussed how it had been used to set goals and review, with P5 stating that she: "*knew what my aims were".*

The difficulty with the paperwork appears to be not the format of the paperwork, but the way it is used in practice. P7, for example, had used the paperwork with two different preceptors, the first he considered to be unhelpful as a preceptor and the second he obviously had high regard for. I have already quoted P7 who questioned the consistency of the preceptors and the training they receive and this is yet a further example of this issue. He states, regarding the documentation used in the preceptorship process that:

> *"the second person allows me to really develop further and get some value out of it, that person showed me the value of it"*

P4 picks up on this point, not because she had a negative relationship with her preceptor, but because she recognised that her preceptor was new to the role of being a preceptor.

She raises the issue of the amount of evidence that needed to be collated for each point on the paperwork, stating that they had: "*overzealously evidenced"* aspects of the work. P1 also raises this as an issue stating that she had lacked guidance on:

"the clarity of how much evidence there needs to be".

The learning point raised in the previous chapter about training for the preceptor would therefore also be relevant here. The documentation if used effectively can help support staff in the *doing* of their role, but staff need to be clear about how it should be used in order for it to become an effective professional tool.

The factors around both formal and informal support have also been previously discussed in terms of the experience of preceptorship. It is this support that enables the *doing* of the role, it not only builds confidence, but teamwork allows for the development of professional identity in terms of semblance and difference in professional roles. The threat to this is generic working which has also been previously discussed. It is here that the use of communities of practice (COP) could be useful. Preceptorship support groups in the past have been occupational therapy specific and run along the lines of a COP group. The current preceptorship groups are run across disciplines and have a much more educational focus. P5 reports finding them geared towards nurses and therefore not useful. Given the importance of support, communities of practice groups may be a useful concept when thinking of how to move preceptorship forward.

Within the data, the issue of training was raised and four of the participants had engaged in occupational therapy specific training. Training in this way allowed the participants to feel that they had more understanding of the occupational therapy role and identity.

The structure of preceptorship includes not only the paperwork and the supervision but the placement of individuals within teams. Potential threats to this structure being effective have already been identified in this work as being: moving (or rotating jobs) within the preceptorship year, changing preceptor and generic working. Therefore the way in which newly qualified staff *'do'* is impacted upon by the organisation they work

within, the training offered, the supervision and support structures and the preceptorship structure itself.

6.6.2 *Being*: role modelling.

Wilcock (1999) describes *being* as the process of being true to our nature, as the contemplation and enjoyment of life, being true to what is distinctive about us. In terms of our professional identity *being* means being true to our professional values and this begins with recognising what those values look like in practice. Preceptorship does this through the use of the preceptor, the preceptors' skills and abilities and how these are perceived by the preceptees, otherwise known as role modelling. Wilcock also describes how this process requires time and preceptorship offers a dedicated year to this process. Wilcock (1999) goes on to consider *being* as a fundamental ontological notion, and as such could become part of the ontological security that Giddens discusses as required for reflexivity (Giddens 1991).[25]

Role modelling is an aspect of preceptorship that is highlighted not only in the College of Occupational Therapists handbook (Morley 2012) but also in the Department of Health guidelines (DOH 2010) and describes a way social learning whereby an individual learns how to *be* and how to *do* by watching a more experienced person.

One of the participants, P2, did not experience the role modelling in a way that met her expectations and this caused her some distress. She viewed the woman who had been in the role of the preceptor as being unsupportive and unprofessional. This, despite having a negative impact in terms of her preceptorship appears to have been a reverse role modelling of a sort, one that makes the participant feel they have learnt how not to *be*.

[25] Giddens (1991) states that in order to have a stable identity we need to have ontological security; that is an unconscious sense of continuity in our life events. This ontological security he likens to the phenomenological concept of bracketing, i.e. that we accept a version of reality as true, without further question in order to function. Without this ontological security, Giddens argues that we cannot trust in abstract systems such as health care and would have no confidence in the wider social world and thereby struggle to maintain a continuous reflexive identity.

The experiences of P2 highlight that to be a role model you do not have to be perfect, you do not have to be likeable even and people will learn how to *be*, or how not to *be* from the different aspects of the people around them. P2 learnt "how not to" *be* from the people she considered 'bad'.

Although during the interviews the participants did not specifically talk about the preceptors in terms of role modelling, they did discuss the issues around role modelling including the skills of the preceptor and their relationship with their preceptors. These factors were discussed in both negative and positive terms, with the positive comments being more prevalent. Six participants made 32 comments about positive skills and relationships with the preceptor compared to four participants making 26 comments about the negative skills and relationships. These comments are made directly about the preceptor; however it is also clear from the data that in the preceptorship year learning can occur from watching the wider team at work, and how the team functions can also influence how the role of the occupational therapist is considered within the team. P3 for example states explicitly when talking about teamwork that:

> *"All (the) stuff I learnt on the ward, I think it's all from watching other staff as well, because they are all very skilled."*

Occupational therapists do work primarily within multidisciplinary teams and therefore it is not surprising that other professionals can be seen as role models. P2 describes a team manager, a nurse, whose positive opinion of her is important. When asked if her team acknowledge that she gets good results in her work she replies:

> *"My senior band 7 (a nurse), who is hard as nails, the toughest girl on the block, she does and that means a lot."*

This not only indicates that other professionals can be a role model, but indicates some of the attributes that P2 finds exemplary in others, and aspires to herself, which is the embodiment of role modelling.

It is, therefore, interesting to look at the skills listed by the participants as being positive as these may then also indicate the skills that the participants aspire to. These were: the

preceptors being supportive, directive, articulate, knowledgeable, nurturing, motivating, experienced and approachable. The negative skills, i.e. the ones not aspired to were: lack of interest, not caring, no guidance, not supportive and no experience with the paperwork. These negative skills are nearly the polar opposite of the positive skills mentioned, and give a very clear image of the skills that the preceptees valued in the people who were in the position of role model. Role modelling therefore, positive or negative during the preceptorship stage, can have a positive impact on the development of professional identity by allowing the participants to identify the skills in the staff around them that they either want to develop or avoid in order to develop themselves as professionals.

6.6.3 *Becoming*: reflexivity and a time for growth.

The structure of preceptorship is such that it allows a set time for the newly qualified practitioner to not only reflect and learn but be reflexive about their role. It is this reflexivity that I believe is the unique contribution that preceptorship time can offer in the development of professional identity.

Wilcock (1999) describes this as the concept of *becoming*, working towards self-actualisation, working towards reaching our potential and that *becoming* is essential to occupational therapy being true to its essence and its beliefs To be reflexive is about *being* and *becoming* rather than *doing*. It is about being able to understand ourselves in relation to others and the world around us and is, therefore, an intimate way of beginning to understand our professional roles and values and their limitations and impacts (Bolton 2014). Bolton (2010) also states that the support of a trusted other, in this case, a preceptor, is vital if this process of reflexivity is to be useful.

The sociologist Anthony Giddens (1991) views reflexivity as being a central theme of identity development. He considers that without the reflexive self the identity cannot be fully formed. He refers to the development of self as a reflexive project, indicating that is it something that takes work over a period of time, and that by engaging in reflexivity we can begin to work towards self-actualisation. Gidden's concepts specifically refer to self-identity rather than professional identity but he also applies his concepts to the wider

social systems in which we exist. In what he refers to as the dynamism of modernity he highlights institutional reflexivity, by which he means that individuals do not develop in isolation but the social systems that we function within also develop and change over time.

The data collected from the seven participants supports the claim that reflexivity is a central function of the preceptorship period. The initial coding of the data provided codes that were then themed under the headings of journey and ownership. Between them, these two themes identify the reflexive content of the interviews where the participants reflect on themselves and their growth over time, not only in terms of practical skill but also in confidence, identity and achievement. By considering their place in their environment and the changes they make to fit within it (for example working in the real world and work life balance) they collectively show a sense of reflexivity that enables them to move forward, indeed, to *become*.

The second coding of the data using *a priori* codes allowed me to specifically look for evidence of this reflexivity and seven participants discussed concepts that could be coded in this way. The code of reflexivity collected 55 specific comments made by the participants that showed reflection about a wide range of subjects including considering their personal traits, their previous careers, and the support they received, their role, identity and skills as well as how they fit into a wider picture in society. The depth of scope within this code reflects the import and complexity of reflexivity. The data shows that whilst being reflexive the participants were willing to consider not only what was positive and what had gone well but also subjects where they had to admit to difficulties as well as how things developed and changed over time.

The development aspect is clear when two of the participants reflect on how they would have performed differently in their first roles post qualification, after they had had some experience. P5 does this by reflecting on her role and feeling that she would do the job differently if she were to go back and P2 does this by reflecting on herself and feeling that her lack of assertiveness impacted on the stress of her first role.

There are four participants who reflect in some way about their personal skills. P2 not only talks about her lack of assertiveness, but also about her resilience to cope with what she regards as being a difficult time. P1 is able to reflect on her confidence as developing throughout the year and P7 reflects on his motivation levels and about how occupational therapy as a concept: *"fitted with (him) as a person".* P6 also considers personal traits in terms of how there is a cross over between her work and personal identity, thinking specifically of her role as a brownie leader.

P2 not only reflects on her personal traits and skills within her interview but also considers working for the Trust, in a rural county, and within the current political climate as well, demonstrating that although she is thinking about herself and her own development she is aware of how she fits within the structure of the NHS as a whole. She states:

> *"I'm really aware of what's going on you know politically and economically . . . and I want to be a good representative of the Trust . . . because I'm really passionate about the NHS".*

P7 also demonstrates a wider reflexivity when he considers the holistic nature of the profession and also gender issues, and P4 when she discusses the impact of the MOCA model (Sherwood *et al.* 2015) in her clinical area of work. This consideration of wider concerns hints at the issues developed by Giddens (1991) in terms of institutional reflexivity. As members of the institution of the NHS, staff share a responsibility to reflect and input viewpoints into the organisation in order for the organisation to develop and change over time. By participating in the research interview the newly qualified occupational therapists enable their reflections to be shared to a wider audience and therefore add to the reflexivity of the organisation.

All of the participants take the opportunity to reflect on the support they have been offered either formal or informal with P4 summing up the importance of the formal support within the preceptorship process. Talking about the development of her confidence she states:

> *"I don't think I would have recognised it if those (preceptorship) processes hadn't been there".*

P4 again links the importance of the structure of preceptorship to what is happening within the wider social context stating:

> *"just working full-time alone for the first time is massive you know . . . so in terms of it being a life stage as well most people have got a lot going on and that's why I keep coming back to that structure".*

This reflection on life stage also continues when participants considered previous jobs and careers, and how they entered into occupational therapy. Some like P4 had come straight from school into university but others had been working for a while in related jobs (such as P7 being a social care support worker) or unrelated jobs (like P5 working in a technical sales job). P3 had worked through university as a single mum and reflected on the support needed to start the course, let alone finish it:

> *"and I remember the first day turning up at Uni thinking I can't do this, I can't go in . . . and they had students there, . . . that were already on the courses, . . . if they hadn't of been there I would have gone home".*

All these levels of reflection are linked to the elements of professional identity identified within the research, linking the level of reflexivity shown by the participants with professional identity. The time allowed within the preceptorship year to consider development and skills is unparalleled at any other time within an occupational therapists career. It is the time and the focus on development and reflection that makes the preceptorship period a unique time, one that encourages reflexivity and the start of the process of *becoming* an occupational therapist.

6.7 What does preceptorship not do?

In asking: in what ways does preceptorship impact on professional identity development? I must also consider what it is that preceptorship does not do to aid professional development. What preceptorship does not do is deliver a fully-fledged professional identity within a year. It makes a start on a large number of factors, and indeed I was presently surprised by my data that showed that a sense of professional identity was

definitely present and reasonably strong in the newly qualified staff that I interviewed. However, preceptorship is part of a continuum and professional identity is ever changing and developing with preceptorship playing an important but small part in the process. There does not appear to be any significant areas missing from the identity definition (according to Mosey 1985 and Creek 2003) but there is an impression that some of the nuances are not there, and that for the participants, time and experience will flesh out the basics and allow for further development. The evidence for this lies not within a single quote, but in the variety of experiences and perceptions that flow throughout the whole research data set. That seven people can create so much data suggests that preceptorship is not only experienced differently by all those engaging in the process, but that the development of professional identity is also different for all. The lack of one clear statement about identity or preceptorship gives credence to the notion that preceptorship cannot be seen as a stand-alone answer to how occupational therapists develop identity, or knowledge and skills. Rather it must be viewed as an important step in this development and a time that enables the newly qualified occupational therapist to reflect on their personal journey of professional identity development.

6.8 Conclusions from the analysis and discussion of the second research question.

The second question asked: *In what ways is the preceptorship process perceived as having any influence on the development of professional identity?* It was then answered in two parts, firstly, using *a priori* coding the data was themed to look for evidence of professional identity and this was then identified and discussed in relation to the known and accepted theories in occupational therapy. Secondly, a framework was used to look at how preceptorship had helped develop those areas. Wilcock's (1999) framework of *Doing Being and Becoming* was used, as it is not only well known and respected in occupational therapy but the terminology is also well used in the literature about identity and identity development.

6.8.1 Key learning points.

Firstly the data is consonant with the literature that within the context of occupational therapy professional identity is socially constructed and changeable. There is a concept of a journey of development and that identity changes over time. The journey of

development starts at a point in time where the profession of occupational therapy as a whole has a duty to promote itself. That is before people have signed up for the formal education, at that stage of preformed ideas. This implies that it is the responsibility of each individual occupational therapist to promote themselves and the profession whenever possible, as it would appear that by individuals endorsing occupational therapy as a career, others have been attracted into the profession. Within this journey, it is clear that as the identity of 'occupational therapist' becomes stronger the identity of 'student' must get weaker. The concepts of socialisation are woven throughout the data and are present at all points in the journey of becoming an occupational therapist. They are indicated in the codes and themes used in the data analysis. It includes that social learning is a key component in the learning of an identity and this includes role modelling and learning from peers.

It can be seen that preceptorship brings together a number of key concepts from identity development theory but they are underpinned by the concept of reflexivity. And it is the reflection and reflexion that make preceptorship unique in terms of how professional identity is formed. At no other time in a therapist's career do they have the amount of dedicated time to focus on development. Whether occupational therapy has a positive identity is however still debatable, as the data implies, that this positive concept of occupational therapy from other staff is something that should not be expected, or is not the norm. The data shows a number of reasons for this, some historical (occupational therapists fiddling around with clay P2), some around understanding the role in different areas of healthcare and some about the language used. With regards to the language, I have suggested that it is Goffman's (1959) work that gives us permission to be able to effectively talk to our patients in layman's terms and use a professional script when conversing with our colleagues. I see this ability to be bilingual as a strength of the profession.

6.8.2 Recommendations based on analysis of findings

The socialisation role of preceptorship and its importance in developing professional identity could be formally acknowledged by the Trust, if not the wider NHS. For the Trust, this might include the reintroduction of formal preceptorship groups that are profession

specific in order to allow social learning and role modelling within the bounds of the profession. From a professional perspective, as part of this recognition of the socialisation process, all members of the occupational therapy profession should take personal responsibility for selling the profession, as preformed ideas may play a significant role before occupational therapy is chosen as a career.

Occupational therapy as a whole profession also needs to consider what it means to have not only a strong professional identity but a positive one as well. This research indicates that newly qualified staff do have a professional identity, and that it does develop, and that although they as individuals were positive, they recognised that it was not always seen as positive from outside the profession. Part of this is linked to language and that as a profession we need to acknowledge and embrace the concept of being bi-lingual as a positive facet of our patient care and professionalism.

6.8.3 Conclusions

In conclusion we can see that the data presents a number of ways in which newly qualified staff consider their individual professional identity and that these areas are reflected in the theories around professional identity development and also in the literature around the subject. In can be seen that preceptorship contributes to the development of professional identity, as part of a continuum of development. Its contribution is unique in that it offers a structured time specifically to learn, and be reflexive about that learning, which does not happen in a formal way in the rest of an individual's career.

Conclusion.

7.0 Introduction

The aim of this final chapter is to critique the research and consider its impact, as well as sum up the research findings and areas for further development. It will also outline plans for the dissemination of the findings. Finally, this chapter will consider what this research has added to the understanding of the subject and body of knowledge. Again I am mindful of Paley's rhetoric trap (Paley 2005) and understand that any recommendations or findings are presented for debate and as discussion points, following the collection of data from a small group of participants.

7.1 Critiques and reflections about the research

This project has been carried out as part of a Doctorate in Professional Studies at Staffordshire University, and had to, therefore, pass through the University Ethics Committee as well as through the Trust ethical processes in order to receive approval for its completion. The research proposal was also academically assessed prior to starting the research process. During the undertaking of the research, I have received regular tutorials from a supervisory team from the university. This supervision has included; in-depth discussions about the interviews, the process and content and discussions about the process of thematic analysis and the conclusions made.

The supervisory team have not been involved directly in the coding and therefore the coding has been my own interpretation of the data. This may be considered as a weakness of the research, however, as the data has been discussed thoroughly with the supervisory team all interpretations have been questioned and discussed. As an insider researcher, there is an element of bias, which has been discussed in the methodology chapter. An element of bias is unavoidable in insider research, and although I have taken steps to minimise it, for example not interviewing people that I have been preceptor for, there are times when being an insider researcher has been difficult. For example, participants talked about staff members and places that I knew about and therefore already had preformed ideas and opinions about. This was favourable in one interview where my insider knowledge made me aware of the difficult circumstances in a specific

work environment and unfavourable in others, where I too had a negative opinion of the member of staff being discussed. Therefore this positionality as an insider has, of course, impacted on my interpretation of the data; however, I have tried in the presentation of these interpretations to be explicit when this has been the case. This reflexive nature is the result of the direct influence Van Manen's (1990) work. His methodology has encouraged not only the way the interviews were conducted and themed, but also the inclusion of reflexivity in the writing up of the results. He views the writing up of the research, not only as a way of presenting results, but as a way of theorising and more importantly demonstrating our interest and commitment to the subject. The inclusion of reflexive statements therefore is not only a result of being an insider researcher but a direct attempt to demonstrate my own personal engagement with the research topic and process as a whole.

The data set incorporated seven interviews and therefore any findings must be treated with caution. The research could be further verified if it was to be replicated within other settings. It does provide an insight into how these newly qualified occupational therapy staff experience preceptorship and consider identity issues.

7.1.2 Unintentional impacts on the research participants.

There has been an unintentional impact of completing research within my own workplace. In raising my own profile, and taking on more responsibilities, I also became known to my research participants. Prior to starting this academic course, I personally knew two of the seven people I interviewed, and although this did not change from my point of view, by being keynote speaker at an internal conference meant that all seven participants had some knowledge of me prior to the process starting. Two then attended a course I ran, prior to being interviewed and a further four were involved in courses I ran after they had been interviewed. This does raise the issue of power in a research relationship, and although the research relationship, like the therapeutic relationship, will always have a bias with power being on the side of the researcher (Alvesson, Skoldberg 2009) there must be an added element to this when the researcher is seen as a senior member of staff within the occupational therapy team. Although I have deliberately done all I can to place power back with the participant, in terms of consent, validation,

decisions re time and place to meet up, there is still a balance to the power in the relationship, and my increased profile possibly has unintentionally skewed that even more in my favour (Savin-Baden, Howell-Major 2013).

7.2 Key Learning

The key learning and recommendations from this research can be split into four succinct areas; that of practice, training, research and policy. These areas include not only the learning from both research questions but also the unanswered questions that arise indicating the need for further research.

The research questions asked were: *How do newly qualified staff, who have recently been through preceptorship, experience the preceptorship process?*
And: *In what ways is the preceptorship process perceived as having any influence on the development of professional identity?*

7.2.1 Practice

There are a number of recommendations and learning points that have an impact on professional practice and should further impact on our reflexive understanding of professional identity in practice.

Within the context of occupational therapy, we can agree that professional identity is socially constructed and changeable. This is indicated in a number of the codes and themes used in the data analysis and it is an underlying aspect of identity formation. It is clear that as the identity of 'occupational therapist' becomes stronger, the identity of 'student' must get weaker.

Preceptorship is part of a continuum that moves people forward from student to qualified competent practitioner. This continuum starts at the point of preformed ideas. In this research, the participants described talking to occupational therapists about their jobs before signing up to become a member of the profession. This implies that it is the personal responsibility of each individual occupational therapist to promote themselves

and the profession whenever possible, as by individuals endorsing occupational therapy as a career, others have been attracted into the profession.

Throughout the preceptorship period, it is the reflection and reflexion that make this time unique in terms of how professional identity is formed. At no other time in a therapist's career do they have the amount of dedicated time to focus on development. This time should be supported by experienced therapists as social learning is a key component in the learning of an identity. This includes role modelling and learning from peers.

Reflective practice, goal setting, appropriate training, role modelling and mentorship during preceptorship can be considered as essential to the continued growth of the individual in terms of the development of confidence and skills. All of these areas are recognised in the existing literature as the being benefits of the preceptorship process and preceptorship relationship. This research then validates the existing literature about the benefits of preceptorship and the development of professional identity (DOH 2010, Morley 2012).

7.2.2 Training

There are recommendations regarding training; that is the training of preceptors as well as preceptees. The research corroborates the literature in terms of highlighting the importance of the skills and confidence of the preceptor (Myrick, Yonge 2004), with participants discussing positive and negative aspects of their preceptors skill levels and also their relationship with the preceptors. These qualities of the preceptor listed by the participants include qualities that cannot be taught. This highlights the need for choice in the role. It would, therefore, be recommended that staff should make an active choice about becoming a preceptor.

The need for quality and consistency is highlighted in this research. It is clear from that data that there should be training for the preceptor about the preceptorship process and what is expected; this training should include the use of the paperwork.

For the preceptee any training given in the preceptorship year should be occupational therapy specific and aim to increase professional knowledge and skills. The data showed that this professional training was highly valued by newly qualified staff as they aimed to consolidate their professional knowledge and identity.

7.2.3 Policy

I use the word policy here to refer to the way the preceptorship programme is delivered within the Trust in which the research was carried out. Although the programme that is currently delivered is successful there are changes that could be made that would enhance the experience for all those involved in the process. They are presented here as suggested guidelines for best practice:

Staff in the preceptorship year should not rotate posts until preceptorship is complete. Although the split preceptorship post cannot be regarded as intrinsically negative, this research cannot support it as a positive experience. If preceptorship has to be split for some reason, the same preceptor should be retained if possible; if not a formal handover should be considered.

All preceptors should have received appropriate training, prior to taking on a preceptee and actively choose to take on the role. The data found that there was no consistency or clarity in how the documentation is used, the amount of evidence that is expected and how the preceptors approach the process. The research data actually infers that the documentation was not in itself poorly written, but that the guidelines around its use were a significant issue.

Placement of newly qualified staff should be carefully considered and be in appropriate teams that give priority to occupational therapy specific work rather than generic working. The data shows that clarity of role is an area that some of the participants found difficult, and that staff that worked in teams with more defined roles found this easier.

Supportive groups or communities of practice should be reinstated in order to support newly qualified occupational therapy staff, and new preceptors. Formal support was

received by the participants generally in a positive light, but they raised issues of consistency and quality and also appropriateness for preceptorship groups that are multi-disciplinary. These formal preceptorship groups should be profession specific in order to allow social learning and role modelling within the bounds of the profession.

7.2.4 Research

The need for further research is indicated thought out this body of work. Questions that could be asked include:

Are there differences in the professional identities of occupational therapy staff that work in different aspects of health care? Do we have sub groups?

How, if at all is professional identity impacted on by being seen as allied health professional rather than an occupational therapist?

How is occupational therapy perceived by other professions and does this relate to positive professional identity?

Are there gender issues that need to be considered in occupational therapy education or practice?

How do we teach emotional resilience?

There is the ongoing issue of the articulation of our role, do we need to consider ourselves as a bilingual profession, and would this help or hinder issues of professionalism? Jennifer Creek in a personal conversation stated that she felt we were bilingual by accident, and whereas I would refute this, it is an area that could yield numerous opportunities for further research and comment.

There is also an opportunity to take this work further. Mary Morley, again in personal conversation, considers the concept of ‘preceptorship plus’, i.e. a time of further support when therapists move into new positions (either banding or client group). This is an area of research and innovation in practice that is exciting and useful and was raised by one participant as being something that would be valued.

Lastly, in terms of further research, the data implies that a positive identity in occupational therapy is still debatable. Therefore occupational therapy, as a whole

profession, needs to continue to work towards a positive identity. How we go about that and how that can be successful needs to be considered by the professional body as well as its individual members.

7.3. Plans for the dissemination of research findings.

At the time of writing, I am in the process of submitting abstracts to different occupational therapy conferences in order to present these findings. I will aim to have been successful in presenting the findings to the Trust in which the research has been carried out, and at least one other conference prior to this thesis being formally marked. These presentations will be offered as opportunities to discuss the emerging research findings so as not to misrepresent the academic quality of the work.

Following recognition of this thesis as being acceptable for the academic award board, I will seek to submit written papers to profession specific journals.

7.4 What has this research added to the body of knowledge?

This research validates existing literature about the benefits of preceptorship and the development of professional identity. It adds both practical and academic insights into how the preceptorship process enables the development of professional identity.

The research introduces some practical considerations for best practice guidelines for the Trust and its implementation of preceptorship. It offers a more robust understanding of the role of preceptorship in the development of professional identity.

The research recognises the importance of multiple ways of learning how to be an occupational therapist, and the importance of professional identity to the continuation of the profession and the responsibility of each individual practitioner in this.

Importantly the research states that the unique contribution of preceptorship in the development of professional identity is the space and time it offers for reflection and reflexivity.

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Appendices.

Appendix One: Ethics submission form and approval letters

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STAFFORDSHIRE UNIVERSITY

Faculty of Health Sciences

Application for Ethical Approval of Research Project

Applicant's Checklist

Before submitting the application, please tick to confirm that each of the following has been included with the application. If the relevant elements have not been completed or included, the application will be returned for their inclusion. Please note that if the Committee agenda is full, applications will be considered at the next available meeting.

Name of Researcher: Gemma Styles Student Registration No: sv002250	
Document	**Enclosed**
University Ethics form ▪ 2 **COMPLETE** paper copies including all appendices etc. **Single sided. Single spaced When collating documents please do not staple as they may need to be photocopied** ▪ 1 electronic copy – please send as a **SINGLE** document including **All Appendices Etc.** Self Addressed Envelope	☐Yes **Emailed to healthsciencesethics@staffs.ac.uk** ☐Yes ☐Yes
Signatures: ▪ Of researcher ▪ Of supervisor or head of Unit (e.g. of Programme Area)	x☐Yes ☐Yes
Risk Assessment	☐Yes x☐N/A
Participant Information Sheet/s *(language appropriate to the recipient*	x☐Yes ☐N/A
Participant Consent form/s *(language appropriate to the recipient*	x☐Yes ☐N/A
Letter/s of invitation to participants *(language appropriate to the recipient*	x☐Yes ☐N/A
Interview schedule/s	x☐Yes ☐N/A
Questionnaire/s	☐Yes x☐N/A
Letters giving permission for access to participants or confirming that full LREC ethical approval is not required.	☐Yes ☐N/A
Other relevant information e.g. participant questionnaires, tests, product information	☐Yes x☐N/A

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APPLICATION FOR ETHICAL APPROVAL OF RESEARCH PROJECT

This form must be completed by the researcher. The completed form should then be e-mailed (adding appendices etc., to form one single document) to healthsciencesethics@staffs.ac.uk and 3 hard copies and a self addressed envelope with the appropriate signatures sent to Helen Sutton, Faculty of Health Sciences, Blackheath Lane, Stafford, ST18 0AD **for Stafford Committee meetings and** Natalie Lowndes, Faculty of Health Sciences, Science Centre, Stoke-on-Trent for **Stoke Committee Meetings**. (Please see timetable of submission dates on Faculty Ethics web site (http://www.staffs.ac.uk/academic_depts/health/research/ethics/index.jsp) Proposals for staff research projects that require ethical approval are also considered by this Panel.

Applicants are invited to attend the Ethics Panel meeting. Please email healthsciencesethics@staffs.ac.uk. for a time of attendance.

It is essential that you attach subject information sheets (letters), informed consent forms and any **instruments** to be used.

1. RESEARCHER

Name and Student No (if appropriate): Gemma Styles SV002250

Address: 15 Exeter Drive , Wellington, Telford TF1 3PR

Faculty: Health Sciences

Award: Doctorate In Professional Studies

Supervisor/ Head of Field :Peter Kevern

Academic status of applicant: Doctoral Student

Commencement and expected duration of project**: January 2017**

2. RESEARCH PROJECT

Title: *"Developing professional identity in occupational therapy: a phenomenological study of newly qualified staff and their experiences in the preceptorship period."*

Please offer a brief paragraph indicating answers to the following questions where relevant:

- *Where the research is to be carried out;*
- *Whether adequate facilities are in place enabling the project to be properly carried out;*
- *Whether procedures are in place given the occurrence of any adverse event;*
- *Names of other individuals or organisations involved in the project;*

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- *Whether other approvals have been gained or are to be sought.*

The research is intended to be carried out within the confines of the organisation known as South Staffordshire and Shropshire Healthcare Foundation NHS Trust. There are few facilities required, namely a room to interview people. Recording device and computer facilities are the candidates own. Consent forms will be signed by participants that include circumstances where a breach in confidentiality may be required. The Trust need to give research and development approval, but this can only be sought once ethical approval from the university is gained

3. PURPOSE OF RESEARCH PROJECT

Please offer a brief paragraph indicating:
1. *The aims and objectives of the project;*
2. *Its rationale;*
3. *The research question or specific hypotheses to be tested;*
4. *The background to the project.*

Aims of the investigation
The overall aim of research is to explore the experiences of newly qualified occupational therapy staff with reference to professional identity and the role of the preceptorship year in developing this.
The research questions are:
- How do newly qualified staff, who have recently been through preceptorship, experience the preceptorship process?
- Is the preceptorship process perceived as having any influence on the development of professional identity?

Context of the investigation
There are two distinct political themes guiding the NHS at the current time, one of austerity and one of quality.
Agenda For Change (Department of Health. 2005a) and the financial austerity of the time has created a backdrop where occupational therapists are in danger of being reduced in number and re-graded which has implications for supervision, mentorship, preceptorship, the development of the profession, and general learning. Documents that follow Agenda For Change, such as the national quality commission skill mix document (National Quality Board 2013) and department of health papers, High Quality Work Force and Closing The Gap (Department of Health 2014a, Department of health 2008) also deal with these issues and there is a risk that traditional occupational therapy roles, along with those of other health professions, will be in future carried out by unqualified, and cheaper staff.
The issue of quality is one that is initially raised in the disturbing Francis Report (Francis 2013). The repercussions of its 290 recommendations will be felt in the NHS for years to come, however its impact for patient dignity and safety will be positive. It leaves in its wake a thread, that moves through the subsequent policies that seek to put its recommendations into practice, of transparency, candour, patient centeredness, professionalism and responsibility (Department of Health 2014b, Department of Health 2013, National Advisory Group on the safety of patients in England. 2013, NHS England 2014).
This current political climate means it is more important than ever to be able to articulate as a profession, who we are, what we do, our unique skills and the added value of our profession, the ability to do this is intrinsically linked to professional identity. Wilcock (2000) feels that a strong identity can start with language, a concept that the College of

Occupational Therapists developed with their paper Recovering Ordinary Lives (College of Occupational Therapists. 2006). Jennifer Creek's work on defining the profession, not only recognised its complexity, and began to raise the issues of the use of language in the profession but also gave a working definition of professional identity for the profession to move forward with (Creek 2003).
Morley's (2012) definition of preceptorship includes that it is there in part to support the ongoing development of professional identity in newly qualified staff. The Preceptorship Framework (Department of Health 2010) focuses on the benefits of preceptorship to both staff and the employer, these are listed as being for the newly qualified worker; increased confidence, professional socialisation into the work environment, job satisfaction, feeling valued, taking personal responsibility for commitment and knowledge, and for the employer; enhanced quality of patient care and experience, better recruitment and retention, reduced absence and sickness and an ability to identity staff who may need support. Prior to her 2012 handbook Morley emphasises the need in the preceptorship process to work with experienced staff in order to learn skills and knowledge from them (Morley 2007b). The need to work with role models has also been linked to the development of professional identity, with Clarke and Martin et al (2014) claiming that you cannot develop professional identity without having a good role model to learn from.
The benefits to having a strong professional identity are well documented in the literature and reflect the benefits of the preceptorship process designed, amongst other things, to support it. They include more confident and competent staff (Holland, Middleton et al 2012a), increased retention (Wright 2001), decreased likelihood of stress and burnout (Edwards and Dirette 2010), a clarity in the definition of roles and core skills (Von Zweck 2008) and more effective teamwork (Wakefield, Boggis et al 2006, Hallin, Kiessling et al 2009) and a clear articulation of the profession as a whole (Molyneux 2001, Russells 2014). The work of Crossley and Vivekananda-Schmidt (2009) regards having a professional identity is a pre requisite for accepting the responsibilities and obligations of a profession.

NB. It is not the job of the Faculty Research Ethics Committee to consider the methodology of the research project. However this Committee does need assurance that the appropriate methodology has been properly considered before it can consider whether the project is ethically justifiable.

4. BRIEF OUTLINE OF PROJECT

Please offer a <u>summary</u> of the procedures it is proposed to follow in carrying out the project. Such descriptions might vary according to the nature of the project and the academic area involved, but they should normally include at least the following:

1. *The design of the project (including, where appropriate, issues of statistical power);*
2. *The procedures to be followed;*
3. *The participation of subjects in the project;*
4. *How the design of the project and the procedures followed are likely to assess the research question or test the hypothesis in question or establish some significant result.*

Theoretical basis
To study such a complex profession I have chosen a phenomenological framework. Phenomenology seeks to explain how we experience what we do, and is concerned with the experience rather the search for absolute truth and is intrinsically linked to self (Howell 2013, Fulford, Thornton et al 2006). Phenomenology gives insight into how I as a researcher seek to understand the truth about professional identity in occupational therapy.

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I will draw on the work of Max Van Manen. His book *Researching the Lived Experience* is written in order to be a practical guide to research rather than a purely theoretical work (Van Manen 1990). Van Manen has the same epistemological grounding as Heidegger; he is particularly interested in the lived experience rather than the absolute truth and also observes that phenomenological engagement is always personal. Opportunistic complete member research includes sharing a world view with the members of the group that is being researched as well having a genuine commitment to the group. The research role is mainly overt; however Adler and Adler (1987) recognise that researchers in this position often have to create a research role or space for themselves and that the role of researcher may well change their position, status and condition of pre-existing relationships within the group. In short there will be a period of transformation for the researcher, in terms of their ongoing relationship to the group. I have been able to negotiate with my work place for space and time in order to 'be' a researcher during the data collection process. This will allow me to fully consider the issues of bias that the context of phenomenological engagement by its very nature includes and give them full attention in the process of data analysis (Hellawell 2006).
Van Manen's work is written from a pedagogical stance and although I am not researching pedagogy in particular Van Manen does state his work is relevant to nursing and other such professions (p1) and preceptorship is referred to as using adult learning methods within the preceptorship policy of the Trust (Anon. 2014), and pedagogy is strongly associated with continuing professional development (Morley 2007a).
By using Phenomenology in this research, the complex epistemology of the profession can be reduced to the individuals understanding of what about the profession is important to them. Each individual will be influenced by a number of factors that have shaped their experiences within the preceptorship year and a phenomenological approach will allow individuals to determine and examine these factors for themselves.

Methods of investigation
Interviewees will be invited to take part in a recorded interview that will last approximately an hour and be held in a time and place to suit them. The Interview question is:
I'm interested in all of your thoughts about your experiences in the whole of the preceptorship process and also how it helped you to develop your professional identity as an occupational therapist. From the time you started until you finished that first year. Anything that you want to talk about, anything that stands out for you or that you see as being important or interesting is of value to me. Can you talk me through your experiences? This takes the form of a 'grand tour' question designed to elicit experiences

After interview data collection has taken place the interviews will be transcribed using the standard transcript conventions as outlined in Flick (2009 p300-301). I will complete this process myself so as to immerse myself in the raw data (Phillips, Pugh 2010). This data will then be kept in anonymised form on a password protected computer, with the original recording being deleted as soon as the interview data is securely stored.
In order to analyse the interview data I will use a thematic coding technique. I will utilise the work of Guest and MacQueen et al (2012) who's book Applied Thematic Analysis is congruent with Van Manen's work but also a helpful 'how to' guide for a novice researcher. Thematic analysis is described by Braun and Clarke (2006) as a stand-alone research technique and Guest and MacQueen et al claim it as an inductive analysis technique for qualitative data.

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5. RECRUITMENT OF SUBJECTS

This section should contain clear information indicating the basis on which the proposed participating subjects are appropriate to the project. Normally researchers should adequately answer the following questions:

1. *The number of subjects involved in the study (including the adequacy of the sample size) and how it is proposed to recruit them;*
2. *Whether there are any inclusion or exclusion criteria, together with their justification;*
3. *The age range of subjects; the gender balance of subjects; and the state of health of subjects;*
4. *Whether there is any inducement to participate in the study;*
5. *Whether the project involves any special groups requiring some additional justification or permission (e.g. whether subjects are especially vulnerable, i.e. children, students, the elderly, those with learning difficulties or mental health problems, those with some disadvantage or dependency, those in hospital or those in prison).*

I intend to invite to interview band five occupational therapists who have been through the preceptorship process within the last four years, Access to the sample population is facilitated through a number of mediums, firstly I have the implied support of the Trust, as they are funding my studies, this is not yet formalised by research and development approval which will be sought after I have gained ethical approval from the University. Secondly, I have direct support from the Head AHP within the Trust, who has given me an opportunity to speak at a Trust event to promote my research. As an 'insider' researcher I also have direct access to individual's, teams and managers within the Trust, and flexibility from my own manager to allow research time. Exclusion criteria are anyone who I have been preceptor for, anyone whom I currently manager, and anyone who did not complete their preceptorship within the Trust. There are no exclusion criteria based on age or gender or disability.

At any one time in the Trust there are approximately 12 staff in a band five rotation post and at least two other substantive posts that are at band five level. Firstly, an up to date list of staff in post will need to be acquired before research participation is sought, and management approval for these staff to partake in research needs to be gained prior to asking staff to volunteer. The sample size is likely to be small, as not all staff will either be eligible or agreeable to being involved, however this is not considered an issue in phenomenological study as a small number of in- depth interviews are preferable to large scale data that is not as rich in content (Smith, Flowers et al 2009).

Other information regarding the participants will be asked, including gender, age at the point of preceptorship and if they had any prior career before commencing occupational therapy training. The purpose of the last question is to allow Holland's Trait theory (Holland 1985)) to be applied to mature students.

There will be no inducement to be involved with the study, and no vulnerable groups are involved.

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6. Participation of Subjects

Please provide two documents. These are an Information Sheet and a Consent Form, and each should be attached to your application. The first must ensure that the subject has a proper understanding of their participation in the project, and the second that they have given informed and voluntary consent to their involvement in it. Some notes for guidance follow.

INFORMATION SHEET

This will be provided to the subject prior to taking consent, and must explain the broad purpose of the project, the basis on which the subject has been chosen, what is required of the subject in the project, whether there are any possible disadvantages or risks in taking part, the benefits gained by taking part (either to the subject, the researcher or the scientific community), what will happen if something goes wrong, what happens to any information obtained about the subject, the expected results of the study, who is responsible for it, and a contact name. The Information Sheet must be written in a clear, informative, and intelligible way.

The Information Sheet must include a description of how subjects are involved in each stage of the study. This should relate back to §4 above. Their participation will vary according to the nature of the project, but will explain what is required of each subject (i.e. what kinds of measurements or observations will be undertaken, and by what means) and especially those that involve some risk or discomfort or which have other ethical implications (i.e. administration of substances, sampling of bodily fluids or tissue, or placebo or control groups, or genetic information).

CONSENT FORM

A properly designed Consent Form must also be attached to this application. It should include [a] the title of the research project as in Section 2 above, [b] opportunity for confirmation by the subject that they have read and understood the Information Sheet (see above) and have been able to ask questions, [c] that their involvement is voluntary and that they have the right to withdraw at any time without providing reasons and without their rights being affected, and [d] that they understand that personal information about them may be looked at by researchers or other responsible individuals.

The Consent Form should indicate how individual informed and voluntary consent will be obtained. Sometimes (as in the case of Question 5 in §5 above) it will be necessary to indicate how parental or guardian agreement will be obtained.

The Consent Form must include space for properly dated signatures of the subject that they agree to participate in the project, together with the names of the person taking consent and/or the researcher.

7. Information and Data

The application must contain a clear statement of what information will be collected about each subject, the data obtained as part of the procedures described in §4, how it is proposed the data will be stored, how the data contributes to the project, together with a statement of how long it will be stored and how eventually discarded.

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Please offer answers to the following questions:

1. *What information about the subject do you wish her or him to disclose to you in order for the project to commence?*
2. *What data will be gained about the subject in the various stages of the project?*
3. *What form does this data take (measurements, observations, audio/video tape recording)?*
4. *How will this data be stored (manually or electronically)?*
5. *How is protection given to the subject (e.g. by being made anonymous through coding and with a subject identifier code being kept separately and securely)?*
6. *What assurance will be given to the subject about the confidentiality of this data and the security of its storage?*
7. *Is assurance given to the subject that they cannot be identified from any publication or dissemination of the results of the project?*
8. *Who will have access to this data, and for what purposes?*
9. *How is the data relevant to the project and the determination of its results?*
10. *How will the data be stored, for how long, and how will it be discarded?*

1. Information collected about the individual will be Gender, Age at preceptorship and any prior career to becoming an Occupational therapist. Participants can refuse to give information.
2. Data will be collected during the interview and will include the participant's views and opinions about the preceptorship process.
3. This data will be collected on an password protected digital recorder and then transcribed onto a password protected computer and memory stick. Once the data is secured on the computer it will be deleted from the digital recorder.
4. Encrypted memory sticks, transcripts and any other data will be stored in a secure cupboard when not in use and the digital recorder will only be carried by the investigator to and from interviews and will be kept securely at all other times.
5. None of the participants will be identified by name or work place and pseudonyms will be used on all stored material.
6/7. Participants will sign a confidentiality form that advises that information is anonymous and confidential.
8. Data will be accessible by the Chief investigator and the supervisory team if needed for the purpose of analysing and theming raw data in order to answer the research questions.
9. See above
10. Data, including original transcripts will be kept on two memory sticks, kept securely for a period of Ten years in accordance with the University Code of Practice.

8. RISK, HARM AND OTHER ETHICAL CONSIDERATIONS

This final section invites an estimate by the researcher of the perceived benefits or outcomes of the project weighed against the possible harms caused to the participating subject. Please submit two brief paragraphs. The first should identify both [a] any potential risks or hazards that might be caused to subjects or the researcher, in addition to any discomfort, distress or inconvenience to them, together with any ethical problems or considerations that the researcher considers to be important or difficult in the proposed project; and [b] offer an explanation of how it is proposed to deal with them, along with any justificatory statements.

It is not envisaged that there is any risk to the researcher as all interviews will take place on Trust property with Trust staff. There may be a small risk that participants will disclose information which is in breach of the professional code of conduct, and this is specifically mentioned in the consent form. Also information about counselling and complaints

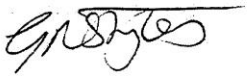
procedures will be given at the interview. I have excluded from the participation group anyone for who I have been the preceptor and anyone whom I currently line manage/supervise. I am not in a management position within the trust so these exclusion criteria should prevent any related ethical difficulties arising.

The second paragraph provides an opportunity for the researcher to highlight any remaining ethical considerations and to respond to them in a way which may assist the Research Ethics Committee in arriving at some judgement upon the proposal. This second paragraph is not an invitation to take on the work of the Committee, but rather emphasises the expectation that both researcher and Committee share the responsibility for assuring that the proposed research will be carried out ethically and with full regard to ethical principles.

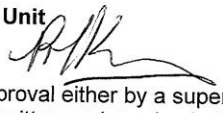
I have worked for the Trust (in its different configurations) for 18years so there is an issue of Bias to be considered. I have identified that these biases include my own education, my knowledge of other occupational therapists, my personal relationships with other senior occupational therapists, and my experience of working in different areas of the NHS Trust as well as my own professional identity as an occupational therapist. There is also potential that the participants in the research may also have their own bias in reference to me, either from personal relationship with me, or knowledge of my work or even gossip within the workplace. It is important that each of these issues are analysed in terms of their potential effects on the research process and how they may affect my analysis of the data and that they are sufficiently acknowledged within the academic arena.

9. SIGNATURES OF RELEVANT PERSONS

I undertake to carry out the project described above in accordance with ethical principles. I have completed the application in good faith. I accept that providing false information constitutes scientific fraud and will be subject to appropriate disciplinary procedures.

Signature of Researcher  **Date** 10/9/14

I have examined this proposal, confirm that the rationale and methodology is appropriate and that it can proceed to the stage of ethical consideration.

Signature of Supervisor or relevant Head of Unit  **Date** 10/9/14

This research proposal has received ethical approval either by a supervisor on behalf of the Committee or has been considered by the Committee and received ethical approval.

Signature of Chair of Faculty Research Ethics Committee **Date**

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a

ETHICAL APPROVAL FEEDBACK

Researcher name:	Gemma Styles
Title of Study:	Developing professional identity in occupational therapy: a phenomenological study of newly qualified staff and their experiences in the preceptorship period.
Award Pathway:	
Status of approval:	Approved

Action now needed:

Your project proposal has now been approved by the Faculty's Ethics Panel and you may now commence the implementation phase of your study. You do not need to approach the Local Research Ethics Committee. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

Comments for your consideration:

Thank you for addressing the committee's comments. There are a couple of things we would strongly recommend:

Remove your home address and home telephone number from the information sheet and just use your email address. I have made the changes to the info sheet (attached) so you can see what I mean.
A document has just been circulated concerning working off campus – there are important data protection implications that you will need to familiarise yourself with since you are keeping the data at home (see attached).

Signed: Professor Karen Rodham
Chair of the Faculty of Health Sciences Ethics Panel

Date: 31st October 2014

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

A Keele University Teaching Trust

R&D Department
Block 7
St George's Hospital
Corporation Street
STAFFORD ST16 3AG

Telephone: 01785 221168

Our Ref: AB/R342

Date 15 January 2015

Ms Gemma Styles
15 Exeter Drive
Wellington
Telford
TF1 3PR

Dear Gemma

Study title: Developing professional identity in occupational therapy

We have considered your application for access to patients and staff from within this Trust in connection with the above study.

On behalf of the Trust and the Responsible Care Professionals within the Directorate have now satisfied themselves that the requirements for Research Governance, both Nationally and Locally, have been met and are happy to give approval for this study to take place in the Trust, with the following provisos:

- That all researchers coming into the Trust have been issued with either a letter of access or honorary contract by ourselves
- That you conform to the requirements laid out in the letters from the University Ethics dated 4 December 2014 which prohibits any changes to the agreed protocol
- That you keep the Trust informed about the progress of the project at 6 monthly intervals
- If at any time details relating to the research project or researcher change, the R&D department must be informed.

Your research has been entered into the Trust database and will appear on the Trust website.

As part of the Research Governance framework it is important that the Trust are notified as to the outcome of your research and as such we will request feedback once the research has finished along with details of dissemination of your findings. You will be asked to provide a copy of the final report and receive an invitation to present final feedback via our research seminar series. To aid dissemination of findings, copies of final reports are placed on our Trust Website. To this end, please contact me towards the completion of the project to discuss the dissemination of findings across the Trust and a possible implementation plan.

If I can help in any other way please do not hesitate to contact me.

Yours sincerely

[redacted]

R&D Manager

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

A Keele University Teaching Trust

Allied Health Professions
Trust Headquarters
Mellor House
St George's Hospital
Corporation Street
Stafford
ST16 3SR

Tel: 01785 221430
Fax: 01785 221165

4 November 2014

Gemma Styles
Occupational Therapist
Diamond Jubilee House
Doseley Road North
Dawley
TF4 3AL

Dear Gemma

Re: Research Project "Developing professional identity in Occupational Therapy: a phenomenological study of newly qualified staff and their experiences in the preceptorship period"

As Professional Lead for Allied Health Professionals within South Staffordshire and Shropshire Healthcare Foundation NHS Trust, I give permission for you to approach specific Occupational Therapy staff to engage in your research. I am aware that your criteria for inclusion in this study is Band 5 Occupational Therapy staff that have been through the Preceptorship process within this Trust in the last four years and that you plan to exclude anyone that you have been preceptor for or are currently managing in order to address potential ethical issues raised by this.

I understand from you that:

1. Staff involvement will include one recorded interview that will take place in their work place at a time convenient to them and their working day.

2. Staff will have access to information sheets and signed consent forms that give details about confidentiality, and that they will be given information regarding how to make complaints and counselling services if required.

3. Recorded interview data will be transcribed anonymously and stored on password protected computer and memory sticks that are stored by you in a secure location.

4. This data will be accessed by you and, if required, your supervisory team at Staffordshire University, in order to aid analysis.

As this study is being conducted as part of your Doctorate in Professional Studies you advised me it will be disseminated at a local and national level and that the participants are made aware of this.

You informed me ethical approval from Staffordshire University was gained on 31st October 2014.

As a result of the above Gemma, I am delighted to give managerial and professional support for your involvement of Occupational Therapy staff in this research project, and I wish you every success with the completion of your studies.

Yours sincerely

[redacted]

Allied Health Professions Lead

Appendix Two: Participant pack

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

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STAFFORDSHIRE UNIVERSITY

1st March 2015

Dear colleague

Re: an invitation to be involved in a research study:

Developing professional identity in occupational therapy: a phenomenological study of newly qualified staff and their experiences in the preceptorship period.

I am a band six Occupational Therapist working for South Staffordshire and Shropshire Healthcare Foundation NHS Trust. I am currently undertaking a piece of research as part of my doctoral studies at Staffordshire University

I would like to invite you to take part in the above research project. In order to participate you should be a band five occupational therapist who has been through the preceptorship process in the last four years within this Trust.

Enclosed with this letter are an information sheet and a consent form, if you meet the qualification criteria and if you are happy to go ahead with the study please sign the form and return it to the above address or email.

I will then contact you to arrange a suitable time to come and speak with you.

Thank You

Yours sincerely

Gemma Styles

Occupational Therapist

Doctoral Student.

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

A Keele University Teaching Trust

STAFFORDSHIRE UNIVERSITY

Participant Information Sheet

I am a band six Occupational Therapist working for South Staffordshire and Shropshire Healthcare Foundation NHS Trust. I am currently undertaking a piece of research as part of my doctoral studies at Staffordshire University. I would like to invite you to take part in the research study. Before you decide, please take time to read the following information and talk to others about the study if you wish.

Study title

Developing professional identity in occupational therapy: a phenomenological study of newly qualified staff and their experiences in the preceptorship period.

What is the purpose of the study?

The overall aim of research is to explore the experiences of newly qualified occupational therapy staff with reference to professional identity and the role of the preceptorship year in developing this.
This study forms part of the Doctorate of Professional Studies currently being undertaken with Staffordshire University.

Why have you been chosen?

You have been selected to take part in this study because you are a Band Five Occupational Therapist, who has undertaken their preceptorship year within the Trust, in the last four years.

Do you have to take part?

It is up to you whether or not to take part, if you do, you will be given this information sheet to keep and be asked to sign a consent form. You are free to withdraw at any time, without any repercussions for your own professional life, and without giving a reason.

What will happen to you if you take part?

If you choose to take part, I will contact you to make arrangements so that we can meet for an interview. I anticipate that we will need to meet for between one and one and a half hours. We can meet at your workplace at a time convenient to you.

What do I have to do?

We will only meet for one interview, during which I will ask you to talk about the aspects of preceptorship that are important to you. Following the interview I will transcribe the conversation verbatim and this transcript will be returned to you in order for you to confirm that the transcript is a true representation of our conversation.

What will happen to the information that is provided during the interview?

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All interviews will be anonymous. The interview will be transcribed without anyone's name and only pseudonyms will appear on the recording or its transcripts.
The transcribed conversation and any publication associated with this study will not contain your name, although some of your words may be included in these reports. All audio recordings will be destroyed once interviews are transcribed.

What are the possible benefits of taking part?

There is no direct benefit to you taking part in this study; however, I anticipate that the findings will add to the professions understanding of preceptorship as well as to the Trust's practice of preceptorship in the future.

What happens when the research study stops?

After the interviews are completed, the research will be written up into a thesis format for submission to Staffordshire University as part of a degree award.

What if there is a problem or you need advice?

If you need to contact someone regarding this research, please contact myself, the researcher on sv002250@student.staffs.ac.uk or ring 07800 992366.

If you have any complaint about the way you have been dealt with during the study you may alternatively contact my research supervisor, Peter Kevern at Staffordshire University (p.kevern@staffs.ac.uk or 01785 353766).

Will my taking part in this study be kept confidential?

Your participation in this study will remain confidential. Some of your words may be used as quotations in the final write up of the study but you will not be identifiable. This is normal for this type of study.

What will happen to the results of the research study?

The results of the study will be formally presented for the award of Doctorate of Professional Studies (Staffordshire University). I would also anticipate that some parts of this work will be presented for publication in relevant journals and at conferences.
You will not be identified in any report / publication. If you decide to take part, I will ask you if you wish to be sent a copy of the paper or a summary of the results on conclusion of the research.

Who is organising and funding the research?

This research is being organised and undertaken by myself. I am in receipt of funding from South Staffordshire and Shropshire NHS Healthcare NHS Trust.

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Who has reviewed the study?

Prior to any work being undertaken this study has been reviewed by the Faculty Ethics Committee, Faculty of Health Sciences, Staffordshire University, and the Research and Development Department of South Staffordshire and Shropshire NHS Healthcare NHS Trust.

Thank you for considering taking part in the study and taking the time to read this information sheet.

If you are interested in taking part, please contact me using the following email address: sv002250@student.staffs.ac.uk

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CONSENT FORM

Title of Project: Developing professional identity in occupational therapy: a phenomenological study of newly qualified staff and their experiences in the preceptorship period.

Name of Researcher: Gemma Styles

Please initial all boxes

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that there is no compulsion for me to participate in this research project and, if I do choose to participate, I may at any stage, withdraw my participation without giving a reason. ☐

I have the right to refuse permission for the publication of any information about me Any information which I give will be used solely for the purposes of this research project, This may include publications ☐

If applicable, the information, which I give, may be shared between the researcher and supervisors of this project in an anonymized form ☐

All information I give will be treated as confidential, unless there is a violation of the professional code of conduct (college of Occupational Therapists 2010) noted then confidentially must be breached. ☐

I agree to take part in the above study. ☐

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_____	_____	_____
Name of Participant	Date	Signature

(One copy of this form will be kept by the participant; a second copy will be kept by the researcher(s)

Data Protection Act: Under the Data Protection Act 1998. The information you provide will be used for research purposes and will be processed in accordance with the University's registration and current data protection legislation. Data will be confidential to the researcher(s) and will not be disclosed to any unauthorised third parties without further agreement by the participant. Reports based on the data will be in anonymised form. Data will be stored in an anonymised, secure format for ten years.

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CONSENT FORM: transcriptions.

Title of Study: Developing professional identity in occupational therapy: a phenomenological study of newly qualified staff and their experiences in the preceptorship period.

Name of Researcher: Gemma Styles

Participant number: …..

1. I confirm that I have read the interview transcript dated …….. ☐

2. I confirm that I have been offered the opportunity to make amendments to the transcript. ☐

3. I confirm that the transcript is an accurate record of the interview. ☐

4. I understand that anonymous direct quotes from the interview may be used in the study report and subsequent publications. ☐

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Name of Participant	Date	Signature
Name of Researcher	Date	Signature

Appendix Three: Code books and definition of themes

Table 4 Code Book (emerging codes)

Name	Definition	Sources	References
Prior to OT	Any reference to work done before OT training actual or planned.	7	16
Formal support positive	Reference to formal support structures given in the preceptorship process, supervision, preceptorship groups of a positive nature.	6	25
Documentation	Reference to preceptorship documentation.	6	28
OT and nurse	Specific references to the relationship and or differences between OT and nursing.	4	16
Relationship with preceptor	Reference to specific relationship issues between the preceptor and preceptee.	6	10
Skills of preceptor positive	Reference to skills attitudes, attributes or experience of the preceptor.	6	22
Informal support positive	Reference to informal support mechanisms outside of supervision and preceptorship arrangements positive.	6	15
Confidence	Any reference to the concept of confidence, development of, feeling of change in confidence of the participant.	6	30
Training	Any reference to training carried out within the preceptorship period, or views about training within this period.	5	18
Daunting	References to feelings of fear or apprehension. Overwhelming re workplace.	5	16
Role	Any discussion of the role of OT.	5	22
Defining and describing OT	How participants describe what they do and define their job to those either within or outside of healthcare.	7	41
Journey growth	Any reference to the concept of development over time, a journey, growth in skills confidence or competence.	7	22
The real world	In reference to people perceiving practice differently to being a student, or being at Uni, or on placement.	4	11
Evidence	Discussion of evidence needed for the preceptorship paperwork.	5	10
Achievement	Sense of achievement or accomplishment, or not, at the end of the preceptorship process.	4	7
Skills	Any specific mention of skills or skill development by the preceptee.	6	27
Teamwork	Reference to the wider team, good or bad.	7	27
Student mode	Any reference to life as a student, working as a student, still feeling like a student.	5	8
How could it be better	Ideas put forward as to how preceptorship could be improved.	4	9

Split preceptorship	Reference to more than one preceptor or more than one place.	2	6
Assumptions and expectation	Any reference to aims/goals/expectations assumptions both positive and negative about the work situation (does not apply to Uni).	5	15
Absence of preceptor	Preceptor or main supervisor absent, mat leave sick leave other.	1	5
Criteria	Meeting the criteria of preceptorship and or supervision or other development.	1	1
Protection	Any reference to the concept that as a preceptee you are protected or looked after.	3	8
Work life balance	Any reference to home life and work life.	5	12
Personal traits and resilience	Reference to individual personality traits or sticking power/resilience.	4	10
Politics	Reference to the politics of the organisation or national politics.	3	4
Patient care	Direct reference to patient care when linked to emotion, skills confidence etc.	4	7
Passion	Any reference to strong feelings about the role/job/identity of OT.	2	3
Uni experience	Experience of Uni, education	5	22
Identity	Any reference to the identity of OT either formation, what it is, how it develops (not a definition include that in defining OT).	4	20
Negative view of OT	Any reference when other professions/professional people or individuals have talked about OT in a way considered negative or unfavourable.	3	7
Positive response to OT	Any response or view from others that is positive in nature about OT.	3	7
Risk	Any reference to risk, to self, patient, other or organisation.	1	1
Lone OT	Reference to being the only OT working alone.	2	4
Professionalism	Reference to concepts of professionalism, being a professional.	2	11
Structure	Structure of the process of preceptorship.	2	7
Rotation	Comments regarding a rotational post.	4	13
Preceptorship	Comments about the direct process of preceptorship, knowledge of the process, opinion of the process (does not include information about the people involved).	5	25
Learning styles	Reference to styles or methods of learning.	3	6
CPD	Any reference to direct or indirect CPD.	3	6
Who's involved	Reference to the people involved in the process.	3	5
Gender	Discussion of gender issues.	1	3
Formal support negative	Negative view of the formal support offered.	3	5
Informal support negative	Discussion of negative issues of informal support.	2	2
Skills of preceptor negative	Issues relating to poor skills or lacking	4	13

	skills of the preceptor.		
Relationship with preceptor poor	Discussion re poor relationship with preceptor.	3	13
Documentation positive	Positive feedback re documentation.	5	7

Table 5 Definition of themes

Theme	Definition
Support	Discussion of the formal and informal support available in the preceptorship period including positive and negative issues as well as the concern of being a lone OT
The Organisation	Matters concerning the organisation itself and how preceptorship was managed including team work and views of occupational therapy
The Preceptor	The skills and attributes of the preceptor and the relationship with preceptor
Ownership	Personal responsibility and attributes that contribute to the process including skills, assumptions and internal definitions of OT
A Journey	The concept of developing over time
Structure	The formal structures including documentation and criteria for the process

Table 6 Codes grouped into themes

Preceptor theme	Support theme	Structure theme	Journey theme	Organisation theme	Ownership theme
Relationship with preceptor	Formal support positive	Documentation positive	Confidence	Who's involved	Learning styles
Skills of preceptor positive	Informal support positive	Structure	Journey growth	Rotation	Professionalism
Relationship with preceptor poor	Formal support negative	Documentation	The real world	Patient care	Identity
Skills of preceptor negative	Informal support negative	Evidence	Achievement	Politics	Passion
Protection		CPD	Daunting	Split preceptorship	Personal traits and resilience
Absence of preceptor	Lone OT	How could it be better	Student mode	Training	Work life balance
		Criteria	Uni experience	Preceptorship	Skills
				Risk	Role
				OT and nurse	Defining and describing OT
				Teamwork	Assumptions and expectation
				Positive response to OT	Gender
				Negative view of OT	

Table 7 Question Two: *a priori* code book

NAME	DEFINITION	SOURCES	REFERENCES
Reflexivity	Reflexive or reflective statements	7	55
Develops over time	Professional experience	7	33
Socialisation	Code of ethics External influences	7	37
Clarity of role	Domain of concern Legitimate tools Roles responsibilities and duties Assessment, Treatment Outcome	6	20
CPD and training	Research Evidence based practice Audit CPD	4	6
Differentiation	Linking structures Models Theory , Frame of reference Concepts	7	41
Knowledge and skill	Practice skills Body of knowledge Professional thinking Client centred practice The OT process Goals and desired outcomes	6	22
Language	Lack of common vocabulary	5	11
Philosophy	Philosophical assumptions Professional values and beliefs People Health Occupation	6	42

Appendix Four: Example of fully coded transcript, taken from Nvivo including example screen shots to demonstrate coding.

Transcription interview four

Date **//****

(3.07)I: one of the things I'm doing before we get into the main interview is just collecting a little bit of data around how old people were when they started their OT training and whether they did anything else prior to being an OT, and this is because there is a theory that certain personality types gravitate towards certain jobs really, so would you mind if I ask how old is were you when you started your OT training?

P4: I was 18

I: 18, so you went straight from school?

P4: straight through from school, to college to university.

I: yeah, so you didn't have a previous career as such?

P4: no.

I: did you always want to do OT?

P4: no, no, I wouldn't say I did. I think I wanted to be a speech therapist for a very long time, and it wasn't until the summer before, before starting the occupational therapy degree that I found that really. I looked into speech and language therapy and thought actually that isn't for me. I know I want to work with people, and I know what, roughly what field I want to go into but I actually don't think that that's the profession for me and I felt a bit lost after that point and was just, just started to visit universities with health and social care campus and find out more about different courses and that was when I came across occupational therapy.

I: oh right so where did you train?

P4: Derby

I: Derby, right thank you let's put this out of the way, it's not so intimidating when you don't have pieces of paper in front of you. I'll keep that one there just in case I forget what I'm doing (both laugh)

P4: it's like you get used to your assessments don't you really but having it there it's still reassuring

I: so like I said, what I'm doing is looking at whether or not preceptorship helps or not, in how we form our professional identity as occupational therapists. So, my question is really a very broad one really, and it is for you to talk about your preceptorship year, your experiences, anything you think was important or interesting or noteworthy, anything that you think is important to say is what I'm interested in listening to really, so it's really for you just to talk

around your experiences of that whole period of time in your career and how you felt it helped or didn't help.

P4: that's very broad that really isn't it. Where do you start?, I think in terms of, I know you mentioned about the background side of things as well, so I think that is relevant in terms of, you're talking about professional identity aren't you? and I think one of the things I didn't have any experience prior to doing the degree but I did a lot of things outside of University, relating to occupational therapy that I think played as much as the role in the initial part of my professional identity development as preceptorship for me, so I think I got, I was the student rep for the specialist section of mental health so used to go down to London and sit on the committee and helped to, you know, setup their conference, and I would chair paper presentations and that I think I had to step up doing that in a way that you didn't have to at Uni which I think, I drew on those skills a lot during my preceptorship year and I think if I hadn't, if I hadn't of done that I would have been more reliant on the preceptorship paperwork and process I think, particularly in terms of my confidence and you know, being young and professionalism and those types of things. I know from meeting with, having a lot of friends and social networks that were in the same place at the same time, that I was sometimes a bit more confident than them. in meetings, for example or in, you know, the more formalised sort of elements of your first role, earlier on, and those things felt a bit easier to tick off, you know, I already had something published, I'd already gone and done a few different things, so I felt a bit more confident, but I think for me what preceptorship did was provide myself and my colleague, because there was only two of us in my first role, I was in older adults community mental health team and the band six that I was working with hadn't had a band five with her before, so I think it gave us both the structure to know where to start really and, and that's really important, it's a very confusing, I don't know, I just I'm trying to think back as its quite a long while ago now but I remember it being such a demanding time, that transition, just knowing that the responsibility is really on you for the first time, and I think the process of preceptorship is quite reassuring in that respect, that you are, it's that structure for demonstrating your skills and your skill development over that initial year and I think that's quite reassuring for you and for the individual who is your preceptor or as well and who is your colleague especially when you don't know each other and they know that you're inexperienced that they have that process. I think it develops a good rapport with your manager and it supports you working towards that first appraisal process as well because that's baffling when you first do your first KSF because it's just massive when you're new so. I think the structure of it, is very very important and I would say that's probably one of the biggest benefits.

I: when you say structure, are you meaning the paperwork or the timeframe or both?

P4: all of those different elements really I think, because I was rotational as well so there was a sense that I've got a time limit here as well, and because preceptorship was as well a year I felt like it helped to pace what I was trying to do. I felt it helped to, like I say, identify, because you feel like you don't know, you go through feeling like yeah I've done this I've got a degree to like and oh hang on I don't think I know anything. and you do, and that's why the preceptorship is so important because it helps to, in what feels like such an overwhelming time, define all of the different skills and elements of the role that you need to think about and it breaks it down for you in a way, that I could do now, but would have found a bit more challenging perhaps to articulate when I had never worked in an older adult community mental health setting either, as well so, I

think that in that respect the structure was really really important, and the paperwork and having that there and I know, I know since, that I've spoken with friends and colleagues that haven't had that structured paperwork that we've had available here, or they've been working off nursing preceptorship, or those kind of things and how that has made process quite confusing for them and perhaps slower for them as well. So I've always felt that that was probably a really positive experience I took for granted maybe in your first year that this trust had already set up, because I qualified five, is it over five years ago now so it wasn't long after preceptorship had been established and there were lots of places that didn't have it. You know it was common to go to an interview and say "do you have preceptorship" and for people to give you a fluffy kind of "yes we are aware of it but were not quite there with it yet" sort of response, whereas here it was established there was preceptorship meetings there was a structure.

I: so when you came for your interview you actually asked about it?

P4: yes it did, yeah

I: right, so did they then talk about preceptorship at University or..?

(11.56)P4: I was very aware of it because of working with the specialist section. I think it was, I imagine it will have been definitely covered at University, but I remember having a conversation with Mary Morley about it, she had a stand at one of the conferences and I can remember talking to her about it, and thinking this is really important, for when we qualify and wanting to learn a little bit more, so it was always on the radar for me to find somewhere that had a really good support structure when you qualified. I was very aware that I had always known I wanted to go into mental health but my last mental health placement was within my first year so I felt very, and they were very clear at Uni you would get one, so I left my first year thinking this can't be my last experience, so I went and got lots more but on the other hand as well, I still entered my first post, thinking I haven't worked in mental health setting since my first year and I was very aware of that and therefore the support structure of preceptorship year was very important. That being said though it wasn't perfect. Some elements of it I think, the fact that it was a relatively new thing and neither I, or my preceptor had been through that process before. so you know although there was the structure there, there were a lot of questions and I think it was evident that it was being done differently with different preceptees and preceptors if that makes sense. so for example I remember for the elements about health and safety and a couple of the policies related tick box elements of the preceptorship paperwork, which is one of the issues, it can be a bit tick boxy, I remember having to verbally feedback my knowledge of and also do like written pieces on it because my preceptor wanted really robust evidence, and I think at times when I reflect back on it, I think that didn't benefit me at all, I think I was doing it so we overzealously evidenced and when actually you think about it you demonstrated it in supervision you demonstrated it within your practice and, and I know other OT's, because I actually worked at the (name of centre) and one of the OT's there actually said "oh my God ,why you doing that. That such a waste of your time you know you've demonstrated it while you've been here" and I know she then spoke with my preceptor and the demands reduced to be like, slightly less tick boxy and more actually we are happy that that has been achieved and that we don't need this folder that was this big (holds hands apart) with paraphrased policies to demonstrate that that's what your achieving, so I think in that respect it, it can be a bit of a gripe in your first year when you really want to be

concentrating on going away and thinking about the evidence base of what you're doing when you are spending your time in paperwork and books you want to be doing patient -related stuff and your own kind of further development and education stuff rather than necessarily retyping policies. Whilst they're important I think once you've demonstrated an awareness of them and practical use in your work and there's no issues I don't think. So I think that's probably about guidelines to go with the paperwork and I don't really remember their being in-depth ones, I don't know whether there were those for preceptors, and I think actually that there is this expectation that the preceptor, you going into the post thinking that my preceptor is my preceptor on high (both laugh) and you think they know everything and actually for them it can be a really new experience for them as well ,it was for mine.

I: so your preceptor didn't have previous experience of doing that role?

P4: no no. But luckily back then within the trust there was a preceptorship meeting that we all attended and there was a part that was just for the preceptees and a part that was just for the preceptors so that's why during that first year I felt like I was, I think that made the process easier because you are able to say what, that this person is doing this for their evidence and would that be okay to me and you were thinking oh maybe that's a bit excessive and I got a marker to say actually elsewhere people are doing this, and, and also really just like peer support during the process as well. But I do remember it feeling quite demanding ,because we did it so robustly and I used to do a lot of it in my own time which I think probably did affect my work life balance but you've just come from Uni so it it's not a foreign experience and just remember thinking when my preceptorship was over, I remember thinking oh my God I've got all this time it's lovely and how wonderful this is, so yes it was time-consuming to do it properly and thoroughly, but beneficial I guess really. I want to waffle too much.

I: it's all right its good

P4: it's also a little bit of a while ago from me now about 3/4 years so it's, thinking back really especially when you're rotational really and you like let me go back a couple of different job roles.

I: you kind of mentioned that when you came out of University you already felt your confidence was slightly higher than that of some of your peers. did preceptorship help that develop more or not?

(17.52)P4: I think it gave me a forum to acknowledge that with, so that structure for example enabled me to perhaps identify, because I was going through the paperwork and we used to, I had really good group when I first started with the preceptees and we used to go for coffee and really chat through and I think, I don't think that when I left university I realised that I was confident I think I felt like overwhelmed, it's like when you first get in a car when you've learnt to drive, you know that you've learnt you know that you've been told you can drive safely but you still think in oh god, somebody's let me be in a car and I just remember feeling like that when I first started and somebody's letting me see patients and I'm on my own and I remember saying to (name) can you check my notes and she said, no I don't need to check your notes and I was like oh okay (laughs) so preceptorship provides that forum for you to have those conversations about why that person is comfortable and I think from conversations with my peers, it made me realise that actually I wasn't perhaps as daunted by something's when it practically came to it, as they were,

and it was more the formal stuff I think just that sense of, that sense of being in a professional role because it is a different version of you isn't it? and that at Uni your much more informal and even when you're giving a presentation you're going back out and, back to your flat with your roommates and with the chaos and whatnot, but I think because I had been in lots of positions where I had been, the only student who was sat at meals with the group of 15 occupational therapists who were all more experienced than me, that didn't daunt me as much as, I would sit with my friends and they would be like, my God I've had to go into a meeting today and I just felt like I couldn't follow what was being said, whereas for me I was like that's fine just ask you know were not supposed to know everything, and people, everybody has been in your shoes so I felt like that couple of years of experience, it didn't make me any better at being an occupational therapist but it just was that confidence that it's okay not to know everything and the confidence that this is your first year. I still felt overwhelmed, but the preceptorship process I think enabled me to sort of identify that I felt more confident, if that makes sense, and I think I don't think I would have recognised it if those processes hadn't been there, particularly the peer support element.

I: so those were meetings that were held, what monthly or?

P4: they were held here, no over at one of the other meeting rooms I think, and they were they were either monthly or every other month, I can't tell you exactly because I can't remember, they were relatively frequent and the first part was set up so we would all attend, preceptors and preceptees, and we would sort of discuss a variety of different topics, the paperwork and you know. and I think because we were all quite comfortable with each other so we would feed back where we were at with things, and then the preceptors would all leave and provide us with like a half an hour period where we could talk about the process where we were going and that developed quite a supportive little group and that we would meet actually outside of work as well you know, just for coffee and that was really nice and really helpful and a couple of us knew each other from Uni anyway, and I think those, you can't undervalue those relationships and I know, I don't know if we have those now here I don't know if we have proper preceptorship meetings here.

I: no they're slightly different now they have preceptorship workshops where you do I think it's four in a row but not preceptorship support group as such.

(22.22)P4: that still enables you to meet each other I suppose though and you can go on to develop those things if you want, but I personally found those really invaluable because it is a real journey your first year, particularly when like me you've come straight through from college to university. and I think it's probably a very different experience if you have previously worked in healthcare but if you haven't I think it is, just working full-time alone for the first time is massive you know and you've come back from Uni and you, for a lot of people at my life stage you were in your first house that you are gonna be staying in for a period time, a lot of you relocated back to, or to be with jobs, so in terms of it being a life stage as well most people have got a lot going on and that's why I keep coming back to that structure. that's why that so invaluable really because everything can just feel, I just remember, that's what I remember most from that period of my life it just felt like there was just a lot going on so when things were structured and you knew what was expected of you and things were clear that was really helpful and then the peer support

element was very supportive as well so they were the key factors really. but there was obviously ways that the preceptorship process could be improved and the gripey things with the paperwork and being a tick box exercise if you let it be and if it's not interpreted in a way that's supportive if things are taken very literally, but that's the case with you know your appraisal paperwork and you know so, in a way learning those skills of negotiating what is expected and what evidence you are gonna use and going through those processes there things, and skills your gonna use as you go on anyway, to be honest but at the time you do have a little whinge about it don't you, why am I just typing up the health and safety policy (both laugh).

I: a couple of times you've mentioned the word professionalism .what does that mean to you?

P4: professionalism. I think it's, I think it's part of your identity, it becomes part of your identity more so than anything. for me it was quite a big journey because I started Uni, I'll be honest and one of my lecturers actually fed it back to me in one of my last weeks of Uni that I was, I started university with multi-coloured hair and a sense of apathy about education and you know I, yeah this is gonna be a breeze and, and Uni is gonna be amazing man type stuff and that obviously didn't go unnoticed by people because it was in my final year that one of my lecturers quite bluntly said that he thought I'd been apathetic and would potentially drop out in my first year, but he felt that I'd come on an immense journey and he was very interested to see what I would go on to do in my career after Uni but he just summarised that I had been on a bit of a journey in relation to that and I think that he was probably referring in a way to the development of my professional identity and ownership of actually the role of being an occupational therapist and what that means and the responsibility associated with it and actually it's not just about going to a way to Uni and having a laugh and that was a process for me at Uni and quite a sharp one if you think about it I did arrive with multi-coloured hair and then leave having achieved a lot of things. it was a real journey so, for me it's about that professional identity and that professional you know persona, it's about understanding and having an appreciation of your roles and responsibilities and it's doing the right thing by your patients really isn't it so, it's that whole package but I think for most people it does become part of your identity so sometimes I don't take my occupational therapy hat off properly when I get home so my partner will be like you're still in work mode so go and have a cup of tea in the kitchen and come back when you're not, so I must present slightly differently to him when I'm still thinking about work. I think maybe that is different for different people, depending on your personality but I do have a bit of a, I know I have the sort of personality in its raw form that's not great for work you know, I don't take myself too seriously at all, I'm really scatty at times, I'm the most disorganised person ever and never arrive for anything outside of work on time, you know people arranged to meet me half an hour you know later, well earlier than when they intend to because they know then we'll arrive at about the same time and that, you know there are things I like about myself but aren't part of my professional identity so there is like personal (me) and professional (me) and, and that's a journey that's a process that starts from the early days of University and you sort of, I think if I had have had my experiences that I had at Uni in the different forums outside of Uni I think it would have been more than a sharp learning curve during the preceptorship year than it was, but it was still a process that was still happening as well during the preceptorship year. Because I was young as well I was 21 and I was working with a team where the youngest person was 29/30 so I was like a little baby, the baby of the team you know, which looking back actually didn't faze me maybe it would have if I had different experiences but that is a massive journey to go on, particularly when

you think you are very young because there's a lot of responsibility associated with working in in the jobs that we working in isn't there?, and I think when you haven't had a lot of life experience there are scenarios that can be quite challenging, which challenge your ability to remain professional you know, when you, I remember in my first year somebody disclosed sexual abuse and that's the first time you've come across that, then maintaining professionalism becomes a different sort of challenge really doesn't it because it's, and that's something you only get really good at with the experience, you don't ever become okay with it do you and it's, but you don't realise how much you draw on your professionalism during those moments you know. and during those experiences I think having the more structured supportive preceptorship period, I don't know those sort of experiences are easier to cope with when you've got that role to go back to so regularly I think if it was just like olden days, expected to hit the ground running and get on with it and have the same level of supervision and whatnot as you have 10 years down the line I don't know if that, if those things would have been as easy to deal with or actually the process of evaluating how you have managed those situations and you know coped with them I don't think that would have been as easy perhaps, because I think most preceptors have at least got quite a few years or a reasonable amount of years under their belt to be able to

I: so a bit of experience

(30.54)P4: so in a way I think it's protective of preceptee as well I think isn't it, and your well-being really

I: you have kind of talked about roles and responsibilities how do you describe occupational therapy to people who don't know what you do?

P4: depends very much if I'm on a night out (both laugh) I don't, because sometimes I find you know, I don't go out much anymore but when I used to go out a lot when I was a bit younger I used to find you would end up in really lengthy conversations, it would either go one of two ways where people would glaze because you had said to many words that didn't really have a lot of meaning for them or, I would get into conversation about, about the job and actually you're out and about, but in terms of describing it to, if you met somebody who you were wanting to discuss your job or you met a new friend who perhaps didn't understand your job role, I tend to try to keep it nice and simple initially and then you can build up on that later date so I tend to describe my role as being a healthcare related role that I work in mental health and that my job is to support individuals to live as healthy and fulfilled life as possible despite the fact that they might be experiencing difficulties in their life at the moment, so and then it depends on how they respond to that as to what you say next. and to how you build upon that, I've spoken to very concrete people that perhaps struggle a little bit more with the mental health element and so I sometimes say that if you fell off your horse and you really wanted to continue to go about your life again but you've broken both your legs and then I simplify it, for children or for people who are really very concrete about things or might struggle with some concepts and if somebody is more able and more open to discuss it you can have a much broader conversation can't you. Some of my friends that are interested, you can have really fab conversations about life and meaning and you know all those sort of things that us occupational therapists like to chat about. So it does depend ,although I will say that I probably fail as an occupational therapist because my dad still calls me an occy health nurse and he understands completely what my job role is and I've

heard him explain what I do but it's the title, it seems to have stuck from a very long time ago and I have to keep saying to him, we all do it ,the whole family say (name) no she's not an occupational health nurse, and I'm like, "I don't work in occupational health" and he says "I know I know". And I'm like "stop It" (both laugh) I can't believe I haven't managed to knock that out of him yet

I: what about if you've got to describe what you do to colleagues, have you ever had that situation where you've had to..?

P4: God, we have that all the time don't we, very much so .there's varying degrees of understanding isn't there and lots of stereotypes isn't there that we experience, and I think from my experience it's been different in different settings, so I was very privileged in the first team I worked in they had a really fantastic understanding and appreciation of the occupational therapy role, so it was never as much of a challenge as I found it when I've worked on wards, where you've got people coming and going and I think you know, that it is a challenge and you have to have lots of dialogue don't you about it and, it's a really difficult question to ask because you approach it so differently depending on what the misunderstanding is, if you're explaining it to somebody who actually, like I've had students who perhaps haven't come across occupational therapy in a mental health setting before or have perhaps experienced it in a different respect and those the best types of colleagues to be describing it here because they are quite often open and they just want to learn, whereas if you're you know, I have come across a housekeeper who asked me over Easter whether we would be face painting today, and that's a completely different, that's a completely different conversation that's got to be had then because you've got to sort of unpick where that has come from first ,maintain your composure and try and then professionalism does come to the fore that because you do just want to go "no" and I think in those instances you've got to take time to sort of step it back a little bit and say, I like to find out what they think if they've got a predefined opinion because then that informs then what I communicate to them about the profession so I've had many, that that domestic is a bit jaded I think, but we've had many a conversation about but that might have been what you've experienced in the past but this is very much what you're doing today and actually when you see this happening, so when you see cooking session were not doing it to make a mess and cause difficulty or actually it's very therapeutic and here are the reasons why so, I like to use practical examples of how an intervention is achieving you know, the therapeutic goals but if you are talking more, in a more, broad sort of approach then that's more challenging. We are introducing MOCA over on forensics so there are lots of those conversations happening at the moment, about what we do and how that's gonna be changing and what the value of that is gonna be and what how that is going to influence the patient and the impact that is going to have on the multidisciplinary team, so you've got to be both an advocate for occupational therapy and also its defender at times, with some people who perhaps have got predefined judgements. Forensics is an unusual service because I think a lot of staff have been there for such a very long time, less so now because lots of people of moved since they had some of the changes, but when I first started there was people that had been there to such a very long time and had predefined ideas based on perhaps what they had seen happen in the past and they had blurred occupational therapy with the activities coordinators that used to be there and its, so there are lots of conversations to be had, it's very difficult to answer because it's very ,you don't have, I don't have a stock answer I like to evaluate the situation and why I want to have the conversation.

I: where you are now, so in the forensic service, is your role clearly different from that of your nursing colleagues do you think?

P4: absolutely, I would say it's probably the most defined out of all of the roles I've had I would definitely say I think because, because we are ward linked as occupational therapists ,but we are also therapeutic program linked, so we are linked to (unit name) which is the therapeutic department, so technically I'm not based on the ward, so I think that sometimes prevents you from doing the more generic day to day things that help out on the ward, so I think that in that respect it separates you from the team, you are like a peripheral team member rather than like a 'in the mix' team member and that affects you, but in terms of your actual role with the way that we are going because we are changing the way that we work into be more MOCA friendly You know our role is going to become more of a consultancy role we're going to be doing a lot of the assessments we are gonna be supporting people to set the groups up but not necessarily facilitating them it's that, it's that, it's promoting the fact that our role is going to be very much about supporting the provision of occupational therapy assessments and interventions but not necessarily completing all of the interventions, that we would be providing, guidance, support an assessment and whereas historically I think the understanding of the role is that you know meaningful occupation and in some cases activity is the occupational therapists job and its actually sort of saying no, rehab is our job as a multidisciplinary team and this is our contribution to that and this is our role within that process and this is how we can support that process so that, we have a role with pacing rehab, and we have a role in you know activity analysis, we have a role in identification of patient needs and appropriate need based group development ,and it's you know communicating those things really.

I: so it's interesting that the trust is doing this VDT MOCA, see I've done the training the VDT (both laugh)

P4: I know I should call it the VDT but it's a whole other word you've got to slot in,

I: it's different, I work in dementia services so MOCA means something different in dementia services so it's a cognitive assessment for people with dementia but, it seems interesting that the trust is on-board with a way of working that's very much about occupational therapy taking the lead, how are people reacting to that in your service?

P4: I would say it's very interesting because obviously we've got four, we've got four different wards so you've got four different teams to sort of observe that happening within. We're lucky that we've got the ICU(name) which has been selected for one of the pilots so their whole nursing team has been trained and whilst that's early days that only happened a couple of, a couple of weeks ago may be months or so and I think that that has had a significant impact on the way that the team is receiving the development of the MOCA based kind of occupation, which is now MOCA focused occupational therapy input. For example there ward manager apparently went into a meeting the other day and (name) my band six nearly cried with joy because he went in and quite eloquently put across the reasons why the different ways the occupational therapist is going to be working in the future is gonna be beneficial to patients and the work of the multidisciplinary team and because he had an understanding of the model he was able to articulate that as well whereas I think on some of the other wards we are at different stages with it and I know on (name of ward) where I work the rehab side, there is the ICU and the acute they are the most

ahead they have started with their task assessments things and they were given the training earlier and that decision was made based on the fact that the pilot would be happening on the ICU so it's more important whereas on the rehab side of the unit we are a bit behind, so at the moment there is a bit of mixed reception as I can tell I think, so it sounds like a really ridiculous thing but the model's name doesn't help sometimes it really doesn't does it, and I think sometimes people can judge things before they've given it a chance so, my approach is very much, we've got ward management that are very much on board and they have a rudimentary understanding whereas I've also go on board some of the, you know people who were gonna be good leaders when it does come into place you know, you know the skills and strengths of your team when you work in a team, and so we have used that and I have got one healthcare support worker who is particularly enthusiastic and I sort of said once this comes in you are gonna be the link, so I think that's really important but there is, not so much to my face, so being someone who visits the ward you don't know what's been said when you not there, but I do sense that this probably a bit of cynicism and oh another way of working, another model ,another change, and there's a lot of change fatigue over there in that sense. so I'm not letting that deter us too much so were going to focus pretty much on it beginning with more education and we finally got away days coming up so we could do a presentations there and then the plan is that there will also be drop in sessions throughout the week where staff can book time to discuss their patients within the model's framework and I think once we started to do more assessments and people are getting the information and it makes, and actually makes sense that they can practically apply it, then it's just about ongoing promotion and education. It can be a long process, it can feel a bit daunting at times but I think it's very well suited to forensics and there's lots of examples of other forensic units where it works very well and I get quite excited about it.

I: that's good

P4: I do I think it's forensics it's what occupational therapy in forensic services have needed really and actually is not too different to what has been said for a long time but I think it's an assessment that gives us sort of once again a structure to say, actually you know we've been saying this one size fits all groups approach doesn't work, this is why. And this is specifically why it will be harmful to these specific individuals and this why this group will be beneficial to these specific individuals so I think because it comes out with such practical, you can make very practical recommendations from MOCA assessments, fingers crossed, we'll get somewhere with it.

I: good if you think back to your preceptorship year again, were you given the opportunity during that year to do any training around different assessments or you know, other than your mandatory training?

P4: I did do the Allen's cognitive levels training which I did towards the end of my preceptorship year, which was a shame really because it's used more prevalently and when I went over to the acute inpatient service I did try to keep up using it, but I manage d to use it a reasonable amount of times but I think that tailed off as I moved through different services and I'm actually having a refresher in it coming up so that's good. But I felt like during my preceptorship year I had a reasonable amount of training, I felt like, I didn't feel like there was, like I remember going to a dementia conference held at (name of town) so I was supported to go on training. I think I felt aware that there was, that it was important to attend training that was relevant to me, so I was

aware that I was in older adults services for a year and the likelihood of me going into another older adults services post after that year was very slim so I was mindful of things, so I know towards the end of that year, with the exception of the Allen's, I didn't like ,do anything that I knew that would take that opportunity away from someone else who really needed to use it so I think you are aware that it's a rotational post anyway, generally I think but I felt like I had quite a few different training opportunities and learning opportunities which were quite positive. to be honest not vast quantities there been other years that I've done more but I think that is actually appropriate so you want to get the foundations really robust aren't you so that you leave you first year thinking yeah I can do this that's the aim isn't it.

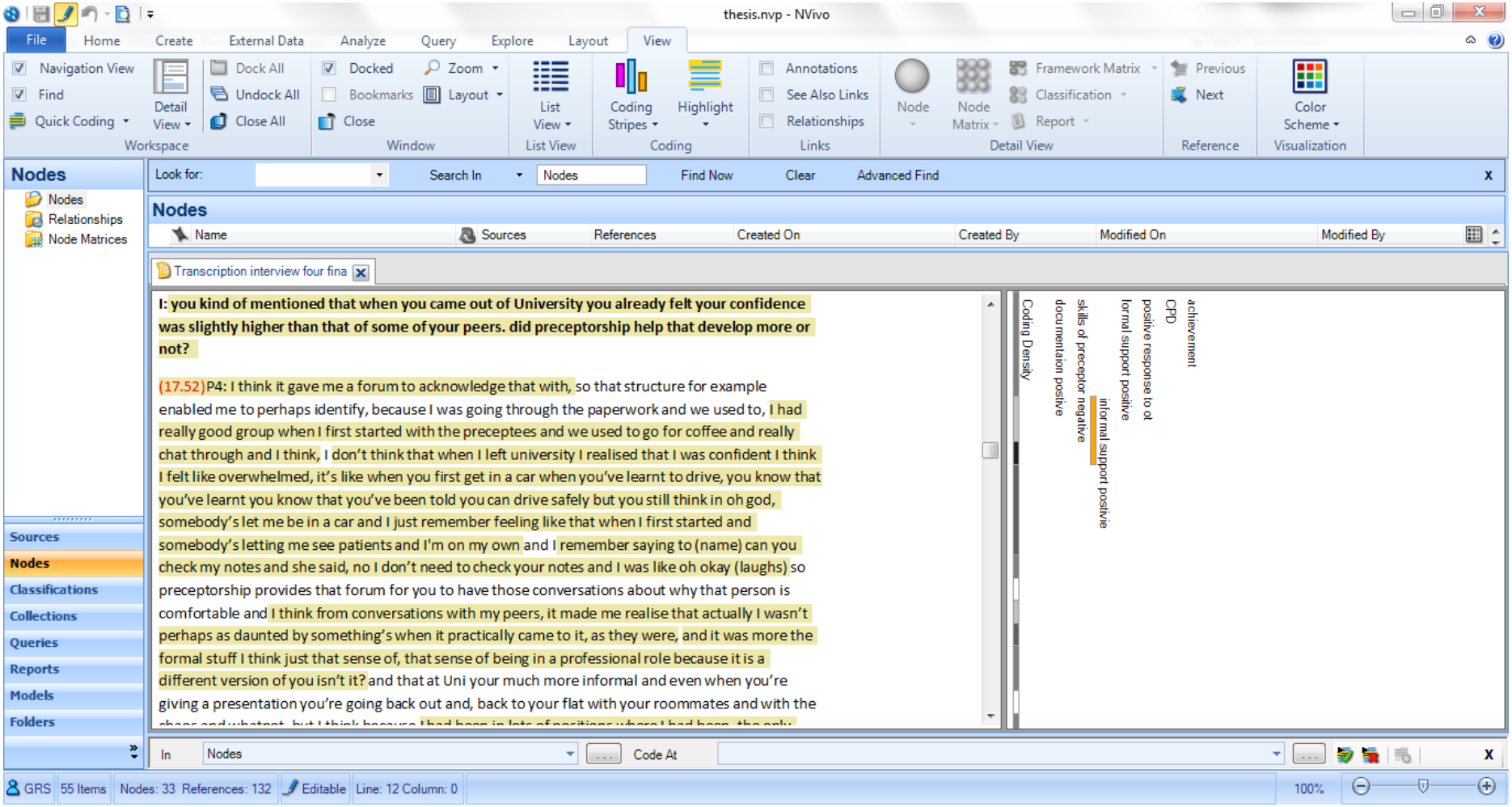
I: and did you? when you got the end that preceptorship year did it feel like yeah I can do this?

P4: yes I did. I very much felt like that and then I think because you rotate I had that period where in that first week when I got into acute, I went oh hang on a minute can i? (both laugh) you go from thinking yes I know what I'm doing here, I've got the feedback and support of the team, and then you moved into adult inpatient and I was like oh no, but then you realise you transfer your skills you realise that the support doesn't end and that actually as a profession we are really supportive of each other aren't we , so we are very good with supervision and we are and I think like I say it very much gave me the skills because I was expected to hit the ground running a lot more so when I rotated and although I do have those moments where you think oh my God again, that very quickly passes in a way that it doesn't in your first year, you know, because you are aware that your skills are transferable aren't they and because you are not so wrapped up in the preceptorship you have the time to go away and read to your hearts content and you know visit the library do all those things that you want to do, shadow people in abundance because you not so much worrying about those foundations, you are applying them somewhere new, so yeah.

I: is there anything else you want to say about your preceptorship year before we finish?

P4: not that I can think of

I: thank you very much then. Brilliant.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I: you kind of mentioned that when you came out of University you already felt your confidence was slightly higher than that of some of your peers. did preceptorship help that develop more or not?
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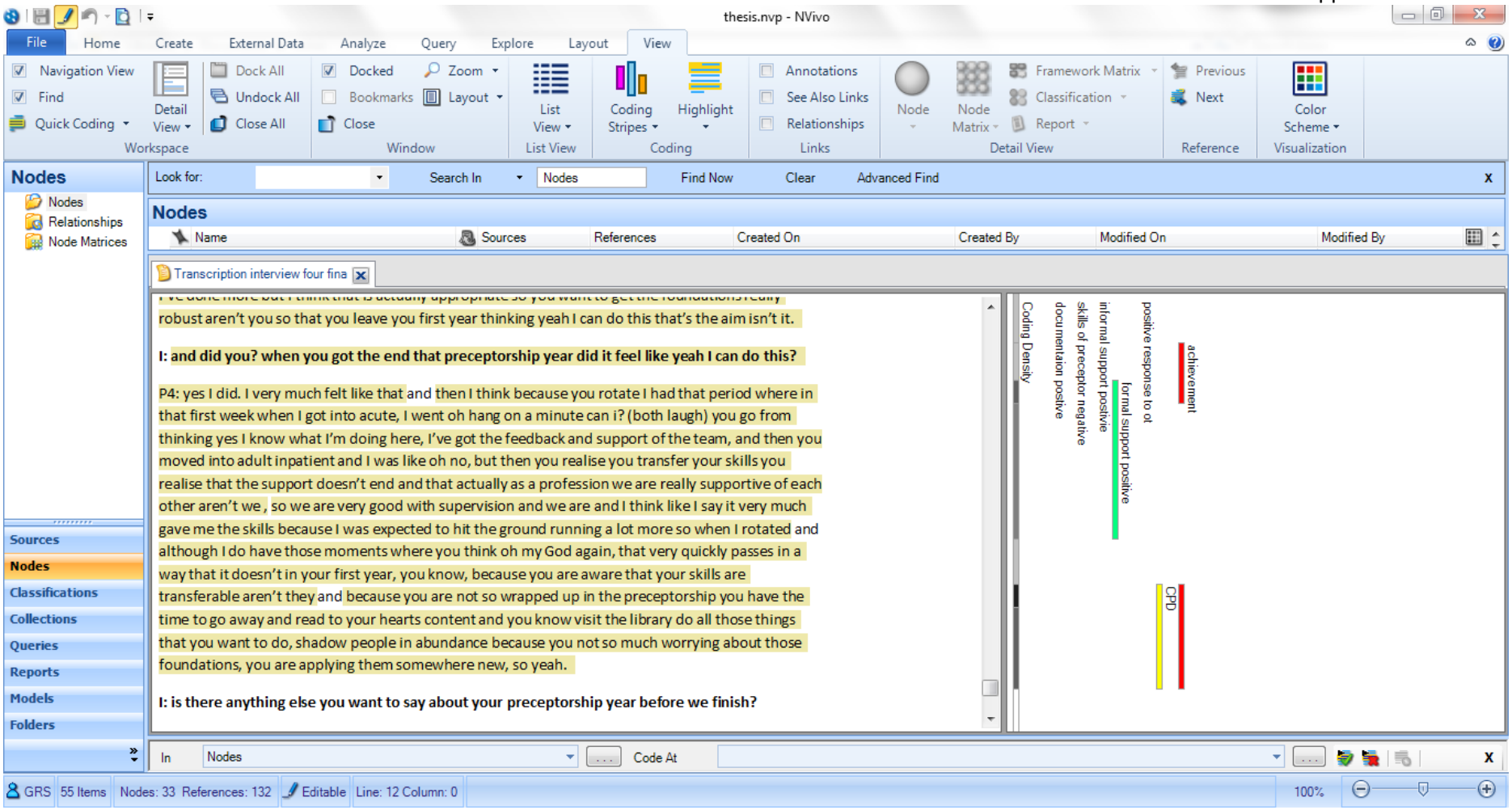
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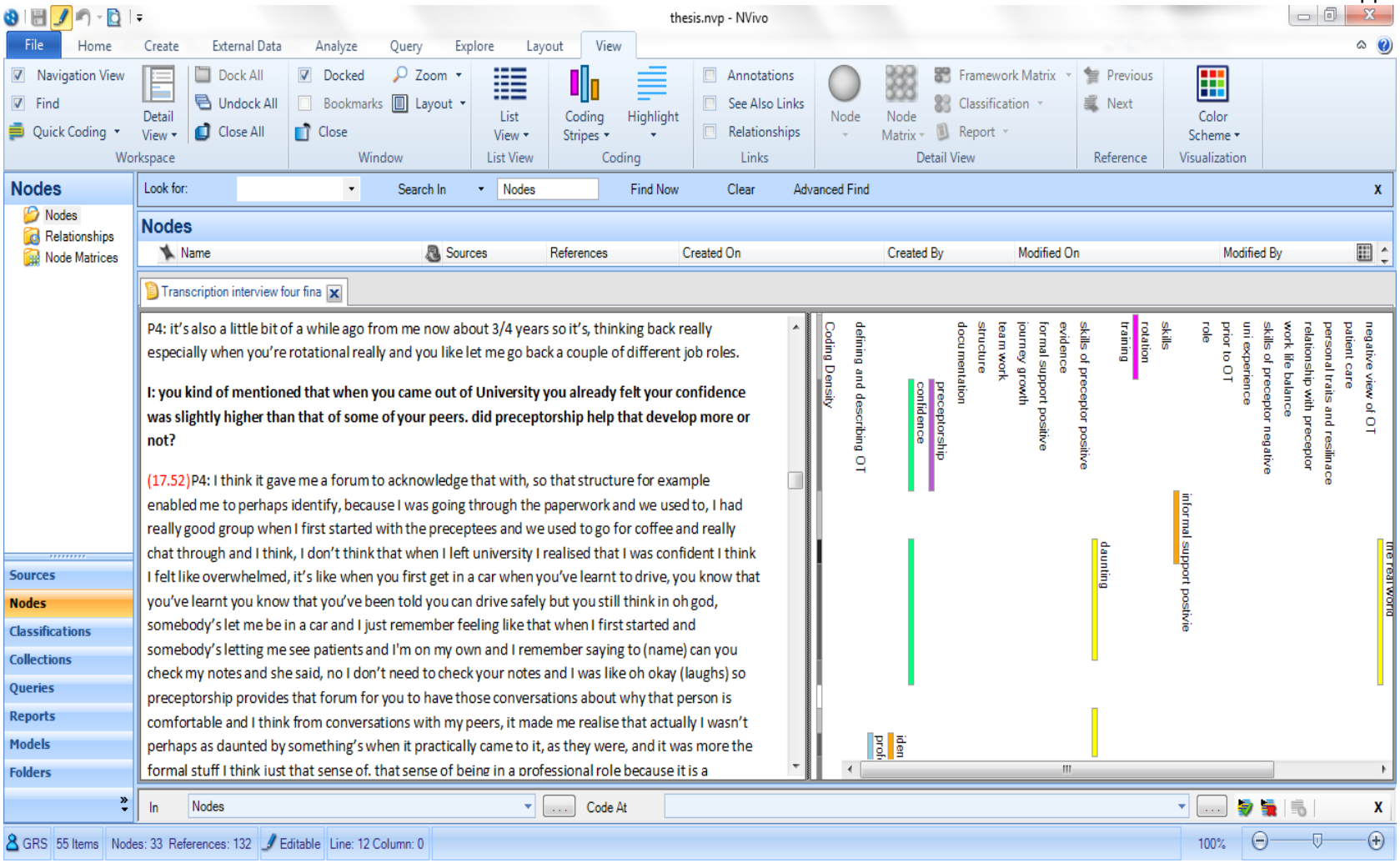
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P4: it's also a little bit of a while ago from me now about 3/4 years so it's, thinking back really especially when you're rotational really and you like let me go back a couple of different job roles.
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(17.52)P4: I think it gave me a forum to acknowledge that with, so that structure for example enabled me to perhaps identify, because I was going through the paperwork and we used to, I had really good group when I first started with the preceptees and we used to go for coffee and really chat through and I think, I don't think that when I left university I realised that I was confident I think I felt like overwhelmed, it's like when you first get in a car when you've learnt to drive, you know that you've learnt you know that you've been told you can drive safely but you still think in oh god, somebody's let me be in a car and I just remember feeling like that when I first started and somebody's letting me see patients and I'm on my own and I remember saying to (name) can you check my notes and she said, no I don't need to check your notes and I was like oh okay (laughs) so preceptorship provides that forum for you to have those conversations about why that person is comfortable and I think from conversations with my peers, it made me realise that actually I wasn't perhaps as daunted by something's when it practically came to it, as they were, and it was more the formal stuff I think just that sense of. that sense of being in a professional role because it is a
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