An Exploratory Study Into the Use of Perceive Recall Plan Perform System of Task Analysis in Clinical Practice in New Zealand

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ABSTRACT

This study aimed to investigate the extent to which, and how occupational therapists use the Perceive Recall Plan Perform System of Task Analysis (PRPP) in their clinical practice in New Zealand. Web-based questionnaires were used to elicit occupational therapists’ perspectives on adoption and implementation of the PRPP in practice, the benefits and challenges that they experience, and the factors that affected their use of this standardised occupation-based assessment at their work settings.

The results show that 63.5% of the occupational therapists began using the PRPP in their clinical practice within the first month after training. There were variations in the ease and frequency with which they were able to administer the PRPP. The common challenges experienced were high workload and lack of time to consolidate new knowledge and skills. Successful implementation of the PRPP is dependent on therapists’ motivation, supportive workplace, and sufficient time for new learning to take place.

This study supports the idea that integrating new learning and skills into current practice are complex and affected by many factors. A team approach is important to enable PRPP trained practitioners work in collaboration with their employers (managers/funders) to make the best use of the supports and resources to facilitate and consolidate new knowledge and skills into their practice.

Keywords: Perceive Recall Plan Perform System of Task Analysis, PRPP, occupational therapy practice, survey research, New Zealand
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DEDICATION

This research project is dedicated to my parents and to my family and friends, for their endless love, support and encouragement in making the successful completion of this study a reality.
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LIST OF ABBREVIATIONS

A-ONE ...... Arnadóttir OT-ADL Neurobehavioural Evaluation
ACLS ........ Allen Cognitive Level Screen
AOTA ....... American Occupational Therapy Association
AMPS ....... Assessment of Motor and Process Skills
CAOT ....... Canadian Association of Occupational Therapists
CCFR ....... Continuing Competence Framework for Recertification
CMOP-E ... Canadian Model of Occupational Performance and Engagement
COPM ...... Canadian Occupational Performance Measure
HPCAA ..... Health Practitioners Competence Assurance Act
ICF .......... International Classification of Function, Disability and Health
MMSE ...... Mini Mental State Examination
MOHO ...... Model of Human Occupation
NZAOT ..... New Zealand Association of Occupational Therapists
OPI ........ Occupational Performance Issue
OPM(A) .... Occupational Performance Model (Australia)
OREG ...... OTNZ Ethics Review Group
OTNZ ...... Occupational Therapy New Zealand
OTBNZ ..... Occupational Therapy Board of New Zealand
PRPP ........ Perceive Recall Plan Perform System of Task Analysis
RECOP ...... Research Ethics Committee of Otago Polytechnic
SIGs ........ Special interest groups
WFOT ...... World Federation of Occupational Therapists
WHO ........ World Health Organization
WPTAS ..... Westmead Post Traumatic Amnesia Scale
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CHAPTER ONE - INTRODUCTION

Chapter one presents an overview of this research project. This includes the background information that led to the completion of the study, the context in which it occurs, and a justification for undertaking this research. The research question and study aims are explained, with a brief outline of the research project.

Occupational Therapy in Acute Care

I am a New Zealand-trained occupational therapist practicing in the acute care (physical) settings of a tertiary care inner city hospital where services are provided for patients age 18 and above, who have experienced a sudden deterioration in their medical and functional level due to all kinds of illnesses and conditions, ranging from the onset of a new condition or traumatic event (e.g., myocardial infarction or fall/collapse) to worsening of progressive disease (e.g., heart failure or dementia).

Occupational therapists in acute care (physical) provide services in restoring occupational performance, preventing further decline and coordinating care for patients with a diverse range of medical conditions and complex needs (American Occupational Therapy Association, 2012; Robertson & Blaga, 2008). The challenges to practicing in this setting include patients’ medical instability, resource limitation, and constrained timeframe to complete evaluation and intervention for safe discharge (Blaga & Robertson, 2008). Additionally, there is the pressure of discharging patients after a short hospital stay to decrease healthcare costs (Griffin & McConnell, 2001, Robertson & Finlay, 2007) and political initiatives such as Health targets, a set of national performance measures on effectiveness of health services in New Zealand (e.g., shorter stays in emergency departments) (Ministry of Health, 2012).

Early effective discharge planning is imperative to allow safe and optimal discharge for patients from acute care settings. Many factors can impinge on the discharge proceedings, but the key to this is the team communication which ensures that essential information is shared. The importance of a comprehensive discharge assessment from all personnel was stressed by Crennan & MacRae (2010) who indicated this was important to minimise a patient’s need for hospital readmission. The key factor that lead to a successful discharge are “timely information about
client’s transfer to home care, adequate information about their functional status, cognitive potential, and medical treatment” (Eija and Maria-Leena, 2005, p. 292).

Acute care occupational therapists play an important role in improving a patient’s ability to perform everyday occupations by taking into account their personal needs, capacities, and preferences when planning intervention and making discharge recommendations (Townsend & Polatajko, 2013; Townsend & Wilcock, 2004). Effective and confident communications for conveying the meaning of occupational therapy interventions to other healthcare professionals, and to advocate for patients and their families are core skills in occupational therapy practice to maximise positive outcomes in acute care (Robertson & Blaga, 2008).

The occupational therapy assessment process involves assessing patient’s occupational performance issues and challenges related to their occupational engagement. This means taking a holistic approach to understanding the dynamic and interconnected relationship between the person (strengths/weaknesses), their environment (resources/barriers), and their occupation (Kielhofner, 2009; Townsend & Polatajko, 2013). The assessment methods include but is not limited to: occupational performance assessment and task analysis in areas of self-care, productivity, and leisure with the use of standardised and non-standardised assessments (Kielhofner, 2009; Townsend & Polatajko, 2013). Occupational therapy interventions typically target the person, their occupation and environment collectively with an aim to maximize the individual’s occupational performance and minimise barriers that impede occupational engagement in occupations. A range of enablement skills (i.e., collaborate, consult, coordinate, design/built, engagement and education, see Townsend & Polatajko, 2013) may be utilised by occupational therapists when providing and evaluating interventions to their patients. Usually, the therapeutic interventions in acute care (physical) include patient and family education, provision of necessary adaptive equipment and referral to other services to enable patients’ safe discharge from the hospital facility (Blaga & Robertson, 2008, HealthPoint, 2012).

The reality in acute care settings is that the pressure to discharge patients has lead to occupational therapy practice being reduced to essentials. It is common to
implement a process of assessment, intervention and discharge planning at the same time. This is necessary due to the short length of the patient stay and the need for rapid decision-making regarding discharge. High readmission rates suggest that discharge planning is ineffective because of great demand for fast decision making and ‘quick fix’ solutions (Crennan & MacRae, 2010). Robertson & Blaga (2013) found time constraint is a major reason for non-standardised observational performance-based assessments being used rather than standardised assessments to record patient progress and assist in acute care discharge planning.

It is essential for occupational therapists to critically evaluate the assessment tools they use by asking the following questions: How valuable are such assessments, particularly in assessing and developing intervention plan to meet client needs? Do these assessments adhere to the core values and attitudes of occupational therapy practice? This is because when assessment is inappropriately used, it could hinder outcomes for clients and services, and could damage our professional credibility.

**Reason for Interest in This Topic**

The belief that occupational therapy has a unique contribution to patient care in the acute setting has inspired and prompted me to advance my knowledge and skills in clinical reasoning so that I can critically evaluate occupational therapy assessment process and better contribute to the quality of service. There are three main experiences and observations that have contributed to my perusal of this topic. The importance of each one will be discussed in turn.

Firstly, occupational therapists are experts in occupational functioning, and their unique contribution is commonly overlooked by clients, the public, and some of our multidisciplinary colleagues because this is not captured in the assessment procedure (Hocking, 2001; Kielhofner & Forsyth, 2001; Trombly, 1992). Historically, a bottom-up approach to assessment and treatment, with a focus on the deficits of occupational performance components (physical, cognitive, and affective) was believed to be prerequisite to successful occupational performance (Hocking, 2001; Kielhofner & Forsyth, 2001; Trombly, 1992). However, confusion and dissatisfaction may result when the impact of deficits on occupational performance is unclear and
separated from client’s occupational performance goals. Gillette (1991) stated that “the basic concepts of a profession should be reflected through the tests and measurements used in its practice, this means functional assessment of performance based on test that measure change in occupational performance” (p. 565).

Secondly, there is a need to use standardised assessment and outcome measurement in reporting assessment findings and recommendations. This is supported by Welch & Foster (2003) who strongly emphasised the need for occupational therapists to reaffirm their role in health care by undertaking an ‘objective’ occupational performance assessment. In acute care practice, it is essential for occupational therapists to use a validated assessment that actually reflects their patients’ occupational needs. Moreover, to effectively informing professional opinions and decisions about their patients’ safety and functional capacity to participate in a range of occupations (including self-care, productivity, and leisure), their eligibility for services and assistive devices, and discharge destination.

I recently completed a postgraduate course on Outcome Measure and Occupational Therapy Practice. During the course I had the opportunity to look in-depth into the Perceived Recall Plan and Perform System of Task Analysis (PRPP) (Chapparo & Ranka, 1997). The PRPP was developed by occupational therapists (Dr. Chris Chapparo and Dr. Judy Ranka) for occupational therapists out of the need to have a standardised assessment system that is designed to be time-efficient and flexible to be used with a wide variety of clients at all levels of function and diverse cultural backgrounds (Chapparo & Ranka, 1997). The system focuses on assessing the impact of cognitive deficits on the performance of clients occupational roles and tasks and providing occupational therapists guidance to develop effective intervention plans with measurable goals (Chapparo & Ranka, 1997). Henceforth, that there is the potential to implement the PRPP in acute care practice (Please refer to Chapter Two for details where this assertion is supported).

Finally, last year I completed five days PRPP assessment training course facilitated by the founders of the PRPP (Dr. Chris Chapparo and Dr. Judy Ranka) in New Zealand. The trainers have actively encouraged course participants to implement the PRPP assessment as early as possible to promote change in practice after the
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training course (Dr. C. Chapparo and Dr. J. Ranka personal communication, 15th March 2013). However, I did not start using the PRPP assessment in practice immediately after training as recommended by the trainers. In fact, it was about six months later, before I first started trying to implement the system into my acute care practice, which as a result I struggled. In my reflection some of the main challenges are:

1. My lack of confidence post-training as I was overwhelmed by the five days course and felt lost as to how I should or could implement the PRPP assessment. Particularly when there is no literature or critical research that focuses on how to adopt and implement the PRPP assessment in acute care practice.
2. The challenge of considering a new occupational therapy model and ways of looking at task analysis and information processing descriptors and their definitions.
3. The lack of structured PRPP assessment documentation or report format for acute care practice. I have also looked into examples from other settings but still find it hard to fit them into my practice setting.
4. As a result of a high patient turnover and caseload, I did not get enough time to process task analysis from a PRPP framework. In some ways, it was easier and seemed more favourable to ‘stick’ to my old routine of practice.

These experiences have motivated and interested me to explore how New Zealand occupational therapists perceive using the PRPP and whether or not it is used in practice following the training course.

**Justification for the Study**

The PRPP literature published to date has focused on the value of the assessment and intervention for particular client population or diagnostic groups rather than the extent to which occupational therapists use or do not use it (refer to Chapparo & Ranka, 2014a for the complete list of the PRPP publications to date). To my knowledge, before undertaking this research project, there was no research that has captured the extent to which, and how occupational therapists use the PRPP in
their clinical practice after completing the training course. This exploratory study will investigate the realities of the use of the PRPP, identify factors that affect occupational therapists’ adoption and implementation in everyday practice.

**Project Aim and the Research Questions**

The aim of this research project is to investigate the extent to which, and how New Zealand occupational therapists use the PRPP in their clinical practice. This is further broken down into following objectives:

1. To explore factors that may influence occupational therapists’ implementation of the PRPP in their practice.
2. To identify the benefits and challenges of implementing the PRPP in clinical practice in New Zealand.
3. To establish the types of support New Zealand occupational therapists have and/or may require in enabling them to foster implementation of the PRPP into their practice.

**Overview of the Chapters**

This research project is presented in five chapters. Chapter One, “Introduction” has set the scene in relation to the purpose of the study, which is to explore how or if New Zealand occupational therapists adopt the PRPP into their practice after the training. I have described why this study is of interest to me and my belief that its purpose is to contribute to the growing body of research on the PRPP.

Chapter Two: The literature review contextualises the study by providing an overview of the use of assessment and outcome measure in occupational therapy, the importance of occupational performance as the outcome variable in professional practice, health service, and research. This chapter follows some of the key literature on factors that influence clinical reasoning in selecting and implementing assessments in occupational therapy practice. The rationale as to why the PRPP is considered as a valuable assessment and outcome measure tool, and its implication into occupational therapy practice are presented.
Chapter Three: The methodology and methods used for this study are outlined. A descriptive and explorative form of inquiry are defined and justified in the context of the research question. The participant sampling process and the data collection and analysis methods are explained. Lastly, the ethics of this research is discussed.

Chapter Four: The findings of this research are presented. The participants’ views are captured by analysing the qualitative data and narrative section of the survey on how the PRPP trained occupational therapists perceive the implementation of the system in their practice.

Chapter Five: The discussion focuses the key findings in relation to the research questions and related literature. The potential implications and recommendations for occupational therapists’ professional development in relation to using the PRPP will be presented. Finally, the limitations of this study are discussed, and conclusions are drawn along with recommendations for future research.
CHAPTER TWO - LITERATURE REVIEW

The purpose of this chapter is to discuss the use of assessment and outcome measures in occupational therapy. It will provide an overview of the role of assessment in practice, the use of standardised measures and its relationship with outcome measurements, and the importance of occupational performance as an outcome variable in occupational therapy practice. Finally, an overview of the Perceive Recall Plan Perform System of Task Analysis (PRPP) (Chapparo & Ranka, 1997) that will be the focus of this exploratory study.

The Nature of Assessment and Outcome Measures in Occupational Therapy

Accurate and timely assessment is fundamental to the occupational therapy problem-solving process and sets the scene for ongoing intervention. The Occupational Therapy Process Standards (New Zealand Association of Occupational Therapy [NZAOT], 2007) have criteria set for each stage of the process including the assessment and the evaluation of outcome stages. The purpose is to ensure consistency of delivery of occupational therapy services (NZAOT, 2007). For example, in the assessment stage, criteria 4.3 states “assessment [must be] comprehensive, appropriate for the purpose, and culturally safe” and criteria 4.6 states “the occupational therapist [must] follows the protocols and procedures relevant to the assessment used, and where required, has completed the relevant training for the assessment selected” (NZAOT, 2007). Furthermore, in the evaluate outcome stage criteria 7.2 states “the processes used for evaluation [must be] consistent with the processes used for assessment and intervention (NZAOT, 2007).

The Continuing Competence Framework for Recertification (CCFR) Practitioner Handbook outlined that New Zealand occupational therapists have the professional responsibility to make sure that whenever possible their practice is evidence-based and consistent with established literature and research findings (Occupational Therapy Board of New Zealand [OTBNZ], 2011). Unsworth (2011) emphasised that the key precursor to evidence-based practice is the need for practitioners to routinely utilise validated outcome measures in their practice.

This is important, more than ever before, to demonstrate the quality and effectiveness of services delivered. The College of Occupational Therapists (2013)
strongly stressed, “without accruing data… occupational therapy will fail to grow, and
the profession will be challenged to produce the robust information that will be
essential to support future commissioning of occupational therapy services” (p. 1).

The importance of using standardised assessment and outcome measure is
well supported in the literature where it is suggested that their use would strengthen
professional credibility and provide effective communication with different
stakeholders (clients, carers, and other health professionals) (Douglas, Liu, Warren, &

Clinical Reasoning in Occupational Therapy - A Problem Solving Process

Occupational therapists play a significant role to help their clients with
‘problems of living’ to optimise their engagement and participation in all occupational
domains (self-care, productivity, and leisure) across the lifespan. The objective is to
ultimately improve the health and wellbeing of individuals, groups, and communities
(OTBNZ, 2012a).

Occupational therapy is a complex intervention. The success in practice
incorporates the occupational therapist’s thinking skills, thought processes, and
decisions making that interact in a complex and dynamic way throughout the
occupational therapy process.

Robertson & Griffiths (2012) define problem solving as a “cognitive approach
to reasoning that is encapsulated within the occupational therapy profession by the
use of the ‘OT [occupational therapy] process’... which has a series of steps including
referral, data collection, assessment, problem identification, planning, intervention
and evaluation” (p. 1-2). Rogers & Holm (1991) described this as essentially having
two stages: problem identification and problem resolution.

This first stage includes assessment procedures and culminates in the
perception of the problem which is crucial to the solution that will be considered
(Robertson, 1999). Rogers (2004) stated, “active problem formulation requires the
collection of data to describe the problem and identify its causes. From the abundance
of data collected, practitioners select the data that are most relevant to the problem
under the consideration.” (p. 20). This process is based on their knowledge, clinical
reasoning skills, and interpretation of the usefulness of information available and an understanding of the context which will influence the options available and limitations to problem solving (Fawcett, 2007, Rogers, 2004). Included in these influences are the theories, conceptual models or frames of reference that occupational therapists choose to adhere to in their practice, which provides an explanation and insight into client’s occupational performance and participation discrepancies (Kielhofner, 2009; Rogers & Holm, 2009).

Literature describes different styles of reasoning that occupational therapists employ to apply the problem-solving process and will, therefore, impact on their assessment decisions. It is thought that different types of reasoning serve different purposes and respond to various aspects of the clinical problem (Fleming, 1991a, 1991b, Schell & Cervero, 1993). Four types of reasoning will be described in this chapter.

**Procedural Reasoning**

Procedural reasoning focuses on identifying occupational therapy problems and selecting assessment and treatment (procedures) to remediate a person’s occupational performance issues based on the disease and disability (Fleming, 1991b, Unsworth, 2001, Ward, 2003). The cues that convey ideas and initial hypotheses about client’s occupational performance deficits are often related to a medical condition and information extracted from the referral, clinical notes, and multidisciplinary team discussion, which are predominantly medically based (Robertson & Griffiths 2012).

Rogers & Masagatani (1982) found that a medical diagnosis is the most critical factor that influences the way occupational therapists assess their clients and formulate a problem statement and treatment plan. Robertson (1999) emphasised it is common for occupational therapists in medicine to have a generic goal (such as safe discharge) before the situation is defined. However, prejudice can become an issue if the occupational therapist has made up their mind before seeing the situation for themselves or listening to the client and their advocate (Robertson, 1999).
Interactive Reasoning

Interactive reasoning helps to refine the occupational therapist’s initial hypotheses by considering the client as a person and examining the illness experience (Fleming, 1991b, Unsworth, 2001, Ward, 2003). Studies have shown interactive reasoning is applied by occupational therapists in their sessions to establish rapport and effective communication, to know the client as a person, to understand a disability from the client’s viewpoint, to individualise treatment, and for reality checking (Fleming, 1991b, Ward 2003). Overall, this is an approach of maintaining client-centered practice in occupational therapy. Creek, Ilott, Cook & Munday (2005) believe there is a positive correlation between the degree of engagement and the success of the intervention. Thus, they emphasised “the therapist-client partnership is more than just an ideal to which we aspire; it is the essence of good occupational therapy” (p. 283).

Conditional Reasoning

Conditional reasoning focuses on the perspective of the person’s condition (including the illness and its meaning), and the impact of this on the broader social, physical, and temporal context in which he/she lives (Fleming, 1991b, Ward, 2003, Unsworth, 2001). This style of reasoning is strongly intertwined with procedural and interactive reasoning. In other words occupational therapists interpret the client in the context of their current situation and their past, and envision what the future will be like. Such vision is then a reference point to select an intervention that best meet the client’s needs.

Pragmatic Reasoning & Worldview

The term ‘pragmatic’ in Oxford Dictionary (2014) is defined as “dealing with things sensibility and realistically in a way that is based on practical rather than theoretical considerations”. Pragmatic reasoning considers the therapists’ practice environment and possibilities of intervention within a given setting. For example, the impact of time on an individual therapy session and the types of resources that could be available for the client. Robertson & Griffiths (2012) and Schell & Cervero (1993) noted this style of reasoning is influenced by the level of skills and experience a
therapist has. Hooper (1997) referred this particular context as a therapist’s ‘worldview’.

Hooper (1997) and Unsworth (2004) stressed that therapist’s personal context is not a form of pragmatic reasoning but creates the platform in which all models of reasoning occurs. Therapist’s worldview is an individual’s frame of mind about life and reality, which encompasses the ethics, values, beliefs, and internal volition of the therapist. Studies show some occupational therapists would be intrinsically inspired to use of ‘self’, personality traits, or interpersonal intelligences to maximise their client’s participation in therapy in order to attain the best possible outcome for their clients and strive for excellence in their practice (Unsworth, 2004; Ward, 2003).

The importance of these frameworks for reasoning is that they provide an understanding of approaches to the assessment phase of problem-solving. Another factor impacting on reasoning is the experience of a therapist. Differences between novice and expert therapists are found in several studies (e.g., Gibson et al., 2000; Mitchell & Unsworth, 2005, Unsworth, 2001).

Schematic processing (Hagedorn, 1996) may be one of the frameworks that help to explain the difference in the level of knowledge, experience, and ability in clinical reasoning. For instance, occupational therapists create an image about the client’s problem based on available cues (collected, organised, selected, and interpreted). This image becomes more refined in the occupational therapy process as they interact with their clients and assess their occupational performance. The closer the image matches the therapist’s schema (experience and knowledge), the more automatic thinking occurs. In contrast, active problem-solving takes place when the image and schema varied considerably (Rogers, 2004).

Mattingly & Fleming (1994) found that procedural and interactive reasoning seems to integrate and compensate one with another in the practice of experienced therapists. Perhaps this is why Ryan (1999) and Sumsion (1999) concluded that experienced therapists have a better grasp of the client’s viewpoints and find it is easier to support their client’s autonomy than novice therapists. These differences in experience as well as in styles of reasoning will impact on the focus in assessment processes and could result in differences in the identification of the problems for intervention.
Nevertheless, experience can also be a two-edge sword, while it can offer guidance in problem solving, it can have the potential to hinder our capacity to shift our gaze and look beyond the obvious (Robertson, 1999). Therefore, an important question that all occupational therapists must ask and reflect upon regularly in continuing professional development is: To what extent are the clients’ views being explored in our assessment? Furthermore, can the use of standardised assessment and outcome measures strengthen our clinical reasoning and improve clinical judgement for better decision making?

Assessments in Occupational Therapy

Assessment is defined as:

The overall process of selecting and using multiple-data collection tools and various sources of information to inform decision required for guiding therapeutic intervention during the whole therapy process. It involves interpreting information collected to make clinical decisions related to the need of the person and the appropriateness and nature of their therapy (Fawcett, 2007, p. 5).

There are many challenges to using assessment effectively and implementing them in a way that can benefit clients and services (this is further elaborated below). According to Duncan (2011), the key skills required for effective assessment in practice are:

• clinical judgement of what is to be assessed and evaluated,
• decision-making regarding the assessment tool and method that is most appropriate to clients’ needs and purposes,
• good observation skills and objectivity,
• present consistent and accurate results timely, and
• clear communication of results to relevant personnel.

The three main methods of gathering information (Duncan, 2011) about client's occupational status are through:

• asking questions using self-report, checklists, questionnaire or interview.
• testing occupational performance component(s) (such as physical, cognitive, or affective functional abilities and limitations), or
• observation (such as client’s performance in ‘occupational form’), in an artificial (such as hospital, clinics), or natural (such as home, workplace, school) contexts.

These methods can be in non-standardised or standardised format, each has its advantages and disadvantages depending on the need and aim of its use in practice. For example, self-report tools strongly dependent on client’s insight in order to recall information accurately and to understand and reflect upon his or her perspective of occupational challenges associated with their everyday contexts (Clarke, 2003; Corr & Siddons, 2005). This places a significant demand on client’s cognitive, executive, and linguistic function skills, such as memory, verbal fluency, and literacy, as all are needed to complete the assessment accurately (Schofield, 2006). Observation assessments directly assess and evaluate client’s occupational performance of chosen task(s) in areas of self-care, productivity, leisure and rest. However, observing a number of tasks can be time-consuming, and the reliability and validity of results may be questionable in the non-standardised form (Fawcett, 2007; Sands & Goodacre, 2013).

**Standardised and Non-standardised Assessments**

In order to reap the full benefits of an assessment, it is important that an appropriate measure is selected that matches the client and the practice context (Alotaibi, Reed, & Nadar, 2009; Duncan, 2011; Piernik-Yoder & Beck, 2012). In many instances, it would be appropriate to use a standardised assessment in order that reliability and validity are assured.

A standardised assessment is defined as:

A published measurement tool, designed for a specific purpose in a given population, with detailed instructions provided as to when and how it is to be administered and scored, interpretation of the scores, and results of investigations or reliability and validity (Cole et al., 1995, cited in Fawcett, 2007, p. 22).
However, in many practice contexts, time and resource availability have led to occupational therapy assessment methods being compromised (Alotaibi et al., 2009; Piernik-Yoder & Beck, 2012). For example, Managh & Cook (1993) found in their study, practitioners’ value standardised instruments, however several adaptations and modifications were made to the way the instrument was administered. This is due to practical reasons such as the time taken to administer the assessment, and the reality that it may be used for the purpose more than what the assessment entails. In addition to practicality, usefulness is equally important, which is about providing meaningful, relevant, and rigorous information for the administrator and consumer (Patton, 1997).

As discussed earlier, implementation of any intervention should always be guided by assessment findings that are based on the conceptual framework of the profession (Clemson & Fitzgerald, 1998; Smith, 1992).

According to Fawcett (2007), there are several main reasons in literature for non-standardised assessments used in occupational therapy practice on grounds of:

- Perceived to be more client-centred.
- Qualitative aspects of occupational performance are thought to be more fittingly ascertained.
- A lack of appropriate standardised assessments.
- Client may not tolerate the lengthy standardised assessment.
- Limited funding to purchase standardised measures.

A national survey study across clinical settings found that in America standardised assessments are more frequently used by occupational therapists in paediatric practice setting compared to adult settings (Piernik-Yoder & Beck, 2012). This difference may reflect a service approach difference between paediatric practice, which is developmental, and adult settings that focus on compensatory and/or rehabilitation approaches. The authors also suggest that this may reflect paediatric occupational therapists’ need to select a measure to match their clients’ age and diagnosis in order to determine eligibility for services.

It is critical for occupational therapists to be fully aware of the limitations of using a non-standardised assessment. Non-standardised assessment findings are more
subjective and open to interpretation when compared to the psychometric rigour of findings gained from a standardised assessment (Fawcett, 2007). Consequently, this makes feedback of assessment outcome to clients, families, or multidisciplinary team difficult, particularly when being challenged to prove the efficacy of assessment and intervention (Welch & Forster, 2003). Standardised assessments that have been developed through sound research provide a more objective measure of change.

Fawcett (2007) reported that ‘adaptive syndrome’ is common in occupational therapy practice whereby practitioners take different components of standardised assessments and integrate these into a composite assessment tool for particular client groups or service needs. The fundamental concern of this approach is that the reliability and validity of the instrument and its findings are compromised because the standardised assessment protocols for administration and scoring have been altered. For this reason, occupational therapists must have a good understanding of the psychometric properties of the measures they will use. Fawcett (2007) also stressed that historically many standardised tests adopted by occupational therapists are created by other professional groups, principally psychology and medicine. The disadvantage of borrowing tests from other disciplines is that these tests often have inherent problems for occupational therapists in that they do not always fit well with occupational therapy professional philosophies and practice and do not assess or measure client’s activity limitation, participation restriction, or efficacy of treatment and service provided.

**Top-down versus Bottom-up Assessments**

Historically, bottom-up assessments have been more dominant in occupational therapy practice because they fit a medical model of disease, diagnosis, and treatment (Coster, 1998, Stewart, 1999). As described by Brown & Chien (2010) these instruments mainly focus on body structure and the function (impairment) level of the International Classification of Function, Disability and Health (ICF; World Health Organisation [WHO], 2001). By contrast, top-down assessments take a holistic approach and focus on individual’s participation in meaningful contexts. This perspective links closely to the activities and participation level of the ICF framework (WHO, 2001).
A combination of these approaches is often used in practice. For instance, in New Zealand, Robertson & Blaga (2013) found that top-down non-standardised assessments (such as interviews and observations) are commonly used by New Zealand occupational therapists in acute care practice to evaluate patients’ occupational performance and capacities and provide information about their home environment and occupational profiles. Bottom-up standardised cognitive screening assessments such as the Allen Cognitive Level Screen (ACLS), the Neurobehavioural Cognitive Status Examination (Cognistat), the Westmead Post Traumatic Amnesia Scale (WPTAS), the Mini Mental State Examination (MMSE) are not uncommon in their practice to further investigate assumptions related to safety in discharge procedures when situations were particularly complex.

Researches on occupational therapy assessment practice have revealed that occupational therapists are more likely to use top-down non-standardised assessments, to establish their client’s safety, occupational performance, and need for service. While bottom-up standardised assessments are more frequently used to identify client’s performance component deficits (Alotaibi et al., 2009, Coster, 1998, Douglas et al., 2007, MacDermid, Soloman, Law, Russell & Stratford, 2006, Robertson & Blaga, 2013, Schofield, 2006). Although assessing impairments to identify factors (performance components) that affect occupational participation and performance of daily life is important, many researchers stress that it is not the primary focus in occupational therapy practice (Fisher, 1998; Kielhofner, 2009; Mathiowetz, 1993; Trombly, 1995). Significant concerns have been raised from these studies because it was found that respondents’ main barriers to using standardised measures were their lack of time and lack of knowledge about available instruments and measurement properties. Additionally, the most cited reason to choose and use specific assessments by occupational therapists was simply their ‘availability’ in the practice settings. Without a doubt, this is an untenable rationale and poses a serious risk to both the quality and safety of services and their stakeholders (clients, carers, professionals, and funders), and has an adverse impact on professional credibility (Alotaibi et al., 2009; Piernik-Yoder & Beck, 2012). The ability to rapidly, reliably, and sensitively determine a client’s occupational performance status using an assessment tool is essential for effective treatment planning and evaluating the effectiveness of intervention, both at a client and at a service level (Welch & Forster, 2003).
Outcome Measures in Occupational Therapy

Unsworth (2000) stated:

Current pressures to document outcomes and demonstrate the efficacy of occupational therapy intervention arise from fiscal restraints as much as from the humanitarian desire to provide the best quality health care to consumers. However, measuring outcomes is important in facilitating mutual goal setting, increasing the focus of therapy on the client, monitoring client progress, as well as demonstrating that therapy is valuable. (p. 147)

In recent years, the need for appropriate, sensitive, and standardised tools in occupational therapy has grown (Fawcett, 2007, Unsworth, 2000). The demands for efficient and effective services are pushing occupational therapists to document outcomes and prove the efficiency and efficacy of their intervention, and professional credibility (Fawcett, 2007). However, despite a decade of expectation, evidence still suggests that consistent use of outcome measures remain low in occupational therapy (Bowman, 2006, Bowman & Llewellyn, 2002, Duncan & Murray, 2012, Stapleton & McBrearty, 2009).

Barriers to routine use of outcome measures in occupational therapy practice have been identified in the current literature. These were grouped into themes at both the individual therapist’s level and the organisation level. The barriers at the individual therapist’s level are practitioner’s lack of self-confidence and motivation, and knowledge about outcome measures’ psychometric properties, together with insufficient time to use outcome measures in clinical practice (Bowman, 2006, Bowman & Llewellyn, 2002, Duncan & Murray, 2012). The barriers at the organisational level include: low organisational priority, lack of management support, absence of suitable outcome measures and funding to purchase the appropriate measurement tools, and poor interpretation and misleading presentation of data (Bowman & Llewellyn, 2002, Duncan & Murray, 2012).

These barriers are identical to the barriers to using standardised assessment in occupational therapy practice as discussed earlier. A major challenge for occupational therapists is to articulate what should or could be measured when participation in
occupation is the foundation of practice to all therapeutic interventions. This would require incorporating variables that are difficult to define, measure, and quantify (Robertson & Colborn, 2000). Therefore, before practitioners can precisely decide what needs to be measured and how to measure it, the antecedent would be to intelligibly identify and describe the essence of any assessment/intervention goal in occupational therapy.

Many researchers (e.g., Bowman & Llewellyn, 2002, Cusick & McCluskey 2000, Dubouloz, Egan, Vallerand, & von Zweck, 1999, Duncan & Murray, 2012) highlighted that occupational therapists need specific and continuing professional development to competently select and utilise outcome measure(s) for their practice.

Fisher & Jones (2010) strongly recommends that occupational therapists assess and evaluate their clients using a top-down approach that begins broadly by gathering information about the client, current circumstances and their needs and desires to participate or perform tasks to fulfil their chosen occupations and life roles. Fawcett (2007) explains the advantages of using this approach are to help the therapists to gain an early understanding of the person’s values and needs, to facilitate the development of the therapist-client partnership, and to provide an accurate understanding of the person and their problems which is critical for the identification of relevant and meaningful treatment goals. This is indispensable, as the World Federation of Occupational Therapists (WFOT) Statement of Occupational Therapy declared that “the outcomes in occupational therapy are client-driven and diverse and measured in terms of participation, satisfaction derived from occupational participation and/or improvement in occupational performance” (WFOT, 2012, p. 1). Welch and Forster (2003) asserted that the rising need for occupational therapists to reaffirm their unique role in health care by undertaking an ‘objective’ occupational performance assessment to assist therapists’ to clinically reason through appropriate interventions for their clients.

**Impact of Cognition on Occupational Performance**

Occupational performance is defined as “the ability to choose, organise and satisfactorily complete meaningful occupations” (Canadian Occupational Therapy Association 1997 [2002], p. 30).
Chapparo (2010) explained:

Effective performance is thought to be supported by a number of cognitive capacities… (that) include attending, perceiving, recognising, remembering, judging, learning and problem solving… (which also incorporate) the ability to apply cognitive strategies to sensing, thinking, monitoring… to self-regulation of emotions, mood, affect and appropriate behaviour during task performance. (p. 183)

For this reason, any cognitive deficits will have at least some impact on one’s occupational performance and quality of life. Stroke, traumatic brain injury, infectious diseases, tumours, dementia, substance abuse, organic cause of psychiatric symptoms, mental health or existing congenital conditions may cause cognitive disorders (American Occupational Therapy Association [AOTA], 2011). Individuals may experience problems focusing and maintaining attention, detecting sensory changes in the environment or interpreting cues from the body or the task. They may also experience problems remembering important information, organising their thoughts, making choices or judgments in their reasoning, or even an inability to pace performance to match the task or contextual requirements (AOTA, 2011). These difficulties are commonly present in clients with general medical/psychiatric disorders across different clinical settings.

In contemporary practice, occupational therapists are required to determine and understand cognitive impairments and explain the impact they have on their client’s performance in everyday occupations and routines. Ranka (2005) pointed out that many assessments of perception and cognition used by occupational therapists are limited in their abilities to meet the demands of contemporary practice because they:

- Have been designed for use with specific diagnostic and age groups.
- Have a narrow focus and do not assess totality of perception and cognition.
- Have limited sensitivity to assess clients with low-level (e.g., semi-comatose, end stage dementia) or higher level of cognition.
- Are time-consuming (to administer and report on).
- Are not useful in measuring outcome.
• Lack of a model to guide practitioners to develop interventions aimed at improving impairments, activity limitations or participation options.
• Have cost associated (e.g., test kit, score sheet, result generation).
• Lack a theoretical foundation to explain why the test is constructed as it is.
• Are unable to assist practitioners in understanding and explaining the impact of cognitive impairments or a client’s performance of everyday tasks.

There is an increasing awareness of the limitations of traditional (bottom-up) standardised assessment that measure cognition and/or perceptual skills without the person’s occupational context (Chapparo & Ranka, 1997). Many studies (e.g., Bottari, Swain, & Dutil, 2007; Crennan & MacRae, 2010; Samsonraj, Loughran & Secker, 2012; Wales, Clemson, Lannin, & Cameron, 2012) have supported the importance for occupational therapists to use (occupation) performance-based standardised assessments to correctly interpret the information of occupational performance issues within the client’s context. This relies significantly on practitioner's observational and clinical reasoning skills, including their construct of theoretical knowledge and critical evaluation. Moreover, the need to document these findings and track outcomes are pivotal to assist in both treatment and discharge planning. Stewart (1999) asserts, “when clinical judgement is based on objective assessment arising from the use of standardised instruments rather than intuitive guesswork, occupational therapists’ decision making can be seen to be more rational and consequently defensible” (p. 422).

**Perceive Recall Plan Perform System of Task Analysis**

As discussed earlier, contemporary occupational therapy practice demands an assessment system that has a standard administration protocol; flexible enough to be used with a wide range of clients at all levels of function and different backgrounds (Chapparo & Ranka, 1997, Corr & Siddons, 2005, Fawcett, 2007, Unsworth, 2000). Additionally, it must be cost-effective, time efficient, and can provide guidance to clinical decision making for planning occupational therapy interventions (Corr & Siddons, 2005, Fawcett, 2007, Unsworth, 2000).

According to Chapparo & Ranka (1997), the Perceive Recall Plan Perform System of Task Analysis (PRPP) was developed to meet such demands of
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occupational therapy practice. This instrument has undergone continuous revision and review since 1985 in response to the limitations identified by occupational therapists based on contemporary methods of assessment and managing clients with brain injury. The PRPP was developed based on the Occupational Performance Model (Australia) [OPM(A)] and a task analysis methodology (Chapparo & Ranka, 1997; Ranka, 2014). This is used to determine the person’s information processing problems in the context of tasks and activities of daily living that are meaningful and relevant to them (Chapparo & Ranka, 1997; Ranka, 2014).

Chapparo & Ranka (2011) stated “the assumption underlying the (PRPP) assessment structure is that people, with or without disorders of cognition, have been found to use the same set of cognitive strategies performing most everyday occupations” (p. 150). On that account the use of PRPP is premised on three assumptions. Firstly, the interpretation and utilisation of information to perform actions and/or the cognitive processing to required to complete a task is influenced by the person’s processing capacity and the demands in the context of the tasks being performed. Secondly, the implementation of information processing strategies in performing everyday tasks are observable and identifiable. Lastly, therapeutic interventions are able to impact on the execution of information processing strategies to improve task performance (Chapparo 2010; Nott, Chapparo, & Heard, 2009).

The PRPP is a context-based performance assessment such as the occupational therapists observe and evaluate their client’s performance based on a sample of occupations identified by the client, their family/carer or significant others that is relevant to his/her needs and roles (Chapparo & Ranka, 1997; 2013). This instrument simultaneously measures occupational performance and outcome of occupational therapy intervention at both the level of body structure and function and at the level of activity and participation of the ICF (Nott & Chapparo 2012; Nott et al., 2009).

According to the PRPP researchers (i.e., Chapparo & Ranka, 1997; Nott & Chapparo 2012) the PRPP assessment approach is different to existing bottom-up and top-down assessment tools such as, the Rivermead Perceptual Assessment Battery, Rivermead Behavioural Memory Test, and Assessment of Motor and Process Skills (AMPS) in that they limit the evaluation to the perceptual and/or cognitive skills or a set of standard functional tasks in isolation from the person’s context.
As a ‘system’ the PRPP can be used “as a formal, scored test of occupational performance, a framework to observe occupational performance, a questionnaire to seek written information about one’s perception of occupational performance skills, capacities and difficulties, or as an interview about the perception of one’s capacity to apply cognitive strategies in everyday life” (Chapparo & Ranka, 2013, p. 1). The extent of the analysis is affected by the complexity of the task and the performance of the individual (Aubin, Chapparo, Gélinas, Stip, & Rainville, 2009).

The Two Stages of Analysis

The PRPP consists of two stages of analysis. Stage One of the evaluation involves a standardised behavioural task analysis, whereby everyday activity performance is broken down into steps, and errors of accuracy, omission, repetition, or timing in performance are identified (Chapparo & Ranka, 1997; 2011; 2013). An overall mastery of an individual’s ability to do specific and relevant occupations is generated from this information (Chapparo & Ranka, 1997; Fry & O’Brien, 2002; Nott & Chapparo, 2008).

Fry & O’ Brien (2002) appraised the benefits of using PRPP as being:

Measurable occupational performance goals (set by the client and/or their carer that) can be re-evaluated following intervention. As this assessment does not have a predetermined set of functional tasks, it promotes a client-centred approach and enables assessment and retraining in any task selected by the client and/or carer. (p. 183)

Stage Two focuses on identifying observable cognitive strategy deficits resulting in performance errors. It uses cognitive task analysis methodology to evaluate the information processing strategies that form the basis of occupational performance. These are perception, recall, response planning, and performance as central quadrants in the PRPP System’s theoretical model (Nott & Chapparo, 2008; refer to Appendix A, Figure A1). These quadrants are interrelated hence difficulties experienced in one quadrant will influence performance in another. In this assessment errors in cognition in each quadrant are identified as actual observable behaviours
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(Chapparo, 2010). In total, 34 different information processing strategies, termed descriptors on the outer circle of the PRPP System are rated on a three-point scale indicating how effectively the person applied each cognitive strategy (Nott & Chapparo, 2008).

**Criteria-referenced and Client-centred Assessment**

The PRPP provides occupational therapists with a structured way of analyzing their clients’ cognitive (information processing) abilities in any occupational performance task and developing a client-centred approach to intervention (Chapparo & Ranka, 1997; Fry & O’Brien, 2002; Nott & Chapparo, 2008). For it to be used in occupational therapy practice, practitioners must complete a formal PRPP training course.

Fry and O’Brien (2002) highlighted the task-analysis approach of identifying cognitive deficits in daily occupations shifts occupational therapy assessment away from medical models of diagnosing cognitive and perceptual disorders and becoming occupational performance focused. Using the PRPP assessment enables occupational therapist to identify and describe the behaviours of concern in the performance of everyday tasks and relate this to information processing strategies (Chapparo, 2010, Fry & O’Brien, 2002).

**Critical Evaluation of the PRPP**

Corr and Siddons (2005) emphasised that measurement tools must have their validity, reliability, sensitivity, and clinical utility established so that the outcome measures used by occupational therapists are accurate, applicable, reproducible, practical and easy to use in their daily practice. The checklist designed by Jorosch-Herold (2005, refer to Appendix B) was utilised to critique the PRPP and determine its psychometric properties and its clinical utility in occupational therapy practice.

**Reliability & Validity**

Recent studies have concluded that the assessment procedures of the PRPP are highly reliable in measuring the occupational performance of adults with diagnosis of
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schizophrenia (Aubin, et al., 2009), dementia (Voigt-Radloff et al., 2011), traumatic brain injury (Bootes, & Chapparo, 2010; Fry & O’Bien, 2002), human immunodeficiency virus (HIV) associated neurocognitive disorders (Ranka & Chapparo, 2010), and children with learning difficulties (Lowe & Chapparo, 2010).

The PRPP has a strong construct validity that is parallel to conceptual models of information processing and occupational performance, and other occupation-based standardised assessments such as, Arnadóttir OT-ADL Neurobehavioural Evaluation (A-ONE) and AMPS (Nott & Chapparo, 2012).

The PRPP has a moderate inter-rater and test-retest reliability for children with autism, adults with acquired brain injury, schizophrenia, and mild dementia population (Aubin et al., 2009, Nott et al., 2009, Steultjens, Voigt-Radloff, Leonhart, & Graff, 2012). Aubin et al., (2009) questioned whether the difference among assessors’ clinical skills, knowledge, and experience with the PRPP assessment might have contributed to a lower inter-rater reliability. The common limitations found among these studies were a small sample size and a limited number of trained and experienced assessors. Therefore, as concluded by the researchers, the results can only be interpreted as exploratory (Aubin et al., 2009; Nott et al., 2009; Nott & Chapparo, 2012; Steultjens et al., 2012).

Traumatic brain injury studies using case study research methodology found the PRPP enables therapists to objectively observe their client’s performance of any task/sub-task, identify cognitive functional deficits, and develop occupational therapy treatment plan to remediate the performance issues (Fry & O’Brien, 2002, Nott & Chapparo, 2008). “The information derived from this instrument can be used to establish measurable, client-centred goals for intervention planning” (Fry & O’ Brien, 2002, p. 187). Furthermore, the instrument is “sensitive to information processing abilities and changes to these abilities (on repeated measures) over time” (Nott & Chapparo, 2008, p. 190).

Nott and Chapparo (2008) proposed that:

(The) use of visual representation of change (in clients’ ability to apply information processing strategies during occupational performance i.e., Appendix A, Figure A2 and A3) may be an effective method of demonstrating assessment findings (and the effectiveness of
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occupational therapy related intervention) to members of multidisciplinary team, clients, and families. (p. 196)

Nott & Chapparo (2008) concluded that further studies with greater statistical power involving larger sample size are needed to enable generalisation of findings to any stages of recovery and disease progress in various patient and population groups.

No published research has been found that has explored the PRPP and its cultural validity. However, several authors of the PRPP research recommended it is culturally appropriate since the assessment are contextually relevant. (Aubin et al., 2009; Nott et al., 2009). The ability to choose the tasks undertaken in the PRPP allows occupational therapists to allow their clients and/or their carers of different cultural background to select any task or routine that is meaningful to their specific roles (Fry & O’Brien, 2002). Hence, ecological validity of the PRPP is thought to be supported by being a criterion-referenced measure involving everyday activities or tasks. This has not been investigated in the PRPP research studies to date.

Clinical Utility

The PRPP provides occupational therapists with a systematic approach to explain individual’s occupational engagement and performance level, maintain occupation-focused practice and measure outcomes (Chapparo & Ranka, 1997, Mackenzie & O’Toole, 2011).

The system is a unique occupational performance-based assessment and can be only administered by registered and practicing occupational therapists who have completed a formal five-day training by the assessment developers (Chapparo & Ranka, 1997, Ranka, 2005). Chameleon Courses (2012) describes the PRPP as a time-efficient assessment tool. Stage One can be administered and scored during the time it takes the client to do the task. Stage Two can be administered during the task performance and takes approximately 10-15 minutes to score once a therapist is familiar with the assessment. However, the overall time taken to administer the assessment will vary by individual, depending on the complexity of tasks assessed and the severity of information processing difficulty.
There is no standard report format for the PRPP assessment. According to Dr. C. Chapparo and Dr J. Ranka (personal communication, 15th March 2013) this quality provides occupational therapists flexibility to develop report structures and styles that best suit their area of practice and client group needs.

It is clear that the PRPP is still in its infancy as there are limited publications available. However, this standardised assessment is starting to gain popularity among academics and the professional community. There is increasing evidence of its versatility and clinical utility in different healthcare settings and patient groups in recent years, and it is supportive of practitioners needing to their shift focus from a traditional medical model to occupation-based models. Occupational therapy philosophy and its practice recognises that “engagement in meaningful and purposeful occupation is the most effective way to empower patients, facilitate independence, and advance health” (Smith-Gabai, 2010, p. xi). For this reason, the PRPP could be viewed as a potentially valuable tool for occupational therapists to establish and maintain their professional role and credibility in practice when working with various clients identified with cognitive-related occupational performance issues.

The PRPP System Training in New Zealand

The PRPP was first introduced to New Zealand occupational therapists in February 2007 as a 5-day assessment-training course facilitated by the founders from Australia. Dr. Chris Chapparo and Dr. Judy Ranka. Subsequently, the PRPP assessment training courses were offered in February 2009, June 2011, and March 2013 and a 4-day intervention-training course was offered in June 2011 (Chapparo & Ranka, 2014b).

As reported earlier, the PRPP literature to date has tended to focus on the value of the assessment and intervention for a particular client population or diagnostic groups rather than the extent to which occupational therapists use or do not use it. International literature search before this research project suggested there is no research study that has been conducted in the past that captured how or if occupational therapists adopt the PRPP into their practice after the training. For this
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reason, the aim of this research project is to explore how New Zealand occupational therapists perceive the use of PRPP in clinical practice.
CHAPTER THREE - METHODOLOGY

This chapter outlines the research methodology and method utilised for this study. It begins by stating the research question and objectives of the study, followed by the explanation of the underlying theoretical perspectives taken for the research approach used. The discussion includes the decisions related to designing the questionnaire and rationale of using to non-probability sampling. The data collection and data analysis methods undertaken during this study are described in full details. Lastly, ethical considerations and measures to provide trustworthiness are also discussed.

Research Question

The central research question of this study is to investigate the extent to which, and how New Zealand occupational therapists use the Perceive Recall Plan Perform System of Task Analysis (PRPP) (Chapparo & Ranka, 1997) in their clinical practice.

This research question is subdivided into the following objectives that shaped the design of the overall study. These were to:

- Explore factors that influence occupational therapists’ implementation of the PRPP in their practice.
- Identify the benefits and challenges of implementing the PRPP in clinical practice in New Zealand.
- Establish the type of support occupational therapists have and/or may require in enabling them to foster implementation of the PRPP in their practice.

Research Paradigm

All research studies do vary between researchers because every researcher has their beliefs and values and how they interact with the worlds around them. Nevertheless, there are certain standards and principles so-called, paradigm that guides researchers in making decisions throughout the research process, from study design choices to interpretation of the results (Khanal, 2012).
The nature of the research questions shapes the research methodology and the development of the study design (Dawson, 2009; Denscombe, 2010). This study is framed by the post-positivist paradigm, which assumes the phenomena (observable facts and events) have antecedent causes, and do not occur in a haphazard way. This signifies the underlying causes of natural phenomenon and its qualities can be scientifically studied and explicated (Vanderstoep & Johnston, 2009). Having said that, post-positivism proposes, “truth can only be slowly and imperfectly arrived at given the limitations of the research process” (Fox, Martin & Green, 2007, p. 11). The characteristics of post-positivist research are as the following:

Firstly, post-positivists believe it is impossible for a researcher to be thoroughly objective and bias-free as “all perception is biased by who we are and who we claim to be” (Vanderstoep & Johnston, 2009, p. 171). The researcher acknowledges that he cannot take a neutral or value-free position in the research. The research design, interpretive and analytic process and the findings are all consciously and unconsciously shaped by background, experience and skills, and ways of knowing.

Secondly, post-positivists argue positivism approaches to research are at risks of objectification by labelling those researched as ‘subjects’ in the study. That is, when the researcher takes on a superior position as an expert while those studied are laypeople (Vanderstoep & Johnston, 2009). Post-positivists recognise the contribution of people who take part in data collection as research participants or respondents for their collaboration and their significance to the research. Unlike qualitative researchers who hold the view that meanings are created by those who make sense of their experience, post-positivists perceive the role of the researcher is merely to report participants’ views or experiences. Any data analysis and interpretation is clearly declared by the researcher and is weighted equally to anyone else’s interpretation (Fox, Martin & Green, 2007; Vanderstoep & Johnston, 2009).

Thirdly, the ability to generalise findings is challenging from a post-positivism perspective (Vanderstoep & Johnston, 2009). This is because the interplay between people and their environment are dynamic. The research only takes a snapshot of a moment in time. Accordingly, any conclusion drawn from studying the sample data
does not necessarily apply to the population of interest or forecast the future rigorously, due to the unforeseeable changes that make up the real world (Loiselle, Profetto-McGrath, Polit, & Beck, 2011). Furthermore, Weaver & Olson (2006) questioned the completeness of understanding of the phenomenon when a researcher has overall control of the research design, questions asked, and analysis of the result. They argue that by only examining a portion of the whole person through the questions asked, a researcher selects information and ideas to audiences with his agenda. In some ways, a full grasp of participants’ viewpoints about the phenomenon may be lost.

The aim of this research project is to explore the implementation of the PRPP in occupational therapy practice in New Zealand. It was also intended to identify whether there were any relationships between variables such as occupational therapist demographics, professional education, practice contexts, and post-training supports on their competence and confidence in adopting and applying the skills and knowledge of PRPP in their practice. On that account, the post-positivist paradigm was congruent with the aim and of this research project and the limitations did not impact on the essence of this study that was exploratory in nature.

**Research Methodology**

The PRPP literature to date has always focused on the value of the assessment and intervention for particular client population or diagnostic groups rather than the extent to which occupational therapists use or do not use it. To the researcher’s knowledge (based on an extensive literature survey), there is no research that has captured the extent to which occupational therapists use the PRPP in their clinical practice in New Zealand and it is not clear to how they implement the PRPP in their practice following the attendance of the assessment course training. A survey method based on descriptive-exploratory methodology is therefore appropriate to gain insights about the use of the PRPP in occupational therapy practice in New Zealand.

According to Marczyk, DeMatteo, & Festinger (2005) a descriptive approach is defined as “the process of defining, classifying, or categorizing phenomena of interest” (p. 16). The approach was used to depict the characteristics of research
participants (including demographics, academic, years of experience, and areas of occupational therapy practice) and their experience of using the PRPP in their practice after completing the training course.

The word ‘exploration’ according to Collins Dictionary (2014) means “actions are done in order to discover something or learn the truth about something.”

Exploratory research serves the purpose to gain insight, discover new ideas, and increase knowledge of the setting, group, or phenomena when a subject investigated is relatively new and unstudied (Adler & Clark, 2011; Marczyk et al., 2005; Ruane, 2005; Rubin & Babbie, 2011). Neuman (2007) is of the opinion that descriptive and exploratory research is similar in some aspects that both “often blur together in practice” (p. 16). This appears to align with Kielhofner’s (2006) viewpoint that: “descriptive research often takes advantage of naturally occurring events or available information in order to generate new insights through inductive processes. Consequently, descriptive investigations often serve as exploratory purpose” (p. 58).

All these reasons have collectively contributed to the researcher's belief that the most appropriate and practical post-positivism method of inquiry that reflects the descriptive and exploratory nature and purpose of this study is survey research, which will be explained in the next section.

Research Method

Survey research is a form of systematic scientific inquiry that is characterised by using structured questions to elicit self-report information from a sample of respondents to describe, compare, or explain knowledge, attitudes, and behaviours (Burns et al., 2008; Fink, 2002; Forsyth & Kviz, 2006). The aim of the survey is to gather data as accurately and precisely as possible from a sample of respondents within the population of interest (Bowling, 2005; Burns et al., 2008). Fink (2002) describes a typical survey process includes the following research activities: “setting objectives for information collection, designing the study, preparing a reliable and valid survey instrument, administering the survey, managing and analysing survey data, and reporting the results” (p. 1).
Survey research is ideal to explore the research topic because it can investigate professional attitudes, knowledge and the practice of participants from a range of practice settings (Forsyth & Kviz, 2006). There are many types of survey methods, and each has a different set of advantages and considerations. An online survey was considered to be the best way for a descriptive-exploratory cross-sectional study of this nature using non-probability sampling to obtain information from potential participants in this research project. It is relatively inexpensive and time-efficient compared with other modes of survey data collection (Sue & Ritter, 2012). It provides a convenient mean of surveying and reaching potential participants that are practicing occupational therapy over vast geographic and practice settings in New Zealand.

A fundamental reason behind the researcher's choice of online survey method is that this study is being carried out and submitted as a research project report in part fulfilment of a Master of Occupational Therapy degree at Otago Polytechnic which has to be completed within a set timeframe. It is the preferred method for data collection to answer the research question. Furthermore, the researcher also needed to keep costs of the study to a minimum as the study is largely self-funded. For this reason an online survey using digital technologies was considered an ideal data collection strategy that made the best use of resources available for this research project.

The rapid advancements in online survey services have enabled researchers to create digital surveys effectively even for those with limited technical knowledge. Online survey services such as SurveyGizmo are user-friendly and offer numerous resources and tools like survey templates to assist researchers to easily begin the process of creating a new questionnaire. The services offer step-by-step instructions, tutorials, and online forum with support staff (SurveyGizmo, 2014). The other advantages of online survey research include low administration cost, effective data management (i.e., minimise data entry error), flexibility on survey design options, and maintain respondents’ anonymity which enable them to more freely and honestly answer the questions from the comfort and privacy of their own environment (Denscombe, 2011; Forsyth & Kviz, 2006; Sue & Ritter, 2012).
Survey research is sometimes regarded as an effortless research approach as anyone can write down a list of questions and distribute it. However, the quality of study and the reliability of the information gathered can vary considerably. A rigorous questionnaire for survey research, that is high quality and value that producing representational data can be challenging and laborious to develop, test, and administer. Boynton & Greenhalgh (2004) stress that “inappropriate instrument and lack of rigour inevitably lead to poor quality data, misleading conclusion and woolly recommendations” (p. 1312).

Design and Instrumentation

Before this study, there was no existing survey instrument that was designed to investigate occupational therapists’ practice and their experience after attending PRPP assessment training. The researcher therefore created a survey instrument based on similar studies by Chard (2000, 2004, & 2006) that had looked at how occupational therapists used the Assessment of Motor and Process Skills (AMPS) in their practice following the training. As a novice researcher the following guidelines and recommendations were followed in the designing of the survey instrument for this project (Burns et al., 2008; Boynton & Greenhalgh, 2004; Kelley, Clark, Brown, & Sitzia, 2003; Williams, 2003).

A cross-sectional survey design was used to collect data that described the status of a phenomenon at a single point in time (Kelley et al., 2003). In this instance, the impact of the PRPP on the practice of trained occupational therapists in New Zealand. The major advantages of this approach are that it is economical and easy to manage (Loiselle et al., 2011).

There are two types of questions in the questionnaire, namely open-ended (unstructured) questions and closed-ended (structured) questions.

The open-ended questions are useful for uncovering new or unanticipated responses where no previous data exists. Participants are given opportunities to state their viewpoints. However, they may take a longer time to answer especially for those who are less articulate (Loiselle et al., 2011). In comparison, the closed-ended
questions are quicker to answer and simple to code. Responses can be as simple as yes/no choices, multiple tick boxes, ranked in order of preference or in a Likert scale format (Loiselle et al., 2011). Some of the closed-ended questions in this questionnaire include an ‘other’ tick box option and/or a comment section. These allow respondents to add in answers that are not on the list thus providing opportunities for them to give any further explanation about their responses.

The content of the questions was generated in three ways: Literature search and review of related research areas, consultation with the PRPP subject matter experts and the research supervisor, and finally the researcher’s practice experience. The aim was to develop a concise questionnaire that could reliably describe and explore the use of PRPP by occupational therapists in their practice in New Zealand. The content and face validity of the survey were established through pilot studies, this is discussed in the next section.

The layout of the questionnaire is important in survey design. Studies have shown that the wording and the order of questions have an important influence on response rate and responses given by participants (Burns et al., 2008; Williams, 2003). For this reason, the length of the questionnaire was relatively short at 29 questions. The questionnaire was piloted (Stage one and Stage two) and confirmed that on average it should not take more than 15 minutes to complete. Great attention was given to make sure the questions were unambiguous and instructions were clearly worded.

The questionnaire was constructed in three sections. Section one gathered general information about participants and their history of PRPP assessment training. Section two focused on exploring participants’ experience of using the PRPP such as the factors that affected their adopting decision and subsequent implementation in everyday practice, as well as suggesting strategies that may support greater use in practice and providing their opinion of the relevance of its use with clients from diverse cultural context (such as Maori, Pacific Islander, Asian) in New Zealand. Section three elicited demographic information such as, gender, ethnicity, qualification, field of practice, area of specialty, and years of practice in occupational therapy (Appendix C).
The order of the questions in the questionnaire was designed to be as efficient as possible for participants to complete. “Skip-logic” was used to direct respondents to a set of questions based on their response to a previous question, which according to Sue & Ritter (2012) is an essential feature that significantly contributes to the validity of the survey response. This is because respondents are not forced to read and answer unnecessary questions in the questionnaire. Use of carefully balanced skip logic using a web-based questionnaire allowed the researcher to collect specific data comparing respondents who have used the PRPP System to those who have not used it in their practice.

The web-based online questionnaire was developed using the SurveyGizmo™ tool (http://www.surveygizmo.com; Boulder, Colorado) which specialises in developing online survey, and collecting and managing survey data. The paper version of the questionnaire was designed using Microsoft Word for Mac 2011 and it was formatted into a printable version with correct layout and Otago Polytechnic branding with support from the Communications & Marketing Management Project Specialist (Ms. Katie Duncan) of School of Design at Otago Polytechnic, Dunedin.

Validating the Survey Instrument

Pilot Studies

The quality of questionnaire data depends on participants interpreting and understanding the questions and instructions in a consistent manner, as intended by the researcher (Burns et al., 2008; Kelley et al., 2003). Pilot studies were used to ensure the content and face validity, as well as the clarity of instructions, the question design and the response choices of the questionnaire (Burns et al., 2008; Kelley et al., 2003). The questionnaire was piloted through field pre-testing (Forsyth & Kviz, 2006). Debrief questions were included to seek feedback from the field tests which allow unforeseen problems in the questionnaire to be addressed and have greater content validity before doing the data collection (Fowler, 1995 cited in Forsyth & Kviz, 2006). The pilot was in two stages:

First stage. The first stage of the pilot involved a questionnaire in paper form during the February 2014 Master’s School week (Occupational Therapy) in Dunedin.
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Three classmates volunteered to give general feedback around the layout, time required to complete the questionnaire, grammar/syntax of the instructions, questions and answer formats. Following this the questionnaire was re-edited, and an online questionnaire was created using the SurveyGizmo™ tool (http://www.surveygizmo.com; Boulder, Colorado) for the pilot in the second stage.

**Second stage.** The second stage of the pilot required occupational therapists who had completed the PRPP assessment training to complete the online questionnaire and provide specific feedback by answering the following questions:

- Is the objective of this study clear?
- Is the wording of the survey clear?
- Do you feel comfortable answering the questions?
- Can you complete the survey within 20 minutes?
- Are the answer choices compatible with your experience?
- Do any of the questions require you to think too long or hard before responding? If so, which one?
- Do any of the questions produce irritation, embarrassment, or confusion?
- Has any important issue been overlooked?

The PRPP-trained occupational therapists in Australia were identified as ideal candidates for the pilot in this stage to provide specific feedback, and enable the researcher to hold the target population of PRPP-trained occupational therapists in New Zealand. Assistance was sought from the PRPP subject matter experts in New Zealand to act directly as the intermediary of information about the pilot part of the research project in the second stage with potential candidates in Australia.

During the term of the pilot, four PRPP-trained occupational therapists in Australia expressed their interests to participate. Subsequently, two completed the pilot online questionnaire and provided their feedback, and two dropped out. Based on the feedback received, some minor amendments were made to the layout and format of answering the questions. Further piloting was not an option for the researcher due to time constraints on this research project.
Target Population & Sampling

The sample of this study was chosen using non-probability convenience sampling (Sue & Ritter, 2012). The inclusion criteria set for the study were that the participants were currently practicing occupational therapists and had completed the PRPP assessment training course. They could not be randomly selected for the study due to lack of accurate data regarding the number of currently practicing occupational therapists in New Zealand that have completed the PRPP System assessment training course in the country or overseas. Furthermore, the number of Maori registered occupational therapists in New Zealand is proportionally low compared to occupational therapists of other ethnicities i.e., New Zealand European/Pakeha (Turia, 2009). Hence, participants are self-selected into the sample through completion of the online questionnaire.

Participant Recruitment

The online survey was open for a two-month timeframe (1st May 2014 to 30th June 2014). The nature of the study design meant that the sample was self-selecting, limited to those who chose to respond to the invitation published in the *OT Insight* monthly magazine in May 2014, and/or through invitation letters to:

- All the members of all the national special interest groups (SIGs) of the Occupational Therapy New Zealand (OTNZ), previously known as the New Zealand Association of Occupational Therapy (NZAOT),
- All the registered New Zealand occupational therapists who had agreed to receive notification of research in the Occupational Therapy Board of New Zealand (OTBNZ) database, and
- All the occupational therapists who completed the PRPP assessment course training in New Zealand.

Letters of invitation (Appendix D) and reminders (Appendix E) were sent by email and contained information briefly describing the research project, the goals and its survey procedure. Additional information included: the anonymity of participants, voluntary participation and the right to withdraw, contact information of the researcher and his supervisor, and the Universal Resource Locator (URL) link to the Web-based questionnaire hosted by SurveyGizmo™ (http://www.surveygizmo.com;
Boulder, Colorado). Reminders were sent three weeks after the initial invitation by the OTNZ and OTBNZ.

The online web-based survey link was also posted on the homepage of the research project blog administered by the researcher (http://prppresearchnz.blogspot.com).

**Data Collection**

The online web-based questionnaire was completed anonymously, and consent was assumed by participants' voluntary completion of the questionnaire. All data collected was transmitted in encrypted format. This helped to ensure that any data intercepted during transmission could not be decoded and that individual responses could not be traced back to any individual participant. All data collected was held in a password-protected computer, and web-based online questionnaire server hosted by SurveyGizmo™ (http://www.surveygizmo.com; Boulder, Colorado). Only the researcher had access to this and was also responsible for compiling and analysing the data collected.

**Data Analysis**

Data analysis is the systematic organisation and synthesis of research data allowing the researcher to make sense of information gathered from the study, and to answer the research question (Loiselle et al., 2011). The study questionnaire included two types of data: quantitative and qualitative.

The quantitative data were summarized using descriptive statistics (numbers, frequencies, and percentages) and graphical output by the SurveyGizmo™ tool (http://www.surveygizmo.com; Boulder, Colorado). The researcher consulted with an expert in survey design and statistics, who confirmed that data collected in this study was not rigorous enough to meet the criteria for statistical analysis due to the low response rate and small sample size. If conducted, the statistical results may consequently prove misleading because of confounding factors, biases or both (Ms. Patricia Haden, Personal Communication, 17th July 2014).
Cross tabulation (contingency table) analysis was thought to be an effective way to explore the relationship between two variables to provide additional information concerning variation in use of the PRPP in occupational therapy practice. The data is summarised in table form.

Both the researcher and his researcher supervisor complete the initial data analysis independently and then compared findings to develop a final record to provide some elements of a peer review. The qualitative data were analysed by grouping the responses for each question into important themes (DePoy & Gitlin, 1998). For the questions that contained both quantitative and qualitative data a further analysis was carried out to verify whether these findings were matched. This process allowed in-depth examination of the data collected.

Treaty of Waitangi & Cultural Considerations

All research undertaken in New Zealand has to consider cultural safety. Even though this research project is not aimed specifically at Maori, the Treaty of Waitangi obligations regarding partnership, protection, and participation should be adhered to in any research that impacts on the Maori people (Health Research Council of New Zealand, 2010). The researcher had considered any specific issues that would be pertinent to Maori occupational therapists, Maori clients, or of relevance to any other groups related to the Treaty of Waitangi. This included consulting the Kaitohutohu Office of Otago Polytechnic, Dunedin for constructive critique on the proposed project and its potential impact on Maori (Whakapapa, Tika, Manaakitanga, and Mana) (Appendix F).

The focus of this study was to explore the implementation of the PRPP in occupational therapy practice in New Zealand. In particular it was hoped to determine, whether there were any relationships between variables such as occupational therapist demographics, professional education, practice contexts, and post-training supports that influenced occupational therapists adopting and applying this system in their practice. Having a better understanding about the use of this standardised occupational based assessment in New Zealand occupational therapy practice could be invaluable to Maori and other cultural groups’ stakeholders. The findings derived from this project could inform and enable Maori to make future
decisions about investment in the PRPP in their health and social services. Furthermore, the collection of ethnicity data can provide valuable baseline data for other researchers or Maori communities in future research.

Based on the researcher’s knowledge there is no reference to tikanga (custom), whakapapa (history), whenua (land and environment), iwi Maori (Maori people) or taonga (including Maori language) in this research. However, there is a possibility that the research participant may make reference to things Maori including knowledge and/or about Maori when answering the questionnaire. If Maori content was evident in the data collected, support would be sought from the research supervisor when analysing the data. In addition, the researcher was aware of the need to seek other services / personnel for further consultation as required. Both the Kaitohutohu Office and the OTNZ/NZAOT confirmed that Kaitohutohu Office of Otago Polytechnic, Dunedin was the appropriate body to offer this support.

**Ethics Implications**

The researcher is a New Zealand registered occupational therapist with a current practicing certificate. He complied with all requirement under the Health Practitioners Competence Assurance Act (HPCAA) 2003 (OTBNZ, 2003), and upholds high professional standards that all practices as outlined in the OTBNZ professional Code of Ethics (OTBNZ, 2004).

It was not anticipated that participants would be subjected to any harm or exploitation, and there were no patients involved in this study, therefore, ethical approval was only sought and obtained from the Research Ethics Committee of Otago Polytechnic (RECOP), Dunedin, and the OTNZ Ethics Review Group (OERG), Wellington.

The initial ethics application was submitted to the RECOP on 10th December 2013. Following the feedback from the RECOP, the researcher has amended the original application and provided additional information as requested by the RECOP for re-submission on 26th March 2014. This included further evidence of written confirmation and agreement from people and organisations involved in supporting
this research project (Appendix G, H, and I). The ethics approval was obtained from OREG on 3rd March 2014 (Appendix J) and RECOP on 4th April 2014 (Appendix H).

Several ethics principles were followed during this study including, anonymity, informed consent, right to withdraw, and protection from harm.

**Anonymity**

This survey study is not designed to collect any personal data such as name, age, and contact details. Hence, individual participants’ responses cannot be identified. When developing the online web-based questionnaire the setting of the survey service, SurveyGizmo™ is set up following the Anonymous Survey guideline (SurveyGizmo, 2013) to ensure participants and their answers are anonymous.

**Informed Consent**

All potential participants received a letter of invitation, and a reminder letter that included information describing the research project, goals, and its survey procedures, anonymity of participants, voluntary participation, right to withdraw, and the contact details of the researcher and his supervisor.

This information was also displayed in the Participant Information Sheet on the first page of the online questionnaire. The web-based survey is set-up, so that potential participants must click a button “Next” indicating that they have read the consent information and agreed before participating in the survey. Once the button is selected, the participants were redirected to the online web-based questionnaire. The survey questions were not viewed by participant until they clicked on to indicate their voluntary participation in the research project.

**Right to Withdraw**

Participation in this research project was entirely voluntary. All research participants had the right to not be involved in the study. Those who did not wish to be involved were informed that they would not be disadvantaged in any way. Additionally, they could withdraw from completing the questionnaire at any time.
However, once they had submitted their completed questionnaire they were not able to withdraw, as their data was not traceable.

**Protection from Harm**

No potential harm to research participants was anticipated. All registered and practicing occupational therapists in New Zealand have access to a supervisor through the Continuing Competence Framework for Recertification (CCFR) (OTBNZ, 2011). If this questionnaire raises any issue about participant’s own practice, they could discuss this in supervision with their supervisors. Hence, this was recommended and a reminder in the final “Thank You” statement encouraged participants to take any issue that arose while completing the survey to their supervision when they submitted their completed online questionnaires.
CHAPTER FOUR: THE FINDINGS

This chapter reports the findings of the survey completed by occupational therapists who have attended the Perceive Recall Plan Perform System of Task Analysis (PRPP) assessment training course. Section one starts with descriptive results regarding the demographic profile of respondents and their practice settings. Section two reports the respondents' practice values, the reasons they complete the PRPP training and the supports they sought and received. Section three reports respondents’ perspectives on the PRPP assessment in relation to their practice.

In presenting the findings figures, tables and descriptive commentary are used. The key respondents’ comments are extracted from open-ended survey questions and presented in italics with respondents’ ID numbers. Symbols and abbreviations used in presenting findings are: n = number of respondents and numbers in parentheses indicate percentage.

About the Respondents

A total of 50 online survey responses were received; 43 surveys were fully completed, and seven were partially completed. There were 39 female and four male occupational therapists, of which 32 were New Zealand European, three Pacifica, two Asian, and six identified as “other” ethnicities (1 African, 2 Australian, 1 New Zealand/Pacific Islander, 1 South African Indian, and 1 Welsh).

Out of the 43 respondents, 32 (74.4%) had completed occupational therapy training in New Zealand, and 11 (25.6%) had undergone the professional training in countries such as the United Kingdoms, United States of America, Canada, Australia, South Africa, and Zimbabwe.

The majority of respondents (24: 55.8%) held a bachelor’s degree, 15 (35%) held a diploma, and one (2.3%) held Master’s entry level qualification in occupational therapy. Three (7.0%) respondents indicated that they had completed more than one degree/qualification.
The Respondents’ Occupational Therapy Practice

Years of Practice Experience

Thirty-one (72.1%) respondents had been practicing occupational therapy for more than ten years in total. Of these twenty-three (53.5%) respondents had over ten years of practice experience in New Zealand. The differences between respondents’ years of practice in New Zealand and their years’ of practice in total can be found in Table 1.

Practice Areas & Specialities

The majority (65.1%) of respondents (28) were employed in hospital and health services (District Health Board), nine (20.9%) respondents were in school (education) settings and eleven (21%) were in the private sector (of these, seven were self-employed) (Figure 1). The respondents provided occupational therapy services to clients of all age groups (4.7% birth to three, 37.2% children, 32.6% adolescents, 55.8% adults, and 41.9% elderly). They were from a broad range of work environments, including acute, community, rehabilitation, and diverse clinical specialities and settings. They were predominantly based in the community (20, 46.5%), rehabilitation (17, 39.5%), mental health (15, 34.9%), and school (11, 25.6%) settings (Figure 2).

Work Hours

Over two-third (33; 74.4%) of respondents worked close to full-time between 30 to 40 hours per week. Three (7%) reported they worked 40 plus hours a week. A total of eleven (25.5%) respondents worked part-time, five (11.6%) reported working between 21 to 30 hours, and six (14%) worked 11 to 20 hours.

The PRPP Trainings

The PRPP Training Courses Attended

Forty-two of the respondents completed the five-day PRPP assessment training course in New Zealand between 2007 and 2013 and one respondent completed her training in Australia in 1997. Sixteen (37%) respondents had also
completed the PRPP intervention (4 days) training course; 14 people in 2011, one in 2009 and one in 2013.

Financial Support Received

According to the survey data, 27 (62.8%) respondents had received full funding from their employer. The remainder had co-funding options; seven (16.3%) had received partial funding from their employer, six (14%) had sought funding either from a fund raising, part of undergraduate curriculum study, scholarship or received a discount from the course organiser. Three (7%) respondents indicated that they had to self-fund for the PRPP assessment training course (Figure 3).

Reasons for Attending the PRPP Assessment Training

The respondents attended the PRPP assessment course for a variety of reasons. Of all the respondents, 36 (83.7%) wanted to learn to use the PRPP as an occupational-based assessment, 10 (23.3%) wanted to learn to use it to measure outcomes, nine (20.9%) were responding to recommendations from colleagues, four (9.3%) were sent by a manager / funder. Two (4.7%) indicated other reasons for attending, which were wanting to maximise the use of occupational performance model and the training was part of their undergraduate curriculum.

Key Features of the PRPP

The features of PRPP assessment that mostly reflected respondents’ practice values were: being flexible (i.e., can be used with a variety of clients regardless of their performance level, disability/medical condition, age, gender, or cultural background) (83.7%), occupation-based standardised assessment (60.5%), and able to assess the impact of cognitive deficits on a client’s occupational performance, roles, routines, and tasks (58.1%). In contrast, the PRPP assessment features that least reflected the respondents’ practice values are: being able to accurately measure changes and outcomes accurately (14%), economical (9.3%), and that it is time efficient (4.7%). These comparisons are presented in Figure 4.
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Adoption of PRPP into Clinical Practice

Is PRPP Used in Practice?

The respondents were asked if they had ever used the PRPP assessment in their practice. Of the 43 respondents, two (4.7%) reported never used the assessment tool. The remaining 41 respondents, three (7.3%) began using the PRPP within the first two days, nine (22%) within the first two weeks, 14 (34.2%) within the first month, 14 (34.2%) within two to five months, and only one (2.4%) began more than five months after completing the five-days PRPP assessment training (Figure 5).

Decision-making Factors to Use the PRPP in Practice

The respondents were asked to rate the importance of factors that affected their decision-making related to the use of PRPP assessment. The five key factors were: therapist’s task-analysis skills (27, 65.9%), confidence (21, 51.2%); time available (21, 51.2%) to administer the assessment and client’s occupational needs (24, 58.5%); carer / family’s goals (21, 51.2%). The findings are summarised in Table 2, Table 3, and Table 4.

The Variations in the Use of PRPP

Forty-one respondents who had experience in the use of PRPP assessment reported it could be used in a variety of ways and purposes. All of them described using it as a framework to observe occupational performance of their clients. Twenty-seven (68.3%) and 28 (65.9%) reported having used the formal scoring test of occupational performance in Stage One and Stage Two respectively. Eleven (26.8%) used the assessment as an interview format to assess the perception of their client’s capacity to apply cognitive strategies in everyday life. Nine (22%) used the questionnaire format to seek written information about their client’s perception of occupational performance.

The Frequency in the Use of PRPP

The respondents were asked how frequently they used the PRPP assessment in their practice. Out of 41 respondents only one (2.4%) reported used it “daily”. Two (4.9%) used it “less than daily but at least once a week”. Eight (19.5%) reported using
it “several times a month”, 22 (53.7%) used it “several times a year”, and three (7.3%) used it “less than once a year” (Figure 6).

The survey responses were not robust enough to validate the use of variance analysis using statistical tests. Therefore, non-statistical cross-tabulation (comparison report, SurveyGizmo, 2014) analysis was used to examine trends in the survey data across groups to identify factors that might have an important association with the use (frequency) of PRPP.

The cross tabulations (comparison reports) show likely trends in the frequency of PRPP assessment used in occupational therapy practice by respondents with the following characteristics. The PRPP assessment tool was more frequently used by occupational therapists who:

- Were in private practice (Table 5),
- Worked fewer than 30 hours a week (Table 6),
- Self-funded their training course (Table 7),
- Completed the PRPP assessment training course in earlier years (e.g., 1997 and 2007, Table 8),
- Implemented the PRPP assessment into their practice immediately (e.g., within two weeks post-training, Table 9),
- Reported it was easy to use and without any barriers (Table 10, 11, and 12),
- Received supports post-training (Table 13), and
- Reported greater change to their practice (Table 14).

The respondents’ had mixed viewpoints about their experience in implementing the PRPP assessment in practice. Their responses from answering the survey questions were analysed thematically and were summarised into themes in the following section.

**Implementation of PRPP in Clinical Practice**

**Cultural-relevance to Use PRPP in New Zealand Context**

The respondents were asked about the relevance of the PRPP assessment on assessing clients from diverse cultural context (i.e., Maori, Pacific Island, Asian) in
New Zealand. All of the 41 respondents indicated PRPP is a relevant tool within a multicultural context. For example:

“... What I realised and enjoyed was finding what a ‘usual’ way of completing an activity was for that culture, e.g. Asian person cooking veges sitting them on a small plate on top of steaming rice inside a saucepan was a normal way for them to cook when I checked with their family - had I just used my own cultural context that would have been seen as an error.” - 149

“It is a great tool to use across cultures. I have used it well with Pacific island, Maori, Indian, Asian and Pakeha clients and families... who have English as their second language.” - 104

“Very relevant because it does not involve prescribed tasks as for example does AMPS. Also accounts of [sic] persons context.” - 130

Many respondents emphasised that the PRPP assessment is relevant when the following conditions are maintained:

“Neutral - but theoretically should be a relevant assessment as long as assessor considers how a client attempts a task may have cultural difference to themselves. ...” - 17

“... time must be [sic] taking in analysing the task to ensure both [client and therapist] agree on the steps and way it is to be done.” - 18

“... before beginning the assessment and when interpreting the assessment, you need to have some understanding of the culture of the person you are assessing - so that you can interpret their behaviours correctly.” - 40

“... [because] it is not a normed assessment from another country used on NZ population. It does rely in the [sic] therapists skills in recognising and acknowledging cultural differences but it does allow for it within the test as clients are assessed in context.” - 139
Perceived Ease to Use PRPP

The respondents were asked about how easy or difficult it was for them to use the PRPP assessment in their practice. Just over half of the respondents reported “very easy” (5, 12.2%) or “moderately easy” (16, 39%), while the others reported “a little difficult” (18, 43.9%) or “very difficult” (2, 4.9%) to use. The four key themes identified were that:

- The PRPP assessment was straightforward to administer in practice (11, 26.8%).
  
  “Working in the community I can easily carry out the assessment with good client [sic] buy in due to flexibility of the assessment and assessment medium (i.e. any task).” - 119

  “I can use it in a number of ways as a formalised assessment or as an observation tool. It is easily explained to teachers & carers or colleagues.” - 139

- Need a refresher of the course material to guide their use of the assessment (10, 24.4%).

  “Because I don’t use it as frequently as I’d like to, I often find myself needing to refer to training booklets for refresher.” - 10

  “It has taken lots of practise to use with frequently using the course material for clarification.” - 12

- It is best to use the assessment frequently to improve confidence and skills in administration (15, 36.6%).

  “I use it as my assessment of choice so it gets easier with practice.” - 35
• On the opposite side, when it was not used frequently it became very time consuming and difficult particularly in aspects of the PRPP language / terminology and report writing.

“Difficulty with the language/descriptors of Information Processing Operations used in Stage 2; different language used to the neuropsych-based definitions that I have used the last 10 years and found [the assessment process] very time consuming having to refer to manual for every single descriptor when scoring Stage 2.” - 17

“I am on an acute ward and find that to do justice to this assessment it is time consuming for making it and then writing it up…” - 19

“As I [sic] haven’t used it as often as I would like, every time [sic] you come to do it [sic] you need to get [sic] your head into that way of thinking and it seems to take a long time to analyse it and write up the notes / report and think about possible intervention ideas.” - 79

“Completing the PRPP assessment was relatively easy, however it was the report writing that I had difficulty with.” - 62

“Have had some lack of clarity around scoring the task analysis, due in part to my irregular use of the tool in its entirety.” - 68

“I don’t use it enough to feel confident, so it takes some time.” - 142

Perceived Strengths of the PRPP Assessment

The five main themes on the strengths of using the PRPP assessment were that:

• It is a standardised tool with a structural and flexible approach for assessment and evaluation; can be used across any diagnosis, condition, age, and occupational context (26, 60.5%).
• It is an occupation-focused observational framework that is based on the professional model of practice (20, 46.5%).

  "... I feel like an OT when I use it, and it reminds me of OT models of practice." - 39

  "It is occupation focused, it is an ecological measure and fits my practice values..." - 106

• It enables occupational therapists to identify clients’ strengths and weakness and precisely pinpoints cognitive difficulties or issues impacting on occupational performance (13, 30.2%).

  "[The PRPP assessment] helps identify how cognitive impairment is impacting on function and narrow down exactly what processing components are affected and therefore where intervention should be focused..." - 79

  "... Allows education to client, family, and colleagues about difficulties and limitations in OP [occupational performance]." - 119

• It enables clear communication and is received positively by stakeholders (13, 30.2%).

  "... Facilitates robust reporting using occupational therapy language. Provides sound evidence e.g. for use in court reports.... helpful information for carers.” - 35

  "... The feedback I have received from families and other professionals has been incredibly positive.” - 104

  "... Useful as outcome measure especially with ACC processes.” - 119

  "... Helps teach teachers, parents, and TAs which prompts & cues to use” - 139
“... Able to communicate the impact of cognitive difficulties functionally on occupational performance to other rehab team members, clients and families, in words that we all could understand.” - 149

• It maintains a client-focused approach (11, 25.6%).
  “Can be used across cultures, age and functional level. The flexibility to use any task” - 18
  “Non-threatening to clients.... in a wide variety of settings.” - 142
  “The client is able to choose the task and criteria. It is more appropriate cross culturally and for different client populations.” - 151

Perceived Limitations of the PRPP Assessment

The three main themes on the limitations of using the PRPP assessment identified were that:

• It takes a long time to consolidate course information and develop confidence (13, 30.2%).
  “I love this ax [assessment] but cannot afford the time needed to be dedicated to it, to use it as designed and give it justice... I wish I worked in a different dept. at the dhb [District Health Board].” - 19
  “... If not used frequently it is very difficult to get back into using it.” - 147
  “Now it has been some years since I’ve used the tool, would probably need some re-learning before using.” - 149

• There is a need to learn the specific PRPP System of Task Analysis terms and additionally communication can be challenging to explain to those who are unfamiliar with the assessment (8, 18.6%).
“Some of the PRPP terms used can be confusing…” - 113

“Quite wordy and jargony.” - 130

“... Language has to be learnt as not what we assumed it means.” - 153

- Writing a formal assessment report is very time consuming (11, 25.6%)

Perceived Barriers to Use PRPP Assessment

The respondents were asked whether there are any barriers to the use of the PRPP assessment: over two-third (29, 67.4%) reported “Yes” and nearly a third (14, 32.6%) respondents reported “No”.

The three primary barriers that most frequently reported by respondents were:

- Time constraints to learn and implement it (18, 42.9%).
  
  “TIME TIME TIME I am in acute and this is fast paced and I need to quick assess and quickly write it in notes.” - 19

  “Time, and time to revisit concepts…” - 39

  “... Time to do both the assessment and to interpret and write up the assessment results.” - 40

  “I feel I should be taking videos often and reviewing these to get the best out of the assessment and the time to do this is often a problem.” - 59

  “… Evaluation process of using the tool can be time consuming.” - 144
• Practice context influences (12, 28.6%). For example:

“... any barriers to my use of the PRPP within my present work context related to time constraints and the need to use educationally relevant tools such as IEP and curriculum measures” - 68

“... Within the education sector, this assessment was excellent, now I’m in Community, with very limited hours, I only get time to do the very basics (equipment issue etc.).” - 70

“... due to this being unpaid in the ACC system, then I would do fewer assessments that I would like.” - 119

“Not enough people on MDT and teaching team understand the outcome measures of the PRPP.” - 130

“... Rest of team / funders understanding the information the PRPP gives.” - 149

“Time and high caseload - needs conscious effort to use it in acutes” - 153

• Not confident to use the assessment when not used frequently (10, 23.8%).

“Time constraints gaining competency; it is quicker and easier to fall back on what I know and am confident with.” - 17

“Do not feel confident in the write up of the PRPP in my practice setting. Want to work with a group of peers but there [sic] are none locally.” - 26

Supports Used to Implement PRPP Assessment

When asked about the assistance that respondents received to support them to implement the PRPP assessment in practice: 23 (53.5%) used the PRPP manual / resources; 16 (37.2%) sought supports from other occupational therapists; 14 (32.6%)
received supports from PRPP-trained occupational therapists; six (14%) sought supports from PRPP instructor; five (11.6%) had study time, and three (7%) had support from their occupational therapy manager/supervisor. Fifteen (34.9%) respondents reported that they had set up or joined a PRPP support group. Ten (23.3%) respondents reported they did not have any support. The findings are shown in Figure 7.

**Potential Enablers for Implementing the PRPP Assessment**

The respondents were asked to identify what would have enabled them to implement the PRPP assessment more effectively in their practice. The perceived enablers from the respondents were:

- Having PRPP-trained peer support groups and regular supervisions (17, 39.5%).
  
  “Perhaps observing someone doing assessments, discussing results and then perhaps assist me to carry out assessment and provide feedback.” - 30

  “More time and space to practise as an OT, support/discussion to re acquaint myself with the tool.” - 145

- Having more regular opportunities and time to practice and analyse (12, 27.9%).
  
  “Ongoing review of assessment to ensure accurate use of the descriptors” - 126

  “PRPP trained OT to observe in action!” - 130

- Establishing PRPP special interest group and having regular news and updates from the PRPP trainers (7, 16.3%). For example:
  
  “... Having ‘super users’ to assist within DHB’s for example.” - 83
“... more support with use of Stage 2 to ensure correct areas identified.” - 153

• Having effective self-management i.e., time, create opportunities to practice, change attitude (6, 14%).
  “Time - say 1-2 hours a week for first 1-2 months after training to dedicate to administering and scoring to gain confidence and familiarity with PRPP.” - 17
  “Heightened awareness - links with other people using it in a similar work environment; Something to make me focus on using it rather than going back to my old ways of doing things.” - 148

  “Me making it a priority in my practice. Doing some re-education by myself and/or retraining. Having the support of my managers/employers to do the above. Other OTs in our work setting being trained so we are all ‘speaking the same language.” - 149

  “Commitment… change of attitude with using it even if caseload busy…” - 153

• Using supplementary technology to support transferring learning into practice (5, 11.6%).
  “Having access to technology that supports using videoing students as part of the assessment. Currently, saving video’s within our office has been extremely difficult (software issue) and have resulted in a very slow and labour intensive process - before you even get to analyse the video” - 40

  “Possibly a computerized assessment sheet to reduce (the) time completing this would increase my use. This could also increase intervention planning if there was an easier transfer of info to formulate intervention plans” - 119
“Trying to ensure that you have recalled everything when learning new assessment - videoing made this easier” - 126

“More computers and better space to allow one to focus on report writing” - 146

- Educating other professionals about its use (4, 9.3%).
  “More understanding from other professions and buy-in from MDT…”
  “ - 19

  “More people trained to offer support and motivation. Support in the initial stages to get it up and running in practice.” - 79

  “… As a professional leader, I am working to get more OTs trained (by attending the training) and it has become the preferred OT tool to fund (rather than the AMPS) in our service.” – 142

Changes Made Since Using the PRPP Assessment

When asked if any aspects of respondent’s occupational therapy practice had changed after completing the PRPP assessment training, 23 (53.5%) reported it changed some aspects, 18 (41.9%) stated it changed a great deal, and 2 (4.7%) found no change to their practice. The five main themes identified from respondents about their practice were:

- Better observational skills of task performance (23, 53.5%)
  “The observations are a lot more enhanced, and you can clinically reason as to why (my clients) cannot do what they are supposed to do, and work from that assessment” - 62

  “I was able to advise on strengths and weaknesses for each client with a lot more clarity (based on just observations completing a task)” - 130
“... as now there is an organised way to describe the client’s ability to do a task... “ - 142

- Effective communication with others (13, 30.2%)
  “Much better equipped to write occupation focused reports” - 35
  “Allowed me to describe my observations more specifically” - 119
  “PRPP has given me a new language to help explain to parents & teachers what are the barriers to learning, (and) what prompts (and) cues that can help that child develop” - 139

- Able to precisely identifying the cause of occupational performance issue (12, 27.9%)
  “I feel more confident in having a flexible/ occupation focused tool that can be used in many different ways. I turn to the PRPP if I am really trying to break down complex clients and the information processing difficulties.” - 147

- Enhanced practice to be client and occupation focused (12, 27.9%)
  “It has enabled more occupation-based practice - it gives (me) the opportunity to consider information processing giving a broader picture of what might be impacting performance. - I’m able to measure change in performance” - 12

  “I feel that I have better understanding of how clients using their thinking skills to do, or act intentionally on their environment to do meaningful activity” - 68

  “I feel more confident and equipped with assessing occupational performance and providing occupation focused interventions” - 87
• No or little changes (2, 4.7%)

“Has fallen back on assessments I am confident and familiar with” - 17

“Very little use of the assessment” - 111

“... It has been hard to implement into practice, especially in a setting where others are not using it.” - 148

The findings and themes emerged from the thematic analysis presented in this chapter are worthy of further discussion in the next chapter.
CHAPTER FIVE - DISCUSSION

The aim of this research project was to explore the use of Perceive Recall Plan Perform System of Task Analysis (PRPP) by PRPP-trained occupational therapists in New Zealand. In light of the study findings presented in the previous chapter, the researcher will discuss the key findings and examine the adaptability and ability to implement the PRPP as a standardised assessment and outcome measure tool for occupational therapy practice in New Zealand. Learning new knowledge and skills and implementing these within current practice are complex and affected by many factors, some recommendations for occupational therapy practitioners and managers are proposed. The chapter will conclude with reflections on the study limitations and noting ideas for further research.

Using the PRPP in Professional Practice

The central research question of this study was to investigate how the PRPP was used in practice following attendance at a training course. It was anticipated that this occupation-therapy specific tool would build on occupational therapy core assessment and evaluation skills. Interestingly, not all the respondents used the PRPP in their practice and the frequency with which they did use it varied considerably (Table 5 to Table 9).

A recurring theme identified by respondents was that they needed to stay focused, to apply and practice their newly acquired knowledge and skills immediately after the training. A key challenge that arose from the respondents was using the PRPP for the first time after course completion. The survey results indicated over half (26 out of 41; 63.5%) of the respondents began to use the PRPP in their practice within the first month after the training (Figure 5). Practitioners were required to seek and learn ways to integrate the new approach to assessment and evaluation into their practice that may be well established and habitual. Hence, a degree of change in practice was to be anticipated. Importantly, many respondents reported when their momentum slipped away, it became more challenging to refocus when other circumstances inevitably intervened. The study findings suggest that the use and non-use of PRPP by respondents were likely to be tied to several factors which will be discussed below.
Work-related Factors

Workplace challenges such as being behind with work and a lack of recognition for continued support can hinder the use of the PRPP following training. Having sufficient time to practice and develop the new skills and having employer’s support to do this are two recurrent themes.

Managers’ Support

Study respondents highlighted the importance of having the managers’ support in their professional development and in the adoption of the PRPP at their workplaces. This finding of this study raised the question about support availability in respondents’ practice settings. Only three respondents (7%) reported having received support from their managers/supervisors, and while ten (23.3%) reported that they did not receive any assistance to implement the PRPP assessment in practice (Figure 7).

Some employers had invested resources for their staff to attend the PRPP training course and by giving them study leave to complete the training but few had then supported the therapists to implement their new learning. McCluskey & Cusick (2002) found changes in practice were more likely to succeed when encouraged and supported by managers. This study has provided some insight for employers that positive changes in therapists’ practice such as, practice being more client-centred, occupation focused, and effective communication skills (see Chapter Four) were achievable and resulted from therapists attending the PRPP training course and implementing the skills learned.

The respondents who implement the PRPP assessment regularly in practice were likely to be very highly motivated. This is illustrated by one person who stated:

“I have used it frequently which is what is needed to understand the assessment... I feel that continuous assessment of the tool assists in competencies in using it” - 113
Peer Supports

From this study, respondents reported having received supports from PRPP-trained occupational therapists (14, 32.6%), PRPP instructors (14, 32.6%), PRPP support group (15, 34.9%), and other occupational therapists (16, 37.2%). These results suggest that having overt supports from peers and/or subject matter experts are necessary when implementing new knowledge and skills in practice. Lockyer (1992) reported that liaising with colleagues or experts and learning from them is more likely to facilitate practitioners to implement new knowledge and skills. In fact, two respondents pointed out that being the only occupational therapist trained in the use of PRPP in their clinical areas has made it harder for them to get the support they needed. They emphasised there is a need to have more occupational therapists trained to use this tool and a need to set up a local support group. The need for on-going mentoring support after training to facilitate the transformation of knowledge into practice is important. These findings may also reflect the challenge to access support from the Australia trainers by PRPP-trained occupational therapists practicing in New Zealand. Is the issue uniquely to practitioners of the PRPP in New Zealand or countries outside Australia? Do occupational therapy practitioners in Australia have greater access to supports after training? Answers to these questions await future research.

Use of Supplementary Technology

The results of this study support Daley’s (2001) findings that part of the process of making new knowledge meaningful involves using it in practice. Since respondents had made a conscious decision to attend a PRPP course, they had a positive attitude towards learning the PRPP, and might have anticipated that further work was required to learn how to apply this occupation-based standardised tool to aid in assessing and measuring outcomes of their practice.

McAdam, Thomas and Chard (2001) found poor resource access and a lack of additional support for occupational therapists were the main difficulties they encountered when implementing new skills learned in practice. In this study some respondents explained having access to video recorders and computers, and having the skills to use these were necessary when learning ways to incorporate the PRPP into their practice. The selection of resources and supplementary technology by
occupational therapists to help them gain competency in implementing PRPP in their practice may vary individually based on practitioners’ preference. This is an area of study worth further investigation in the future.

**Therapist-related Factors**

The majority of respondents reported challenges related to making changes to their practice when implementing something new. It appeared that their psychological / emotional state rather than the tool itself, posed challenges for therapists. The findings suggest that the longer the time delay before using the PRPP assessment, the harder it can be to get started (Table 10). Subsequently, the less frequently the PRPP assessment is used may result in the perception that there are barriers to its implication (Table 11 and Table 12). The three main constraints when first starting to use the PRPP assessment identified in this study were as follows.

**Learning a New Language**

The challenge of learning a new language (i.e., the PRPP descriptors) that is consistent with the information processing model. One difficulty is that the same terminologies can have quite different meanings in other theoretical frameworks (e.g., Assessment of Motor and Process Skills [AMPS], Fisher & Jones 2010). For instance, there were respondents who found it was challenging to learn the PRPP descriptors when the same words or terms had different meanings to other theoretical frameworks they had learnt and used in their past experience or current practice. Therefore, they explained it was time consuming and laborious to learn and apply all domains appropriately in Stage Two of PRPP analysis. Nonetheless, there were other respondents who expressed no concerns in that regard, and found that it has given them a way of communicating with other stakeholders as it is relatively easy to understand. Determining the factors that could explain such differences between these two groups of respondents is beyond the scope of this study and a subject for future research.

It appears that different terminologies have been used by different researchers and theorists when describing clinical reasoning in occupational therapy could cause ambiguity and lead to confusion and misinterpretation by therapists who are still
learning these concepts. Rogers (2004) stressed that confusion in standardised terminology could result in a lack of unity for professional thinking and communication. As emphasised by Blijlevens & Murphy (2003) this may impact on our professional accountability as health professionals: “professionals must be able to use language to convey their professional concepts and values to readers [stakeholders]” (p. 7).

Keponen and Launiainen (2008) reported positive outcomes of using the concepts and assessments of the Model of Human Occupation (MOHO) as the resources to support occupational therapists in developing occupation-focused clinical reasoning and deepening their knowledge and theory, and its implication in their practice. They achieved this by implementing the five-steps process in the form of learning through reflection and practice. One possible solution to overcome the language barriers and limitations as noted by Rogers (2004) is for therapists to revisit the use of the Occupational Performance Model (Australia) (Chapparo & Ranka, 1997) as the development of the PRPP assessment was based on this professional model. These analyses are beyond the scope of this study, but future research should explore these potential theoretical mechanisms in turning knowledge into practice.

**Inexperience Administering the PRPP**

Many respondents found it takes a long time to develop confidence and to consolidate course information. They had to utilise diverse resources including the training manual, course notes, and additionally sought supports from peers and/or experts who were PRPP-trained and had experience in using this tool. Some respondents reported they noticed an improvement in their observation and assessment skills, and felt more confident. For them, using the PRPP had advanced both their skills and confidence levels, so that change in practice might was not too stressful and was rewarding. The challenges to integrating the PRPP into practice in the early period of learning was reported to be intense, but eventually softened as changes to practice occurred.

Schematic processing (Hagedorn, 1996) is one of the frameworks that help to explain the differences between novice and experts in their clinical reasoning. This
framework could be applied to explain the integration of the PRPP into practice because of the magnitude of knowledge and experience required. For example, in the PRPP Stage Two analysis, the therapist creates an image and gains an understanding of the client’s participation and performance issues based on available cues (collected, organised, selected, and interpreted) using the PRPP. The image becomes more refined as therapists interact with their clients and evaluates their occupational performance. The closer the image matches with experienced therapist’s schema (knowledge and experience), the more automatic their thinking and action become. In contrast, active recall, thinking, and problem-solving skills occur for the novice therapists when their image and schema vary considerably (Rogers, 2004). This may be a pivotal factor that differentiated who went on to, and frequently use the PRPP and who did not.

As discussed earlier, each respondent is likely to have their own style of working with clients, which has been well developed, honed and practised over the years. Introducing something new could throw off this equilibrium for both the therapists and their clients. For some respondents, allowing clients to choose tasks for assessment caused consternation for existing clients as well as the therapists. Nevertheless, the literature indicates that clients feel more comfortable and less stressed when there are good therapist-client relationships (Creek & Bullock, 2008; McAdam et al., 2001). Therefore, the findings of this study may reflect the apprehension felt by less experienced or skilful practitioners and their service delivery philosophy. Further research will be needed for clarification of this issue.

**Professional Position and Roles**

Respondents indicated that the nature of their work demands did determine their use or non-use of the PRPP in their professional practice. Some respondents emphasised the additional time required to complete the assessment including explaining things and negotiating goals with their clients. These therapists might be reflecting the operational challenges due to high service demands rather than best practice in occupational therapy. For example, high turnover (acute care) settings puts great pressure on therapists to focus on discharge, which results in them not having sufficient time to assess and reassess their clients adequately. Conversely, slow
turnover (community-based) areas characterised by slower progress also placed a challenge on therapists because of lower demands to evaluate and measure outcomes. This is illustrated by one person who stated:

“Most of my clients are not performing tasks independently and my role does not call for such in-depth assessment...” - 30

Nevertheless, the PRPP was reported as working particularly well in other areas, such as school and rehabilitation settings. The respondents in these settings highly valued this assessment for its ease of use, as a structure to assess and re-train cognitive impairments, and its ability to compare performance over time. Additionally, it was described as being a good way to explain the impact of cognitive difficulties on occupational performance and the subsequent intervention to clients, families, and both intra- and inter-professional colleagues.

Creek & Bullock (2008) stated “occupational therapy interventions are most effective when the client is an active partner, fully involved in setting goals, taking decisions and engaging in activity” (p. 123). This view is supported by Jenkins & Brotherton (1995) who found practitioners and clients learn best through repeated exposure to real clinical scenarios. Successful learning and practice arose out of opportunities and situations that fostered therapeutic partnership between practitioner and client. In other words becoming more efficient and effective at using the PRPP might have the effect of ceasing to perceive using the PRPP as a daunting task and more as a tool where partnership with the client is a central tenant. This may explain the changes in practice of occupational therapy as identified by the respondents of this study who have adopted and continue to use the PRPP after training. That is, being more client and occupation focused, having better observational skills of task performance, precisely identifying the cause of performance issues, and communicating effectively with others.

Two respondents reported that their use of the PRPP at work was limited due to reduced clinical contact time because of their professional position in a leadership role. An interesting side note to these findings is that the PRPP framework was used informally for supervision and monitoring of staff performance, although the rationale
was not given, it would be interesting to explore the practice context behind the non-clinical way of using the PRPP by trained practitioners in future research.

Is There a Client-related Factors?

The main findings of this New Zealand study on the implementation of the PRPP by occupational therapists across clinical specialties and practice environment in New Zealand were similar to the results found by Chard (2000, 2004, 2006) who investigated into the use of AMPS by occupational therapists after training. That is, the adoption and implementation of a standardised occupation-focused assessment within therapists’ existing professional practice are influenced by both therapist-related and work-related factors.

The main difference in finding between Chard’s studies and this study is that some of the difficulties therapists had in developing and implementing new occupational therapy assessment skills were evidenced as client-related issues by participants in Chard’s studies (2000, 2004) (i.e., making sure clients understand the purpose of the assessment, assessing clients with low functioning, within their natural context [home], or in fast turnover [acute care] settings) but not from the respondents in this study. The respondents of this study reported that both client’s occupational needs and their carer’s/family’s goals were two important factors that influence the decision of therapists to use or not to use the PRPP (Table 2). However, there is no evidence to suggest that respondents’ challenges in implementing the PRPP were related to their clients. In fact the literature review (see Chapter 2) and the findings of this study support the notion that selection and implementation of any assessment is based on therapist’s clinical reasoning and the service priorities and demands of different practice settings.

A direct comparison of findings between Chard’s studies and this study is not possible because of different demographics of participants and their practice context, different research methods used for data collection and data analysis, and different standardised occupation-based assessment tool (AMPS versus PRPP) being studied. However, it would be valuable for future research to compare the adoption and
implementation of these two assessment tools by occupational therapists in the same setting to gain a better understanding of the process and the factors which affect it.

**To Use or Not to Use the PRPP**

Practitioners’ adoption and implementation of the PRPP in their practice varied. This study did not have consistent and strong evidence to define work-related and therapist-related factors and their interrelationship that influenced practitioners’ use of the PRPP in their practice.

For some therapists, there was a dilemma between using the PRPP that was regarded as ‘effortful’ compared to an ‘off-the-shelf assessment’ that was quick and easy to administer. The interest on occupational therapists’ clinical reasoning to select alternative assessment tools as opposed to the PRPP assessment, and whether other forms of assessment provide equal, reliable measures or outcomes to guide intervention planning process with their clients are certainly topics beyond the scope of this study, but one that merits further study.

Despite all the work-related barriers and therapist-related challenges, it is interesting to note that there were only two respondents who reported having never used the PRPP in their practice. One respondent explained she was not using it because of her role and client groups did not have the demand for such an assessment, and the other respondent commented not feeling confident to use it in her practice setting as there was no peer or support group available locally.

It is worth inquiring about the possible non-response phenomenon in this study. That is the PRPP-trained occupational therapists in New Zealand who did not participate in this study. It remains undetermined whether they practice differently than study respondents. This is certainly an area worth further study to explore issues that contribute to the non-use of the PRPP by occupational therapists, and identify resources and practical strategies to help practitioners to overcome any problems in practice. This is a challenging area for research because currently there is no database that accurately keeps an accurate record of all the PRPP-trained occupational therapists registered to practice in New Zealand.
There is some recognition from respondents that if the PRPP assessment is what they want to use, they must invest time and energy in learning how to use it competently and confidently, in such a way that would promote evidence-based occupational therapy practice in their work settings. This study has found that respondents who had sufficient time, and had diverse supports to consolidate knowledge and skills gained during the course of learning and clinical practice were likely to persevere and implement the PRPP successfully and contribute to positive changes in their practice.

Practical Implementations and Recommendations

The results of this survey study indicated that the respondents started using the PRPP at different points in times, and the frequency and the ways in which individual therapists used the PRPP varied. This may suggest that each therapist was at different stages of readiness to adopt and implement new skills and knowledge to change their current practice.

Stages of Readiness to Change the Practice

Occupational therapy practice is ever evolving, being prepared to change current practice to improve service delivery and clinical outcomes is essential for occupational therapists and the development of the profession. The Transtheoretical Models of Change [TMC] (Prochaska & DiClemente, 1984 cited in Miller & Rollnick, 2002) provides a practical paradigm of behavioural change that is related to a person’s readiness. This model will help to better understand and evaluate the process of change, from learning through to practice implication, in relation to professional development and practice.

According to the TMC, change occurs in six stages: precontemplation, contemplation, preparation, action, maintenance, and relapse. Each stage involves different strategies for advancing behavioural change (Arnaout & Martino, 2010). For example, in the first stage of precontemplation, therapists have no reflection on current practice and may be unaware of the needs and benefits for change (e.g., using a standardised occupation-based assessment), or unwilling to, thus resulting in no change. In the second stage of contemplation, therapists begin to think about change, they might show interest in obtaining and critically appraising the information on
perceived benefits, costs of, and barriers to change versus remaining with the status quo. A decision to change leads to the preparation stage where therapists learn specific skills in order to modify their practice. In the third stage of action, therapists begin to change practices that might involve cessation of an existing, well-established routine in their practice. In the final stage of maintenance, there is evidence of long-term change (usually more than six months) in therapists’ practice. That said, ‘habits are hard to break’ it is easy for anyone to slip back into old habits if there is no incentive to maintain and support the new practice.

Efficient and effective change is dependent on doing the right things (processes) at the right time (stage). Therefore, tailoring the intervention strategies or supports to match practitioner’s readiness (or stages of change) is essential because a mismatch could create resistance and impede change (Miller & Rollnick, 2002). Additionally, the theory of flow (Csikszentmihalyi, 1990 cited in Law, 1991; Reid, 2011) asserts that individual satisfaction is achieved when their skills and challenges in activities are in balance with a supportive and non-threatening environment. Some respondents in this study seemed well aware of this and noted that both having an understanding and supportive managers and time to consolidate learning and develop proficiency were necessary to transfer the PRPP knowledge and skills into their day-to-day practice.

In order to optimise change, motivation and external supports are important factors to consider when adopting and implementing the PRPP in practice settings. For example, therapists in the precontemplation and contemplation stages need information. This is important to ensure they have the opportunity to evaluate the benefits and costs, and to consider the changes involved in individual’s practice and service delivery when introducing a new tool for assessment and outcome evaluation.

The human response to change fluctuates between resistance and enthusiasm, therefore, the types of strategies and supports needed will vary at different stage, and by different individuals. McCluskey & Cusick (2002) emphasised that having good management and positive role models are vitally important in commitment to change. Furthermore, a person’s motivation can be strengthened by setting objectives and learning plans in collaboration with peers and support groups (Grol & Grimshaw, 2003). These arguments are supported from the findings of this study.
The 17th century French philosopher Blaise Pascal (1623-1662) stated “people are generally better persuaded by the reasons which they have themselves discovered than by those which come into the mind of others” (Lane & Rollnick, 2009, p. 157). Indeed, Chilvers, Harrison, Sipos, & Barley (2002) and Hammond & Klompenhouwer (2005) stressed that knowledge alone rarely change practice. A practical approach of implementation strategies to support therapists moving from precontemplation to action and maintenance stages are also needed. Therefore having an awareness of the ‘stages of change’ is important for both therapists and their managers as it will guide and enable them to implement appropriate strategies and supports tailored to their readiness for change at an individual and organisational level.

The Role of Reflective Learning in Practice

The use of reflection to facilitate learning and its application to confirm knowledge and change the way occupational therapists envision their practice has been widely advocated in literature (Fone, 2006; Hunter & Blair, 1999; New Zealand Association of Occupational Therapists [NZAOT], 2012; Occupational Therapy Board of New Zealand [OTBNZ], 2012b).

Reflective practice is more than a thoughtful practice and involves questioning your own thoughts, actions, values and beliefs. In today’s fast-changing health care environment it is a key skill for learning in occupational therapy practice. Jarvis (1992) defined it as “a form of practice that seeks to problematise many situation of professional performance so that they can become potential learning situations and so that practitioners can continue to learn, grow and develop in and through practice” (p. 180). For most practitioners supervision provides an opportunity to review practice and become more attuned to personal ways of working and learning opportunities.

Supervision for occupational therapists is essential to enhance professional development, clinical competence, and safe practice (Cusick et al., 2004, NZAOT, 2012). Lowe, Rappolt, Jagial, & Macdonald (2007) reported workload demands, resource availability (e.g., time, staffing level) and practice culture (e.g., learning environment, openness to innovation, expectation, and management support) may
hinder or facilitate occupational therapists’ ability to carry out reflection in their
practice. Again, this has highlighted that adequate management supports and
supervision are necessary for practitioners’ professional development and service
delivery in any health care organisations (Bridge & Twible, 1997). These views are
supported by findings of this study (see Chapter 4).

Future Research

The PRPP is a relatively new assessment tool for use by occupational
therapists in New Zealand but is fast gaining popularity. From the discussions in this
chapter, there is a strong need to continue future research in this area and the findings
of this study can serve as a baseline. While several ideas for research have already
been offered in this chapter, the following are considered to be the most important for
the practice of occupational therapy and continuing professional development. Firstly,
it would be interesting to explore the value of the PRPP in promoting client-centred
and occupation-focused occupational therapy service from different stakeholders’
(clients and/ their families, professional colleagues and service managers)
perspectives. Secondly, a replication of this study to compare the findings with other
countries such as Australia, Canada, and other European countries where PRPP
training courses are being offered (Chapparo & Ranka, 2014b) would give further
information. Thirdly, a longitudinal study to examine the trends, issues, and causality
between learning and implementing new skills would be helpful as it is unclear
whether the experience and processes are universal or unique to those learning to use
standardised occupation-based assessment (i.e., AMPS and PRPP). Lastly, would
there be any differences between new graduates and senior occupational therapists in
using this assessment in their practice?

Limitations of the Study

There were some limitations to this study. Firstly, the piloting participants
were all voluntary PRPP-trained occupational therapists practicing in Australia.
Hence, they may represent values and practice on the use of PRPP different to that of
New Zealand counterparts. Furthermore, time constraints of this research project did
not allow locating more occupational therapists to complete further piloting.
Secondly, the sample population, the sample size, and recruitment methods were not
entirely satisfactory because it was a self-selected convenience sample of occupational therapists who had completed the PRPP assessment training and were registered by OTBNZ and were members of Occupational Therapy New Zealand. It is possible that participants in this study were more motivated, evidence-based, or have had fewer difficulties in using the PRPP than non-responsive practitioners. Data collection and analysis may be biased because there is no database that accurately identifies or keeps a record of all the registered occupational therapists in New Zealand who are PRPP-trained. This would need to be addressed in order to ensure the rigour of future research. Lastly, it is possible that there could have been unintentional influence in data analysis by a researcher who was PRPP trained. However, it is hard to determine the extent of influence the researcher had over the result.

Conclusion

This study has explored the extent to which, and how occupational therapists in New Zealand use the PRPP and their perspectives on the benefits and challenges of adopting and implementing this tool in their clinical practice.

The integration of new knowledge and skills (PRPP) into practitioners’ existing practices is a complex process as indicated by findings of this study. In fact, attending the PRPP training, and adhering to formal recommendations and evidence-based research findings in isolation may not be sufficient to enable PRPP trained occupational therapists to use this tool in their practice. The main challenges identified by the study respondents when they began to use the PRPP were their inexperience with the assessment tool, their high workload, and lack of support and time to consolidate their learning from the course.

The findings of this study suggested the key influential factors to adopting and implementing the PRPP are related to the therapists themselves, the nature of their everyday practice, and what supports are available at their workplaces. In specific, firstly, occupational therapists’ experience, knowledge, skills and practice values could affect their reasoning, readiness and persistence with implementing the PRPP. Secondly, practitioners’ decisions to use or not to use the PRPP is likely to be tied to their practice area and work demands reflecting the professional positions and the
roles they hold (clinical and/or managerial). Lastly, the availability of supports and resources in occupational therapists’ workplace (i.e., managers, peers/experts, supplementary technology), can influence therapists’ professional development and competency in administering the PRPP. Interestingly, these findings echo similar results reported by Chard (2000, 2004, & 2006) who had investigated the use of AMPS by occupational therapists. It should be noted that there is no evidence in this New Zealand study to support the notion that client-related factors can affect the use of PRPP tool by trained occupational therapists.

Change in occupational therapy practice is possible and can lead to improvement in professional practice. For instance, the majority of respondents in this study who saw the value of PRPP had invested time and effort into learning to administer the PRPP with supports from their workplaces. They reported that the use of the tool had led to changes in their practice. These included better observational skills of task performance, the ability to effectively convey their professional perspectives to others, and the reinforcement of their practice as client- and occupation focused. The evidence of this study would seem to reaffirm the PRPP founders’ vision and their purpose of developing the PRPP to be a standardised occupation-focused assessment that supports occupational therapists to use a top-down approach in their practice (Chapparo & Ranka, 1997).

The results of this current study suggest that the respondents were at different levels of competence and readiness to use the PRPP in their practice. Thus, collaboration between occupational therapists and their managers/funders is important to clearly identify and understand needs so that the right type of resources and supports can be allocated and utilised effectively. This approach will enable PRPP trained practitioners to successfully consolidate their knowledge and skills enabling them to use this tool for assessment and outcome evaluation so that a high-quality occupational therapy service can be delivered and professional credibility enhanced.
REFERENCES


measurement, and analysis. Maidenhead; Berkshire, UK: Open University Press.


A STUDY INTO THE USE OF PRPP IN CLINICAL PRACTICE


A STUDY INTO THE USE OF PRPP IN CLINICAL PRACTICE

http://www.otboard.org.nz/LinkClick.aspx?fileticket=5W5yvumrHRE%3d&tabid=239&mid=643


Table 1

Respondents’ years of experience in occupational therapy practice

<table>
<thead>
<tr>
<th>Less than 1 year</th>
<th>1 to 3 years</th>
<th>4 to 6 years</th>
<th>7 to 10 years</th>
<th>More than 10 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>In total</td>
<td>0 (0%)</td>
<td>1 (2.3%)</td>
<td>4 (9.3%)</td>
<td>7 (16.3%)</td>
</tr>
<tr>
<td>In New Zealand</td>
<td>0 (0%)</td>
<td>3 (7.0%)</td>
<td>10 (23.3%)</td>
<td>7 (16.3%)</td>
</tr>
</tbody>
</table>
Table 2

The degree of importance client factors contributes to respondents’ decision-making to use the PRPP assessment in their practice

<table>
<thead>
<tr>
<th></th>
<th>Very important</th>
<th>Fairly important</th>
<th>Neutral</th>
<th>Not so important</th>
<th>Not at all important</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary diagnosis</strong></td>
<td>4</td>
<td>4</td>
<td>19</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>(9.8%)</td>
<td>(9.8%)</td>
<td>(46.3%)</td>
<td>(26.8%)</td>
<td>(7.3%)</td>
</tr>
<tr>
<td><strong>Secondary diagnosis</strong></td>
<td>2</td>
<td>4 (9.8%)</td>
<td>17</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>(4.9%)</td>
<td>(41.5%)</td>
<td>(36.6%)</td>
<td>(7.3%)</td>
<td></td>
</tr>
<tr>
<td><strong>Level of cooperation</strong></td>
<td>17</td>
<td>14</td>
<td>6</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>(41.5%)</td>
<td>(34.1%)</td>
<td>(14.6%)</td>
<td>(9.8%)</td>
<td>(0.0%)</td>
</tr>
<tr>
<td><strong>Level of occupational</strong></td>
<td>13</td>
<td>15</td>
<td>7</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td><strong>performance</strong></td>
<td>(31.7%)</td>
<td>(36.6%)</td>
<td>(17.1%)</td>
<td>(9.8%)</td>
<td>(4.9%)</td>
</tr>
<tr>
<td><strong>Occupational needs</strong></td>
<td>24</td>
<td>11</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(58.5%)</td>
<td>(26.8%)</td>
<td>(9.8%)</td>
<td>(2.4%)</td>
<td>(2.4%)</td>
</tr>
</tbody>
</table>
Table 3

*The degree of importance carer/family factors contributes to respondents’ decision-making to use the PRPP assessment in their practice*

<table>
<thead>
<tr>
<th>Issue(s)</th>
<th>Very important (20)</th>
<th>Fairly important (16)</th>
<th>Neutral (4)</th>
<th>Not so important (1)</th>
<th>Not at all important (0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal(s)</td>
<td>21</td>
<td>15</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Expectation of</td>
<td>10</td>
<td>15</td>
<td>12</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>occupational therapy service</td>
<td>(24.4%)</td>
<td>(36.6%)</td>
<td>(29.3%)</td>
<td>(4.9%)</td>
<td>(4.9%)</td>
</tr>
<tr>
<td>Burden and stress</td>
<td>11</td>
<td>16</td>
<td>10</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(26.8%)</td>
<td>(39.0%)</td>
<td>(24.4%)</td>
<td>(7.3%)</td>
<td>(2.4%)</td>
</tr>
</tbody>
</table>
Table 4

*The degree of importance therapist factors contributes to respondents’ decision-making to use the PRPP assessment in their practice*

<table>
<thead>
<tr>
<th>Factor</th>
<th>Very important</th>
<th>Fairly important</th>
<th>Neutral</th>
<th>Not so important</th>
<th>Not at all important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time available to administer the assessment</td>
<td>21 (51.2%)</td>
<td>15 (36.6%)</td>
<td>3 (7.3%)</td>
<td>1 (2.4%)</td>
<td>1 (2.4%)</td>
</tr>
<tr>
<td>Task-analysis skills to administer the assessment</td>
<td>27 (65.9%)</td>
<td>10 (24.4%)</td>
<td>3 (7.3%)</td>
<td>1 (2.4%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Confidence in using the assessment</td>
<td>21 (51.2%)</td>
<td>18 (43.9%)</td>
<td>2 (4.9%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Attitude towards using a standardized tool</td>
<td>9 (22.0%)</td>
<td>20 (48.8%)</td>
<td>10 (24.4%)</td>
<td>1 (2.4%)</td>
<td>1 (2.4%)</td>
</tr>
</tbody>
</table>
Table 5

*Cross tabulation on the respondents’ field of practice and how frequently the PRPP assessment is used in their practice*

<table>
<thead>
<tr>
<th>How frequently have you used the PRPP assessment?</th>
<th>Hospital and health service (DHB)</th>
<th>Private practice (self-employed)</th>
<th>Private practice (employed)</th>
<th>School (education)</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Less than daily but at least once a week</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Once a month</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Several times per month</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Several times per year</td>
<td>16</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Less than once per year</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>7</td>
<td>2</td>
<td>8</td>
<td>4</td>
</tr>
</tbody>
</table>
Table 6

*Cross tabulation on the respondents work hours per week and how frequently the PRPP assessment is used in their practice*

<table>
<thead>
<tr>
<th>How frequently have you use the PRPP assessment?</th>
<th>Up to 10 hours</th>
<th>11 to 20 hours</th>
<th>21 to 30 hours</th>
<th>31 to 40 hours</th>
<th>More than 40 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Less than daily but at least once a week</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Once a month</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Several times per month</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Several times per year</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>Less than once per year</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>6</td>
<td>5</td>
<td>27</td>
<td>3</td>
</tr>
</tbody>
</table>
Table 7

Cross tabulation of the funding source(s) for respondents to complete the PRPP assessment-training course and how frequently they use the PRPP assessment in their practice

<table>
<thead>
<tr>
<th>How frequently have you use the PRPP assessment?</th>
<th>Self-funded</th>
<th>Employer funded</th>
<th>Self &amp; employer funded</th>
<th>Other funded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Less than daily but at least once a week</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Once a month</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Several times per month</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Several times per year</td>
<td>1</td>
<td>15</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Less than once per year</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>25</td>
<td>7</td>
<td>6</td>
</tr>
</tbody>
</table>
Table 8

Cross tabulation of the year respondents completed the PRPP assessment training course and how frequently they use the PRPP assessment in their practice

<table>
<thead>
<tr>
<th>How frequently have you used the PRPP assessment?</th>
<th>2007</th>
<th>2009</th>
<th>2011</th>
<th>2013</th>
<th>Other 1997</th>
<th>Other 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Less than daily, but at least once a week</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Once a month</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Several times per month</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Several times per year</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>12</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Less than once per year</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>6</td>
<td>14</td>
<td>14</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 9

Cross tabulation of how soon respondents began using the PRPP assessment post-training and how frequently they use the PRPP assessment in their practice.

<table>
<thead>
<tr>
<th>How frequently have you use the PRPP assessment?</th>
<th>Within 2 days</th>
<th>Within 1 to 2 weeks</th>
<th>Within 1 month</th>
<th>Within 2 to 5 months</th>
<th>More than 5 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Less than daily but at least once a week</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Once a month</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Several times per month</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Several times per year</td>
<td>0</td>
<td>3</td>
<td>9</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Less than once per year</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>9</td>
<td>14</td>
<td>14</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 10

*Cross tabulation on how soon did respondents began using the PRPP assessment and how easy is it for respondents to use PRPP assessment*

<table>
<thead>
<tr>
<th>How easy it is for you to use the PRPP assessment?</th>
<th>Within 2 days</th>
<th>Within 1 to 2 weeks</th>
<th>Within 1 month</th>
<th>Within 2 to 5 months</th>
<th>More than 5 months</th>
<th>Never used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very easy</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Moderately easy</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>A little difficult</td>
<td>0</td>
<td>3</td>
<td>10</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Very difficult</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Never tired</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>
Table 11

*Cross tabulation on how easy is it for respondents to use PRPP assessment and how frequently they use PRPP assessment in their practice*

<table>
<thead>
<tr>
<th>How frequently have you used the PRPP assessment?</th>
<th>Very easy</th>
<th>Moderately easy</th>
<th>A little difficult</th>
<th>Very difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Less than daily but at least once a week</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Once a month</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Several times per month</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Several times per year</td>
<td>2</td>
<td>7</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Less than once per year</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>16</td>
<td>18</td>
<td>2</td>
</tr>
</tbody>
</table>
Table 12

*Cross tabulation on any barriers to use PRPP assessment and how frequently respondents use PRPP assessment in their practice*

<table>
<thead>
<tr>
<th>How frequently have you used the PRPP assessment?</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Less than daily but at least once a week</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Once a month</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Several times per month</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Several times per year</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Less than once per year</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>27</td>
</tr>
</tbody>
</table>
Table 13

Cross tabulation on type of assistance that supported respondents to implement the PRPP assessment in their practice and how frequently the PRPP assessment is used in their practice

<table>
<thead>
<tr>
<th>How frequently have you used the PRPP assessment?</th>
<th>PRPP trained Occ. Therapist</th>
<th>PRPP instructor</th>
<th>OT manager / supervisor</th>
<th>PRPP manual / resources</th>
<th>Other OT</th>
<th>Study time</th>
<th>Other</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Less than daily but at least once a week</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Once a month</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Several times per month</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>6</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Several times per year</td>
<td>8</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td>9</td>
<td>2</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Less than once per year</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>6</td>
<td>3</td>
<td>22</td>
<td>16</td>
<td>5</td>
<td>15</td>
<td>8</td>
</tr>
</tbody>
</table>
Table 14

*Cross tabulation on the degree of change in respondents’ practice after completed the PRPP assessment training and how frequently the PRPP assessment is used in their practice*

<table>
<thead>
<tr>
<th>How frequently have you used the PRPP assessment?</th>
<th>No change</th>
<th>Changed some aspects</th>
<th>Changed a great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Less than daily but at least once a week</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Once a month</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Several times per month</td>
<td>0</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Several times per year</td>
<td>1</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>Less than once per year</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>21</td>
<td>18</td>
</tr>
<tr>
<td>Occupational Setting</td>
<td>Percentage</td>
<td>Count</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------</td>
<td>------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Hospital and health service (DHB)</td>
<td>65.1%</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>School (education)</td>
<td>20.9%</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Private practice (self-employed)</td>
<td>16.3%</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>9.3%</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Private practice (employed)</td>
<td>4.7%</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Government department / crown agency (not DHB)</td>
<td>2.3%</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Retired</td>
<td>0.0%</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Community / Voluntary organization</td>
<td>0.0%</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>43</td>
<td></td>
</tr>
</tbody>
</table>

Figure 1. The respondents’ occupational therapy practice settings
Figure 2. The respondents’ occupational therapy practice areas (specialties)
Figure 3. What type of funding source did respondents’ receive for the PRPP assessment training?
### Figure 4. What are the features of PRPP assessment that best reflected respondents’ practice values?

<table>
<thead>
<tr>
<th>Feature</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexible i.e. Can be used with a variety of clients regardless of their performance level, disability/medical condition, age, gender, or cultural background.</td>
<td>83.7%</td>
<td>36</td>
</tr>
<tr>
<td>An occupation-based standardised assessment</td>
<td>60.5%</td>
<td>26</td>
</tr>
<tr>
<td>Able to assess the impact of cognitive deficits on client’s occupational performance, roles, routines, and tasks.</td>
<td>58.1%</td>
<td>25</td>
</tr>
<tr>
<td>Able to assess occupational performance, routines, tasks, and subtasks in client's context.</td>
<td>44.2%</td>
<td>19</td>
</tr>
<tr>
<td>Based on an occupational therapy model (Occupational Performance Model (Australia))</td>
<td>23.3%</td>
<td>10</td>
</tr>
<tr>
<td>Able to support planning occupational intervention.</td>
<td>20.9%</td>
<td>9</td>
</tr>
<tr>
<td>Able to accurately measure changes and outcomes.</td>
<td>14.0%</td>
<td>6</td>
</tr>
<tr>
<td>Economical (a one-off training course without additional costs)</td>
<td>9.3%</td>
<td>4</td>
</tr>
<tr>
<td>Other (please describe)</td>
<td>4.7%</td>
<td>2</td>
</tr>
<tr>
<td>Time efficient</td>
<td>4.7%</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>43</strong></td>
<td></td>
</tr>
</tbody>
</table>
Figure 5. How soon after the training did respondents begin using the PRPP assessment in their practice?
Figure 6. How frequently did respondents use the PRPP assessment in their practice?
Figure 7. What type of supports did respondents received to support the implementation of PRPP assessment in their practice?

<table>
<thead>
<tr>
<th>Support Type</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRPP manual / resources</td>
<td>53.5%</td>
<td>23</td>
</tr>
<tr>
<td>Other occupational therapist</td>
<td>37.2%</td>
<td>16</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>34.9%</td>
<td>15</td>
</tr>
<tr>
<td>PRPP-trained occupational therapist</td>
<td>32.6%</td>
<td>14</td>
</tr>
<tr>
<td>None, no assistance received</td>
<td>23.3%</td>
<td>10</td>
</tr>
<tr>
<td>PRPP instructor</td>
<td>14.0%</td>
<td>6</td>
</tr>
<tr>
<td>Study time</td>
<td>11.6%</td>
<td>5</td>
</tr>
<tr>
<td>Occupational therapy manager/supervisor</td>
<td>7.0%</td>
<td>3</td>
</tr>
</tbody>
</table>

Total: 43
Appendix A: A Synopses of the PRPP System of Task Analysis

The Perceive Recall Plan Perform System of Task Analysis (PRPP) (Chapparo & Ranka, 1997) was developed based on the Occupational Performance Model (Australia) [OPM(A)] and a task analysis methodology (Chapparo & Ranka, 1997; Ranka, 2014). With training, the PRPP provides a structured way to diagnose information processing problems in the context of tasks and activities that are meaningful and relevant to the person (Chapparo & Ranka, 1997; Ranka, 2005; Ranka, 2014). The PRPP System consists of two stages of analysis.

Stage One of the evaluation involves a standardised behavioural task analysis, whereby everyday activity performance is broken down into steps, and errors in performance (accuracy, omission, repetition or timing) are identified. An overall mastery of an individual’s ability to do specific and relevant occupations is generated from this information (Chapparo & Ranka, 1997; Fry & O’Brien, 2002; Nott & Chapparo, 2008). A task mastery score can be calculated by dividing the number of ‘error-free’ steps performed over the total number of task steps the multiple by 100 to obtain a percentage. Stage Two focuses on identifying observable cognitive strategy deficits resulting in performance errors. It uses cognitive task analysis methodology to evaluate the information processing strategies that underpin occupational performance. These are perception, recall, response planning, and performance as central quadrants in the PRPP System’s theoretical model (Nott & Chapparo, 2008; Figure A1). These quadrants are interrelated; any difficulties experienced in one quadrant will influence performance in another. In this assessment errors in cognition in each quadrant are identified as actual observable behaviours (Chapparo, 2010). In total, 34 different information processing strategies, termed descriptors on the outer circle of the PRPP System are rated on a three-point scale indicating how effectively the person applied each cognitive strategy (Nott & Chapparo, 2008; Figure A2 and Figure A3).

In conjunction with the individual, their family/carer or significant others, measurable occupational performance goals can be set and re-evaluated following intervention. As the PRPP does not have a predetermined set of functional tasks, it promotes a client-centred approach and enables assessment and retraining in any task selected by the client and/or carer (Fry & O’Brien, 2002).
Appendix B: Checklist for Critical Appraisal of Studies Reporting Validity, Reliability and Responsiveness of Outcome Measures

<table>
<thead>
<tr>
<th>Methods</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the purpose of the study clearly defined and focused on examining one or more measurement properties, that is validity, reliability or responsiveness?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Is the instrument described and is there a standardised protocol for administration and scoring which is described fully?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Are the observers/testers appropriately trained or certified?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Were the data collected on an appropriate sample which is representative of the population to whom the measure will apply?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Is the sample size adequate? (Is there a power calculation?)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Results: validity</th>
<th>Yes</th>
<th>No</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the measure make intrinsic sense - face validity (expert opinion/consensus)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Does the measure sample the content/domain adequately?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Is there evidence of the test’s construct validity?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Does the test discriminate between healthy and diseased group (known-groups method)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Do the test values agree with the value of a similar test or gold standard (concurrent or convergent validity) or with a future outcome (predictive validity)? If yes, then:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. What is the strength of the correlation?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. What are the confidence limits, if given?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. What is the internal consistency (relevant where scales have multiple items that sum up a total score)?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Results: reliability</th>
<th>Yes</th>
<th>No</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is the test-retest reliability?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Have appropriate statistical measures been used to assess agreement between two or more occasions using the same observer?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. What is the level of agreement (for example, Kappa or ICC)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. What are the confidence limits, if given?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. What is the inter-tester reliability?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Have appropriate statistical measure been used to assess agreement between two or more observers?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. What is the level of agreement (for example, Kappa or ICC)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. What are the confidence limits, if given?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Results: responsiveness</th>
<th>Yes</th>
<th>No</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the instrument capture clinical change?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. What is the magnitude of the responsiveness of the instrument (for example, effect size or standard response mean)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Is there evidence of floor or ceiling effects?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Appendix C: Participant Information Sheet & Questionnaire

Participant
Information Sheet

Dear Participant,

My name is Frank Lu. I am a Master’s student in the Otago Polytechnic School of Occupational Therapy and am conducting this research study in partial fulfillment of my degree requirements working under the supervision of Dr. Linda Robertson.

The project is entitled “An exploratory study into the use of the Perceive Recall Plan Perform (PRPP) System of Task Analysis in clinical practice in New Zealand”. This study has been approved by the Occupational Therapy Postgraduate Committee and the Ethics Committee of Otago Polytechnic.

The 3 key objectives are:

1. To explore factors that may influence occupational therapists’ implementation of the PRPP System of Tasks Analysis in their practice.

2. To identify the benefits and challenges of implementing the PRPP System of Task Analysis in clinical practice in New Zealand.

3. To establish the supports New Zealand occupational therapists have or may require in helping them to implement the PRPP System of Task Analysis in their practice.

You are invited to participate because you have completed the PRPP assessment training. It is our hope that this information will benefit the practice and profession of occupational therapy by having a better understanding about the benefits and challenges of using this standardised occupation-focused assessment in diverse clinical settings in New Zealand.

All experience and opinions are important, even if you have not used the PRPP System of Task Analysis after your completion of the PRPP Assessment training. The more occupational therapists taking part of this survey, the more enriched the results will be.

The online survey should take approximately 15 minutes to complete.
The survey does not collect identifying information.
All responses will be recorded anonymously.
If you choose not to participate you will not be disadvantaged in any way.

You may withdraw to complete this online survey at any time except once you have submitted the online survey, as the data is not traceable.

If you have any questions regarding this survey or the research project in general, please do not hesitate to contact my research supervisor or myself.

If you have read and understand the above statement, please click on the “Next” button below to indicate the following:

1. I have read the information provided above.
2. I have asked all the questions that I have at this time.
3. I agree to participate in this research study.

Thank you again for taking time to participate in this study!

Frank Lu NZROT MOTNZ
Master’s Student (Occupational Therapy)
Department of Occupational Therapy
Otago Polytechnic
Email: prppresearchnz@gmail.com

Dr. Linda Robertson NZROT MOTNZ
Research Supervisor
Department of Occupational Therapy
Otago Polytechnic
Email: lindar@op.ac.nz
PRPP Assessment Training
1. What year did you complete the PRPP Assessment (5 days) training?
   - 2007
   - 2009
   - 2011
   - 2013
   - Other (please specify)

2. In which country did you complete the PRPP Assessment (5 days) training?
   - New Zealand
   - Other country (please state the country)

3. What was your main reason for attending the PRPP assessment course training?
   - Wanted to learn to use it as an occupation-based assessment tool
   - Wanted to learn to use it as an outcome measure
   - Wanted to learn it for research purposes
   - Recommendations from colleagues
   - Sent by the manager / funder
   - Other (please describe)

4. Which of the following features of the PRPP Assessment best reflect your practice values? (Please tick the 3 main features that apply)
   - An occupation-based standardised assessment
   - Time efficient
   - Economical (a one-off training course without additional costs)
   - Based on an occupational therapy model (Occupational Performance Model (Australia))
   - Flexible i.e. Can be used with a variety of clients regardless of their performance level, disability/medical condition, age, gender, or cultural background.
   - Able to assess occupational performance, routines, tasks, and subtasks in client’s context.
   - Able to assess the impact of cognitive deficits on client’s occupational performance, roles, routines, and tasks.
   - Able to support planning occupational intervention.
   - Able to accurately measure changes and outcomes.
   - Other (please describe)

5. Please state your funding source for the PRPP Assessment training?
   - Self-funded
   - Employer funded
   - Self & employer funded
   - Other (please describe)
6. Have you completed the PRPP Intervention (4 days) training?

☐ No
☐ Yes (please specify the year)

7. Have you ever used the PRPP Assessment?

☐ No (Please go to Q18)
☐ Yes

8. How soon after the training did you begin using the PRPP Assessment?

☐ Within 2 days
☐ Within 1 to 2 weeks
☐ Within 1 month
☐ Within 2 to 5 months
☐ More than 5 months
☐ Never used

9. How frequently have you used the PRPP Assessment?

☐ Daily
☐ Less than daily, but at least once per week
☐ Once a month
☐ Several times per month
☐ Several times per year
☐ Less than once per year

10. How easy is it for you to use the PRPP Assessment?

☐ Very easy
☐ Moderately easy
☐ A little difficult
☐ Very difficult
☐ Never tried (Please go to Q18)

In a couple of sentences please explain your reasoning for your answer

[blank space]
11. For each of the **client factors**, please rate their importance when deciding to implement the PRPP Assessment with a client.

<table>
<thead>
<tr>
<th>The client’s</th>
<th>Very important</th>
<th>Fairly important</th>
<th>Neutral</th>
<th>Not so important</th>
<th>Not at all important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary diagnosis</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Secondary diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive assessment results</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of cooperation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of occupational performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
12. For each of the **carer / family’s factors**, please rate their importance when deciding to implement the PRPP Assessment with a client.

<table>
<thead>
<tr>
<th>Carer / Family’s</th>
<th>Very important</th>
<th>Fairly important</th>
<th>Neutral</th>
<th>Not so important</th>
<th>Not at all important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expectation of occupational therapy service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burden and stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. For each of the **therapist’s factors**, please rate their importance when deciding to implement the PRPP Assessment with a client.

<table>
<thead>
<tr>
<th>Therapist’s</th>
<th>Very important</th>
<th>Fairly important</th>
<th>Neutral</th>
<th>Not so important</th>
<th>Not at all important</th>
</tr>
</thead>
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<tr>
<td>Time available to administer the assessment</td>
<td></td>
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<td>Task-analysis skills to administer the assessment</td>
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<td>Confidence in using the PRPP Assessment</td>
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<tr>
<td>Attitude towards using a standardized tool</td>
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14. The PRPP Assessment can be used for a variety of purposes. How do you use it in your practice? (Please tick all that apply)

- A formal, scored test of occupational performance (Stage 1)
- A formal, scored test of occupational performance (Stage 2)
- A framework to observe occupational performance
- A questionnaire to seek written information about the client’s perception of occupational performance
- An interview about perception of client’s capacity to apply cognitive strategies in everyday life.
- Other (please describe)

15. From your experience, what are the **strengths** of using PRPP Assessment?

16. From your experience, what are the **limitations** of using PRPP Assessment?

17. What are your views about the relevance of the PRPP Assessment on assessing clients from diverse cultural context (i.e. Maori, Pacific Islander, Asian) in New Zealand?

18. Are there any barriers to the practical use of PRPP Assessment in your practice?

- No
- Yes

In a couple of sentences please explain your reasoning for your answer
19. Have you received any assistance that supported you to implement the PRPP Assessment into your practice? (Please tick all that apply)

☐ PRPP-trained occupational therapist
☐ PRPP instructor
☐ Occupational therapy manager/supervisor
☐ PRPP manual / resources
☐ Other occupational therapist
☐ Study time
☐ None, no assistance received
☐ Other (Please specify)

20. In your opinion, what enables you to implement the PRPP Assessment efficiently and effectively in your practice?


21. To what degree has your practice changed after completing the PRPP Assessment training?

☐ No change
☐ Changed some aspects
☐ Changed a great deal

In a couple of sentences please explain your reasoning for your answer


Finally some information about yourself:

22. What is your gender?

☐ Female
☐ Male

23. What is your ethnicity?

☐ New Zealand / European
☐ Maori
☐ Pacifica
☐ Asian
☐ Other (Please specify)
24. What is your original occupational therapy qualification?

- Diploma
- Bachelors
- Masters (entry level i.e. to obtain registration to practice as an occupational therapist, you needed to have completed a Masters degree in occupational therapy)
- Other (please specify)

25. In which country did you complete your occupational therapy qualification?

- New Zealand
- Other country (please specify)

26. Please tick the boxes that best describe your field of practice.
(Please tick all that apply)

- Hospital and health service (DHB)
- Private practice (self-employed)
- Private practice (employed)
- School (education)
- Government department / crown agency (not DHB)
- Community / Voluntary organization
- Retired
- Other (please specify)

27. Please tick the boxes that best describe your area of practice (specialty).
(Please tick all that apply)

- Birth to three
- Children
- Adolescents
- Adults
- Elderly
- Acute Care
- Community-based
- Home health
- Mental health
- Outpatient
- Rehabilitation
- School
- Work/Industry
- Leadership & Management
- Residential Care
- Teaching (Tertiary)
- Other (please specify)
28. In a typical week about how many hours do you work?

☐ Up to 10 hours
☐ 11 to 20 hours
☐ 21 to 30 hours
☐ 31 to 40 hours
☐ Other (please describe)

29. How many years have you been practising as an occupational therapist?

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<th></th>
<th>Less than 1 year</th>
<th>1 to 3 years</th>
<th>4 to 6 years</th>
<th>7 to 10 years</th>
<th>More than 10 years</th>
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<tr>
<td>In Total</td>
<td></td>
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<tr>
<td>In New Zealand</td>
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</table>

Thank you for completing this survey.
Your contribution to this survey is greatly appreciated.

If any issue arose while you were completing this survey, we strongly encourage you to take it to supervision to ensure it can be addressed.

Please regularly visit this blog for updates about this project
Blog: http://prpprearchnz.blogspot.co.nz/
Appendix D: Invitation Letter

Dear Participant,

My name is Frank Lu. I am a Master student at Otago Polytechnic in the Occupational Therapy Department under the supervision of Dr Linda Robertson. You are invited to participate in a research project entitled: “An exploratory study into the use of the Perceive, Recall, Plan, Perform (PRPP) System of Task Analysis in clinical practice in New Zealand”.

This study has been approved by the Occupational Therapy Postgraduate Committee and the Ethics Committee of Otago Polytechnic. There are no identified risks from participating in this research project.

It is hoped that this information can benefit the practice and profession of occupational therapy by gaining a better understanding about the benefits and challenges of using this standardised occupation-focused assessment in diverse clinical settings in New Zealand.

All experiences and opinions are important, even if you have not used the PRPP System of Task Analysis after your completion of the PRPP Assessment training. The more occupational therapists taking part of this survey the more enriched the results will be.

The electronic survey should take approximately 15 minutes to complete.

The survey does not collect identifying information. All responses will be recorded anonymously. You will not be disadvantaged in any way should you choose not to participate. You may withdraw to complete the online survey at any time except when you have submitted the online survey, as the data is not traceable.

Simply click on the link below, or cut and paste the entire URL into your browser to access to the survey:


We would appreciate your response before 30th June 2014.

If you would prefer to fill out a paper version of the survey, please email Debbie Davie debbied@op.ac.nz and request a hard copy with free return postage to the Occupational Therapy Department at Otago Polytechnic.

If you have any questions regarding this survey or the research project in general, please contact my research supervisor or myself.

Sincerely,

Frank Lu NZROT MOTNZ
Master’s Student of Occupational Therapy
Department of Occupational Therapy
Otago Polytechnic
Email: prppresearchnz@gmail.com

Dr. Linda Robertson NZROT MOTNZ
Research Supervisor
Department of Occupational Therapy
Otago Polytechnic
Email: Lindar@op.ac.nz
Appendix E: Reminder Letter

PRPP-trained Occupational Therapists Wanted for Research Study

Dear Participant,

A few weeks ago you were invited to participate in a research project entitled: “An exploratory study into the use of the Perceive, Recall, Plan, Perform (PRPP) System of Task Analysis in clinical practice in New Zealand”. If you have filled out the survey, thank you so much!

This message has gone to everyone in the selected sample population. Since no personal data is retained with the surveys for reasons of confidentiality, we are unable to identify whether or not you have already completed the survey.

If you have completed the PRPP training(s) and not had a chance to take the survey yet, I would appreciate your reading the message below and complete the survey.

It is hoped that that this information can benefit the practice and profession of occupational therapy by having a better understanding about the benefits and challenges of using this standardised occupation-focused assessment in diverse clinical settings in New Zealand.

All experiences and opinions are important, even if you have not implemented the PRPP System of Task Analysis after your completion of the PRPP Assessment training. The more occupational therapists taking part of this survey the more enriched the results will be.

The electronic survey should take approximately 15 minutes to complete.

The survey does not collect identifying information. All responses will be recorded anonymously. You will not be disadvantaged in any way should you choose not to participate. You may withdraw to complete the online survey at any time except when you have submitted the online survey, as the data is not traceable.

Simply click on the link below, or cut and paste the entire URL into your browser to access to the survey:


We would appreciate your response before 30th June 2014.

If you would prefer to fill out a paper version of the survey, please email Debbie Davie debbied@op.ac.nz and request a hard copy with free return postage to the Occupational Therapy Department at Otago Polytechnic.

If you have any questions regarding this survey or the research project in general, please contact my research supervisor or myself.

Sincerely,

Frank Lu NZROT MOTNZ
Master's Student of Occupational Therapy
Department of Occupational Therapy
Otago Polytechnic

Email: prppresearchnz@gmail.com

Dr. Linda Robertson NZROT MOTNZ
Research Supervisor
Department of Occupational Therapy
Otago Polytechnic

Email: Lindar@op.ac.nz
Appendix F: Record of Consultation (Kaitohutohu Office)

Record of Consultation
Re: PRPP Research Assessment Proposal: Frank Lu

27 November 2013

Kia ora Frank,

I thought it may be easier if I made comments below- so you can see them in the context of your work below...
You will want to keep a record of this consultation for yourself, and ethics so I’ve put this info into a Word doc.

My comments are in blue

I’ve added a few notes in your PRPP Research Assessment Proposal too.

Overall I think your proposal is quite strong, so from a Kaitohutohu perspective we would have no further comments at the consultation stage. The Ethics committee (of which Kaitohutohu also sits on) would be interested in how you respond to the comments received here. Some comments are “Think about” rather than “Make Changes” comments – so you are not expected to respond to all of these.

If you have any further questions please don’t hesitate in emailing me back

Ka mihi
Gina Huakau on behalf of Kaitohutohu

From: Frank Lu [mailto:mails2frank@yahoo.com]
Sent: Sunday, 24 November 2013 4:35 p.m.
To: Gina Huakau
Cc: Linda Robertson
Subject: Re: Research Project Consultation - Kaitohutohu Office

Hi Gina,

Thank you for offering to look into my research proposal (enclosed with this e-mail). I am based in Auckland and available online (after 6pm after full-time work). E-mail may be the most preferable and efficient way to get in touch...

I am seeking formal advice and feedback from Kaitohutohu Office to make sure that the research protocol upholds the principles of Treaty of Waitangi throughout all research stages as I work toward my Master’s degree in Occupational Therapy with supports from my research supervisor and the advisory groups.

I am following the guidelines suggested by Health Research Council of New Zealand (HRC) in preparation for this consultation with the intension to ensure that research contributes to Maori health development in co-operation and collaboration between Maori organizations and groups whenever possible.

My research project primary focuses at exploring how occupational therapists in New Zealand use the Perceive Recall Plan Perform (PRPP) System of Task Analysis in their clinical practice following the PRPP Assessment training. (Please refer to my research proposal and questionnaire drafted attached).

This research project is recruiting participants who are New Zealand registered and practicing occupational therapist that had completed the PRPP Assessment training only.
In 2008 a mere 2% of the 2159 registered occupational therapists were Maori (Turia, 2009). Currently there is no data on how many of them are PRPP Assessment trained.

I would be careful with statistics like this, as ethnicity data has a lot of inconsistencies in it, especially in capturing people who are of mixed ethnicity. I would re-word this sentence – please take our ‘mere’ – I acknowledge it’s not your intent but it doesn’t read well.

Simply stating that currently the number of Maori registered OT’s is proportionally lower compared with Pakeha OTs and referring to Ruria would suffice here.

Does this research involve Maori participants?

- Participation in this research project is voluntary.
- The participants are anonymous when they complete the questionnaire, as there will be no direct personal data collected.
- Nevertheless, I believe there is the possibility that there will be Maori participants. This is notified from Question 27 of the questionnaire when participants describe their ethnicity.

Ka pai. I did note this in your attached document and I think capturing this information is important and will give you thy opportunity to analyse your data in different ways. I noted in your text that AGE wasn’t included- so you may like to consider this as you are capturing other demographics.

- The collection of ethnicity data is not of primary use to the research proposal itself but can provide valuable baseline data for other researchers or Maori communities.

Again, I would re-word this sentence – ‘not of primary use’ – I acknowledge it’s not your intent but it doesn’t read well. How about: The collection of ethnicity data can be provide valuable baseline data for other researchers or Maori communities.

What are the processes and procedures will I need to have if there are Maori participants in my research?

Does this research have specific Maori content? Will the research seek and analyze Maori data?

- To my knowledge there is no reference to tikanga (custom), whakapapa (history), whenua (land and environment), iwi Maori (Maori people), or taonga (including Maori language) in this research. However, there is the possibility that participants may make references to things Maori, including knowledge and/or about Maori when answering Q20 of the questionnaire.

If there are Maori content in the data collected. I will be seeking my research supervisor for support at data analysis. I am hoping Kaihutohu Office will be able to bring their cultural knowledge and expertise to our research endeavors.

I like how you have identified you will seek support during data analysis stage – as this keeps the intent of a relationship, and not just ‘checking facts’ at the end of a process. If early on, you seek this support then you will need to go to your supervisor who can help bridge the appropriate support. If the OT school thinks this is via the Kaitohutohu office, then we can go from there, but equally there may also be a Maori post-graduate OT who could assist you here. So we’ll come to that once you know what information you have gathered and what type of support you need.

Does this research impact on Maori?
- Having a better understanding about the current practice of PRPP Assessment in New Zealand from this research project could be invaluable to Māori and other cultural groups and stakeholders.

- The findings gained from this project could inform and enable Māori to make future decisions about investment in this assessment in their services. This is significant as decisions made may influence on resource management, continuing professional development goals for occupational therapists, and their delivery and quality of occupational therapy, and the outcomes for service users.

*Please change ‘them’ to Māori.*

**Will the Maori community have an interest in the proposed research result?**

*To maximize the research project’s potential benefits are there any other procedures in place to ensure findings are actively disseminated to Māori beside the disseminated plan stated in the research proposal?*

I couldn’t see your dissemination plan in your doc? Sorry I’ve probably just missed it, but you could try producing a summary of key findings when you are finished, and make it available online. Or better still send it via PDF to Service providers (public and private) who have OT services OR employ OTs. I say this because is the South Island there are number of NGOS who employ OTs but not as OTs. So services like that may be interested in what tools their employees could be using, (or already use) and how it effective it is.

Just a thought…

This is my first research project. As a novice I am keen to seek advice and feedback about my research proposal from a cultural and social perspective and continuing consultation aiming to make submission to the ethic committee by end of December 2013.

Thank you for your time and support.

Yours sincerely,

Frank Lu NZROT MNZOT
Master of Occupational Therapy Student

cc: Research Supervisor - Dr Linda Robertson

On Thursday, 21 November 2013 1:39 PM, Gina Huakau <Gina.Huakau@op.ac.nz> wrote:

*Kia ora Frank*

Thank you for your email. If you would like to send your information to me and I can start to look through it on behalf of Kaitohutohu.
After this, we will discuss this as a team and come back to you.
We may request to meet with you, or continue to dialogue via email. Are you in Dunedin? Or available online?
You are welcome to enroll yourself in the student moodle page, the link is: [http://moodle.op.ac.nz/course/view.php?id=2808](http://moodle.op.ac.nz/course/view.php?id=2808)

Thanks again for your email. Ka mihi Gina
To whom this may concern,

My name is Frank Lu. I am a Master student at Otago Polytechnic in Occupational Therapy Department under the supervision of Dr. Linda Robertson. Currently I am in the process of writing up the ethics applications for submission.

All research undertaking in New Zealand has a cultural consideration. As part of preparing the ethics proposal the researcher needs to consider any specific issues that would be pertinent to Maori occupational therapists, or Maori clients, related to the Treaty of Waitangi.

My research project is primary focused on how occupational therapists practicing in New Zealand using the Perceive Recall Plan Perform (PRPP) System of Task Analysis in their clinical practice following the PRPP Assessment training. By having a better understanding about the current practice of PRPP Assessment in New Zealand could be invaluable to Maori and other cultural groups stakeholders. The findings gained from this project could inform and enable them to make future decisions about investment in the PRPP Assessment in their services.

I am keen to seek consultation and from Kaitohutohu office about my research project for constructive critique on the project proposal and questions in the questionnaire (drafting) and exploring its potential impacts on Maori. This is to make sure the foundation of Tikanga Maori is maintained in this research project.

As a postgraduate student of Otago Polytechnic I would like to gain access to Moodle page for relevant information. Furthermore, I would like whom should I send electronic copy of my research proposal and the draft questionnaires to the Kaitohutohu office for consultation as I have queries i.e. questionnaire (cultural oriented questions), dissemination of results, opportunities etc.

I am looking forward to hear from you.

Thank you for your kind attention.

Frank Lu
Master’s student of Occupational Therapy
Student ID: 09003523
Appendix G: Agreements (Chameleon Courses & PRPP Subject Matter Experts)

Seeking written confirmation of agreement / provision with PRPP subject matter experts

<table>
<thead>
<tr>
<th>Frank Lu <a href="mailto:mails4franklu@gmail.com">mails4franklu@gmail.com</a></th>
</tr>
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<tbody>
<tr>
<td>Chameleon Courses <a href="mailto:chameleoncourses@gmail.com">chameleoncourses@gmail.com</a></td>
</tr>
<tr>
<td>5 March 2014 22:25</td>
</tr>
</tbody>
</table>

To: Frank Lu <mails4franklu@gmail.com>  
Cc: "Lindar@op.ac.nz" <Lindar@op.ac.nz>

Dear Frank

**Agreement to act as PRPP Subject Matter Experts (SMEs)**

Thank you for your email seeking written clarification of the relationship agreement between Chameleon Courses partners (Carolyn Simmons Carlsson NZROT and Wendy Burrows NZROT) and yourself in relation to your Masters research project through Otago Polytechnic.

**To clarify, our intent and relationship with you as the post-grad student and researcher is as follows:**

1. In acting as PRPP System of Task Analysis (Chapparo & Ranka, 2007) SMEs we have been well informed about the extent and nature of your research project.

2. From the outset and throughout our engagement with you, we have operated on the basis that your research project is not in any way connected to the business of Chameleon Courses. Furthermore your research is definitely not perceived as a "service evaluation" of courses offered by Chameleon Courses. We have many other robust systems for service/course evaluation, least of which would be a research project that explores your question of scholarly interest.

3. In discussions with you, we have offered and are willing to email disseminate information about your research project to former PRPP Assessment course participants in New Zealand, who have attended a PRPP assessment course training. This email will be a means of inviting occupational therapists to volunteer to participate in your research survey. We will be expecting no further contact with any volunteer participant following this dissemination and we will be explicitly stating this in the email.

4. Should a reminder email be required, please re-contact us to request a second email cascade to the group. We understand that you will also be using other means of participant invitation dissemination, so figure once via Chameleon Courses will be sufficient. Please note that we will in no way be held accountable for any potential 'no-replies' / poor response rate as we cannot guarantee that peoples' emails are necessarily current in our contacts list.

5. Chameleon Courses understands and does not wish to have any involvement in the data collection and data analysis process. This is your research project and your 'baby', conducted in partial fulfillment of a Masters degree with Otago Polytechnic and we recognise this implicitly.

6. Similarly, Chameleon Courses understands that the dissemination and publication of this project will be independent of any of our input and be the intellectual property of the researcher and authors. To this end, Chameleon Courses does not wish to be acknowledged or referenced in any of your publications.

We wish you all the very best in your project. Enjoy the learning journey which we have been
happy to support you on as SMEs.

Kind regards

cc. Linda Robertson Primary Supervisor Lindar@op.ac.nz

Kind Regards

Chameleon Courses
Bringing you the courses you would love to go on! Creating optimal learning environments!

Carolyn Simmons Carlsson & Wendy Burrows
m Carolyn: 027 259 3312 or Wendy: 021 1325 338

Find us on Facebook: Chameleon Courses

Seeking support re: Online Survey Pilot (Stage 2)

Chameleon Courses <chameleoncourses@gmail.com> 5 March 2014 22:21

To: Frank Lu <mails4franklu@gmail.com>
Cc: "Lindar@op.ac.nz" <Lindar@op.ac.nz>

Dear Frank

Seeking volunteer participants to provide feedback on your research on-line survey tool

Thank you for your email. We are happy to support Stage 2 of your pilot research project by connecting you with potential Australian occupational therapist participants who are PRPP-assessment trained.

Please could you send us a very brief synopsis of your project with your contact details, so that we can let the occupational therapists know why we are contacting them on your behalf. This only needs to be a short paragraph. This then would allow them to contact you directly once we have emailed them and would work better in terms of them acting on their choice to contact you and volunteer to participate, rather than us giving you their names without consent and you contacting them. In this way Chameleon Courses will simply act as the intermediary deliverer of initial information about your project. You can certainly provide anyone with more information, including your deadlines, once they have made contact with you directly.

We would also stipulate in our email that Chameleon Courses in no way involved in your research, that you are acting independently as part of your Masters study, and that we do not stand to gain from your research project, nor so we seek to influence it in any way. If you can get this to us ASAP this will expedite the process for you.

cc. Linda Robertson Primary Supervisor Lindar@op.ac.nz

Kind Regards

Chameleon Courses
Bringing you the courses you would love to go on! Creating optimal learning environments!

Carolyn Simmons Carlsson & Wendy Burrows
m Carolyn: 027 259 3312 or Wendy: 021 1325 338

Find us on Facebook: Chameleon Courses
Response from OTNZ re ethical approval for circulation of research

Fi Graham <fi.graham@otago.ac.nz> 3 March 2014 16:17
To: “Frank Lu (mails4franklu@gmail.com)” <mails4franklu@gmail.com>
Cc: Morgan Fitzgerald <membership@nzaot.com>

Dear Frank

On behalf of OTNZ we would like to advise that your request to circulate an invitation to participate in research regarding NZ OT’s use of the PRPP has been given approval without any further information required.

If you would like to prepare an invitation email including the link to your survey we will circulate to the relevant special interest groups. Please email this to Morgan Fitzgerald who handles this.

On behalf of OTNZ, all the best with the project.

Fi

---

Dr Fiona (Fi) Graham • Senior Lecturer

Rehabilitation Teaching & Research Unit (RTRU), Department of Medicine

University of Otago, Wellington • PO Box 7343, Wellington, 6242, New Zealand

T: 03 338 3217 | W: www.uow.otago.ac.nz/rehab

E: fi.graham@otago.ac.nz Skype: Fiona.graham1

University of Otago  Te Whare Wānanga o Otago
Appendix I: Agreements (Occupational Therapy Board New Zealand)

Master’s Research Project - An Exploratory Study on the Implementation of PRPP System of Task Analysis in Clinical Practice in New Zealand

On 11 March 2014 10:56, Andrew Charnock <Andrew@otboard.org.nz> wrote:

Dear Frank,

If you could draft an email you wish circulated to practitioners on our register that have consented to receiving information about research I will sent it out.

Remember the line of communication is from them to you so they will need your contact details – email/website/blog etc.

Regards,

Andrew Charnock
Chief Executive/Registrar
Occupational Therapy Board of NZ
Level 10
ASB House
101 The Terrace
WELLINGTON
DDI +64 4 918 4745
Fax +64 4 918 4746

mobile 0212435007
email Andrew@otboard.org.nz
website www.otboard.org.nz

This email and any files transmitted with it are confidential and contain privileged or copyright information. You must not present this message to another party without gaining permission from the sender. If you are not the intended recipient you must not copy, distribute or use this email or the information in it for any other purpose than to notify us. If you have received this message in error, please notify the sender immediately and delete this email from your system. We do not guarantee that this email is free from viruses or any other defects although due care has been taken to minimise the risk. Any views expressed in this message are those of the individual sender, except where the sender specifically states them to be the views of the Occupational Therapy Board of NZ.

Andrew Charnock <Andrew@otboard.org.nz> 13 March 2014 08:34
To: Frank Lu <mails4franklu@gmail.com>
Cc: James Winstanley <James@otboard.org.nz>

Dear Frank,

My response to your questions in red below

Regards,

Andrew Charnock
Chief Executive/Registrar
A STUDY INTO THE USE OF PRPP IN CLINICAL PRACTICE

Occupational Therapy Board of NZ
Level 10
ASB House
101 The Terrace
WELLINGTON
DDI +64 4 918 4745
Fax +64 4 918 4746
mobile 0212435007
e-mail Andrew@otboard.org.nz
website www.otboard.org.nz

This email and any files transmitted with it are confidential and contain privileged or copyright information. You must not present this message to another party without gaining permission from the sender. If you are not the intended recipient you must not copy, distribute or use this email or the information in it for any other purpose than to notify us. If you have received this message in error, please notify the sender immediately and delete this email from your system. We do not guarantee that this email is free from viruses or any other defects although due care has been taken to minimise the risk. Any views expressed in this message are those of the individual sender, except where the sender specifically states them to be the views of the Occupational Therapy Board of NZ.

From: Frank Lu [mailto:mails4franklu@gmail.com]
Sent: Wednesday, 12 March 2014 9:00 p.m.
To: Andrew Charnock
Subject: Re: Master’s Research Project - An Exploratory Study on the Implementation of PRPP System of Task Analysis in Clinical Practice in New Zealand

Dear Andrea,

Thank you for offering to circulate invitation emails to practitioners of OTBNZ that have consented to receive information about my research project and the online questionnaire.

Currently I am still waiting for OTNZ and the other party to confirm on their dates to support my research project by circulating the invitation and reminder emails to potential participants.

Overall, I am hoping the invitation can be sent out simultaneously by all parties in the same week. Hence, I need to have a clear idea of the time frame required during this preparation phase.

My questions are:
- How soon do I need to give the invitation and a reminder email to you to prepare for circulation when the survey is ready to start data collection? Any time, but you may want to wait until after 1 April as our recertification process will be complete by that point and we will have a new list of those practitioners who have indicated a willingness to be involved in research.

- How soon will the invitation email be sent out after you received it? As above, but within a few days I would say.

Once again, I am grateful for your kind attention and support on my research project.

Kind regards,

Frank Lu NZROT MOTNZ
Master’s student (Occupational Therapy)

This email is intended solely for the use of the addressee and may contain information that is confidential or subject to legal professional privilege. If you receive this email in error, please immediately notify the sender, delete the email and destroy any printed copies.
4 April 2014

Frank I-Chien Lu
Department of Occupational Therapy
Otago Polytechnic

Dear Frank Lu

Ethics 576 “An exploratory study into the use of the Perceive Recall Plan Perform (PRPP) System of Task Analysis in Clinical Practice in New Zealand”.

Thank you for your attention to the questions our reviewers put to you. They have now considered your responses and I am pleased to be able to let you know that Ethics 576: An exploratory study into the use of the Perceive Recall Plan Perform (PRPP) System of Task Analysis in Clinical Practice in New Zealand" has now been approved by the Otago Polytechnic Research Ethics Committee.

We wish to remind you that at the conclusion of your project you should send a brief outline of your findings to the Research Ethics Committee for our records.

We wish you the best for this project.

Sincerely,

Bridie Lonie
Chair – Research Ethics Committee