

This study addressed how practice educators define occupational therapy student competence. A qualitative approach was used to gain the beliefs and viewpoints of five occupational therapy practice educators working in neurological rehabilitation through semi-structured interviews and group discussion. Verified thematic analysis was used to structure and describe the information collected.

The complexity of the concept of competence was highlighted by the participants, who felt that it was part of their professional responsibility to ascertain whether a student had achieved a sufficiently high level of competence to pass into the professional status. However, the participants found it difficult to articulate explicitly what it was that they searched for. Four main areas were highlighted – observable behaviour, clinical reasoning, continuing development and professional and personal attributes – but the importance of student self-awareness, risk assessment and reasoning skills over theoretical knowledge was identified as a major influencing factor on competence.

Piecing Together the Jigsaw: How do Practice Educators define Occupational Therapy Student Competence?

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Introduction

Competence within the health care professions has entered the public arena, particularly since the publication of *A First Class Service* and *Meeting the Challenge* (Department of Health [DH] 1998, 2000). To ensure the success of the current Government's programme for change, the individuals recruited into and currently part of the workforce need to have the 'knowledge, skills and values necessary to respond to and meet the challenges laid down' (Fisher and Savin-Baden 2002, p229). The 'fitness to practise' of qualified professionals is therefore being rigorously scrutinised and, with the advent of the Health Professions Council (HPC), clinicians will have to prove their competence through continuing professional development in order to remain state registered (DH 2001a). The HPC states that health professionals must adhere to 'standards of conduct, performance and ethics' as well as proficiency (2003, p2).

At the point of qualification, students of the health professions need to have 'the skills and abilities required for the lawful, safe and effective practice of the profession without supervision' (NHS Executive 2000, p15) and, therefore, need to have achieved a minimum level of competence by that point (Linszen 2000).

Within occupational therapy, a student's competence to practise is determined through collaboration between university staff and practice educators, who assess the

student's ability to demonstrate competence within health and social care. However, debates continue around the definition of competence and the performance standards that students should be assessed against (Seale et al 1996, Philips et al 2000).

The concept of 'competence' appears nebulous and complex (Ellis 1993, Eraut 1998, Cheetham and Chivers 1999, Alsop 2001). It is acknowledged that both a judgement and a definition of competence are subjective and that objectivity is as difficult to achieve as the ability to state explicitly what is being assessed (Ellis 1993, Alsop and Ryan 1996, Seale et al 1996). Thus, the 'valid and reliable evaluation of clinical competence in occupational therapy and other related professions remains a challenge' (Polatajko et al 1994, p21). There is, however, a consensus that practice education is one of the essential components in determining competence and developing professional behaviour (Backman 1994, Cohn and Crist 1995, Bonello 2000).

Literature review

Definitions of competence

In 1978, McGahie et al defined competence as 'a broad range of knowledge, attitudes and observable patterns of behaviour which together account for the ability to deliver a specified professional service' (p68). Although definitions of competence vary, it has been stated that there is an

'unspoken consensus on what constitutes competence' (Davies and Van der Gaag 1992, p210) and that the definition of competence is decided and recognised by the members of a profession (Worth-Butler et al 1995). This would suggest that there is a set of core values held by the members of the same profession. However, as Alsop and Lloyd (2002) believed, 'competence is not just a set of competencies that can be teased into individual components to be reviewed one by one', which proposes the idea that the whole should be greater than the sum of the parts.

Ellis (1993) stated that competence was more recognisable when it was missing and that the assessment of it was therefore variable and subjective. It has been suggested that as a term or concept, competence is outdated because of this lack of clarity and of useful measurable information (Parkinson 2000).

Aspects of competence

Several authors have agreed that competence should not be static (Issit and Hodkinson 1995, Hocking and Rigby 2002). It should be a continuing and ever-changing process (Alsop and Ryan 1996), partnered with lifelong learning (Quality Assurance Agency 2001), continuing professional development (O'Hagan 1996) and justification of fitness to practise (Alsop 2001). Hocking and Rigby (2002) and Powell and Waters (1996) proposed that views of competence would be influenced by sociopolitical changes and questioned whether students were competent only for the purpose of an assessment or whether they were also competent for practice and award. The term 'fitness for practice' is being more extensively used to denote the level of competence being looked for, although the term has not been explicitly defined (DH 2001b, Warne 2002).

Other authors have stated that competence should be consistent, and demonstrable over contexts (Neary 2000), with skills being transferred to different situations. However, it could be argued that competence is context-specific and is often 'situated' for assessment (Hollis 1993, Philips et al 2000). Eraut (1994) believed that competence should be measured against visible and overt criteria and stated:

For many types of competence, direct observation is the most valid and sometimes the only acceptable method of collecting evidence. In most cases this is accompanied by some kind of informal questioning of candidates to discover their analysis of the task or situation, their reasons for their actions and their evaluation of what occurred (p201).

Schön (1988, p69) described how a professional could make many decisions across the course of a day and 'make innumerable judgements of quality for which he cannot state adequate criteria'. When related to patient assessment this is seen as professional judgement, based on observation, knowledge, experience and interactions with other professionals rather than on subjectivity. The assessment of students appears more problematic. During the process of assessing student competence, practice educators appear to be using their clinical reasoning skills but lack confidence in making their reasoning explicit.

What became clear through reviewing the literature were the many ambiguities that surround the challenging concept of competence. By its very nature, competence is not the pinnacle of achievement because it is composed of many levels. However, the consensus of opinion appears to be that there is a minimum level, which has to be achieved in order to practise and to achieve successfully the rite of passage to becoming a qualified practitioner (Alsop and Ryan 1996, NHS Executive 2000, Quality Assurance Agency 2001, Bossers et al 2002). Competence cannot be assessed through performance alone or solely through the passing of theoretical and academic examinations: a balance between skill, theoretical knowledge and affective ability is required (Jacobs 1989, Ashworth and Saxon 1990, Barnett 1994, Wolf 1995, UKCC 1999). This would appear to encompass the requirements of a qualified professional to be practically proficient but theoretically knowledgeable, reflective and flexible.

Aims of the study

The aims of the research were to:

1. Explore the definition of competence among practice educators in neurological rehabilitation
2. Determine whether there was an agreement about core values.

This study, therefore, endeavoured to explore the topic of competence as a way of clarifying the researcher's own thinking and also as a way of developing the knowledge and reasoning of fellow practice educators. It formed part of a larger research study, which addressed the influencing factors on the assessment of competence.

Method

Qualitative approach

A qualitative approach was used in this study to explore and enhance the potential for greater depth, richness and understanding. Relying on thoughts and feelings allowed the researcher to discover the meaning that the participants attached to the topic being studied. When little is known about a subject or where there are complexities, the broad themes, ideas and perceptions of those involved are sought in order to gain insights into the pertinent issues (Depoy and Gitlin 1994, Jones 1995). This produces data that are 'data-rich, flexible, stimulating, recall-aiding, cumulative and elaborative' (Punch 1998, p177), but it relies on the participants' willingness to disclose their thoughts and viewpoints to others (Krueger 1994).

Morgan (1997) and Krueger (1994) believed that selecting participants because they belonged to a pre-existing group and because of their common experiences could aid research. The nature of qualitative research is that it is context based in time, person and place. This is acknowledged as both a strength and a weakness. However, as a result of the individuality and subjectivity of the data collected, it is unlikely that the same information would be exactly reproduced if the research project

were carried out with a different set of participants. Although the collected data are not transferable, the information can act as a catalyst for discussion or research in other areas.

Sampling frame

This was a non-random or purposive sample of individuals who had the knowledge or experience that the researcher wanted to represent (Field and Morse 1992, Berg 1998) and it focused on one particular group of individuals: occupational therapists working within neurological rehabilitation and who were practice educators. On the first day of the research, one of the participants was unexpectedly unavailable for the focus group and was removed from the study. Therefore, a total of five therapists were involved in the research (P1, 2, 3, 4 and 6).

Research process

Videoing

A video of a 'student' carrying out an activity (making a cup of tea) with a 'patient' was to be used in the first session to generate initial thoughts on student competence and to standardise the performance being assessed. The practice educators would watch the video as if they were observing a real student and patient interaction, be asked if the student was competent in that session and be asked to identify what they were looking for. Two first-year students volunteered to take part in the video. They were unknown to the educators and, therefore, it was hoped that no preconceptions would influence the results of the study. The students were given a preparation sheet (which identified what they were to do for the video) and a consent form, and were provided with an opportunity to practise the task. They were then videoed by the researcher and shown the video and their consent was gained.

Initial perceptions sheet

The practice educators were brought together to watch the video and to capitalise on the information produced through their dialogue and interaction. After watching the video, the participants were asked to complete an initial perceptions sheet individually. This included open questions, such as:

- Was the student competent in carrying out the activity and why?
- What do you understand by the term 'competent'?
- What do you look for?
- What factors might influence your perception of competence?

The questions in the initial perceptions document were then used again once the group had discussed the video in order to aid and initiate debate. The participants chosen for the study were familiar with each other and often used group discussion to guide their decisions about a student's performance. The practice educators decided what they wished to say as a group and filled in a consensus initial perceptions document. This first session was videotaped and transcribed verbatim.

Semi-structured interview

The participants were then individually interviewed using a semi-structured format to gain greater depth and breadth to the topic. The questions used included information gained from the focus group (for example, You discussed that safety was important, could you tell me more about that?) and reflective questions such as: Can you reflect upon an experience with a student that you feel defined your belief about competence? Do you have an informal model of what competence should be ... if so could you define it?

Each interview differed according to the topics and issues raised by the individuals and was audiotaped and transcribed verbatim by the researcher. The completed documents were returned to the participants for member checking, as described by Lincoln and Guba (1985), to ensure accuracy.

Data analysis

The researcher carried out initial data analysis of the transcripts of the focus group and the interviews. Manual inductive thematic analysis was chosen to use all the information collected. A structured approach was used to construct a system of recording that was easily read and accessible and would ultimately help to show the decision trail to those scrutinising the rigour of the research (Sandelowski 1986, Krefting 1991, Koch 1994). Through many readings of the transcripts, the researcher searched for evidence of major themes by noting significant statements or phrases within each individual's data and comparing these against another individual's data. These common phrases, words, themes or issues were written down on individual pieces of paper and taken back to the practice educators for verification:

Verification entails checking for the most common or most insidious biases that can steal into the process of drawing conclusions (Denzin and Lincoln 1994, p438).

Further discussion was carried out and the group initiated data analysis by grouping the statements into themes and giving titles to the different categories.

It was acknowledged that these sessions should occur as quickly as possible after the initiation of the practice educators' participation in the study in order to reduce the possibility of influencing factors, such as forgetting the topics discussed or additional information being gleaned from other sources.

Pilot study

A pilot study was carried out prior to the main study and involved two practice educators working within acute neurology. They were asked to participate in all the sessions and to comment on the process of the research. These discussions resulted in slight practical changes to the way that the sessions were carried out (for example, showing the video twice), gave an opportunity for all the technology to go wrong and provided assistance to clarify the questions in the initial perceptions sheet. With consideration to time, full analysis of the results was not undertaken for the pilot study.

Once the issues highlighted by the pilot study were resolved, the main research study was carried out.

Philosophical and theoretical frameworks

Of the existing philosophies, interpretative constructivism was chosen as the most appropriate for this study. Glene and Peshkin (1992) described the main goal of interpretivists as seeing the varied and often conflicting views and perceptions of individuals as important in understanding the lived experience. Constructivists believe in multiple realities, that researcher and participants are irrevocably linked during research and that, through interactions with others, consensus agreements between social groups can be held but that reality can change as individuals develop and experience other situations (Denzin and Lincoln 1994, Guba and Lincoln 1994, Streubert and Carpenter 1995).

One of the important philosophical questions centres on the concept of 'truth'. Why trust the results of the study or the researcher's interpretations? The researcher hoped to present the truth as it was at the time that the study was carried out and for the particular society of individuals. Therefore, the participants were involved in verifying the themes and statements and began the process of data analysis with the researcher. The use of fieldnotes and a critical incident journal by the researcher maintained an overt decision trail, clarifying the route taken and why.

Ethical issues

Ideally, this research project would be carried out within a real situation with the researcher observing practice educator and student interactions. This would allow the researcher to note the relationship between these two parties and the process of assessment at first hand. However, this would entail an extensive amount of time on the part of the researcher. Several different practice educators, students and locations would have to be used to gain a broad range of data. It was also deemed to be unfair to involve a student in this process while the student was participating in and being assessed on his or her clinical placement. It was therefore decided that in the interests of time (the researcher was aware of the time required to gain ethical approval for patient involvement) and to standardise the performance being assessed, the described method of using a video would be used to elicit data.

Informed consent and approval were sought and gained from the parties concerned, including the Trust's Research and Development Board and the researcher's university. All the participants in the research were given several opportunities (before and after each session) to confirm or rescind their consent.

Confidentiality was maintained throughout the process by allocating the participants with codes (P1, 2, 3, 4 and 6), which were used on all the documentation other than the consent forms. The participants are referred to using these codes. Other codes were used to denote when the comment had been made, for example, FG (focus group) and I (individual interview).

Findings and discussion

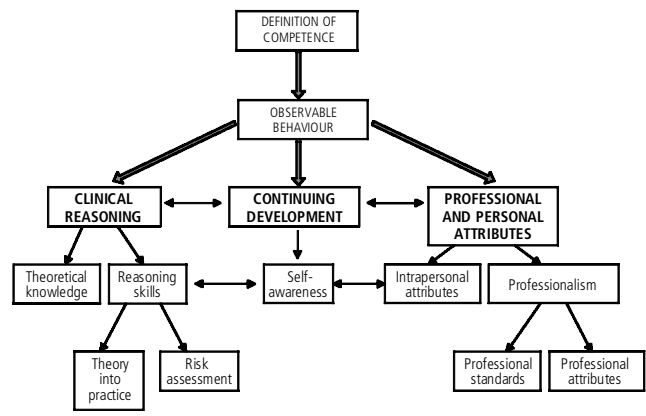
Initially, the group consensus generated the main themes and the statement below:

- Insight into ability
- Observable behaviour
- Professional approach
- Baseline of standards
- Client centred
- Integrates information and is able to generalise
- Adaptable
- Reflective.

The integration of these qualities helps to produce a student who is competent, is able to articulate his or her thinking, looks beyond the boundaries of the immediate activity, is safe and combines core skills with professionalism to present as a rounded practitioner (*Group statement, focus group*).

By using this information and that of the semi-structured interviews, a diagram was created by the participants by categorising all the keywords under main headings. Fig. 1 was achieved by the researcher further subcategorising the keywords and by cross-checking with the participants.

Fig. 1. Main themes identified within the definition of competence.



Observable behaviour

As Fig. 1 shows, the participants believed that competence was an observable behaviour, which encompassed three main areas: clinical reasoning, continuing development and professional and personal attributes. The participants' own comments are used to describe the importance of each area. A participant in the focus group stated:

Competence by its very nature presents as a behaviour, as you can be competent in thinking, or come across in terms of having competence in thinking but not necessarily be able to transfer that thinking into practice (P1:FG).

Clinical reasoning

An important aspect of competence was seen as the thinking process that occurred before, during and after an intervention:

What they are identifying in their assessment, what they are doing with what they have found out, how they are putting it together into a meaningful picture (P6:I).

This was subcategorised into theoretical knowledge and reasoning skills.

Theoretical knowledge

Theory was seen as an important area that was led by the university and was very factual in its nature but could and should be applied in a practice setting. The participants considered that this was the base from which competence grew and that it could be divided into shared theory and profession-specific theory. The 'factual data' or shared theory was felt to be information about subjects such as anatomy and moving and handling and, for example, about government agendas. It was thought that this could be taught and assessed by all professionals. The profession-specific data could include, for example, models of practice and the history and philosophy of occupational therapy. The practice educators believed that these theoretical underpinnings and philosophy of occupational therapy should be understood and used by the student to influence his or her practice. It was vital for a student to have knowledge and understanding of this profession-specific information, which the practice educators felt could be assessed only by an occupational therapist:

I would understand their role [university] is in assessing the student's academic ability to grasp the theory behind occupational therapy practice and principles (P4:I).

There were comments that the practice educators would not like to assess these areas in other professions:

I could probably assess somebody's professionalism, their approach, their manner, how they were able to communicate ... how they would fit into the team but there are areas of skill base, skill knowledge and philosophy I wouldn't want to (P3:I).

This suggested an area of specifics for a particular profession, the core skills and knowledge that differentiate one profession from another.

Reasoning skills

This subcategory was divided into two main sections: theory into practice and risk assessment. The participants felt that reasoning skills added to competence more than mere theoretical knowledge.

Theory into practice: This was seen as the ability to take theoretical knowledge and apply it to whatever situation the student was in. The participants discussed the need to transfer the knowledge and evidence base into practice:

You would look for that ability to generalise into similar things rather than I have just learned this by rote (P1:FG).

It would be a development of reasoning skills that would allow a student to look more objectively at his or her baseline of theoretical knowledge:

Students, particularly third years, need to have the ability to question theoretical knowledge and to be able to weigh one theory up with another so they can actually choose an approach (P2:I).

But the practice educators inferred that the students

were very task based or very orientated to general issues when they arrived on placement:

Students are very keyed in when they get to a placement ... I don't know how to do this, and I don't know how to do that and it is very much about carrying out certain tasks (P4:I).

Although these were important, it was the integrative skills that the practice educator would be looking for and be placing greater emphasis on, as P1 summed up:

It's about that ability to integrate practice knowledge and theory and without that integration their practice knowledge remains very task focused (P1:I).

Risk assessment: The practice educators believed that a student should be insightful and should carry out a risk assessment on himself or herself (this links with self-awareness, reflection and continuing development), but they also wanted to see evidence of students using risk assessment with regard to their patients.

In particular, 'safe versus competent' was a significant topic discussed by all the participants. They believed that risk assessment was something more than safety, but was an important aspect of competence. P2 and P6, in particular, discussed the issue of students carrying out a risk assessment on their patients both prior to and during treatment:

It's about being able to identify risk at the beginning to allow people to take some risk but at the same time to make sure that the risk isn't so great that it will cause people harm (P2:FG).

Just to keep someone safe does not mean you are fulfilling the role of an occupational therapist (P6:FG).

Continuing development

The participants saw this as a role for them to foster, but would be concerned if there was no evidence of it within a student's performance. A student, they believed, needed to show that he or she was able to take on board new experiences, knowledge and constructive criticism and, through reflection, develop his or her competence:

It's about them giving evidence of work that they have done, that they are showing you that they have learned and changed and adapted their approach because of observations you might have made (P4:I).

The participants discussed the need to see the students move on from the point where they started the placement, because development was seen not just as a skill but also as a student's growing self-awareness:

It's the ability to move ... it's not just where you've come in at but the ability to show that having had 6 weeks' experience you have actually moved on and developed yourself (P4:FG).

You could argue that if there is a student who is performing quite highly but had very low insight into their own competency, are they any more competent than the student at the opposite end of the scale who is performing poorly but very aware of when they are failing? (P2:FG).

It was believed that not having insight might affect the way that the students presented themselves and that the acknowledgement and articulation of problems was seen as integral to self-awareness and thus development:

I think if you have somebody who has little insight, who's maybe overconfident for their level of expertise and their level of learning I think that's a difficult one to tackle ... if they acknowledge that they aren't able to do that, I think that acknowledging is a big part of it... if they acknowledge that they are not at a level to be able to do that or that they have an area of weakness (P3:I).

This links with the discussion above about risk assessment. The participants felt that students should be able to see what their own needs were and how that might have an impact on their intervention with the patient, as well as having an awareness of what the patient's needs were.

The participants did express some concerns with regard to student development and believed that placement was not seen by the students as a place to develop but, rather, as an opportunity to improve their grade:

So much expectation, so much riding on this final mark and it ceases to become about the learning experience and their movement from this position to a position where they have developed in terms of their competence to practise, but it's about what mark am I going to get? (P1:I).

It was felt particularly that areas of need or development were not overtly passed on from one placement to another, thereby hindering both the practice educator and the student, and might lead to weaker areas being missed:

Often students are carrying through objectives from earlier placements which would indicate there is perhaps an area of greater need but this is not made overt (P2:I).

The practice educators wished to see the student develop during the placement but felt that it was essential that it was seen as a building block for continuing development and lifelong learning and not purely as the achievement of the minimum standard to pass the placement or to graduate.

Professional and personal attributes

Intrapersonal attributes

The participants discussed the personal qualities of individual students and the influence of these qualities on competence, but it was acknowledged that these attributes were difficult to quantify:

It's not just about their ability to practise, it's about their personality, insight (P3:I).

I find it hard in the final report to comment upon things like attitude because, I mean, how do you measure it ... it's quite subjective (P2:I).

This was identified as one of the most problematic areas in the definition of competence. Could a student who was competent in all other areas become less competent due to

his or her attitude or personality? The practice educators felt that this could be true, but that it would be difficult to articulate objectively or sensitively. It would also be problematic to make change in this area.

Professionalism

All the participants commented on professionalism. They did believe, however, that there were differences between professional standards and professional attributes.

Professional standards: The practice educators believed that professional standards were formal and would include those standards produced by the College of Occupational Therapists and the Health Professions Council and also the standards set by the student's university. These standards alluded to a level of knowledge base, theoretical understanding and clinical skill and decision making. The practice educators would use their knowledge of the standards to measure the student against:

We are responsible for making sure that occupational therapists, who are of a standard, who are actually fit to practise, are graduating (P2:I).

It was commented, however, that there was a level of subjectivity even within this area because the standards often used terminology such as 'appropriate' to describe a behaviour:

There are the guidelines from college [university] but I think you have in your own mind what you understand is safe and fit for practice (P1:I).

This alluded to an individual mental checklist of competence which was used to assess the students. The practice educators felt that they needed to use this and their discussions with colleagues to determine whether a student was competent because they found the university documents unhelpful. They also noted that the assessment documents from each university were different and often asked for different levels of evidence that the student was competent.

Professional attributes: The practice educators did feel that a student should have professional attributes (which could have been developed through experience prior to entry to an occupational therapy course). These attributes had an impact on the way that professional standards were being met. P2 tried to define the attributes of professionalism and began by describing a student who, she felt, was failing in this area:

... being consistently late, not letting you know things, not being where they were meant to be on time, not doing what I had advised them to do (P2:FG).

It was highlighted that professional attributes such as communication, responsibility and organisation were core skills across professions, which influenced the way that the professional carried out his or her interventions and interactions with others. The practice educators believed that these core skills were similar to 'shared theory', in that any member of the team could assess for professional attributes. P4 went a step further and suggested:

I think it's important that ... the assessment, particularly of professionalism and professional suitability needs to be assessed by all the members of the team ... (P4:I).

Summary of findings

Within the study, it was clearly highlighted that for the practice educators there existed an uncertainty over the definition of competence. When asked, they struggled to achieve a concise definition and both the statement and Fig. 1 took some time to produce. This was not unexpected: the researcher had anticipated that the participants would identify a wide range of qualities that together constituted competence. This is in line with the literature, which has also tussled with a definition. Competence is a challenging concept because it 'is a complex structuring of attributes needed for intelligent performance in specific situations incorporating the idea of professional judgement' (Alsop 2001, p259).

Although a broad range of topics was discussed, the topics under greatest discourse seemed to centre on risk assessment, continuing development, self-awareness, intrapersonal attributes and professionalism. The majority of the participants mentioned these in their descriptions. This would suggest that there is a core of behaviour that all the participants agreed on but with differing emphasis. This could be seen to justify the use of an interpretative-constructivist approach because there appeared to be multiple realities which had core values in common.

Subjectivity, however, continued to be a problem. The practice educators struggled to articulate their beliefs on what constituted competence, particularly in the area of the intrapersonal attributes of the student. They felt that this was an important issue, but were concerned that there was too much subjectivity in their identification of problems in this area. They discussed how difficult it was to express and clarify their thoughts and to use evidence to justify their beliefs. Ellis (1993) also described this conflict; he too believed that 'Competence must refer to the total observable behaviours that occur in professional practice, categorised and specified in relation to measurable standards', but acknowledged that there were 'unobservable attributes, capacities and values that a professional should have' (p63).

The participants proposed that students who had self-awareness of their own strengths and weaknesses, and were not afraid to ask for help, were more competent than the students who were not able to reflect on their practice and to highlight areas of difficulty. They wished to see students using integrative skills within their practice. The ability to gather, manipulate, interpret and use theoretical information, experience and feedback, as required by clinical reasoning, was implied to be more useful than having theoretical knowledge alone. This was seen as enabling students to move forward and develop and was a skill that would be transferable across placement areas and be used extensively within their working career.

The practice educators also gave a clear picture that competence was not a static entity: it was dynamic and had many different levels and by achieving competence students

had not achieved the pinnacle of their ability. They all agreed that it was not just factual information that they wished students to possess, but the ability to think, assess, integrate and understand that information and to relate what they knew with what they were seeing and doing. They postulated that certain core aspects of the profession should remain sacrosanct, such as the philosophy and the ethos; these should not and could not be assessed by other professionals, but professionalism and insight should and could be assessed by all involved. As Cheetham and Chivers (1999) highlighted, there are metacompetencies which are common across professions but also, necessarily, there are core components which are unique to individual professions.

Conclusion and recommendations

The findings of the study have been informative for the researcher, giving a greater understanding of student competence and the beliefs of others. Although they cannot be either generalised or transferred, they may create an opportunity for development within the local area to ensure an equitable process for the assessment of competence. As a small-scale exploratory study, the research cannot hope to demonstrate great significance in the world of education or to have wider impact on the assessment of student competence, but it is hoped that the results will act as a catalyst for other readers to examine their own perceptions of student competence.

Hollis and Clark (1993) stated that, as clinical governance places pressure upon health care managers to justify their employee's fitness to practise, this expectation is also passed on to the student. They are expected to work competently within a service as appropriate to their level of study. The definition and assessment of competence remain ambiguous and, although this study has explored the viewpoints of a group of practice educators and has raised some questions for discussion, the concept requires continual examination.

The recommendations for further work in this area would be a larger study to determine practice educators' definition of competence and to explore whether an assessment document integrating the main issues identified (as in Fig. 1) could be developed for use in all universities. The study could then identify if this document had an impact on the ability of the practice educator either to describe accurately the behaviours exhibited by the student or to highlight the areas where the student was not meeting the standard.

Perhaps by using such a format across all the years of occupational therapy education and training and taking it forward into their working lives, students may have a more objective and overt way of identifying their areas of competence and development needs. This would not only prepare them for the need for continuing professional development once qualified, but also provide a way of

structuring their reflection on their performance. Furthermore, if such a format were developed and standardised by the College of Occupational Therapists, a national audit could take place to identify any consistently strong or weak areas in the education and training of undergraduate occupational therapists. A greater level of equality and objectivity of student competence could then be achieved.

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