Documentation of Recreation Therapy and Leisure Opportunities in Long Term Care

By

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Author's Declaration

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

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Abstract

The documentation of Recreation Therapy and Leisure Opportunities in Long-term Care

The Recreation Therapy discipline at Sunnybrook Health Sciences Centre (SHSC) has undergone a series of research initiatives to ensure a patient focused philosophy is integrated into their practice. The purpose of the study is the development of documentation procedures that will enable the recreation therapy practitioners to engage in authentic and professional documentation of the residents' experiences in recreation therapy and leisure opportunities based on a patient focused philosophy.

This research project followed an action research methodology and was guided by a hermeneutic framework adapted from Karkainen and Eriksson (2004). The recreation therapists at SHSC were involved in all aspects of the project as co-research participants. This project employed a variety data collection techniques including focus groups, a hermeneutic dialogue, self-reflective activities and active application sessions.

The information collected through the various data collection phases in this project led to the creation of a new documentation framework and associated sample documentation, which allow for a more patient focused documentation process. A series of quality indicators were also developed in this project to help authentically express the experiences in leisure and recreation of the residents living at SHSC.

This research project has added to the growing base of knowledge focused on the integration of a patient focused care philosophy into the recreation therapy practice at SHSC.

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Chapter One: Introduction

Therapeutic recreation (TR) practitioners often find themselves working in clinical settings that are guided by a medical model of practice. Within the field of TR there has been an ongoing debate regarding how closely the discipline should align itself to the medical model (Sylvester, 1996). However, regardless of one's philosophical standpoint towards the medical model, there are certain practices that must be completed by TR practitioners working in clinical settings, such as the documentation of patient care, which is central to the research addressed in this thesis. The challenge for those espousing an alternative philosophical perspective to the medical model is to meet the requirements of the clinical setting, while remaining faithful to the alternative philosophy.

1.1 Background to the Study

The medical model of patient care has traditionally guided the practice of health care professionals, including TR specialists. The medical model of healthcare provision is problem focused and based in the natural sciences. Parse (1999), in a discussion of the impact of the medical model on nursing practice, describes the medical model as "a mechanistic approach to humans as bio-psycho-social-spiritual beings who can be fixed through diagnostic and intervention methods that objectify the human being" (p. 1383). As well, within the medical model, health is predefined by the medical community, and the major goal is the management and elimination of the problem (Mitchell, 1990). An accepted alternative philosophy to the medical model, which has been adopted by many health care facilities, is patient focused care (PFC). According to Mitchell (1990), PFC

means that "health is defined by the individual and the goal in practice is enhancing quality of life as defined by the person rather than the healthcare provider" (p. 170). There is no single model of practice associated with PFC. It is a philosophical concept of healthcare delivery, which guides practice in healthcare organizations and institutions. Each organization must develop their own PFC model (Mitchell, Closson, Coulis, Flint, & Gray, 2000), which best benefits the patients they serve and the goals they are striving to achieve. The adoption of a PFC model impacts both organizational service delivery and the philosophical perspectives of the members of the healthcare team (Mitchell et al., 2000). However, according to Hornibrook, Pedlar and Haasen (2001) "at the root of patient focused care is the recognition that such care is not a technique but a way of thinking" (p.17).

In some facilities, the incorporation of PFC has led to an attempt to create a more efficient and effective practice (Nicholson, 1995). However, these types of procedural changes may neglect the importance of the philosophical underpinnings of PFC. Adopting a PFC philosophy also requires a shift in the staff's values and beliefs about the patient, to ensure that the emotional and psychological needs of the patient, in addition to the medical needs, are being met. Practitioners must relinquish control over care and involve the patients and their family in the decision making process (Mitchell et al., 2000). Often, one of the changes that accompanies the implementation of PFC is the redesign of documentation procedures to decrease time spent on documentation and increase data accessibility for all healthcare professionals (Townsend, 1993, Mitchell et al., 2000). Again, these changes towards efficiency may neglect the need to incorporate patients' views and experiences into the documentation of patient care.

Documentation of patient care is critical in health care delivery. It has the potential to improve practice by allowing for communication and accountability of patient care among health care professionals and patients and their families. However, it also serves as a legal record of the care provided to the patients, and therefore is required by all health care professionals working in clinical settings (Hansebo, Kihlgren & Ljunggren, 1999; Griffiths & Hutchings, 1999). The majority of research focused on clinical documentation is based on nursing documentation, due to its importance in the nursing practice (Hansebo et al., 1999). Further, most clinical documentation is based on quantifiable measures and focused on the outcomes of medical interventions. Ehrenberg, Ehnfors & Smedby (2001), in a discussion of nursing documentation, state that "a systematically written and process-focused record has been described as an important basis for quality patient care" (p. 133). However, there has been literature critiquing nursing documentation's emphasis on the "problem" and the "process" as opposed to the actual "person" receiving the treatment (Coker, 1998; Mitchell, 1990).

Within the field of TR there has been very little research on both the meaning of TR services within a PFC context and the documentation of TR services. According to Hornibrook, Pedlar, & Haasen (2001), the shift towards PFC in healthcare facilities has occurred simultaneously with a re-evaluation of the philosophical underpinnings of TR. Many TR practitioners claim to offer patient-centered services, however a discussion of what patient-centered care means in TR practice has been limited. Without an understanding of the meaning of PFC, TR practitioners are limited in their ability to provide patient-focused services. In terms of documentation of TR services, the documentation frameworks used by TR practitioners are generally based on nursing

documentation frameworks. As well, the vast majority of TR literature focuses on procedures for documenting client treatment plans that are measurable, quantifiable and pointed towards goals and outcomes of TR interventions, as well as documenting the results of interventions laid out in the treatment plans (Stumbo, 2000; Peterson & Stumbo, 2000, Olsson Jr., 1992). By examining patient-focused care and current documentation practices, TR practitioners will be better able to provide patient-focused services, and document in a way that is consistent with patient-focused care.

1.2 The Evolution of Action Research in Recreation Therapy at Sunnybrook Health Sciences Centre

Sunnybrook Health Sciences Centre (SHSC), a large teaching hospital in Southern Ontario is the site of the following study. Specifically, the study will center on the Recreation Therapy (RT) department at the hospital[1]. The RT discipline at SHSC has therapists working with patients in various departments, including Aging & Veterans Care (A&VC), the Geriatric Day Hospital and in Mental Health Services. The majority of the RT practitioners work in A&VC, on both the physical and cognitive units. The RT department is focused on enhancing the leisure lifestyles of patients through a variety of recreation and leisure opportunities, including community involvement, active living, social groups and entertainment (Sunnybrook and Women's, 2005). The following excerpt from the recreation therapy department vision statement exemplifies the role of the department. "At Sunnybrook & Women's, recreation therapy provides meaningful support to individuals as they strive to improve their lives through leisure. We value

[1] Within the therapeutic recreation field a distinction has been made between the terms Therapeutic Recreation (TR) and Recreation Therapy (RT). SHSC uses the term Recreation Therapy, and as a result the terms TR and RT will be used interchangeably in this thesis.

individuality and the freedom to choose leisure experiences according to personal interests. Together, we explore opportunities for personal growth and development, meeting and helping others, building self-confidence and a sense of belonging".

SHSC adopted a PFC philosophy to guide patient-care in the early 1990's, and accordingly the Recreation Therapy department has also embraced this philosophical model. The PFC model, adopted by SHSC, is guided by Parse's Theory of Human Becoming (Parse, 1998). The Theory of Human Becoming is a philosophy of nursing practice that offers an alternative to traditional nursing philosophy (Parse, 1996), and is described in further detail in the literature review section of the thesis. Though the theory of Human Becoming is a nursing theory, following a PFC philosophy guided by the theory of human becoming allows the recreation therapists to create meaningful relationships with the clients and provide real opportunities for leisure (Cantwell, 2000). As a result the RT department at SHSC has developed leisure opportunities to reflect the principles of PFC to improve practice.

The adoption of a PFC model guided by the human becoming theory, has led the RT department to engage in a series of research collaborations to better understand RT practice in a PFC context. The collaborations with the Department of Recreation and Leisure Studies at the University of Waterloo began with an investigation of the "initial assessment" procedures used by the RT practitioners at SHSC. The results of this collaboration led to the creation of an initial interview guide, called the "Personal Leisure Profile", and a series of recommendations to create more meaningful interactions with the residents of the long-term care facility (Hornibrook, et al., 2001).

A second research collaboration, with the University of Waterloo, was conducted to continue to better understand and improve practice within a PFC model. This project focused on developing an understanding of the meaning of PFC, and its relationship with the experiences of the residents on the cognitive support unit when participating in leisure and RT programs. Data were collected through participant observation, structured interviews with RT practitioners and family members of the residents, and conversations with the residents themselves. The study followed a phenomenological framework, which sought to ensure that the experiences of all study participants were reflected (Cantwell, 2000).

Two major themes emerged from the analysis of the data: *enlivening relationships* and *being with the person*. There was also a third theme focused on *issues of practice*, which provided procedural suggestions for the improvement of patient-focused care. The first two of these major themes – enlivening relationships and being with the person – which focused on resident experiences, are further divided into sub-themes, as outlined below.

Enlivening Relationships refers to the different ways residents and staff related to each other to develop meaningful relationships through the leisure opportunities provided on the cognitive support unit. The four sub-themes associated with the enlivening relationship theme describe the different experiences of residents and practitioners in which meaningful relationships were created. The sub-themes include feelings of enjoyment, a chance for socialization, making a contribution, and involvement in meaningful activities.

- **Feelings of enjoyment** by the residents were apparent in many of the group activities. The recreational activities allowed the residents to enjoy themselves, and the company of others. Evidence of enjoyment included singing, tapping or clapping along with music, or the fact that many residents waited eagerly for the programming to begin.
- **A chance for socialization** was important to some residents; however, due to time constraints of staff members many residents spent a great deal of time alone. During leisure opportunities, residents had the opportunity to socialize with staff, volunteers and other residents, which allowed for unique and meaningful relationships to be created.
- **Making a contribution** seemed to be a very important experience for the residents of the cognitive support unit. These opportunities for contribution occurred in various recreational programs, such as setting the table or helping prepare a meal during a lunch program, or sharing knowledge to help with the success of the group.
- **Involvement in meaningful activities** allowed the residents to become more involved in the activity and the other residents participating in the group. For example, one resident, who was often quiet and removed, became focused and social during a gardening program that was meaningful to him.

Being with the person is the second major theme; it describes the opportunities the practitioners have to create and maintain relationships with the residents by embracing the unique identity of each resident and responding accordingly (Cantwell, 2000). Five

patterns emerged to describe the opportunities for the practitioners to be with the person during leisure opportunities.

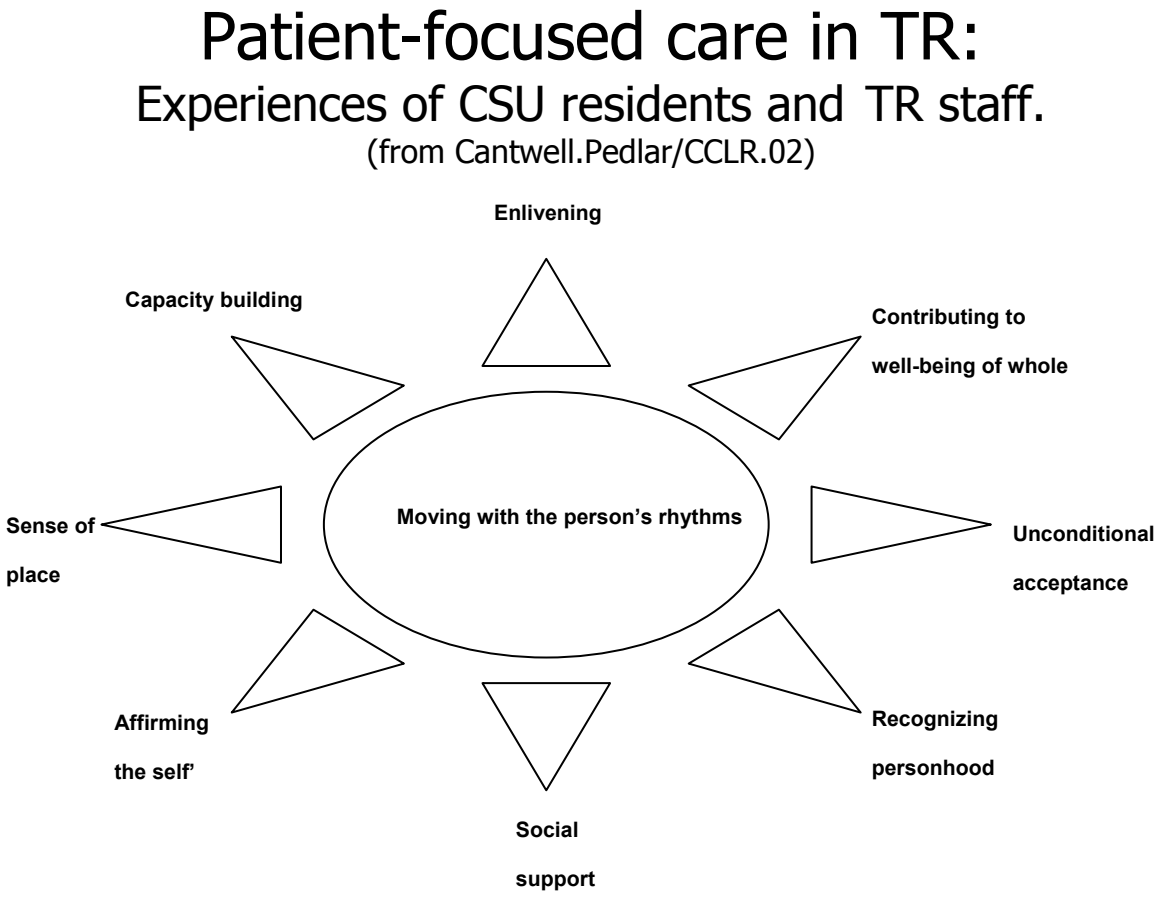
- **Flattery** reflects the flirtatious and charming behaviour of several of the residents towards the practitioners.
- **Language** is important when interacting with the residents. It is important to be aware of the uniqueness of residents to ensure that the language being used by the practitioners is appropriate to the resident.
- **Use of humour** is central to providing enjoyable leisure experiences**.** It also helped to build a caring and warm environment, which promoted being with the person.
- **Non-verbal communication** allowed practitioners and residents to interact in a variety of ways. For example, the use of physical touch and maintaining eye contact were used to connect with the residents. Practitioners noted that they used different types of non-verbal contact with different residents because they knew which residents would react to different forms of non-verbal communications.
- **Hostess-Guest relationship** describes the unique relationships between the practitioners and the residents. The practitioners viewed the unit as the residents' home, whereas the residents viewed their rooms as their homes, and the unit as their community. Accordingly, when the residents were invited to participate in leisure opportunities, they saw themselves as the guest and the practitioners as hostesses of the social event.

The themes derived from the observations of leisure experiences on the cognitive support unit demonstrate the importance of the distinctive and meaningful relationships between the practitioners and the residents, as well as the need to view and treat all residents as unique persons. Through this research a better understanding of the experiences of leisure on the cognitive support unit has been achieved.

Secondary analysis of the above-described research was completed by the RT discipline and their academic advisor at the University of Waterloo to further examine the idea of "community" that was evident in the Cantwell (2000) study involving residents in the Cognitive Support Unit at SHSC. The findings of the secondary analysis identified the different ways community was expressed by the residents. The RTs and the RT academic advisor developed a model to further illustrate the themes. This model is named "Patient-focused care in TR: Experiences of CSU residents and TR staff" and is informally referred to as the "Starfish Model". It became particularly relevant in understanding the concept of community as experienced by the residents within LTC at SHSC[2].

[2] We shall return to the concept of community in LTC in Chapter 4, section 4.4.3.1.

Figure 1 The Starfish Model



To better integrate the findings of the secondary analysis which saw the creation of the "Starfish Model" a committee of SHSC recreation therapists operationalized the "Starfish Model" language into a series of Quality Indicators (QI)[3]. The QI language is in an ongoing process of simplification so that it can be used to communicate and illustrate the residents' experiences of RT and leisure experiences to other members of the healthcare team at SHSC (Miller, 2005). The QIs are as follows:

[3] The evolution of the QI development and application will be further explained as part of the hermeneutic phases discussed in Chapter 4.

- Helping others
- Meeting others
- Respecting others
- Feeling like you belong
- Being yourself
- Believing in yourself
- Developing yourself

1.3 Study Rationale

The RT department is dedicated to the continued improvement of practice through ongoing research collaborations. This study is the fifth research collaboration between SHSC and the University of Waterloo. This study will focus on the documentation of the experiences of the residents participating in RT services within a PFC framework in patient charts. As documentation is critical in healthcare services, and can help improve the quality of patient care through enhanced communication and record keeping, it is a logical next step for continued research. The current RT documentation procedures include a written account of the "personal leisure profile" and a quarterly note for each patient. The quarterly notes give an overview of the patient's experience over the past three months in RT programming.

Six general components were outlined to act as guidelines to assist the therapists in completing the required quarterly notes: 1) Statement of treatment goal; 2) Statement of intervention plan; 3) Therapist's perspective of leisure (including attendance patterns, behaviours, etc.); 4) Patient's perspective; 5) Progression or attainment of goals; and 6) Further plan of action to be taken. The quarterly note is written directly into the resident's chart. This documentation procedure does not incorporate the results of the above-mentioned study and as a result may not reflect the actual experiences of the

residents and the opportunities provided by the recreation therapy practitioners. The development and incorporation of language, which reflects the experiences of the residents in the documentation process, is required to improve this aspect of the RT practice. Further, the majority of the RT practitioners participate in the medical team rounds as a part of their professional responsibilities. Providing the RT practitioners with language that more fully reflects the experiences of the residents will allow the rest of the medical team to better understand and appreciate the importance of leisure in the lives of the residents. Finally, by continuing the research within a PFC framework, the RT practice will continue to improve their ability to offer patient focused leisure opportunities.

1.4 Purpose of the Study

The purpose of the study is the development of documentation procedures that will enable the recreation therapy practitioners to engage in authentic and professional documentation of the residents' experiences in recreation therapy and leisure opportunities. Two objectives flow from the purpose statement to further inform the purpose. The first objective is to develop an understanding of the RT practitioners' perceptions of the current RT documentation process at SHSC. The second objective is to explore how the experiences of the residents participating in RT and leisure opportunities can be documented in a way that is more consistent with patient-focused care and better reflect the residents' experiences.

This information will allow for the development of a documentation framework based on the PFC model guided by the theory of human becoming which will more effectively communicate the recreation therapy experiences of residents to other

recreation therapy practitioners and other health care professionals at SHSC. It is hoped that the development of a new framework for documentation will allow for a balance between creating professional documentation and offering an authentic description of the experiences of leisure opportunities. Better communication of residents' experiences will improve the ability of the recreation therapy practitioners to offer services to meet the specific emotional, psychological and medical needs of the residents, which is an important tenet of a PFC model guided by the human becoming theory.

Chapter Two: Literature Review

2.1 Theory of Human Becoming

Parse's theory of human becoming is a nursing paradigm of practice that provides an alternative to the traditional nursing philosophy of practice. Traditional nursing is generally based on the medical model and is grounded in the natural sciences (Parse, 1999). The theory of human becoming, by contrast, is based in human sciences, where the aim is to develop an understanding of lived experiences. The goal of nursing guided by the human becoming school of thought is quality of life from the perspective of the one living the life (Mitchell & Cody, 1999). Parse's theory is based on the following nine assumptions:

1. The human is coexisting while coconstituting rhythmical patterns with the universe.
2. The human is open, freely choosing meaning in situation, bearing responsibility for decisions.
3. The human is unitary, continuously coconstituting patterns of relating.
4. The human is transcending multidimensionally with the possibles.
5. Becoming is unitary human-living-health.
6. Becoming is rhythmically coconstituting human-universe process.
7. Becoming is the human's pattern of relating values priorities.
8. Becoming is an intersubjective process of transcending with the possibles.
9. Becoming is unitary human's emerging (Parse, 1998, p.19)

These assumptions outline the foundations on which the theory is built. The major themes of the assumptions are that the person is the expert in assessing and judging his or her own health and that the meaning the person attributes to his or her health changes with changes in his or her environment and values. The assumptions also discuss the concept of becoming. Becoming occurs when the person goes beyond the

actual and chooses from the imagined possibilities. Each experience the person has with the universe allows for further human becoming.

There are also three principles of the human becoming theory, which illustrate the idea of living paradoxes. Parse (1998) defines a paradox as a rhythmical pattern of "an apparent opposite. However, these rhythmical patterns are not opposites; they are two sides of the same rhythm that coexist all at once" (p.38). Further, these living paradoxes are not problems to be solved by the nurse or healthcare provider; they are natural rhythms of life (Parse, 1998). The nurse's role, then, is to support the patients as they move through these paradoxes. The three principles of human becoming are as follows:

1. *Structuring meaning multidimensionality is cocreating reality through the languaging of valuing and imaging* (Parse, 1998, p.35). The human is continuously changing and constructing meaning through his or her unique experiences in his or her life situations. Meaning is not always created from explicit knowing, it is also created through tacit knowing. Tacit knowing allows meaning to be created through the person's values and perceptions. The meanings are changed and reconstructed as one expresses his or her values perceptions out loud and with others.

2. *Cocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing and enabling-limiting while connecting-separating* (Parse, 1998, p.34). This principle illustrates the apparent rhythmical paradoxes in the human's relating to the universe. Revealing-concealing refers to the person's

choice of disclosing and not-disclosing. Enabling-limiting refers to the opportunities and restrictions that arise through choosing. Finally connecting-separating refers to the being with and apart from others. Though each paradox seems like opposites, within the human becoming theory both are always present in everyday experiences.

3. *Cotransending with the possibles is powering unique ways of originating in the process of transforming* (Parse, 1998, p. 34). Human becoming is a process of moving beyond the actual. By powering, the human is pushing-resisting the process of forging unique ways of being. This allows the human the opportunity to create new realities towards making transformative change in his or her situation.

Though Parse's theory of human becoming was first adapted as a nursing philosophy, it has informed other healthcare practices, such as TR. The benefit to healthcare practices guided by this philosophy is that patients can define their own quality of life, people's views are honoured (Parse, 1999). Guided by this philosophy practitioners can create authentic relationships with patients, which allows for the patients' perceptions of the given situation to be heard and acknowledged (Mitchell & Cody, 1999).

2.2 Patient Focused Care

Many health care facilities have adopted the patient-focused care (PFC) philosophy to guide practice and patient care. Though there are a variety of incarnations of PFC, according to Mitchell (1990) PFC is when "health is defined by the individual and the goal in practice is enhancing quality of life as defined by the person rather than the healthcare provider" (p. 170). However, it is important to note that incorporating a PFC model into service delivery takes on different forms depending on the priorities of, and the clients using the healthcare facility. Though PFC impacts both organizational service delivery and the philosophical perspectives of the members of the healthcare team (Mitchell et al., 2000), some facilities may focus more on the organizational and management aspects of the model such as creating a more efficient and effective practice, by grouping patients by needs, simplifying documentation and streamlining the number of people involved in patient care (Nicholson, 1995). However, this may limit the success of implementing a truly patient-focused practice, which, in theory, is focused on the person and their emotional and psychological needs. The philosophical shift of the staff's values and beliefs, such as viewing the patient as a person, viewing the patient as the expert, and focusing practice on the patient's desires, is the more long-term and difficult goal (Mitchell & Cody, 1999).

Both the service delivery and the philosophical aspects are important in the implementation of PFC. For true PFC to become reality all staff must embody the philosophical tenets of the model. For example, new frameworks for documentation or other aspects of patient-care can be relatively easily implemented, but if the healthcare

professionals do not value and adopt the philosophical changes and the PFC concepts, the quality of care for each patient will not become more patient-focused.

It is important to note that there are increasing numbers of researchers arguing that PFC may not be the best framework for improving health care. For example, Nolan, Davies, Brown, Keady and Nolan (2004) argue that PFC "may well perpetuate, rather than eliminate, poor standards of care for older people" (p.46). As a result of this, it is important to ensure that the form of PFC truly meets the needs of the patients and improves their quality of care.

2.2.1 Therapeutic Recreation and Patient Focused Care

With the ongoing trend towards the adoption of PFC, many professions have re-evaluated their practice within a PFC framework. The nursing profession has dedicated much research to this end, including research on assessment (Coker, 1998), documentation (Mosher, Rademacher, Day & Fanelli, 1996) and nurse-patient relationships (Mitchell et al., 2000). Though the TR profession has long viewed itself as a patient or person-focused profession (Bullock & Mahon, 1997), the empirical literature examining the meaning of PFC in the practice of TR is limited (Haasen, Hornibrook & Pedlar, 1998). As a result of a series of research collaborations between SHSC and the University of Waterloo investigating how recreation therapy and the provision of leisure opportunities can become more patient-focused, there is a greater knowledge of this topic (Hornibrook, et al., 2001). Further the results of these investigations have directly led to changes in practice towards a more patient focused practice at SHSC (Miller, 2005). Some important findings of the research collaborations include the importance of

authentic relationships between the residents and practitioners and the need to move with the reality of the patient. By developing these relationships and respecting the reality of the residents, an understanding of their unique needs and the meanings they attach to quality of life can be enhanced (Cantwell, 2000). This can then lead to an increased emphasis on patient-focused care.

2.3 Clinical Documentation

Though documentation by nursing staff is a critical component of the nursing practice, the quality and quantity of documentation often varies (Ehnfors & Smeldby, 1993; Ehrenberg et al., 2001; Nilsson & Willman, 2000). This inconsistency in documentation practices can be influenced by many different factors. Various studies have been conducted to better understand the factors that impact on documentation behaviour, in order to improve the consistency of quality documentation by nurses in healthcare settings.

2.3.1 Documentation Behaviours

Both intrinsic and extrinsic factors can influence documentation behaviours. Tapp (1990), through interviews with nurses, found various intrinsic factors, which influence documentation, including the perception by nurses of the limited value of nursing-care plans and the fact that important information was often transmitted verbally and therefore not always documented. Other intrinsic factors impeding documentation include the complexity of nursing theories and frameworks, nurses' intimidation to use medical or nursing terminology, which leads to nurses avoiding documentation requirements. As well nurses reported feelings of disregard for their documentation by other healthcare

professionals, which acts as a disincentive to document on a regular basis. Finally, social factors such as work group values and professional charting patterns can also impact documentation behaviours (Howse and Bailey, 1992). For example, if the work group values actual patient care more than documentation, or if the group values verbal communication more than written communication, documentation will be less important to the team, and will be completed less frequently and with lesser quality.

Research also points to a variety of extrinsic factors associated with lack of quality documentation. These factors include the "time dilemma", in which nurses chose between documentation or actual patient care, lack of space to think and write, redundancy of forms and charts (Tapp, 1990), perceptions of a fragmented charting system, which lead to redundancy in the information communicated between different disciplines, as well as a limitation in the amount of information communicated. Noise, disruptions and unavailability of the chart when charting should be done also emerged as factors affecting documentation (Howse and Bailey, 1992). Tapp (1990) found extrinsic factors that improved the consistency and quality of documentation, such as encouragement and positive reinforcement to document effectively by managers and supervisors. The same study found that when nursing documentation is guided by a theoretical framework, documentation improves, and nurses are more likely to consistently chart patient care.

Renfroe, O'Sullivan and McGee (1990) conducted a study to determine how attitudes, subjective norms, and behavioural intent of nurses impact documentation behaviours. The results revealed that both the attitudes of the individual nurses towards documentation and the subjective norms towards documentation of the nursing team

specifically, and the medical team in general, had a large impact on the documentation behaviour of the nurses. Not surprisingly, when nurses have negative attitudes towards documentation, they are less likely to document effectively and consistently. The subjective norms variable used in this study reflects the social pressure to engage in or not engage in documentation of patient care. When the team has a subjective norm to focus on quality documentation, the nursing staff is more likely to engage in quality documentation behaviours.

The literature points to the fact that both internal and external factors influence the documentation behaviour of nurses. In light of these findings, it is clear that there are a number of changes that could be implemented to improve the documentation behaviour of nurses. Many of the facilitators of quality documentation reported in the literature could be implemented into healthcare facilities to improve nursing documentation, such as managers encouraging and supporting the nurses. As well, many of the inhibitors found to impact documentation could be altered to promote quality documentation. For example, reducing the redundancy of charts and giving nurses quiet places to chart may help improve documentation. Programs and other strategies to help improve the attitudes of the nurses towards documentation, or the norms of their department could also help to improve documentation. Finally, an important finding from the studies is that nurses may not feel comfortable with the nursing terminology and documentation procedure. Implementing educational programs to train nurses on documentation procedures guided by a framework would also be effective in improving documentation.

All of the above-mentioned studies were focused on documentation in nursing practice. However, many of the findings could also explain the documentation

behaviours of other healthcare professionals, such as therapeutic recreation professionals, due to the similar working environments and requirements for practice. As a result, much of the information and findings could be used to improve the quality and consistency of TR documentation as well.

2.3.2 Computerization of Patient Charts

The computerization of charts is one way many hospitals have attempted to simplify and improve documentation. The healthcare environment in Canada is becoming increasingly dependent on computers as health records and other forms of documentation are being converted to computerized forms. Although this computerization brings many benefits to management, communication and patient care, there are also many potential problems, concerns or issues, which may occur with computerization of medical documentation.

Greaves & Dyson (1994) outline various benefits to computerized systems in hospitals. They include improvements in quality, accessibility, legibility as well as increased continuity and availability of information to all healthcare professionals. Other benefits of computerization include the increased ability for research and effective decision-making by managers and healthcare professions due to the extensive amounts of information available to them (Swann, 1994). Potential concerns have also been outlined in the literature. Greaves & Dyson (1994) state that one possible negative outcome of computerized medical records is the lack of privacy for the patient's information. Though there are obvious benefits to medical records being available to all healthcare professionals at different healthcare institutions, the possibility of medical records being

available to others becomes increasingly feasible. The authors also argue that the increased reliance on computerization can also lead to an over-emphasis of the "science" of nursing as opposed to the "art" of nursing. On this note, Greaves & Dyson (1994) state that "science holds high status in contemporary society, and if the scientific elements of nursing are allowed to dominate, through the use of modern technology, nursing may lose part of the essence of its caring philosophy" (p.37).

Moen, Henry & Warren (1999) give a specific example of this potential loss of the "art" of nursing. As the computerization of documentation and patient charts increases, reliance on codes to represent both patient diagnosis and therapeutic interventions become common in documentation. This has led to the development of a variety of classification systems of nursing interventions. These classification systems are very specific and, therefore, do not provide an opportunity to document patient-specific experiences within clinical interventions, or any individual aspects of the patients themselves. Computerization of patient records does increase the efficiency of documentation; however this documentation may come at the expense of patient-focused care.

2.3.3 Documentation and Patient Focused Care

One of the changes associated with the implementation of PFC is the redesign of documentation procedures to decrease time spent on documentation and increase data accessibility for all healthcare professionals (Townsend, 1993). As mentioned above, the PFC philosophy can take on various forms depending on the healthcare institution. However, upon a review of the literature there seems to be a consensus that there is a

specific documentation framework which is accepted as the most appropriate for PFC. This documentation procedure is Charting by Exception (CBE) (Mosher, et al., 1996; Nicholson, 1995; Townsend, 1993). In fact, Mosher et al. (1996) state that, "most hospitals that had adopted the patient-focused care philosophy incorporated ...documentation by exception" (p.219). CBE is a complex documentation system created to decrease the amount of time needed for documentation. Various flow sheets are used to track patient status and the intervention process and outcomes. The flow sheets are designed to replicate the expected outcomes of treatment. Only when there is an "abnormal" response does the nurse or healthcare professional document the response as an exception on the flow chart (Burke & Murphy, 1988).

Though there seems to be a consensus in the literature about the validity of the CBE framework being used as the documentation procedure within PFC philosophy, this framework may not fully achieve all of the deeper principles of PFC. The basic tenet of the CBE framework is that all patients are expected to behave in a predetermined and identical way in response to an intervention. It is only when the patient is "different or unique" that a note is made. To assume that all patients are the same does not allow for each patient to be given the type of care that will uniquely benefit them. Therefore, though CBE may decrease the amount of time needed for documentation (which benefits the staff), it does not provide the opportunity for patient-specific care (which would benefit the patient). Perhaps a greater consideration for the uniqueness of each patient when documenting patient care would lead to a more patient-focused practice.

Many authors have argued that documentation procedures in hospitals espousing the PFC philosophy should be documenting more than the outcomes of the clinical

interventions (Coker, 1998; Mitchell & Cody, 1999). For example Mitchell and Cody (1999) argue that by recording the "concerns, fears, issues or needs likened to [the patient's] situation or quality of life" (p.306) can lead to fewer errors when providing care. Coker (1998) states that by "knowing the person" individualized care can be offered, and a way to enhance "knowing the person" by the healthcare staff is to document such information as the patient's likes and dislikes, their interests and preferred activities, information about family and social supports, background, and their hopes and dreams. It is also important throughout the healthcare experience of the patient to document their reactions to, and perceptions of, the interventions and the illness itself (Mitchell and Cody, 1999). Parse (1999), in a discussion of the implementation of the human becoming theory into clinical nursing practice, expresses her belief in the importance of the person's perspective in medical documentation.

> If documentation is required as part of the structure in the specific setting where nurses and persons meet, the reporting includes the person's description of their experiences, the situations from their view, and the hopes, dreams, and intents related to what is most important to them at the moment. This type of documentation is quite different from standard assessment forms that usually focus on the process rather than the meaning of the situation from the person's own view. The person's meanings of situations are shown in the descriptions. For example, the person's own words are used to provide a health description. Emerging paradoxical patterns of preference in living are apparent in the descriptions and may be documented by the person and nurse. Activities and plans may also be documented but always from the persons', families', or communities' perspective. (p. 1384)

Unfortunately some studies have found that even within facilities claiming to follow the PFC philosophy, information about the person was rarely found in the charts. In a study by Renfroe et al. (1990), only 13% of the charts contained any reference to the patient's emotional or psychological status. The author concluded that either nurses are

not assessing in this area, or they do not appreciate the need to document this information. Coker (1998) found that "health records in long-term care tends to reveal lists of carefully worded professionally perceived problems about the individual, but rarely is it possible to obtain a picture of the *person*" (p.436, emphasis added). These studies show that there is a gap between the philosophy of PFC and its emphasis on the patient, and the actual documentation of aspects of the "person". By incorporating the CBE documentation framework only the patient's "problems" are documented, and therefore the patient is not seen as a whole person and certain aspects of PFC cannot be achieved.

2.4 Therapeutic Recreation

Therapeutic recreation often defines itself as a therapeutic profession, aligned with medicine (Lahey, 1996). The adoption of the medical model as a guiding model for TR has been a major source of debate in the profession. Shivers (2003) believes that structuring the therapeutic recreation process around the medical model has made the profession more accountable to the clients, and has increased the position of the profession in the medical community. Further, the author states that the true calling of TR is the rehabilitation process of the client. Anything else does not truly meet the needs of that client. There are many practitioners who applaud this philosophical trend as a positive choice for the profession. Sylvester (1998), on the opposite end of the debate, argues that to embrace of the medical model as a professionalization technique is largely for the external rewards, such as jobs, status and power. He also believes that this trend may actually undermine the professional development of Therapeutic Recreation, which he believes should be based on the interests and needs of society and the individuals TR

professionals serve. It has also been argued that by attempting to justify leisure as a "therapeutic intervention" the profession risks competition with other therapeutic professions who use activities as therapy, such as physical therapy and occupational therapy. These professions have longer histories, and are better able to provide empirical evidence of their therapeutic interventions. TR has lacked these empirical results (Mobily, 1997), and as a result may not have the same claims on the value of their interventions. The profession of TR may gain greater professional benefits by focusing on the unique aspects of its practice, such as the benefits achieved through leisure and the opportunities for freedom and self-determination.

Despite this professional debate, Lahey (1996) states that "therapeutic recreation finds itself reproducing the clinical-medical model within its own sphere of practice" (p. 22). As a result, much of the documentation systems for TR seem to emulate those of other clinical, medical and therapeutic professions, which are generally quantitative and process and problem oriented. This trend is clearly seen in the therapeutic recreation literature, TR textbooks and some professional or organizational standards.

2.4.1 Documentation of Therapeutic Recreation Services

As with all health care professions, documentation in TR should be considered an important and necessary aspect of the practice. However, many TR specialists may consider documentation to be extra work, or may view it as not as important as other healthcare professions because TR practitioners are not providing *medical* interventions (Shank & Coyle, 2001). Healthcare facilities generally expect that all healthcare professionals, including TR specialists, document their interventions in client records,

which often becomes the official and legal record of the client service. However, documentation by TR professionals can go beyond being simply a legal record of the care provided. Stumbo & Peterson (2004) outline five benefits to quality documentation in TR departments. They are to: 1) assure the delivery of quality service, 2) facilitate communication among staff, 3) provide for professional accountability, 4) comply with administrative requirements, and 5) provide data for quality improvement and efficacy research. The following is an analysis of the therapeutic recreation literature, TR textbooks and some professional or organizational standards, all focused on documentation within the field of therapeutic recreation.

2.4.2 Therapeutic Recreation Literature Focusing on Documentation

There is a very limited body of literature with a discussion of TR and documentation, and none focusing solely on documentation frameworks uniquely for TR. The vast majority of this research is focused on procedures for documenting client treatment plans that are measurable, quantifiable and focused on goals and outcomes of TR interventions, as well as documenting the results of interventions laid out in the treatment plans (Stumbo, 2000; Peterson & Stumbo, 2000; Olsson, 1992).

Olsson (1992), in his article outlining the skills needed and procedures for writing assessment and progress notes in TR, explains the "anatomy of a recreational therapy progress note" (p.172). According to the article the three components of a progress note include: (1) the facts, (2) clinical impressions, and (3) the treatment plan. The facts include observed behaviours, analysis and the client's input on his or her progress. The clinical impression section contains the assessment, the clinical status, time and

prognosis. Finally, the treatment plan includes title of the intervention plan, time, outcome goal, measured objectives and prognosis. This progress note is process based, and does not allow for any discussion of the patient as a person.

The types of documentation often discussed in TR literature are similar to those used in other healthcare professions. Stumbo (1996) lists initial assessments, individualized treatment plans, periodic progress notes and discharge or referral summaries as the types of documentation TR practitioners should be completing, all of which are standard for health care professionals in healthcare settings. Consequently, there has been no research or literature examining how TR documentation may differ from other clinical professions, and the types of adjustments that could be made to standard documentation frameworks to better reflect the TR practice. This limited research into documentation and TR has led to the use of documentation frameworks from other disciplines. The need for TR based documentation frameworks would increase the ability of TR practitioners to better reflect and communicate their practice through quality documentation. Due to this limited amount of research, it is difficult to gain an understanding of the types of documentation procedures being used in practice at various therapeutic recreation settings. As well, there are many aspects of documentation and TR that are left unexamined, such as which aspects of the leisure experience are important to document and the ways to document the leisure experiences of clients in order to improve practice and the services provided to those clients.

2.4.2 Analysis of Documentation Procedures from Therapeutic Recreation Textbooks

As documentation is an essential aspect of the therapeutic recreation practice, information about this topic is often included in TR textbooks. Six TR textbooks were examined to better understand how documentation is being taught to future TR professionals (i.e. Austin, 2001; Austin, 1997; Carter, 1985; Howe-Murphy, 1987; Shank 2002; Stumbo &Peterson, 2004). The different textbooks approach documentation in various ways, and place varying levels of importance on documentation within the TR process. There are certain topics that are included in each of the textbooks, including a description of the importance of documentation in TR, and a list of skills needed to produce quality documentation, such as clinical writing skills and proper grammar.

However, the Stumbo and Peterson (2004) and the Shank (2002) textbooks have the most comprehensive discussion of documentation in TR. Both dedicate an entire chapter to the topic. Upon analysis of the chapters focusing on documentation, two similar trends are revealed. The two trends are: the use of nursing and clinical documentation frameworks and the absence of the client or patient perspectives.

Firstly, research on documentation in nursing has a long history, and has led to the development of many different frameworks for documenting patient care. Both the Stumbo et al. (2004) and Shank (2002) textbooks describe a number of nursing documentation and charting frameworks including: narrative format, problem-oriented medical records, focus-charting, charting by exception, SOAP notes and PIE charting. It is not surprising that TR students are often exposed to these different documentation and charting frameworks since many hospitals have implemented these specific nursing documentation frameworks. However, it may also be important for TR professionals to

be aware that the clinical documentation most prevalent in hospitals may not effectively report the services TR professionals offer to clients. Much clinical documentation is very outcome-oriented and focused on quantifiable changes and recreation services typically do not produce the quantifiable outcomes that will fit into the more standard clinical documentation. Therefore, TR students may be lacking the opportunity to learn how to effectively document TR services, including the experiences of the client.

The second trend observed in the Stumbo and Peterson (2004) and Shank (2002) textbooks is that there is no mention of the importance of documenting client perspectives. Though TR often claims to offer patient/person-centered care, the types of documentation frameworks outlined in the textbooks do not emphasize the importance of the patient and his or her perspective. In order for the field of TR to continue to offer person-centered services, this philosophy must be emphasized in all aspects of practice including documentation.

Upon reviewing the different sources of information on documentation in TR, it is clear that TR documentation is dependant on other professions' frameworks. The profession is lacking in research and in the development of profession specific documentation frameworks. The frameworks, which are often cited in TR literature, are focused on treatment-outcome goals and are limited in their ability to document within a PFC model. These factors may lead to a limited ability for TR professionals to communicate or promote to other healthcare professionals the services TR offers. It may also negatively impact the ability of TR professionals to ensure that the clients are receiving the services that will uniquely benefit them. Further analysis of TR

documentation is needed to make certain that TR professionals are providing the highest quality services to clients within a clinical setting.

2.4.3 Therapeutic Recreation Ontario Documentation Guidelines

Therapeutic Recreation Ontario (TRO) is the guiding body for TR departments in many healthcare settings across Ontario. TRO has developed the "Standards of Practice for Therapeutic Recreation" which guide the practice of its members and member organizations. One aspect of the TRO Standards of Practice is the section devoted to documentation. According to the TRO, the purpose of documentation in TR is threefold: 1) to ensure the accurate and comprehensive collection of information regarding the client and TR intervention through a variety of methods (written, verbal, electronic records), 2) to provide a means of measuring progress through the review of client specific documentation, and 3) to provide a basis of accountability for intervention by TR services. TRO has also outlined two guiding principles for documentation in TR: 1) documentation acts as an effective tool for professional accountability and responsibility and, 2) documentation provides a means of evaluating therapeutic recreation interventions. The TRO's core values embrace person-centeredness in all of the standards of practice for therapeutic recreation.

According to the TRO purposes and guiding principles of TR documentation, outlined above, TR documentation seems to be very much concerned with monitoring and evaluating the TR interventions and providing accountability for the TR profession. Though one of the outlined purposes is a "comprehensive collection of information regarding the client", there is no explicit mention of the importance of the client's

perspective. As a result, TRO depicts client documentation as a more profession-centered practice than person-centered, even though TR has often claimed to be a person-centered practice (Bullock & Mahon, 1997).

Upon analysis of the different sources of information about documentation and TR, it seems clear that more work needs to be done in this area. TR documentation would benefit from frameworks specifically designed for therapeutic recreation and the provision of leisure opportunities. This would allow the expression and communication of the client experiences unique to TR, as well as provide greater focus on the person as opposed to the benefits of TR and the outcomes of interventions.

Chapter Three: Epistemology and Methodological Procedures

As stated in Chapter 1, the purpose of the study was the development of documentation procedures to enable the recreation therapy practitioners to engage in authentic and professional documentation of the residents' experiences in recreation therapy and leisure opportunities. Two objectives flow from this purpose statement to further inform the purpose. The first objective is to develop an understanding of the RT practitioners' perceptions of the current RT documentation process at SHSC. The second objective is to explore how the experiences of the residents participating in RT and leisure opportunities can be documented in a way that is more consistent with patient-focused care and better reflect the residents' experiences.

3.1 Research Questions

The five research questions used to guide the research are as follows:

1) How do the recreation therapists experience the process of documenting recreation and leisure opportunities in a long-term care setting?

2) What are the perceptions of the current documentation requirements of the recreation therapists?

3a) What language is currently being used in resident's charts?

3b) Is this language congruent with a patient focused experience for the residents?

4) What aspects of the recreation therapy and leisure experiences are important to include in the documentation and communication of recreation therapy?

5) What is perceived, by the lead researcher and the co-researchers/practitioners, to be the most effective approach for communicating and documenting the experiences of the residents in recreation therapy services within a PFC context?

3.2 Action Research

Action research is a research strategy designed to both make changes in the system as well as develop knowledge about it. It has often been associated with private industry and organizational development, and is committed to collaboration with the research participants (Small, 1995). However, it has also been used in many human service and community development initiatives (Pedlar, 1995). Action research occurs in a cyclical fashion of planning, acting, observing and reflecting (Lewin, 1946). An important characteristic of action research is that the research plan must be flexible and responsive, to account for the complexity of real social situations (Kemmis & McTaggart, 1988).

Prior to the commencement of the project, I was approached by individuals from the recreation therapy department at SHSC who indicated that the practitioners in the recreation therapy department were eager to improve the documentation practices of the department. Engaging in a research project based directly on the needs or desires of the participants allows for action research to ensue. However, action research can only occur with full participation of all the participants, and a collaborative partnership between the researcher and the practitioners, in this instance the RT practitioners. The practitioners have been involved in a series of action research projects, and are familiar with the self-reflection needed for this type of research engagement in action research allowed the recreation therapy practitioners the opportunity to develop new strategies and frameworks for documentation, which impacted their own professional practices.

3.3 Self-Reflective Practice

Action research fits well with the concept of self-reflective practice, because it promotes the practitioner's practical knowledge in the process of understanding aspects of professional practice. Self-reflective practice, guided by Schön's (1983) thinking on the reflective process of professionals, allows professionals to examine their own personal experiences and knowledge within their professional practice. According to Schön (1983), the history of professional knowledge has been guided by "technical rationality". Technical rationality is based on the rigorous application of scientific theory and techniques to professional practice. The researcher and the practitioner are separate, and placed in a hierarchical relationship, with the researcher placed above the practitioner. The practitioner provides the problem and the researcher solves it. Similarly, the relationship between the practitioner and the client places the practitioner in the role of the expert. Technical rationality is said to gain the profession greater respect and authority; however, this type of knowledge neglects to take into account the situations in professional practice that are unique and therefore cannot be applied to a preset scientific theory.

Schön (1983) advances a new model to describe the type of knowledge used in unique or unpredictable situations. The model of Reflection-in-Action values the practitioner's way of knowing and acting in practice. The model promotes real connections with clients as opposed to a traditional expert-client relationship. Along the same lines, clients are seen to have knowledge and expertise to offer to the practitioner about the service they are receiving. Finally, the model promotes a collaborative, and even interchangeable, relationship between the practitioner and researcher. The

researcher does not maintain a distance from the practice, and the practitioner is involved in the research and not "a mere user of the researcher's product" (Schön, p.323). Self-reflective practice is a guiding principle in the continuing development of the practice of recreation therapy at SHSC (Miller & Pedlar, 2006). This type of professional philosophy allows the recreation therapy practitioners at SHSC the opportunity to both create therapeutic relationships with the resident, and advance practice through collaborative research. Encouraging the practitioners to reflect on their practice enhances the depth and meaningfulness of the data and findings developed in this study.

3.4 Hermeneutics

This qualitative inquiry used hermeneutical techniques to understand and seek a "consensus construction" of the research topic (Guba & Licoln, 2004, p.27). Hermeneutics is based on the contention that meaning is interpreted, not created, and that interpretation can never be absolutely correct or true. Further, the text that is being analyzed must be interpreted within a historical or cultural context in order to understand the meanings within the text (Patton, 2002). This theoretical framework implies "that language, metaphors, words, concepts, and texts are given a central place in the formation of knowledge" (Eriksson, 2002, p. 62).

The fact that the practitioners/co-researchers understand and are guided by Parse's theory of human becoming in their practice will allow for an interpretation of documentation within the context of PFC guided by the theory of human becoming. According to Patton (2002) when employing a hermeneutic approach the meanings in the text must be negotiated among a community of interpreters to reach an agreement of that meaning. For this reason, action research fits well within the hermeneutic tradition,

because it promotes participation in the interpretation process by all members of that community.

The anticipated outcomes of this study were to develop a better understanding of recreation therapy documentation at SHSC and to create a theoretical framework for documentation guided by Parse's theory of human becoming. Karkkainen and Eriksson (2004) propose a constructivist epistemology and a methodology that provides guidance and a framework to understand the documentation of nursing care. The framework employed by Karkkainen and Eriksson was used to inform this study.

Karkainen and Eriksson used an adaptation of Gadamer's hermeneutic dialogue method to apply theory to the documentation practice of nurses. This adaptation of Gadamer's hermeneutic process was developed by Koski (1995, in Karkainnen & Eriksson, 2004a), and consists of four steps for interpretation, which are: (a) the explicit analysis of preunderstanding, (b) hermeneutic dialogue, (c) the fusion of horizons, and (d) active application. The steps outlined by Koski (1995, in Karkainnen & Eriksson, 2004a) were applied to this study.

3.5 Analytic Phases of the Study

This study was conducted according to the analytic phases laid out by Koski (1995, in Karkkainen & Erikssion, 2004a). Conducting the research in distinctive analytic phases not only allowed for a variety of data collection methods, it also allowed for the co-researchers to be involved at various points throughout the study, and play a role prior to, during and after the various analyses and interpretations of the data. This continued participation was an important aspect of the action research process. By returning to the co-researchers each time data were collected and analyzed there was a

greater opportunity to ensure that their perceptions and ideas played a role in the understanding of documentation and the development of a new documentation framework.

The first step, *analysis of preunderstanding*, refers to the fact that in order to interpret and create meaning for a text it is important to be aware of one's preunderstanding and the cultural and historic forces that influence one's view (Karkainen & Erikssion, 2004a). This phase was informed by the first two research questions,(1*) How do the recreation therapists experience the process of documenting recreation and leisure opportunities in a long term care setting?* and (2) *What are the perceptions of the current documentation requirement of the recreation therapists?* As this study relied on the interpretation of co-researchers, it was important for all members to become aware of their personal and the community's preunderstandings of the subject. Focus groups with the co-researchers allowed for a hermeneutic phenomenological (Guba & Lincoln, 2004) examination of the preunderstandings and lived experiences of the practitioners. The focus groups examined such topics as the experiences of, and feelings about documentation, the role and impact of documentation in patient care, and which aspects of this care should be documented. A copy of the focus group topics and probes can be found in Appendix 1.

The second step, *the hermeneutic dialogue,* took place between the text (actual documentation created by the recreation therapists) and the PFC philosophy used by SHSC and the recreation therapy discipline. This stage was informed by the third and fourth research questions: (3a) *What language is currently being used in resident charts?* and (3b) *Does this language represent a patient focused experience for the residents?*

The dialogue consisted of genuine questions which lead to meaningful answers (Koch, 1996). It is in this stage of the hermeneutical process that the substance contained in the text was analyzed, and "an answer is sought to the question of what the text expresses" (Karkainen & Eriksson, 2004, p.270). By using the patient focused care model as the context, the dialogue attempted to reveal how closely aligned the preunderstandings of the co-researchers and the actual documentation texts, are to the tenets of patient focused care. The results of the hermeneutical dialogue set the groundwork for the third phase of the study.

The third step, *the fusion of the horizons*, meant that the negotiation of the various interpretations occurred between the co-researchers. Horizons are the "range of visions that includes everything that can be seen from a particular vantage point" (Koch, 1996, p. 177). This phase helped answer the final two research questions: (4) *What aspects of the recreation therapy and leisure experiences are important to include in the documentation and communication of recreation therapy?* and (5)*What is perceived by the lead researcher and the co-researchers/practitioners to be the most effective approach for communicating and documenting the experiences of the residents in recreation therapy services within a PFC context?* All of the practitioners have experience with documentation, and not surprisingly have different interpretations of the important aspects and language to be used in this process. These interpretations are the RT practitioners' horizons and it is in this step the various horizons (standpoints) of the co-researchers come together. For interpretation to occur the co-researchers must be open to the standpoints of others to allow meanings to be negotiated among the group. This

process was facilitated by activities in the form of a workshop, developed by the lead researcher.

The final step in this hermeneutic process is *active application*. In this final stage "the researcher applies the message contained in the text to the research task" (Karkainen & Eriksson, 2004a, p. 270). In this case, the research task was to develop sample documentation based on the results from the previous three hermeneutic phases.

3.6 Research Participants

At SHSC, the recreation therapy professional team comprises both recreation therapists and recreation therapy assistants. All of these professionals make up the Recreation Therapy discipline. There are recreation therapists working in Mental Health Services, the Geriatric Day Hospital and in A&VC. An important distinction in this study is between the recreation therapist and the recreation therapy assistant roles at SHSC. The recreation therapist attends the departmental rounds and is expected to complete the "personal leisure profile" summary and quarterly notes for his or her residents. The recreation therapy assistant does not attend department rounds, and charts by exception in the resident charts.

Table 1: The analytic phases of the study

	Title	Purpose and Methodology	Research Questions or Research Task
Phase 1	*Analysis of pre-understanding*	• To become aware of the groups' pre-understandings and the cultural and historic forces that influence that view. • Focus groups Involving the co-researchers will attempt to elicit the group's preunderstandings.	(1) How do the recreation therapists experience the process of documenting recreation and leisure opportunities in a long-term care setting? (2) What are the perceptions of the co-researchers of the current documentation requirement of the recreation therapy department?
Phase 2	*The hermeneutic dialogue*	• To reveal how closely aligned the pre-understandings of the co-researchers, and the actual documentation texts, are to the tenets of patient focused care. • The analysis of the focus group transcripts and the actual documentation produced by the co-researchers using PFC as the context.	(3) What language is currently being used in resident charts? (4) Does this language represent a patient focused experience for the residents?
Phase 3	*The fusion of the horizons*	• To allow the various horizons (standpoints) of the co-researchers come together. A workshop involving all co-researchers will consist of various activities to allow the negotiation of an interpretation of the findings of the previous phase.	(5) What aspects of the recreation therapy and leisure experiences are important to include in the documentation and communication of recreation therapy? (6) What is perceived by the research team to be the most effective approach to communicating/documenting the experiences of the residents in recreation therapy and leisure within a PFC context?
Phase 4	*Active application*	• The co-researchers apply the message contained in the texts to the research task.	To develop a greater understanding of documentation of recreation therapy and leisure opportunities, and the creation of a documentation framework for the recreation therapy department.

3.7 Credibility and Trustworthiness

Credibility and trustworthiness are important aspects of qualitative research. Triangulation has generally been presented as a research strategy, which strengthens a study by using a combination of methods or using a variety of different data sources (Patton, 2002). The concept of triangulation suggests that by employing a variety of methods a deeper insight into the subject is possible (Patton, 2002). However, the concept of crystallization is now being put forward as a new concept to increase the credibility of qualitative research (Janesick, 2000). The concept of crystallization recognizes that there are many ways to understand a topic and examining the topic in a variety of ways will deepen the understanding of this topic (Janesick, 2000). Janesick (2000) explain that "What we see when we view a crystal, for example, depends on how we view it, how we hold it up to the light or not." (p.392)

The methodology and epistemology outlined for this study provided many opportunities for crystallization. The hermeneutical philosophy espouses the importance of incorporating and negotiating the interpretation of all co-researchers in the analysis and understanding of the topic, which allows for the topic to be viewed in many different lights. Furthermore, collecting data through the sample documentation from resident charts, focus groups and workshops, as well as using tape recording and videotaping as data collection techniques, provided various views and understandings of the documentation process and the language used in this process. Other aspects of the study also enhanced the credibility and trustworthiness of the study. Due to the action research nature of this study the inclusion of the co-researchers' perceptions occurred throughout the course of the study, which added strength to the findings. Also, I maintained a

reflexive journal throughout the duration of the project. This journal recorded observations, ideas and overall perceptions of the study and its progress. As well, the journal ensured that important aspects of the study were recorded such as reasons for methodological decisions or changes. Review of the journal notes provided me with suggestions of aspects of the data that warranted further analysis.

3.8 Ethical Considerations

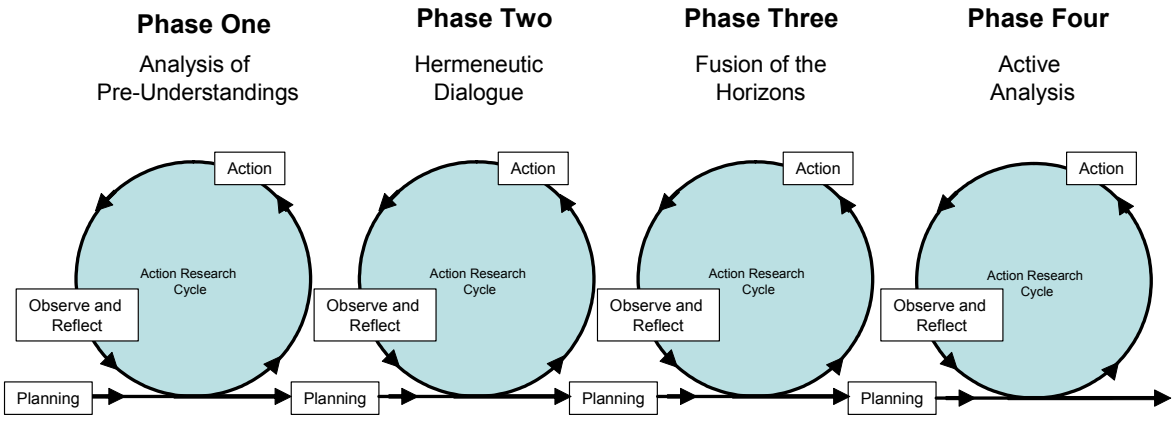
The study was approved by the University of Waterloo Office of Research Ethics. Prior to the commencement of the research project all potential participants were given a presentation on the methodology for the study. The practitioner/participants were then provided with an information and consent letter and were informed that their participation in this study was completely voluntary.

Documentation by the recreation therapists, directly from resident charts, was used as a source of data in this study. To ensure the anonymity of these residents, all distinguishing features were blacked out. Further, all documentation was then transcribed and all identifying features omitted from those transcripts.

Given the nature of action research, feedback, reflection, action and planning between the practitioners and myself was ongoing and constant, as will be apparent from the account of the research process, which follows in Chapter 4.

Chapter Four: The Research Process

4.1 The Cyclical Nature of Action Research



As stated in the methodology section, this research project followed an action research framework. Action research was developed out of the desire to both generate knowledge about and make changes associated with social issues or problems. However, this type of research evolved to find its place in organizational research as a vehicle for both knowledge development and change within organizations. In essence, action research allows for the opportunity to find solutions to practical problems as well as develop scientific knowledge. As a result, the action research framework fit well with both the purpose of the project as well as the environment in which the research took place.

An important goal of this action research project was to develop knowledge surrounding the documentation process in A&VC at SHSC. Fox (2003) argues that due to the nature of action research and the fact that action research is performed in a certain

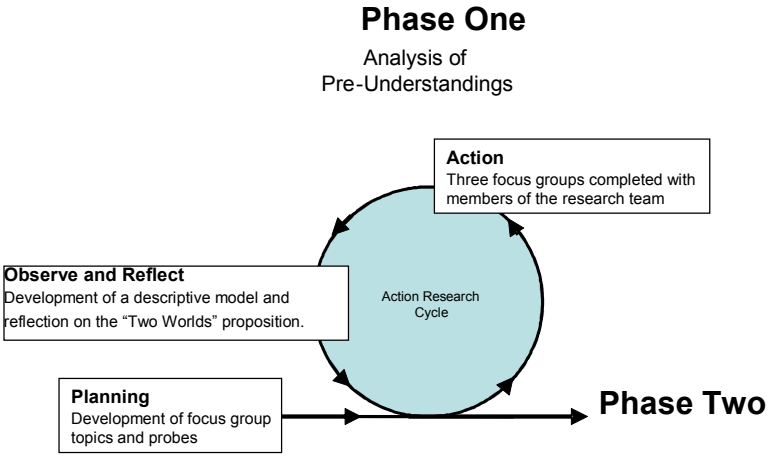
setting with its own unique characteristics it is important to be open to different methodologies throughout the research process. The author states: *we cannot assume that one research design or instrument will be sufficient to answer a question - methodological pluralism or eclecticism may well be the key here* (p.92). In this specific research project a series of methodologies were used to gain knowledge and work towards the final outcomes of the project, including constant comparison, hermeneutic dialogue, content analysis and the active application of research data into practical tools.

The action research process unfolded in a cyclical fashion, through four stages: planning, action, observation and reflection (Lewin, 1946). Upon completion of the reflection stage, the new knowledge and potential issues were incorporated into a new planning process to continue the research process. This continual cycling through the action research steps was advantageous to the outcomes of this project as it allowed for a smooth transition through the four hermeneutic phases applied to this research project.

The hermeneutic framework guiding this project was adapted from Koski (1995, in Karkainen & Eriksson, 2004a) and involved four different phases: (a) the explicit analysis of preunderstanding, (b) hermeneutic dialogue, (c) the fusion of horizons and (d) active application. The action research cycle described above was played out in each of the hermeneutic phases and as each separate phase was completed, the action research cycle was recommenced in the next hermeneutic phase. The reflection stage of the action research process provided the insight to propel the research project onto the next phase of the hermeneutic process. As a result, each phase was informed by the previous phase, which ensured that the results and new insights could be integrated throughout the course of the research project.

This chapter will follow the chronological steps undertaken in this project. Each of the four hermeneutic phases will be discussed independently. Within the discussions of each of the hermeneutic phases, the separate stages of the action research process (action, implementation, observation and reflection) will also be outlined. As well, throughout this section various models, diagrams and tools will be presented. This layout will provide the reader with a clear description of the research process, as well as an understanding of the development of the different models, diagrams and tools, which played a role in the overall incorporation of the new documentation framework into practice at SHSC. Finally, this layout will illustrate how the knowledge developed in each phase of this study was integrated into the final outcomes of the project by linking the reflection stage of one stage to the planning stage of the next hermeneutic phase.

Section 4.2 Analysis of Pre-Understandings



The purpose of the first phase of this study, *analysis of pre-understandings*, was to become aware of the groups' pre-understandings and the cultural and historic forces that influence those pre-understandings. Specifically, I was interested in the way the recreation therapists experienced the department's documentation process and to begin to understand how the environmental and cultural forces impact the documentation of the recreation and leisure opportunities. Given the collaborative nature of action research, all twenty-one of the recreation therapists were invited to be involved in the research analysis as research participants and co-researchers to enhance the level of collaboration.

4.2.1 Focus Groups

A series of three focus groups were conducted with the recreation therapists. The focus groups consisted of five to seven different recreation therapists in each, and focused on the experience of documentation, the experience of daily practice and suggestions for improving clinical documentation. For a complete outline of the focus group topics

please refer to appendix 1. In order to begin to understand the experience and the phenomenon of documentation for the recreation therapy practice, a constant comparison method (Glaser & Stauss, 1967) was applied to the analysis of the focus group interviews. I began the analysis process by coding the transcripts and then created categories to represent the codes. A series of themes and patterns emerged as a result of the initial coding process. While conducting further readings of the text, the themes and categories were compared to determine further relationship between them. The constant comparisons of the codes lead to more dense and complex categories of those codes. The categories developed into themes, which describe the experience of the recreation therapists and the documentation process. The emergent themes were placed into a model to help explain and illustrate the relationship between the themes. These themes are presented in Figure 2 representing a tentative model of the experience of the RTs with professional practice and documentation within the clinical environment, as will be discussed in further detail in the subsequent sections.

4.2.1.1 Member checking as a part of the hermeneutic epistemology

One specific example of involvement in the research process was a member check activity focused on the tentative model (Fig.2) describing the findings of the focus group discussions. This tentative model was presented to the research participants. The model was enlarged and placed on a wall during a full research team meeting. All of the participants were provided with small pieces of notepaper to jot down their reflections, which could be attached to the enlarged model. The participants were thus given the opportunity to make comments, ask for clarification or ask questions about the tentative model by writing on the paper and attaching their notes to the model. All of these

comments and questions were then incorporated into the analysis of the focus group interviews.

This form of member feedback was chosen for two specific reasons. The first is that it allowed the members to feel comfortable sharing their perceptions without having to speak in front of the group, which may have promoted a more open process for sharing opinions. And secondly, it provided me with written comments about the model, which could easily be incorporated into the current model.

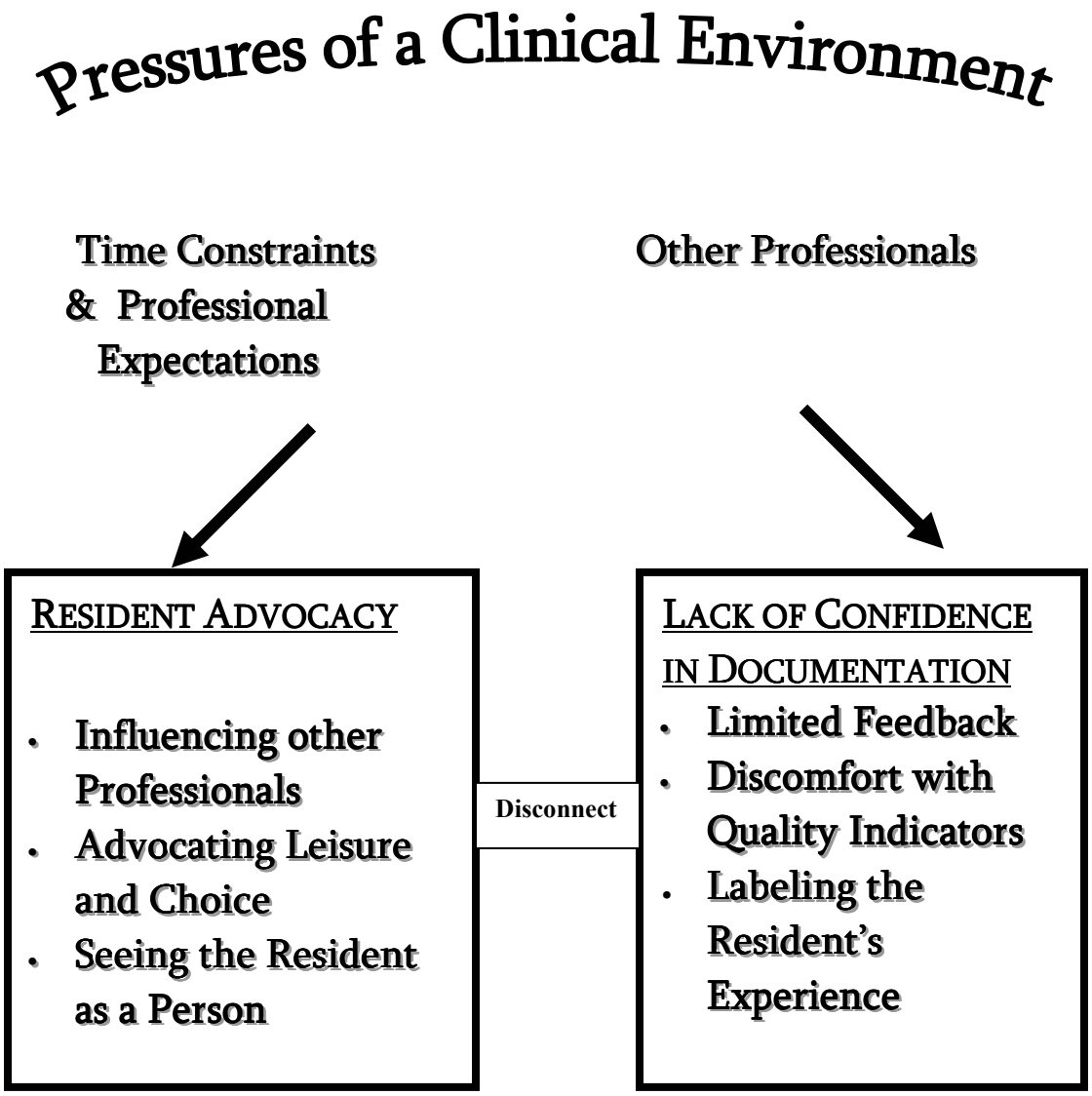
The results of this member check activity were very positive, and much of the results of the analysis and associated model were upheld by the participants. The comments have been incorporated into the discussion of the model to give further meaning to the model. The findings of the analysis of the focus groups and associated member check are therefore integrated in the following account of analysis to further illustrate the connections (and disconnections) between the themes which emerged from the constant comparative analysis of the transcripts.

4.2.2 Analysis of the Focus Group Transcripts

The findings of the focus group analysis generated one overarching theme: p*ressures of a clinical environment*, which in turn impacts daily practice such that two sub-themes emerged to further explain the experience of the RTs, namely: *time constraints and professional expectations*, and *potential impact of other professionals*.. These sub-themes were connected to the RTs practice on several dimensions and most importantly two additional themes identified as *resident advocacy* and *lack of confidence in quality documentation* emerged from the analysis. Considered together, (see Fig. 2), these themes illustrate the pressures, experiences and concerns of daily practice, which

impact the process of documenting patient care for the recreation therapy team in A&VC at SHSC.

Figure 2 Emergent Model: The Experience of Recreation Therapists



4.2.2.1 Pressures of a Clinical Setting

The overarching theme*, pressures of a clinical setting*, is evident in all areas of practice including documentation and is further explained by the following two sub-themes, *expectations and time constraints* and *other professionals*.

Expectations and Time Constraints

The sub-theme, *expectations and time constraints,* illustrates the pressures felt by the recreation therapists on a continual basis in their daily practice. However, to fully understand this theme, it is important to understand the professional and practice-based changes that were occurring in the A&VC at SHSC at the time the focus groups were conducted. Most significant are the changes to the documentation and record keeping expectations for all of the health care professionals in A&VC. There are increased record-keeping expectations, which require the professionals to document daily on all interactions with the residents. As a result of these changes, which were in mid-implementation at the time of the focus groups, the recreation therapists were not only overwhelmed with the quarterly notes, they were also concerned, and often confused, about the new expectations for record keeping. There was a level of anxiety surrounding these changes, which had a significant impact on the sentiments towards documentation in general for the recreation therapy practitioners. The following conversation expresses this anxiety and confusion towards documentation expectations.

RT1: It's really not clear, and then it's not clear, are we dividing our minutes up for that, like MDS or do we give them the full amount of time, some people say we give them the full amount of time…

RT2 Isn't the flow sheet just to record…

RT1: You have to put the minutes too…you do a check.

RT2: But then isn't it just to record what the nurses is going to put in MDS…

RT1: So do you divide it up…

RT2: Because she won't know right…

RT1: But again it's not clear the space, there is only one little space recreation therapists and then if there is more than one recreation therapist how do you squish all of your time in there so…

On top of the new record keeping expectations, there was concern about current expectations as well. The following quote, *…we are supposed to be spending 30 minutes outside…25% of our day outside of direct patient care, so how do you do that?,* demonstrates the frustration with the clinical expectations. This quote exemplifies the desire on the part of the recreation therapists to spend more time in direct patient care, as opposed to fulfilling the non-patient care requirements associated with daily practice in a clinical setting. The following quote, *…when you are doing so many of them, that after a while you just, your hand gets tired and you can only just do so much…* demonstrates how this clinical pressure transfers directly to the quality of documentation of patient care. For example, these pressures and time constraints can have an impact on daily practice and the desire to complete the required tasks. *…we are just going through the motions (documentation) because we are supposed to.*

The final quote to describe this theme points out the contradictory pulls the recreation therapists experience at SHSC, and exemplifies the challenges of practicing within a clinical setting.

Within the clinical setting, there are often pulls from various directions: Direct patient care vs. documentation and statistics, allowing the resident choice vs. getting the resident involved.

The following quote from the member check activity described above also demonstrates how the clinical expectations plays a role in the way the work day is scheduled and the emphasis placed on different practice requirements.

Pressures do weigh heavy on everyday practice…always evaluating how I am spending my time…should be spending my time. Can I dedicate time to non-patient care projects?

Other Professionals

The second sub-theme, which illustrates a further factor associated with the perceived pressures of a clinical setting, is termed *other professionals*. This theme centers around the concept that the beliefs and expectations of the other health professionals have an impact on both the confidence of the recreation therapists related to their documentation skills and the types of documentation the recreation therapists strive to produce. This may stem from the fact that the majority of the other professionals are trained and operate comfortably within the clinical setting following a medical model of practice. This excerpt from one of the focus groups demonstrates that the recreation therapists are often aware that the other professionals have certain expectations from their documentation of patient care and this expectation is often problem-focused.

-It's different though because when they get to you they want to know what they are doing, they don't want to know this other stuff… we don't care…
- They don't want to know the outcome, they want the process.

This quote illustrates a level of frustration about the difference between what the recreation therapists feel is important about their practice, and the perceptions and beliefs of the other allied professionals concerning the recreation therapy practice. This may lead to questioning the type documentation the recreation therapy practice should produce and perhaps the purpose of the recreation therapy documentation in general. Again, there is evidence of a pull between producing clinical medical based documentation, which is more familiar to most health care disciplines, or creating documentation towards the enhancement of the quality of life and the expression of the experiences of the residents.

This second quote from the focus group illustrates the frustration this recreation therapist has with the other professionals' control of team meetings which tends towards more clinical discussions as opposed to more patient focused discussion.

> *…once we do get into a dialogue everyone is like oh, come on let's get back to the…oh, as soon as we get to the information about the family or what ever, its like come on let's get back to it…it's incredible…like you don't even get a good flavour of the individual…you are getting off topic…*

As suggested, the theme, *pressures of a clinical setting*, is an over arching theme, which impacts all areas of practice. It is important to understand this theme, as it is intricately related to the following two themes -- *resident advocacy* and *confidence in quality documentation* -- which characterize the recreation therapists' daily practice. Ultimately, the pressures of the clinical setting and the overall environment, including social and cultural factors, in which the team practices impact the way they experience and produce documentation of patient care. The two themes resident advocacy and confidence in quality documentation will now be described. As these themes are

outlined, it is important to keep in mind the environment in which the recreation therapists practice, as was noted above.

4.2.2.2 Resident advocacy

From the focus group discussion it appeared that one of the most important roles of the recreation therapist is that of resident advocate. This advocacy is evident in various forms, but all are guided by the notion that the resident is a person and thus, should be viewed and treated in that manner. This is expressed in a number of ways by the recreation therapists on a daily basis, such as acknowledging and respecting the uniqueness of each resident, allowing the resident choice and autonomy and moving with the unique rhythms of the each resident. The following three sub themes – *influencing other professionals, advocating leisure and choice*, and *seeing the resident as a person* – are proposed to further illustrate this important role in the recreation therapy practice, and the various ways this role impacts the quality of life of the residents. This role is also important in the documentation process as it allows the recreation therapists the opportunity to document in a way that is faithful to the uniqueness of each resident.

Influencing other Professionals

The first sub-theme of resident advocacy is *influencing other professionals*. Though the recreation therapists feel that other health professionals have an impact on the way they produce their documentation, the team also feels that they can impact other professional's expectations and beliefs both through how they interact with the residents and the type of information they include in their documentation. The following excerpt shows that this recreation therapist believes that the role of the recreation therapist is to

show a "different" side of the resident to other professionals. This "different" side is often evident in leisure and recreation due to the unique structure of the experience.

> *...within the behaviour unit because some of the behaviours are triggered so much by personal nursing contact, we offered a different perspective that is actually positive, so I think that it is really important for the team to see the person in a good light, because I think that if we weren't there that may not necessarily be seen and realize what it is that is triggering the behaviour, that they do it all the time, but actually just something that more just being in the person's face...*

By showing this side of the resident, the other professionals may also begin to see the resident as a *person*, which can impact the way they are viewed and perhaps, as a result, the way in which they are cared for by those health care professionals.

> *...their care might be different as a result of that right? Because they're seeing a new side that you are showing, and they're going "oh", you know, and I think that part of it is another big thing.*

This recreation therapist sees her role as a positive model of how to interact with the resident. This quote illustrates the power of the actions of the recreation therapists, in terms of treating the residents like persons.

> *And I think that if there are things that we are doing it would just maybe...just follow through sometimes naturally for other members of the team, so if they are reading that on the chart and you say that it has worked for this reason, it might just...almost like modeling...*

The results of the member check activity shows that there is a great consensus about this subject. *Yes, yes, yes!...more person centered, a different picture for the team.* However, one of the recreation therapists noted the following: *agree, but feel it sometimes gets lost in a note in the chart, as opposed to verbalizing at rounds.*

Advocating Leisure and Choice

As leisure and recreation professionals the concepts of leisure and choice are very important to the recreation therapists at SHSC. Choice, specifically, is often limited upon entry into a long-term care residence or upon acquiring a disability or a physical or cognitive limitation. As a result, the team accepts and consciously strives to fulfill the role of *advocating leisure and choice* for the residents.

> *…it's also stating that it is their choice and that's okay cause a lot of nurses would say well you need to get him involved, if he's content, or she or whoever the resident is that's their choice, and then I think it's…again it's a judgment of someone else telling them what to do and they actually have rights, so I try to phrase it where they are coming from.*

The following two quotes illustrate that part of advocating for leisure and choice is to educate and explain to the other professionals the importance of choice for the residents.

> *...I think it really helps people to understand how residents can benefit and be involved…I think that we need to show people the value that it has for the residents that choose, and can be involved…*
>
> *...then to know how they are in the groups, and that they have chosen these groups, and that maybe I have tried this group, they've declined…*

The member check activity provided additional insight into the way the recreation therapists understand the role of leisure and choice advocates. They see the role as educator. *That's just education!* wrote one therapist, and another stated that *I agree…the importance of providing education to residents, family members and staff*.

Seeing the Resident as a Person

The recreation therapists' ability to *see the resident as persons*, and interact with them in that way is central to the practice of the recreation therapy team, which has adopted a guiding philosophy of patient focused care. The following quotes demonstrate the role recreation therapy documentation has in allowing the residents to be seen as persons by the other health care professionals.

> *I don't think that the other disciplines…like they are not very good at trying to see how the person is a person, as opposed to their medical person, or their physical person, so I think there is a lot to be learned for everyone to kind of pay attention to that.*
>
> *'Cause I think our notes and our experiences with the residents captures a completely different side or um…essence of them. It's much more positive.*

Further, the recreation therapist believes the ability to see the resident as a person is a skill often unique to the recreation therapy team. *I don't think they understand the person as a whole without having that piece (RT documentation) in there…*

The sub-theme of *seeing the resident as a person* is very closely linked to the other two sub themes of Resident Advocacy, that is, a*dvocating leisure and choice* and *influencing other professionals*. Without their ability to see the resident as a person, and their opportunity to interact with the resident as persons, they would be limited in their role to both advocate leisure and choice and influence other professionals. So the core of the recreation therapy department is their pride in promoting the residents' quality of life through seeing them as persons, and as a result promoting leisure and choice and influencing the other professionals which reflects their adoption of a patient focused philosophy.

4.2.2.3 Lack of Confidence in Documentation

The other significant sub-theme explaining the pressures of the clinical setting is *lack of confidence in documentation*. This theme illustrates the experiences and frustrations of the recreation therapy team around the documentation of patient care. Though most of the therapists acknowledge the importance of documentation in their daily practice, there is a level of unease over the process and expectations. This lack of confidence in documentation stems from various factors. The following three sub themes – *limited feedback, discomfort with quality indicators*, and *labeling the resident's experience* – illustrate some of the potential factors impacting the experiences of documentation for the recreation therapy team.

Limited Feedback

One of the factors put forth in the focus groups was that many of the recreation therapists felt that they received *limited feedback* on their personal documentation. During the focus groups, the recreation therapists explained that though they were given documentation framework and procedures (see introduction of the QIs outlined on p.11, chapter 1), they were not given any guidelines or support for implementing the new procedures into their documentation. As a result, when attempting to produce quality documentation, they were unsure if their documentation was at an adequate standard.

> *RT-I mean that's something that we sort of said we have these quarterly times when we do our documentation, and then someone reviews and then we never hear anything…*
> *???-Right…*
> *RT-So we don't know if we are on the right track.*

Due to this perceived lack of feedback, the recreation therapists expressed the sense that they did not had the opportunity to improve their documentation and as a result increase their confidence with this aspect of the recreation therapy practice.

> *…I am just doing every time, the same way I did it the first time, I don't know if it's been right or wrong, not even right or wrong but just wanting to improve on it, what's missing, or things…or the way that I have worded things, that is not correct.*

It was evident that the recreation team felt very strongly that there was a lack of feedback about the quality of their documentation. Further, many of the recreation therapists believed that there were a variety of ways to increase the feedback and improve the quality of recreation therapy documentation. For example, one therapist stated that *a method for evaluating documentation* and *to have examples of what a great (quarterly) note would look like* would be valuable to the quality of documentation. As well, it was stated that *opportunities to work with your colleagues re: documentation*" would allow them "*to get feedback, support or shar[e] info.* Clearly, the recreation therapy team was unsure, not only about the quality of their documentation, but also about how to improve their documentation. By allowing for more feedback, team work and a focus on improving documentation the recreation therapists felt that their confidence in and the quality of their documentation would improve.

Discomfort with Quality Indicators

A second contributing factor to the lack of confidence in documentation is described by the sub-theme, *discomfort with quality indicators*. As previously discussed in chapter 1, the QIs have been developed through an ongoing process of discussion and

analysis between the recreation therapists and the researchers through an action research process. At the time of the focus group, the evolution and understanding of the QIs by the recreation therapists was still at an initial stage. As a result, there was a level of discomfort with the QIs, which was evident in the focus groups. One of the aspects which lead to this unease is the language associated with the QIs. The following quote demonstrates some of the feelings towards this language.

> *Yeah it's finding the language and the flow, 'cause so much…so much of what we do is hard to capture, yeah…you know it sounds airy-fairy, it sounds very airy-fairy…*

A further possible reason for the a discomfort with the quality indicators may be that majority of the recreation therapists were not involved in the creation and evolution of the quality indicators. As a result they may not have seen the connection between the quality indicator language and their daily practice or the experiences of the residents.

As a result of the discomfort with the language, some of the recreation therapists have suggested that they may avoid using the specific language in their documentation.

> *And I find it easier to talk about the things that represent that, rather than saying…you know if you talk about how he is indicating "helping other's, rather than saying he's helping others, like that's easier for me to talk about than it is putting that language on.*

When the expectation is to use this language in the documentation, but the perception is that of discomfort towards the language, a lack of confidence in documentation is almost inevitable.

Labeling the Resident's Experience

The final sub-theme, *labeling the resident's experience*, refers to the fact that using the QI in the documentation often requires that the recreation therapist make a judgment on the experience of the resident. This requirement is due to the fact that many of the residents are not able to verbalize their leisure experiences, or if they are able verbalize often they do not refer specifically to the specific language associated with the quality indicators. As a result, the recreation therapists must, based on their professional judgment and the reactions of the residents, decide which of the quality indicators may have been experienced by that resident. The following quotes demonstrated a level of apprehension some of the therapists felt about this process.

> *…because often in cognitive support we are not really getting their perspective…*
>
> *…but they are also open to your own interpretation of what "believing in yourself" means, or…and being yourself and meeting others…*
>
> *I do find it difficult to incorporate the new quality indicators in, because then it's me making a judgment call on what they are getting from the program.*

Further, there is a fear that when making such a decision, a misjudgment may occur and the true experience of the resident may not be represented.

> *'Cause we might think that they come because it looks like they like to socialize and meet others, but that's not the real reason, so you sort of have to probe…*

Though this is an important aspect of documentation and part of the professional role of the recreation therapist some apprehension exists among some of the therapists.

The results of the member check activity shed more light on this topic. All of the comments made in the member check activity session substantiated this theme. However, all of these comments referred more to the fact that often the residents experience may be different from the therapists' perception of the experience, and that it is them doing the interpretation. This quote, *it is surprising what they are getting out of the experience* shows that this recreation therapist is aware that she may not always perceive the experience in the same way as the resident.

4.2.2.4 Where to from here?

The tentative model (Figure 2) illustrated the connection between the themes described above. One important aspect of this model is the presence of a potential "Disconnect?" which points to the dis-ease between the main themes of "Resident Advocacy" and "Lack of Confidence in Documentation". This is meant to demonstrate that although the recreation therapists expressed both of these ideas as captured in the above-mentioned themes, they seem to be at odds with each other. In many ways, these concerns were reminiscent of earlier action research[4] suggesting the possibility that the practitioners were operating in *two worlds*. For example, the theme *resident advocate* illustrates the practitioner/resident relationship, and the role of advocacy in promoting the quality of life of the residents.

However, there is a lack of confidence, on the part of some of the recreation therapists, in communicating this relationship in the documentation, due to unease with language and the pressures they experience from some of the other professionals to focus

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[4] See Cantwell (2000) and discussion that follows in section 4.2.3.

documentation on activity involvement opposed to the experience of participation. A further example of the apparent "disconnect" is that the recreation therapists are proud of the fact that their practice embodies the tenets of PFC; however, they are often uncomfortable with using patient focused language, in the form of the quality indicators in documentation to express those tenets and the experiences of the residents. As a result, determining if, in fact, there was a "*disconnect*" between the two conflicting themes (Resident Advocacy **and** Lack of Confidence in Documentation), and if there was, whether it could be bridged was an important action in the ongoing research process. This will be taken up further in the observation and reflection of the focus group analysis (Section 4.2.3)

4.2.3 Observation and Reflection on the Focus Group Analysis: The Two Worlds of the Recreation Therapists

As part of the action research cycle, a reflection on the findings of the focus group analysis was completed to ensure that the knowledge gained through this process could be integrated into the next phase of the hermeneutic dialogue and the ongoing research process. The following is a description of the relationship between the findings of this analysis and the previous research (Cantwell, 2000) on this topic.

The environment in which the recreation therapists practice has a large impact on the documentation process. For example, the characteristics of the environment influence the perception of the types of information that should be included in the documentation of patient-care. It also influences the relationship with, and understanding of the residents' experiences and how this should be expressed in documentation. And finally the

environment influences the amount of time available to complete the documentation task. All of these impact the overall quality of the documentation being produced.

Cantwell (2000) examined the experience of practicing within a patient-focused care philosophy on the cognitive support unit in A&VC at SHSC. The author described the experience of the recreation therapists as being divided into *two worlds*, the world of the resident and the world of the professional. Within the world of the resident, the recreation therapist, in accordance with the Parse's Theory of Human Becoming, moves with the rhythms of the resident and strives to understand the resident's reality. "The focus [in the world of the resident] is primarily on building and maintaining an authentic, caring relationship" (Cantwell, 2000, p. 104) with the resident. This reality may be at odds with the reality of the health care team, family members and volunteers. Within the world of the professional the recreation therapists must juggle different roles, such as relations with family members, volunteers and other professionals. The author concluded that the recreation therapists moved between the two different worlds as part of their professional requirements, and as a result they should strive to balance the two distinct roles as a part of their daily practice (Cantwell, 2000).

The experience of the *two worlds* also emerged out of the focus group discussions in this project, and seems to have an impact on the experience of documentation as well. By moving with the rhythm of the resident and experiencing the *world of the resident*, the recreation therapists have the opportunity to create unique and rich relationships with the residents. As a result of these relationships the recreation therapists gain meaningful and person-focused knowledge about the resident which can be incorporated into the documentation of patient care and allow for person-centered communication among the

other health care professionals. However, while performing in the *world of the professional*, the therapists experience the expectations of the other health care professionals, which also impacts the type of information included in the charts, such as the desire to know what the resident participates in, as opposed to their experience of that participation. On top of the experience of the *two worlds*, the clinical environment also dictates the amount of time possible to dedicate to the documentation process. As a result, tensions are created between the two worlds, and these tensions can have an impact on the therapists' confidence in their ability to produce quality documentation. Some specific tensions that arise include:

Table 2: Tensions between the world of the resident and the world of the professional

TENSIONS	
WORLD OF THE RESIDENT	WORLD OF THE PROFESSIONAL
The desire to produce in-depth and descriptive quarterly notes in the patient charts.	Time constraints and large patient loads which limit the amount of time available to dedicate to patient charts.
The desire to produce authentic quarterly notes to communicate the experience of the residents.	The desire to document using professional language grounded in practical and empirical research.
The desire to allow the residents voice be heard in the documentation.	The need to ensure that important professional impressions of the resident be communicated to the health care team.

4.2.3.1 Description of the Tensions and Resulting Disconnect

It is important to understand how the tensions between the *two worlds* impact the recreation therapy documentation process, as this deeper understanding has played a role in the eventual outcomes of this research project. The first tension, focused on the expectation of the clinical environment, has a significant impact on the perceived quality

of the recreation documentation and the experience of documentation. The time constraints and expectations often lead to negative feelings in regards to the process of documentation. Many of the therapists noted that they dreaded the documentation process because of the amount of time needed to complete the documentation and the deadlines they face. The therapists strive to produce meaningful, high quality documentation, but feel that the expectations and time constraints limit their ability to meet these goals.

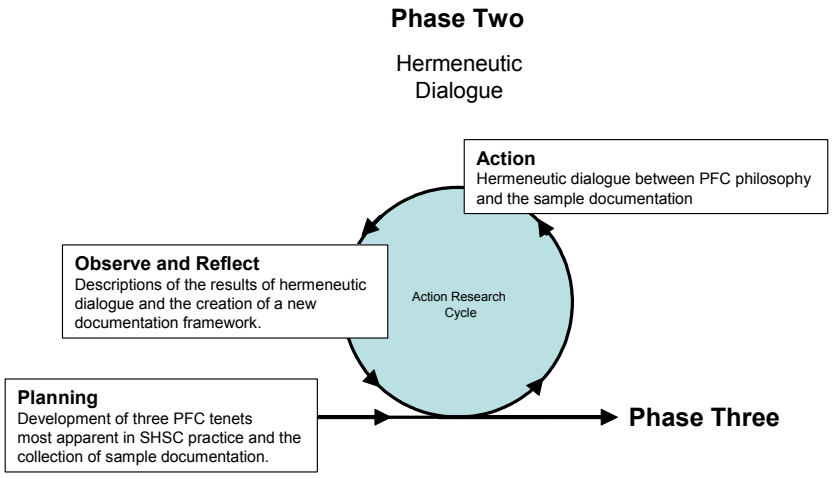
The second tension is focused on the language used in documentation. The therapists pride themselves on their professional status within the health care team, and feel that they have significant input on the care of the residents. As a result, the language that is used in documentation should reflect this professional standing. However, much of the experience the recreation therapists share with the resident, within their world, is meaningful and cannot always be communicated with standardized professional language. As a result, using language focused on quality of life and leisure experiences can leave the therapists feeling that they are not using language that meets their perceived professional status.

Finally, the third tension is related to the focus on patient-focused care, and patient-focused documentation. One important aspect of patient focused documentation, based on the theory of Human Becoming, is to allow for the voice of the patient to be heard in documentation, and not make assumptions about the resident's experience (Parse, 1999). However, it is also important for the therapist to communicate their professional impressions of the resident and information associated with their care to other members of the health care team. There is a concern among the recreation therapy

professionals that by including their interpretation of the resident's experience, they may be in danger of making assumptions about the experience of the resident, and as a result not be true to the voice of the resident.

These three tensions represent the potential "disconnect" between the *two worlds* of the recreation therapists. Though Cantwell (2000) concluded that the RTS are able to balance the roles associated with the two worlds in daily practice, there is a sense that the various roles meet in the documentation process, and the impact of both worlds needs to be negotiated, not balanced in order to meet all of the needs of the documentation process. The tensions give more insights into the sense of "disconnect", which is part of the emergent model (Figure 2, p.51) and as a result may play a role in determining how to negotiate the various roles present in the two worlds. This process of negotiation will create enhanced quality of recreation therapy documentation and the recreation therapists' confidence to produce documentation that meets their professional standards.

Section 4.3: The Hermeneutic Dialogue



The second phase in the hermeneutic framework guiding this research project is the hermeneutic dialogue. The following section will describe the process undertaken in this phase. The stages of the action research cycle were also incorporated into this phase and will be described. A hermeneutic dialogue is based on the concept of the hermeneutic circle, which is "a process of analysis in which interpreters seek the historical and social dynamics that shape textual interpretations" (Kincheloe & McLaren, 2000, p.286). Engaging in analysis through the hermeneutic circle "allows the researched to engage in the back and forth of studying the parts in relation to the whole and the whole in relation to the parts" (p.286). It is important to note that the purpose of the hermeneutic dialogue or circle is not to develop a final interpretation of the given phenomenon, but a continual engagement of all the forces on the interpretation of the phenomenon in question (Kincheloe & McLaren, 2000).

4.3.1 Action: Planning and Implementation of the Hermeneutic Dialogue

Much of the research focused on documentation and PFC has been centered in the medical and nursing communities. I was not able to trace any published research on documentation and patient focused care within the field of therapeutic recreation. However, by examining the philosophy of PFC and from the standpoint of the Theory of Human Becoming (Parse, 1996, 1998), it is possible to determine if the traditional recreation therapy documentation reflects these philosophies. A hermeneutic dialogue will lead to a greater understanding of the relationship between the current documentation framework and patient-focused care.

In this specific study the hermeneutic dialogue occurred between the sample documentation based on the current documentation framework being used in the recreation therapy practice and the PFC philosophy, which guides the recreation therapy practice at SHSC. Samples of documentation completed by the recreation therapists were used as a source of data in this study. All of the recreation therapists were asked to submit four pieces of documentation they had written in patient charts. The following was the description of the four sample documentation texts requested from each of the recreation therapists:

1. One quarterly note that he or she thinks is well written, and reflects the progress of the resident.
2. One quarterly note that he or she thinks could be improved, or that he or she had difficulty writing.
3. One other quarterly note (perhaps one he or she think reflects the types of notes typically written).
4. One "Personal Leisure Profile" summary.

Dividing the samples of documentation into the above-mentioned categories allowed for greater analysis of the type of language that the co-researchers believed effectively reflected the opportunities and experiences in recreation therapy and leisure. It also encouraged the co-researchers to provide sample documentation that they felt could be improved, without feeling conscious of the reaction to that piece of documentation. The majority of the documentation is hand written, and photocopied directly from the resident charts. The documentation was transcribed and resident names were excluded from the documentation.

The other forces involved in the dialogue included my pre-understandings of the documentation process and the environmental and social influences of the organization in which the study was being completed (Karkkainen & Eriksson, 2004a).

The two main research questions guiding this phase of the research were:

1. What language is currently being used in resident's charts?
2. Is this language congruent with a patient focused experience for the residents?

The main goal of the hermeneutic dialogue was to reveal how closely aligned the current documentation framework and the corresponding quarterly chart notes are to the tenets of PFC guiding the practice at SHSC, as well as to begin to understand the aspects of PFC and the experience of the residents which may not be communicated within the current documentation framework. This allowed for a start to the establishment of a novel understanding of the basis for documentation of recreation therapy and leisure experiences.

Much of the literature influencing the understanding of PFC at SHSC (Cantwell, 2000; Parse, 1996) was used to provide insight into the cultural, social and environmental influences on the documentation of patient care. In order to frame the hermeneutic dialogue, I outlined three important tenets of patient-focused care. As principal researcher, I created and identified these three tenets as being most apparent in the patient focused philosophy as it is practiced by the recreation therapy at SHSC. These three tenets were created based on various explanations of PFC and the literature exploring the form of PFC implemented at SHSC. The tenets were used to determine the extent that PFC philosophy is expressed in the documentation of patient care, as follows:

1. A focus on the resident's needs, goals and concerns is vital to the incorporation of PFC into practice and in documentation.
2. The ability to create meaningful relationship and being present with the resident leads to increased PFC.
3. Seeing the resident as the expert in their care and allowing the resident to play a role in all aspects of care increases the likelihood of care being provided which meets the individual needs of the resident.

4.3.2 Reflection and Observation of the Hermeneutic Dialogue

This hermeneutic dialogue guided by the three above-mentioned tenets led to a greater understanding of the relationship between the documentation framework and PFC. The specific outcomes from the hermeneutic dialogue will now be discussed. The first is in relation to the inclusion of the resident's perspective in the quarterly chart note. Though the current documentation framework calls for a description of the resident's perspective (component 4 of the current documentation framework), it does not elaborate on how the perspective should be expressed and the important aspects of the resident's experience. The analysis of the sample documentation demonstrated that often this

component (resident's perspective) is focused on the resident's evaluation of Recreation Therapy programs as opposed to an expression of personal experiences within leisure and recreation for that specific resident.

> *Resident stated that "he is content with his present level of involvement in Recreation Therapy programs".*
>
> *Resident stated "that is the best lunch that I've had in a long time"*

As a result, the resident's perspective may be more focused on an evaluation of the recreation therapy practice than on the resident's actual experience of participating in leisure and recreation opportunities. Since one important component of PFC is that the voice of the resident be expressed, this particular aspect of the current documentation framework may move away from the goals of patient-focused care. The documentation of patient care seems to be more concerned with the evaluation of the recreation therapy programs and less concerned with the personal insights on the experience of leisure and recreation participation.

A second potential disconnection between the documentation framework and the tenets of PFC is that the current framework does not allow for the needs or concerns of the resident to be expressed in the quarterly notes, as the current framework focuses very narrowly on the recreation therapy outcomes. Though this is an important component of documentation in recreation therapy, to be truly patient focused, there is a need to have a greater focus on the resident as a *person* and his or her needs and concerns. This information can then be applied to the understanding of leisure and recreation experiences.

A final issue, which emerged from the hermeneutic dialogue is that of choice. An important tenet of PFC is that the resident plays an important role in the delivery of, and participates in his or her care. The sample notes that were included in the dialogue expressed very little about how the residents were given a choice of participation or non-participation. This important component of PFC was lacking in the current documentation framework.

When interpreting the documentation framework and the sample documentation within the hermeneutic dialogue, it is important to also consider the historical background of the field of recreation therapy. This background is discussed in Chapter 1 of this thesis. In essence, much of recreation therapy is based on problem focused, goal oriented procedures as opposed to a PFC philosophy. In addition to the historical influences on the field of recreation therapy, there are also more local organizational influences. For example, Therapeutic Recreation Ontario's (TRO) (the governing body of Therapeutic Recreation in Ontario) documentation guidelines are goal-oriented. And the recreation therapy practice at SHSC integrated the TRO documentation guidelines into the creation of the current documentation framework. As a result, it is geared towards problem-based recreation and leisure programs and the outcomes of participation.

However, the recreation therapy practice at SHSC has moved away from this type of practice to a practice guided by patient-focused care. It is therefore not surprising that the current framework may not fully address and communicate the three above-described tenets of PFC. The historical, and as a result educational, influences on the recreation therapy practitioners combined with the goal-oriented characteristics of the current framework may play a role in the lack of patient-focused language used in

documentation. The unease with PFC language that the research participants/co-researchers expressed in the focus groups may also be linked to these historic and educational influences as well. Together, these factors have lead to the current documentation framework and substance of the documentation being produced by the recreation therapy practice at SHSC.

The interpretation of the current documentation framework points to the fact that some important aspects of patient focused care may not be communicated in the current documentation framework. As a result of the current interpretation of the recreation therapy documentation framework, and the knowledge created in the previous phases of this research project, a new documentation framework was developed. To ensure this framework would be practical for the recreation therapy practice, a documentation committee of recreation therapists was created to provide insight into the creation of a new documentation framework. The first step of the creation of this framework was an exploration of the current framework to determine which aspects of this framework were useful to the recreation therapists. It was found that is was helpful to have a list of components to guide their documentation. As a result the current framework was adapted to reflect a more patient-focused practice as opposed to an outcome oriented practice. One such example is the change from "treatment goal" in the current framework to "Leisure and Recreation participation" in the mew framework. Upon discussion with the documentation committee and other recreation therapists the framework was adapted and reworked based on their input. The outcome of this process is a new documentation framework for the recreation therapy practice, as presented in Figure 3 on page 77.

Figure 3: Recreation Therapy Documentation Framework

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Quarterly Note Components:

1. **Leisure and recreation participation**: types of interactions the resident has chosen to be involved in.

2. **Resident's perspective**: direct quotes, information from conversations, feedback from resident.

3. **Resident's hopes, concerns and goals:** and how recreation therapy can play a role.

4. **Impression of resident's experience:** ***Quality indicators***, prompts, other experiences, observed behaviours. This is where the therapist has the opportunity to share their professional impressions of the resident and their leisure and recreation experiences.

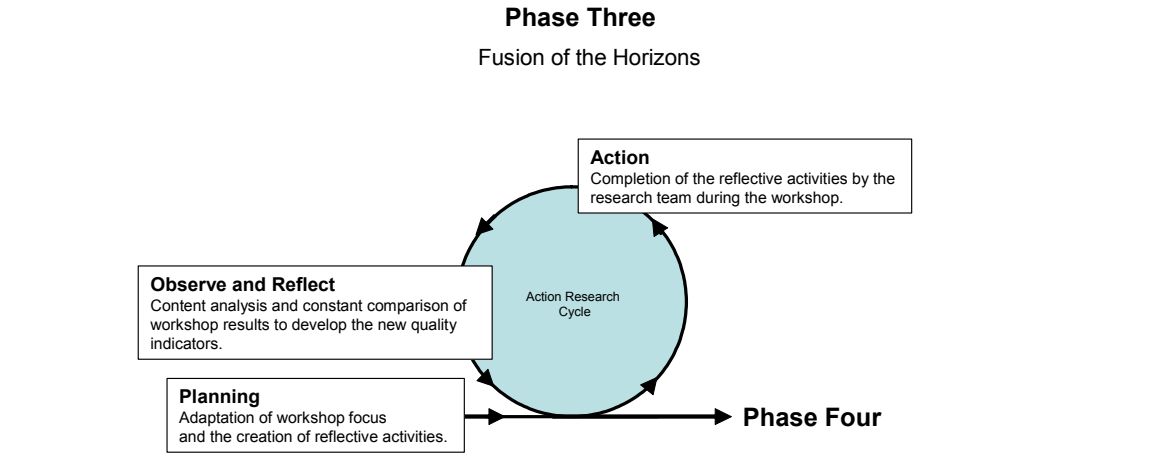
5. **Upcoming leisure and recreation opportunities**: new programs, continue with old activities.

6. **Overall observations of the resident:** person-centered, things you have learned through interactions with the resident (positive ways to interact/ environments for the residents).

* Attempt to include all components in each quarterly note; however some of the components may not be applicable to all residents

This new documentation framework now provides the recreation therapy discipline a framework to guide their documentation. However, it was clear from the focus group sessions completed in the *analysis of preunderstanding phase*, that an important concern for the recreation therapists was the ability to express "the resident's experience" in the quarterly notes. As a result the next hermeneutic phase, *fusion of horizons*, will focus on the discovery of language to express the experiences of the residents. The following section is a description of the process of developing this language.

Section 4.4 Fusion of the Horizon



The purpose of the third phase of this hermeneutic project, *the fusion of the horizon,* was to allow the various horizons (standpoints) of the co-researchers to come together. The two research questions suggested to guide this phase of the research were as follows:

1) What aspects of the recreation therapy and leisure experiences are important to include in the documentation and communication of recreation therapy?

2) What is perceived by the research team to be the most effective approach to communicating/documenting the experiences of the residents in recreation therapy and leisure within a PFC context?

The planning and implementation of this hermeneutic phase was strongly guided by the knowledge gained through the collection and reflection of the data from the previous two research phases (analysis of pre-understanding and the hermeneutic dialogue). Prior to the commencement of the project, it was envisaged that this phase was to take the form of a workshop focused on the creation of a documentation

framework. It was to examine which aspects of the recreation therapy process were most important to the documentation process, and the best way to integrate this information into a documentation framework. However, the two previous phases pointed to some issues surrounding the language (specifically the use of the patient focused laguage), and the manner in which this language was to be incorporated into the documentation process. As discussed in the focus group results section (Section 4.2.2, p.50) there was unease with the use of patient-focused language and its perceived level of professionalism. Further, upon the completion of the analysis of the sample documentation, it was clear that there was little application of the quality indicator language occurring in the documentation produced by the recreation therapists.

A further issue regarding the language used in documentation arose in the previous research phase, as to whether the "interpretation" of the experience of the residents, and specifically the type of language that could be used to ensure the experiences of the residents, were authentically represented in the quarterly notes. This new understanding of the importance of, and the unease with the language in documentation led to a revision of the objective for the workshop. As a result the new purpose of this third phase of the hermeneutic framework was to address these issues, and develop language that would lead to more patient-focused language being used in documentation. This phase then took the form of a research workshop including all of the recreation therapists as co-researchers.

4.4.1 Planning Stage of Fusion of the Horizons Workshop

The planning stage in the action research process was heavily influenced by the knowledge created in the observation and reflection stages undertaken in the previous phase of this hermeneutic project. As a result of the new knowledge, I designed the workshop session to focus principally on language, specifically on the Quality Indicators (QIs), as opposed to trying to both explore the QIs and the documentation process. It was my intention, in accordance with the purpose of this hermeneutic phase, to allow the various understandings (of the individual participants) of the quality indicators to come together, and explore how the quality indicators represented the experiences of the diverse resident population. This process led to the creation of a new collective understanding of the quality indicators among the recreation therapists.

Two activities were developed to encourage a new collective understanding of the quality indicators from the different perspectives of the recreation therapists. The activities were adapted from a model of reflection in clinical practice outlined by Driscoll & Teh (2001). The model, called *The What? Model of Structured Reflection*, is intended to offer "a meaningful exploration of events in clinical practice" (p.99). See Appendix 4 for a detailed description of the workshop activities. The goal of the workshop activities was to encourage the practitioners to make links between their daily practice, specifically their interactions with the residents, and their understanding of the meanings of the current quality indicators. The use of this model of reflection was helpful in encouraging participation and input from all members of the research team, which is critical to successful implementation of an action research project.

4.4.2 Implementation Stage of the Fusion of the Horizons Workshop

During the workshop the participants completed the activities in small groups. Upon completion of the activities, the individual groups were asked to share the work they had completed. To continue the process of *the fusion of the horizons* the other participants were asked to comment on the presentation and share their insights with the whole group. The data collected through these activities was very valuable in the development of a new understanding of the meaning of the quality indicators. Most valuable was the fact that all of the information came directly from the recreation therapists, through direct reflections of the clinical experiences with the residents.

4.4.3 Observation and Reflection of the Fusion of Horizons Workshop Results

The workshop activities resulted in a substantial amount of information. This information was focused on the meaning of the quality indicators from the perspective of the recreation therapists. To ensure the specific language used by the recreation therapists in the workshop activities was conserved and integrated directly into the collective meanings of the QI's, a content analysis process was performed.

As the lead researcher, I compiled the results of the workshop activities, all of the data outlining the evolution of the quality indicators and a wide variety of research focused on the experience of leisure and long term care. I highlighted key descriptor language from all of the above-mentioned sources, and listed the key words most often used to describe the ideas contained in the individual quality indicators. Various sensitizing concepts were also incorporated into this analysis process to ensure that

certain concepts were included in the lists of key descriptor language. A list of prompts/probes for each of the Quality Indicators emerged from the content analysis described above. In addition to creating the list of prompts and probes associated with the quality indicators, I also deleted, added and renamed some of the quality indicators based on the feedback and results of the workshop activities. One specific example of a change to the quality indicator list was the addition of "Enjoyment" as one of the quality indicators to express an important aspect of leisure and recreation in long term care.

The following is a description of the new quality indicators as well as a table listing the prompts and probes. A short description of the current research based on the concept of community in long-term care is included to provide a background into the community based concepts behind the meaning of the quality indicators. This information has been included to ensure that the basis for the creation of the quality indicators is well understood.

4.5 Community in Long Term Care/ Community Model of Care

The premise of much of the programming created and implemented by the recreation therapists, and the understanding of the experience of the residents is based on the idea that a sense of community exists in the A&VC program at SHSC. This notion was born out of the secondary analysis of the data collected by Cantwell (2000) outlined in Chapter 1, which found that aspects of community were very present in the experiences of residents living on the cognitive support unit in A&VC at SHSC.

Though not extensively examined in the current literature, the notion of community in long-term care has been supported by McAllister & Silverman (1999). Most of the research focused on the topic of life in long term care has examined negative

aspects of the experience (McAllister & Silverman, 1999) and as a result we may be unaware that a sense of community may exist in long-term care facilities. In a comparison of two different long term care facilities, one a Residential Alzheimer's Facility and the other a traditional nursing home, the McAllister & Silverman (1999) study found that with the right environments and supports community can certainly exist in a long-term care facility. The authors note that the main facilitators to community in long-term care include staffing, institutional philosophy and programming. The concept of programming facilitating community is especially resonant, in terms of recreation therapy. The authors found that "activities that were frequent, diverse and prolonged enough to allow residents truly to become engaged" (p.80) were helpful in the creation of community. A further key factor seems to be the availability of more intimate activities with smaller groups. These types of association allow for more intimate social interactions between the other residents and with the staff. However, according to the authors the most important factor contributing to a sense of community is the ability to provide choice to the residents about the level and type of activities in which they participate.

Thus, considered together, the secondary analysis of the earlier research conducted by Cantwell at SHSC in the CSU, which produced the "Starfish Model" (see chapter 1, p. 11), and the study by McAllister & Silverman (1999) support the proposition that community can exist in long-term care. More importantly, they demonstrate that the types and variety of recreation and leisure opportunities available to the residents play a substantial role in the creation, maintenance and enhancement of community in a long-term care setting. The recreation therapists are cognizant of this

fact, and as a result base many of their programs on the quality indicators, which as indicated above, through ongoing research initiatives, are linked to the experience of community in long-term care for the residents.

An important process in ensuring that a sense of community is being created and maintained by the recreation therapy profession, as well as ensuring that the experiences of the residents are being authentically communicated, is an ongoing development of the Quality Indicators. As noted earlier, the quality indicators were originally developed to guide the creation and implementation of the recreation therapy practice, and have also been integrated into the documentation process. As a part of the third phase of this project, a deeper, more complete understanding of each of the QIs has been established through the completion of the documentation workshop, which allowed for the *fusion of the horizons* of the recreation therapy team. This fusion has lead to the creation of a new and communal understanding of the QIs. To add further strength to the quality indicators, I provided support and empirical evidence from academic literature to each of the quality indicators. The following is a description of each of the quality indicators, including substantiating evidence from literature focused on leisure, aging and long-term care.

4.6 Description of the Quality Indicators

Enjoyment*: Experiencing a sense of enjoyment during leisure is associated with feelings of achievement and growth, and can lead to many other personal and group benefits. Participation in meaningful leisure and recreation activities often leads to a sense of enjoyment. By giving residents choice and providing a wide variety of leisure and recreation interactions residents have the opportunity to discover and participate in personally meaningful opportunities.*

The experience of enjoyment is a vital component of leisure. Cantwell (2000) found that enjoyment was very important to the residents living on the cognitive support unit at Sunnybrook, and it was often participation in meaningful leisure activities which lead to a sense of enjoyment for the residents. Mannell & Kleiber (1997) define enjoyment, within the context of leisure, as a combination of pleasure and a sense of accomplishment or forward movement. In other words, a sense of enjoyment is more than simple contentment; it involves a sense of achievement and growth. In various studies discussing the meaning of leisure, it is often stated that pleasure, relaxation and fun are important characteristics of leisure. Mannell & Kleiber (1997) state that "leisure pursuits that become personally meaningful and that provide psychological benefits are inevitably structured or organized in ways that provide opportunities for fun and pleasure and are part of the ongoing experience" (p.87). It is therefore critical for leisure experiences to be meaningful to the resident if this sense of enjoyment is to be achieved.

Meeting Others (Being with Others): *The opportunity for social connections is beneficial to well-being and quality of life. Recreation Therapy group opportunities provide residents with the opportunity to develop friendships, meet others or experience companionship.*

There are a variety of studies demonstrating the positive benefits of social interactions for older adults (Glass, Mendes de Leon, Marottoli & Berkman, 1999; Wang, Karp, Winbald & Fragitoli, 2002; Zunzunegui, Alvarado, el Serr & Otero, 2003). However it is important to provide a description of what social interaction and *meeting others* means to older adults, and especially those with dementia or other cognitive declines. In a qualitative ethnography of the experience of clients at a day center for

older adults with dementia, Williams and Roberts (1995) describe a variety of social interactions, which range from friendships to general socializing to companionship. Each of these social interaction patterns differ in the amount of verbal and non-verbal communication present, but are all equally as important in terms of the social benefits associated with the relationship. Further, Kitwood (1997) in his description of the experience of care for older adults with dementia explains that social relationships for this population are simply about being in the presence of others. In the CSU at SHSC, the importance of companionship has also been observed. Cantwell (2000) found that "simple companionship also appeared to be of importance to the residents" (p.454).

The social aspect of the leisure and recreation opportunities in the A&VC program is a clear motivating factor for participation by the residents living in the A&VC program. According to Cantwell (2000), in her analysis of the leisure experiences in A&VC at Sunnybrook, there were limited opportunity for social interactions in the daily routine of the residents and it was uniquely the group activities provided by the recreation therapists which allowed for social interactions among the residents.

Helping others: *Helping others gives residents a sense of purpose and a role to fill. Involvement in recreation therapy opportunities allows residents to help others in a variety of ways, ranging from simple gestures of helping to formal volunteering activities.*

The ability to help, or be helpful has been seen to be linked to quality of life and quality of health in older adults living in long term care institutions (Guse & Masear, 1999). In an investigation of the experience of life in an Alzheimer's facility, McAllister and Silverman (1999) designated "helper" to be an important community-based role in the facility. Examples of the helping behaviours include "assisting each other in getting

dressed, going to bed, finding one's way throughout the facility, or discussing personal concerns and worries" (p.73). This opportunity to help may be even more meaningful to the residents, because as residents in long term care they are often the "receiver" of help by the staff at the institution in which they are living (Williams & Roberts, 1995). Formal acts of volunteering have also been shown to have positive effects on the well-being of older adults (Morrow-Howell, Hinterlong, Rozario and Tang, 2003).

The opportunity to help others is often available to the residents during recreation and leisure experiences at Sunnybrook. Such opportunities can range from small informal gestures to more structured volunteer experiences, all of which have been observed to be important to the well-being and quality of life of the residents. According to Sullivan (2002) helping other residents leads to "a sense of purpose and a role to fill" (p.454). By helping others, in various ways, the resident has the opportunity to contribute to the well-being of the whole and in the creation of community, as well as fulfill various roles in their own life.

Being Yourself (believing in yourself): *A sense of identity and self-worth, which may be decreased upon entry into long-term care, can be enhanced through participation in leisure and recreation. In Recreation Therapy, residents are given the opportunity to choose recreation and leisure opportunities that affirm their personal sense of self.*

Self-affirmation refers to a process whereby individuals strive to affirm or validate cognitive self-images that they deem to be desirable, that is images consistent with those embodied by their ideal self (Haggard & Williams, 1992). At SHSC, in the A&VC program, the residents are given the opportunity for self affirmation, by being provided with the opportunity to choose the recreation therapy programs in which they

wish to participate. The opportunity to choose allows the residents to affirm their personal self-images, without being pressured to participate in activities which may be inconsistent with their personal view of self.

A further aspect of *being yourself* is the opportunity to maintain consistent roles throughout the life span. McAllister and Silverman (1999) found that many of the residents of the Alzheimer's facility played caring roles, such as gardening, working on crafts and helping staff organize events. And upon further examination it was found that "these activities are related to such background factors as the earlier family, work, and community roles" (p.74). Leisure can "affirm one's identity and reinforce valued aspects of one's previous life" (Kleiber, Hutchinson & Williams, 2002, p.228) and in the face of change, such as moving into a long-term care facility, leisure can maintain some sense of continuity (Kleiber, 1999).

Though the continuation of roles over the lifespan is a contributing factor to identity and personhood maintenance, life experiences such as moving into a long term care facility or acquiring a mental or physical illness or injury may impact the ability to continue with previous life roles. Leisure can facilitate the (re)development of interests and the securing of valued life roles (Pedlar, Dupuis, & Gilbert, 1996). Kleiber et al., (2002), use the term "restorying" (p.228) to describe the potential to create a new and unimagined life-story and new life roles. Leisure can lead to the creation of new meaning in life by discovering and participating in new leisure interests. In general, the ability of the residents to make choices and fulfill important personal roles occurs during participation in leisure and recreation experiences at SHSC.

Feeling like you belong: *Feeling part of a community is associated with a greater quality of life. Recreation Therapy enhances the sense of community, and belonging by inviting residents to participate in community events.*

Sense of belonging has not been extensively examined in older adults, but in limited studies it has been shown to be related to dimensions of psychological well-being, such as lower levels of depression, loneliness, and anxiety (Bailey & McLaren, 2005). Therefore, a sense of belonging seems to be an important concept associated with quality of life and well-being in older adults. Sense of belonging is a complicated and comprehensive concept, which must take into account many different aspects of the person and their environment. Renwick, Brown and Nagler (1996) describes belonging in terms of "how environments and others fit with the person" (p.83) which can be divided into physical belonging, social belonging and community belonging. Physical belonging refers to feeling connected to one's physical space, including the sense of privacy and safety. Social belonging refers to the existence of meaningful relationships. Community belonging "embodies the connections people have with resources available to members of a community" (p.84) such as educational and educational programs, and community events and activities.

The sense of place at A&VC can enhance feelings of belonging for the residents. As noted in the study of the experience of leisure in the CSU, Cantwell (2000) found that the residents' viewed their rooms as their homes and the unit as a neighbourhood. This perception leads to the view of the facility as a community. Further, leisure and recreation opportunities played a role in developing the sense of place and community. For example, meal clubs and special events were seen as social gatherings in the

neighbourhood, and the residents took pride in being invited to the events by the recreation therapists (Cantwell, 2000).

Developing Yourself *The opportunity to develop new skills and knowledge can have positive impact on quality of life in later life. The recreation therapy department offers many opportunities for personal and group development such as lecture series, group activities and creative expression.*

The ability to learn, develop new skills or acquire new knowledge is often thought to decrease with aging. As physical and cognitive abilities begin to decline with aging, it has often been assumed that older adults lose the ability to use other skills and enhance their abilities. Many studies, however, have shown that maintaining the use of cognitive skills, and developing new skills may help decrease declines in cognitive abilities (Voelkl, Galecki, & Fries, 1996).

Developing new skills and knowledge may also be associated with maintaining or enhancing quality of life. The center for Health Promotion has developed an approach for enhancing Quality of Life. One component deemed necessary for quality of life is "becoming", which is defined as "what [a] person does to achieve hopes, goals and aspirations" (Renwick et al. 1996, p. 82). Renwick et al. (1996) specify two types of becoming: Leisure becoming and Growth becoming. Leisure becoming promotes relaxation, stress reduction and re-creation in individuals' lives. Growth becoming refers to activities that allow for the "development of skills and knowledge, whether this involves formal or informal education" (p. 84). Both of these types of *becoming* are available in recreation therapy experiences such as the speaker series, language classes, musical concerts and religious groups.

4.6.1 Using the Quality Indicators in Documentation

Since the documentation process is the main focus of this research project, it was also important to develop a better understanding of the process of integrating the quality indicators into recreation therapy documentation. It was felt that developing a list of prompts and probes associated with each Quality Indicator would provide the therapists with a guide as to whether or not, and which quality indicator was being experienced by the resident. The list of prompts/probes associated with each of the quality indicators is not an exhaustive list, but its intent was to provide the therapists with a starting point for using the quality indicators to communicate the experiences of the residents. Table 3 is a list of the prompts and probes associated with each Quality Indicator.

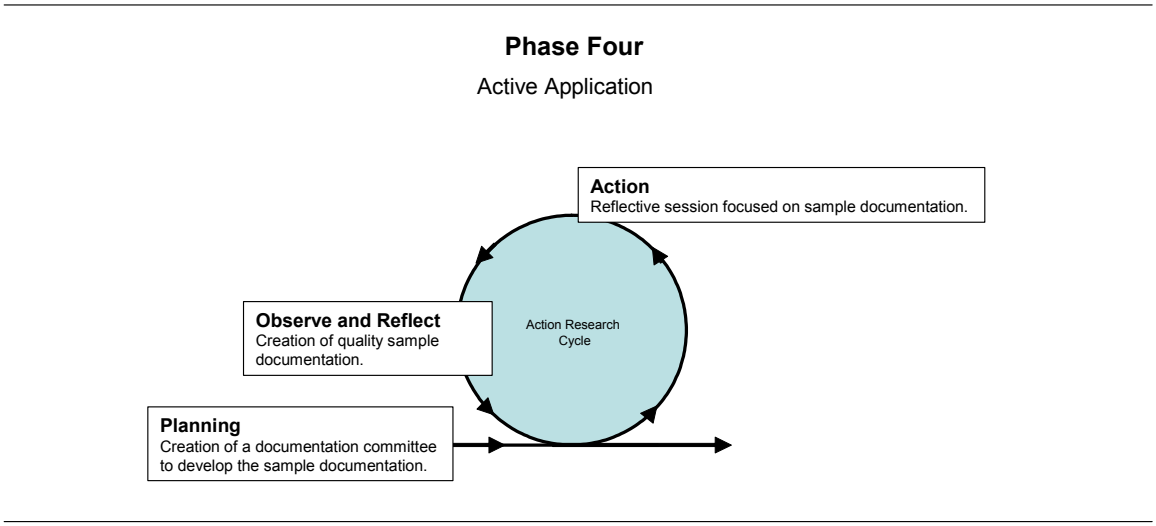
Table 3 Quality Indicator Prompts and Probes

Quality Indicators	Prompts/Probes	Quality Indicator	Prompts/Probes
Enjoyment	• Happiness/Joy • Evidence of pleasure • Escape • Comfort	**Feeling Like You Belong (sense of place)**	• Mutual Respect • Vested interest in community/group • Engagement • Friendship • Sense of contribution • Common heritage/experience
Meeting Others (enlivening relationships)	• Developing relationships • Connecting • Sharing and asking • Reminiscing • Conversation • Being in a group • Companionship	**Developing Yourself (self-development)**	• Developing a new skill • Increased confidence • Acquiring new knowledge • Sense of achievement • Expressions of pride • Meaningful activities
Helping Others (contributing to the well-being of the whole)	• Supporting others • Assisting • Being useful • Advocating • Using a skill • Lending a hand • Volunteering • Chivalry	**Being Yourself**	• Sharing • Expressing a point of view • Desire to continue activity • Expressing choice • Being recognized • Confidence in a skill • Fulfilling old roles • Finding a new role

The quality indicators described above have evolved through an extensive process of analysis, discussion, and research by members of the University of Waterloo, Recreation and Leisure Studies academic community and the recreation therapists at SHSC. The above descriptions of the newly adapted quality indicators and the prompts/probes associated with each will be incorporated into the daily practice and documentation of recreation therapy. The role of the quality indicators will be to ensure that programs and recreation and leisure interactions are developed and implemented to

meet the general needs of the A&VC community. The quality indicators will also play a large role in interpreting, understanding and communicating the experiences of the residents in leisure and recreation opportunities. As will be discussed in Phase Four, Active Application, the QIs as explicated above provided the practice with an opportunity to proceed with the creation of sample quality documentation and determine whether they would be able to move beyond the "disconnect" identified in analysis of the focus group findings.

Section 4.5 Active Application



The purpose of this final phase of the hermeneutic process, *active application*, is for the co-researchers to apply to the research task the messages contained in the texts. In this research project, the message contained within the text included the results of analysis and reflection on the various data collected in the prior three hermeneutic phases, including the focus group results, the sample documentation and the outcomes of the documentation workshop. The research task in this project is the development of quality sample documentation for the recreation therapy practice. These sample documentation notes will attempt to authentically represent the experiences of the residents in the A&VC units of SHSC. They were developed for use by the recreation therapy practitioners to guide their own personal documentation practices.

4.5.1 Planning and Implementation of Active Application Session

It was clear from the focus groups, and comments made by the recreation therapists during the workshop, that having examples of "quality documentation" would be helpful to their own creation of quality documentation. For example, one therapist stated:

> *I think that it would be nice [if] we could just a get a couple of ideal documentations that we could even look at and share and say hey you know this is what could be incorporated when you are doing your quarterlies documents, then you could add your creativity…*

The process used in this phase of the project was based on the concept of self-reflective practice (Schön, 1983). An open call was put out to all of the members of the recreation therapy department to participate in a smaller group, with the goal of developing sample documentation. Three recreation therapists volunteered to take part in the committee, and as a result, the committee was made up of the three recreation therapists, the recreation therapy practice's academic advisor and myself. During the *active application* meeting the recreation therapists were asked to share a profile of a resident in their caseload. As the recreation therapists discussed the resident, I took notes on the important information being shared. While discussing the resident, the therapists were probed with reflective questions to illicit meaningful information about the resident, which came directly from the clinical experiences of the therapists.

The reflective questions used were as follows:

1. Briefly describe your interaction with the resident.

2. What was the resident's reaction to this interaction (Direct quotes from the resident, observed behaviours…)?

3. What was your impression of this interaction?
    a. Can you associate any of the Quality Indicators with the interaction?
    b. What about this interaction do you associate with this (these) Quality Indictors?

4. What other information was discovered through this interaction?

4.5.2 Observation and Reflection of Active Application Session

Once the reflective conversations were completed, I created three sample quarterly chart notes from the information gathered during the active application session. By comparing this information and the documentation framework created as a result of the hermeneutic dialogue, sample notes were developed based on the patient-focused care philosophy. (Please refer to appendix 5 for the three sample quarterly chart notes).

Two significant discoveries were made as a result of the experience of the *active application* process. The first is the direct and multi-directional relationship between reflection on practice and documentation. This relationship will be discussed further in the concluding chapter. The second is the importance of language when incorporating the tenets of patient-focused care into the documentation of patient care.

As discussed, three important tenets of the patient care philosophy were created to guide the creation of the new documentation framework, as follows:

1. A focus on the resident's needs, goals and concerns is vital to the incorporation of PFC into practice and in documentation.

2. The ability to create meaningful relationship and being present with the resident leads to increased PFC.

3. Seeing the resident as the expert in their care and allowing the resident to play a role in all aspects of care increases the likelihood of care being provided which meets the individual needs of the resident.

The sample documentation based on the new documentation framework incorporates these tenets of PFC. By allowing for the resident's needs, concerns and goals an overall understanding of the resident's experience is captured. As well, the components which refer to the resident's perspective and overall observations of the resident provide an even more holistic view of that resident. The tenet focused on the meaningful relationships with the resident is communicated in the new documentation component (in the new documentation framework, see figure 3, p.77) allowing for the "impressions of the therapists". This component provides the opportunity for the therapists to express their professional impressions of the resident based on their unique experiences with the resident. Further, the freedom to incorporate overall observations of the resident gives the therapist the opportunity to express other important observations of the resident, which may allow other health care professionals to create meaningful relationships with the resident. By ensuring that the resident has made choices regarding participation, non-participation or interest in upcoming opportunities, this documentation framework provides evidence that the resident plays a role in the creation of their leisure lifestyle. It is the general agreement of the research/co-researchers that this documentation framework and the accompanying sample documentation allow the recreation therapists to better communicate their practice and the experience of the residents in a patient-focused framework inspired by the theory of human becoming.

Chapter Five: Conclusion

The process of completing this action research project has lead to a greater understanding of the documentation process in recreation therapy and a potential enhancement of the documentation process for the recreation therapy practice at SHSC. A negotiation of the meaning of the QIs, through a hermeneutic process, has allowed the recreation therapy practice to more fully understand, and incorporate the quality indicators into documentation. Patient-focused care guided by Parse's Theory of Human Becoming (Parse, 1996, 1998) was the guiding philosophy throughout the process of the research project and as a result this philosophy is now incorporated into the new recreation therapy documentation process at SHSC.

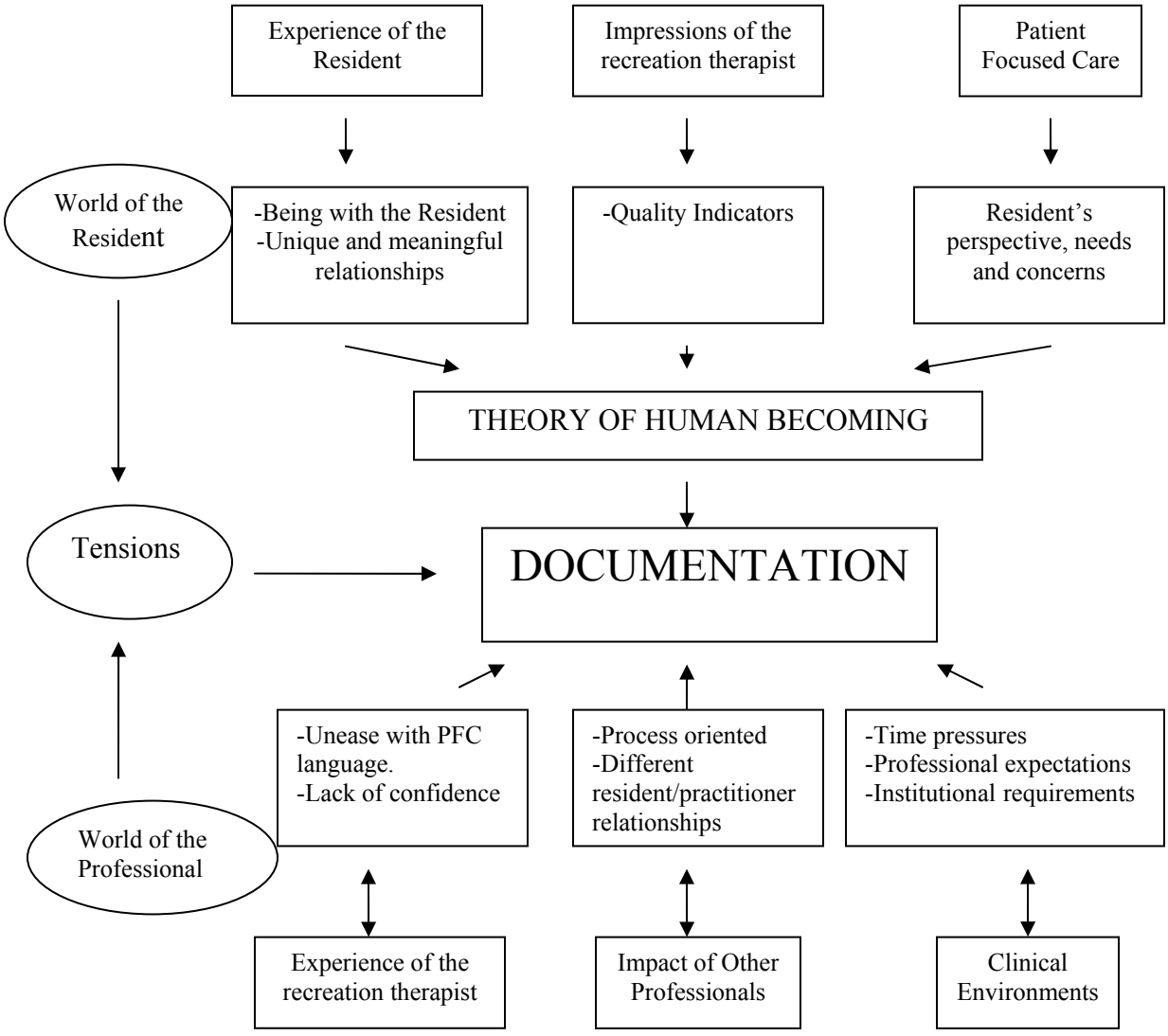
The overall goal of this project was also achieved, namely the creation of a documentation framework, based on the PFC model guided by Parse's Theory of Human Becoming. This documentation framework will more effectively communicate the recreation therapy experiences of residents to the other recreation therapy practitioners, and to other health care professionals at SHSC. In the course of this action research undertaking, two other objectives were achieved. The first objective was to develop an understanding of the RT practitioner's perception of the current documentation process at SHSC. The second objective was to explore how the experiences of the residents participating in RT and leisure opportunities can be documented in a way that is more consistent with PFC and better reflect the patient's experience. In achieving these objectives, a great deal of knowledge surrounding documentation and recreation therapy, specifically at SHSC, has been established. This knowledge was an integral part of the overall outcomes of the project.

As a result of the cumulative knowledge and understanding generated, our project has achieved two significant results. The first is the development of sample chart notes that can be used by the recreation therapists to guide the completion of the quarterly chart notes in the patient charts. The second is a deeper collective understanding of the meaning of the quality indicators in representing the experiences of the residents in recreation and leisure opportunities.

5.1 Two Worlds; One Documentation Framework

The experience of the *two worlds* (world of the resident and world of the professional) described by Cantwell (2000), which was again expressed in the focus groups in this research project, is a constant reality for the recreation therapists practicing at SHSC within the PFC philosophy. The current research project was concerned with the creation of a documentation framework, which would allow for the authentic and meaningful documentation of patient care in A&VC at SHSC. In order to create a framework that would meet the needs of the recreation therapy practice, components of both worlds were considered in this process. This consideration allowed for the environmental and social influences to be addressed, ensuring that the concerns and tensions (see Table 2, p.67) described throughout this research process were addressed in the creation of the documentation framework. The process of negotiating all of the aspects of practice towards a documentation framework is illustrated in Figure 2. This model illustrates the connections between all of these aspects of practice.

Figure 4 Two Worlds; One Documentation Framework



5.1.1 Description of the "Two Worlds; One Documentation Framework" Model

The following is a description of all of the different aspects of practice, from the two worlds, influencing the creation of the documentation framework, as well as its forthcoming implementation. Each of the different aspects of practice will be described and the connections to other considerations will also be explained. Within each of the worlds experienced by the recreation therapists, there are different aspects of practice that influence which components will be included in the documentation framework as well as the type of language used in the quarterly notes. The aspects of practice present in the world of the resident are: a) the experience of the resident, b) the impressions of the therapists and c) the patient-focused care philosophy. The understandings of these three aspects of practice have lead to the incorporation of specific components into the documentation framework. The specific components associated with each of the three aspects of practice outlined above are: (1) statements associated with "the experience of the resident" lead to the inclusion of information that expresses the experience of the resident from their standpoint and (2) statements associated with "impressions of the therapists", from the professional perspective of the therapist concerning the experience of the resident in leisure and recreation opportunities. And (3), the influence of the patient-focused care philosophy ensures inclusion of information about the resident as a person, beyond leisure and recreation experiences (Component 3: Resident's needs, goals, concerns and Component 6: Overall observations of the resident). These are important because all aspects of the resident's experience are important to the type of leisure in which they choose to engage and their experience of those leisure opportunities.

Each of these three aspects of practice is connected to, and promotes the importance of, the Theory of Human Becoming (Parse, 1998) in the daily practice of recreation therapists, and as a result, the documentation of recreation therapy at SHSC. There are three factors that have led to the significant role of Parse's Theory of Human Becoming to the recreation therapy practice. Firstly, the specific version of patient-focused care adopted by SHSC was heavily influenced by the thinking behind the theory of Human Becoming. Secondly, the experiences of the residents are better understood by the therapists due to their incorporation of the human becoming theory into their practice, specifically the therapist's ability to be with, and move with the rhythms of the resident. This ability has allowed for authentic and meaningful relationships to be created with the residents, which then leads to not only professional, but also meaningful impressions of the resident by the recreation therapist.

Finally, the creation and clarification of the quality indicators used to express these impressions, was heavily influenced by the theory of human becoming through various research initiatives and professional collaborations at SHSC. As a result the theory of human becoming has been incorporated by all of the three components of the world of the resident, and therefore has an important influence on documentation.

These are not the only influences on the final documentation framework. The world of the professional also played a role. The following is a description of the role of the world of the professional, and the initiatives incorporated into this research process to alleviate the concerns centered in the experience of the world of the professional.

In the world of the professional, three other aspects of practice influence the creation of the new documentation framework. Much of the experiences from the *world of the*

professional have lead to concerns about the documentation process. The first concern is with the patient-focused language, and practitioners' lack of confidence in their documentation skills. In order to alleviate these concerns, the language was addressed and clarified by grounding the language in examples directly from practice and from academic research on the topic. A more in-depth description of the quality indicators was produced with information gathered in this project to promote a higher level of comfort with the patient-focused language.

A second concern from the *world of the professional* is the influence of the other health care professionals in A&VC, and the type of information seen as being important to their clinical practices. The recreation therapists are influenced by this pressure due to their desire to play an equal professional role in the health care team. There was an attempt to alleviate these concerns by incorporating into the new documentation framework some of the information important to the health care team. The new documentation framework developed as a result of the second phase of the hermeneutic framework guiding this study is as presented in Figure 3. This framework was broken down into six components. Two specific components of the new documentation framework were created to meet the expectations of the other health care professionals: (1) Leisure and Recreation Participation and (2) Upcoming Leisure and Recreation Opportunities.

The final aspect of practice in the *world of the resident* was the impact of practicing within a clinical environment. Though practicing in the clinical setting is a reality and the pressures of this environment, such as documentation expectations and time constraints will always be present, attempts to streamline the documentation process

will help to alleviate some of the pressures. However, most importantly is to ensure that the understanding of these pressures will play an ongoing role in the development and maintenance of the documentation process.

The aspects of practice, present in the world of the resident and the world of the professional, both played a role in the creation of the documentation framework. The knowledge gained throughout the research process and as part of the practitioners' ongoing reflective practice, was also incorporated into the creation of the new documentation framework. The diagram (Figure 4, p.106) illustrates the influences on the documentation process present in both worlds, and the role each played in the creation of the new documentation framework.

5.2 Final Reflections

5.2.1 Patient-Focused Care and Documentation: The Importance of Language

Patient-focused care is increasingly important within the medical community in North America, and is the guiding philosophy of practice at SHSC. In order to adopt a patient-focused philosophy all aspects of practice must be incorporated into this philosophical change, including a shift in the staff value's and beliefs (Mitchell & Cody, 1999) as well as specific aspects of daily practice. Documentation is one of the specific aspects of practice. Donnelly (2005) specifically describes the importance of patient-centered medical records in the implementation of a PFC philosophy in the following statement:

> *Thus, if patient-centered medicine is to become a widespread reality of academic medical centers, educational initiatives must include adoption of a medical record that addresses the person and perspective of the patient as competently as it now addresses the patient's disease (p.33)*

The reason a patient-centered chart note is vital to the incorporation of the patient-centered philosophy is two-fold. First, chart notes reflect the type of practice, but also influence the type of practice. If medical professionals read information that is person-centered they will be more inclined to interact with that person in a PFC way, because "pathology-oriented" records help perpetuate a biomedical model of practice (Donnelly, 2005). Secondly, the language used to describe a resident in documentation can have an impact on how that resident is viewed and cared for by the health care team. Examples of this include incidents when patients are labeled in the chart as "problematic" or their concerns are described as "problems", the patient will begin to be seen as a problem. A

further example of the power of language is when a patient is described by their disease or illness as opposed to a person. This downplays all of the other factors contributing to the experience of the illness for the patient, and may not be addressed in the treatment of the patient. Finally, when an individual is labeled as deficient (eg. retarded), this label can perpetuate itself and become a self-fulfilling prophecy (Bogdan, 1980).

5.2.2 Self-Reflective Practice and Documentation

The concept of self-reflective practice is an important aspect of the recreation therapy practice. By participating in the ongoing reflection of their practice, the recreation therapists have made various steps in developing a greater understanding of their practice. Not only is self-reflective practice congruent with the action research framework, it also lends itself to the development of patient centered practice. In a study focused on the use of reflection as a means to foster client-centered practice within the field of occupational therapy, Duggan (2005) found that reflection can be used to empower the therapists to "develop an increasingly client-centered practice" (p.109), by encouraging the therapists to reflect on the meaning of client-centered practice and to look for opportunities to demonstrate this in daily practice.

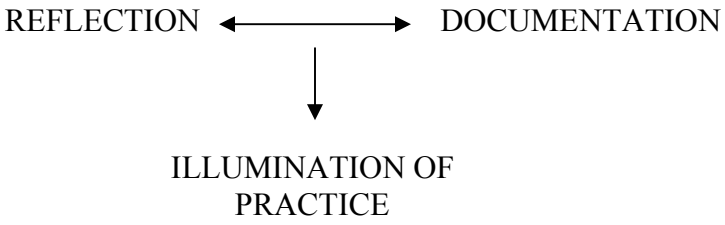
Beyond the reflection on practice described by Duggan (2005), the adoption of a self-reflective practice can produce further in-roads towards patient-centred practice. According to Schön (1983) an important component of self-reflective practice is the professional's ability to shift from the expert to the reflective practitioner. Once the professional has made this shift they are more open to look for real connections with the patients (Schön, 1983). This connection with the patient allows the therapists to move

with the rhythms of the patients, which is a guiding tenet of PFC framed by Parse's Theory of Human Becoming (Parse, 1998). These unique relationships with the residents also lead to a better understanding of the hopes, fears and needs of the resident, which will allow the professional to meet the unique needs of that resident.

Throughout this research project it was clear that the recreation therapists had accepted and embraced the role of reflective practitioner. As reflective practitioners, the recreation therapists developed the ability for self-reflection. This self-reflection was vital to the success of the research. The ability to self-reflect on practice also seems to be an important skill in the production of patient-centered recreation therapy documentation. The final phase of this project involved the *active application* of the data collected throughout the project to the creation of sample documentation. As noted earlier, in Section 4.5, this phase took the form of a working group, in which the recreation therapy research advisor, myself and three recreation therapists met to develop quality sample documentation for the recreation therapy practice. This working session developed into a reflective exercise, and it became clear that reflection on practice is a critical aspect of the documentation process. The recreation therapists were encouraged to reflect on, and describe their experiences with a resident.

The relationship between reflection and documentation can also occur in the reverse direction. By documenting the experiences of the residents and the impressions of the therapists, the therapists are given the opportunity to reflect further on their practice, and re-examine past practical experiences. This can play a role in gaining a deeper understanding of practice, and can lead to improvements in PFC. In a description of a process of developing a reflective practice in nursing, Duke (2000) describes the

experience of documenting her experience. The author described this reflective experience as a way of *illuminating practice* (p.138).



It seems that in general reflection and documentation occurs simultaneously, continuously building upon each other. This continual interchange leads to an increased understanding of practice, or *"illumination of practice"*. As a result of the relationship between reflection and the deeper understanding of practice, reflection can lead to the ability to incorporate more in-depth and authentic information into documentation of patient care. Documentation not only serves as a source of recording and communicating patient experiences, it can also play a role in self-reflection on practice and the implementation and improvement of patient-focused care. There is a continual interplay between reflection and documentation.

Duke (2000) in her description of self-reflection describes her experience of improving practice through the documentation of her experiences. The two key outcomes of the author's experience with documentation and self-reflection were, first, a realization that her clinical judgments were based on her seeing herself as the expert in the care of the patient, and second, that she had difficulty expressing how she knew things. However, as she continued her journey into reflective practice, she found that being aware of her limitations lead her towards a more patient-focused practice, with a

greater ability to substantiate her clinical impressions. The two cautionary notes discussed by Duke (2000), namely the assumption of the expert role and difficulty in expressing one's clinical determinations, have important implications for the recreation therapy department at SHSC, and therefore a movement towards documentation based on the concepts of self-reflective practice could lead to a greater ability for self-reflection in practice, an increase in the potential for patient-focused care, and finally provide the therapists with an increased ability to describe and provide evidence for the quality of their clinical impressions which will strengthen their documentation.

5.2.3 The Action Research Process

As outlined in the analysis chapter, the action research process meshed well will the overarching goal of this project, and lead to substantial gains in the collective understanding of the documentation of the experiences of the residents in A&VC at SHSC. As the main researcher, my experience with the action research process was challenging, rewarding and educational.

One aspect of the action research process which was especially challenging was the open-ended and unpredictable nature of this type of research. Kock (2004) describes this as the "uncontrollability threat" (p.268) of action research, in which the researcher does not have full control over the environment and the research participants. The author continues by stating that this threat can lead to the need for the researcher to revisit the research methods and assumptions. However, the unpredictability of action research can also have positive benefits, by ensuring that the direction the research project takes is meaningful and relevant to the needs of the research participants.

For example, in this research project there was a specific change in direction, which during the planning stages of the research project, could not have been predicted. Upon reflection of the data collected during the first two phases of the project, I observed that comfort with the language, specifically the quality indicators, which were expected to be integrated into the documentation process was of significant concern to the research participants. At this time I noted in my journal that: M*any of the recreation therapists seem to be somewhat uncomfortable with the quality indicators, and they aren't using them in their documentation. Maybe I need to try to establish a better understanding of the quality indicators before I start working on the documentation framework with the expectation that the quality indicators will be included in that documentation framework*. As a result, I focused the majority of the workshop (hermeneutic phase 3: fusion of horizons) on the meaning of the quality indicators, though the workshop was originally to be focused on the documentation framework.

Kock (2004) offers an antidote for the "unpredictability threat" called the "multiple iterations antidote" (p.271). This antidote suggests that the action research should occur in multiple iterations, which allows for the action research cycle to be repeated. This would allow the unpredictability and need for changes in direction to be embraced and utilized in subsequent iterations. Indeed the logic of this antidote was helpful in overcoming the unpredictability of this research project. As a result of the use of the hermeneutic process, which progressed through four phases, the action research cycle was repeated in each phase of the project. This repetition of the action research cycle allowed for continual reflection and planning, which both allowed for, and embraced, the unpredictability of the research process. Further, being open to the

potential need for reexamination and change allowed for a more meaningful and relevant project for the organization and the research participants.

Kock (2004) proposes a second consideration in conducting action research, which I also experienced in the process of completing this project. The "contingency threat" (p.268) leads to the researcher having access to a large body of data. Further this large body of data generally has two characteristics. First, this data rarely "*provides cumulative evidence that points to a particular effect or refers to a particular construct*" (p.268) and second the data is often tied to the social, political and organizational factors associated with the environment in which the study takes place.

The amount of data collected in this research project was significant. Especially due to the number of data collection phases involved in the completion of this research project. However, though the number of research phases led to substantial data, it also helped in the organization and analysis of the data. This is similar to the above mentioned "multiple iterations antidote". By continually moving through the action research cycle, all the data collected in the individual phases are manageable and can be analyzed separately before being integrated into the overall analysis of the research project.

In general, the action research process was beneficial to this project. The fact that the recreation therapists have been through the process and are open to exploring and being critical of their own practice was vital to the success of this project. The success of the hermeneutic process may be particularly related to the use of the action research framework.

5.2.4 Action Research and Hermeneutics

As suggested, the action research process and the hermeneutic philosophy complemented each other. One role of the action research process is to create knowledge and change within an organization, such as in this specific project. In general, this means that a collective of individuals, all being part of an organization, are involved in the change process. As well, there are cultural, social and environmental influences that are specific to that organization which will impact the outcome of the project.

The hermeneutic philosophy can incorporate both the knowledge of the collective of individuals and the characteristics of the organization into the action research process. Firstly, an important component of hermeneutics is to allow for the fusion of horizons (Karkkainen & Eriksson, 2004b). Horizons are the individual understandings of a certain concept. The fusion of the horizons is the process of bringing together the different horizons among the collective of individuals. This allows for the negotiation of meanings, and leads to a new collective understanding of the concept. As a result, the action research team is able to move forward in the research process with this new collective knowledge.

Secondly, the premise of hermeneutics is that data cannot be interpreted without taking into account all of the historic and environment influences. The concept of the hermeneutic circle in which the data is interpreted in relation to other influences gives a foundation for the process of ensuring all factors are considered. This allows the research to ensure that the results of the action research project will incorporate all of the factors present within that organization. This will lead to a consistency between the

organization, the individuals involved with that organization and the outcomes of the action research project.

One specific example from this research project in terms of creating collective meaning among a group of individual members of an organization was the creation of the QIs during the workshop activities. Prior to the workshop, all of the recreation therapists were expected to include the QIs into documentation. However, there was a limited understanding among the individual therapists, and no collective understanding of the meaning of the quality indicators. The process of "fusion of horizons" through the workshop activities was very useful in allowing all of the individual understandings of the research group/recreation therapy practitioners to be incorporated into the final outcomes of this action research project.

5.2.5 Revisiting the Research Questions

This research project was guided by five research questions. Each of the research questions were associated with one of the hermeneutic phases completed in this thesis. The benefit of associating the research questions with the hermeneutic phases is that each question can be investigated and answered in sequence in order to inform the following question.

The first two research questions were associated with the first hermeneutic phase of the research project, analysis of preunderstanding. They are as follows:

1. How do the recreation therapists experience the process of documenting recreation and leisure opportunities in a long term care setting?
2. What are the perceptions of the current documentation requirement of the recreation therapists?

The focus groups completed with the co-researchers, in the *analysis of pre-understanding* phase, allowed for research questions 1 and 2 to be investigated. The co-researchers were able to discuss and share their experiences and perceptions of documentation and their professional practice in general. The phenomenological analysis of the focus group transcripts led to the creation of an emergent model called The Experience of the Recreation Therapists (see figure 2, p.53). This emergent model allows for a better understanding of the experiences and perceptions expressed by the recreation therapists, and provides the new knowledge needed to answer the next two research questions.

The next two research questions are focused on the language used in the documentation of recreation and leisure. They are as follows:

3a. What language is currently being used in resident's charts?

3b. Is this language congruent with a patient focused experience for the residents?

These questions were answered in the second hermeneutic phase research project, *the hermeneutic dialogue*. This phase consisted of a hermeneutic dialogue between the actual documentation created by the recreation therapists and three tenets of patient focused care. This dialogue led to a deeper understanding of how, or if, PFC is being expressed through the language being used in documentation. The results of this dialogue demonstrated that there is a level of incongruence in the language used in the quarterly notes and the tenets of PFC. By answering these questions a new level of knowledge could be incorporated into the following hermeneutic phases and guide the planning and implementation of those hermeneutic phases.

Finally, question 4: *What aspects of the recreation therapy and leisure experiences are important to include in the documentation and communication of recreation therapy?* was associated with the third hermeneutic phase, *fusion of the horizons*. The data collection and analysis associated with answering this question led to the development of the quality indicators and the associated descriptions and prompts/probes (see section 4.4.3.1), which help to communicate the experience of the residents in recreation therapy and leisure opportunities. This knowledge was generated through the workshop activities in this phase. By collectively completing a series of activities focused on the language used to communicate the experience of the residents, a better collective understanding of the QIs was established. The enhanced understanding of the quality indicators, as well as the associated prompts and probes provide an effective way to communicate the leisure experiences of the residents in the documentation of patient care.

Originally the last two research questions (questions 4 and 5) were associated with the third phase of the hermeneutic process, *fusion of the horizons*. However, throughout the progress of this research it became clear that question 5: *What is perceived by the lead researcher and the co-researchers/practitioners be the most effective approach for communicating and documenting the experiences of the residents in recreation therapy services within a PFC context?* could be better answered in the second and fourth hermeneutic phases (*the hermeneutic dialogue* and *the active application*). The data gathered and the subsequent analysis of this data, used to answer this important final question led to the creation of the new documentation framework (Figure 3) the sample documentation created in the *active application phase* of the research project (see appendix 5).

In general the research questions outlined at the outset of the research project provided a logical sequence for the collection of data and information. As a result this information was the foundation for the successful outcomes of this project. Further, the action research characteristics associated with this research methodology allowed for the ability to adapt the process of data collection to effectively answer all of the research questions.

5.2.6 Implications for Recreation Therapy

The present study builds on the growing body of knowledge incorporating the concept of patient focused care and recreation therapy. Previous research has provided insight into how the concept of patient focused care can be implemented into the daily practice of the recreation therapists (Hornibrook et al., 2001), including a better understanding of the experience of the residents (Cantwell, 2000). This study has moved this knowledge a step further by investigating how patient focused care can inform a specific aspect of the recreation therapy practice, namely documentation.

Documentation is a major component of the recreation therapist's professional responsibility, and as a result developing a more meaningful documentation framework, and having the opportunity to focus on their own documentation skills will allow the recreation therapists at SHSC to produce higher quality documentation. The tools created in this study, including the new documentation framework, the quality indicator descriptions and associated prompts/probes, and the sample quality documentation, will provide the recreation therapists with more support and background for the creation of quality documentation.

Though the present study was conducted at Sunnybrook, and many of the outcomes of this project are specific to the practice at the hospital, the overall research and growing body of knowledge towards a patient focused recreation therapy practice could act as a catalyst in the emergence of further research in this area. A greater understanding of patient-focused care in recreation therapy can emerge in different practice areas and with different clients.

As well, using this research project as a guide, other recreation therapy departments can engage in action research projects to enhance aspects of practice, including the documentation process. This specific project demonstrates the steps towards gaining a better understanding of how the process of action research can lead to substantial gains in knowledge and changes in practice within an organization.

Finally, this research project provides evidence to support the argument that if a patient-focused care philosophy is to be adopted by a recreation therapy department, all aspects of the practice must incorporate the tenets of patient focused care. As a result, if the field of recreation therapy is to claim to be patient-focused, more emphasis needs to be placed on ensuring that the practice requirements within the field are congruent with this claim. The TRO standards for documentation can also begin to move towards person centered documentation by indicating and explaining that self-determination (an important aspect of the TRO standards) should be understood in a way that can ensure person centeredness in therapeutic recreation documentation.

5.2.7 Recommendations for Future Research

The current research project has lead to the development of a documentation framework with the goal of authentically communicating the resident's experience of recreation therapy opportunities. To ensure that this framework does meet this goal it would be beneficial to complete an evaluative trial of the framework. Various techniques would help to evaluate the framework. Completing a peer review of the documentation produced as a result of the new framework will allow all of the research participants an opportunity to evaluate the quality of the documentation. As well, in order to examine the extent the documentation authentically reflects the experience of the residents it would be beneficial to include the residents in the evaluation process. This would increase the knowledge of the experience of the residents, and increase the recreation therapist's ability to ensure the voice of the resident is being expressed in the documentation procedure, which is a key tenet of the patient-focused philosophy guiding practice at SHSC.

Appendices

Appendix 1:

Main Focus Group Topics and Probes:

1. Perceptions and experiences of the current documentation procedures in the recreation therapy department at Sunnybrook and Women's.

    i. What role does documentation play in the delivery of RT and leisure opportunities?
    ii. How much, if any, importance do you place on documentation in leisure services?
    iii. What are your experiences with documentation here at SHSC?
    iv. What are your feelings about the department's current documentation requirements?
    v. What are your thoughts about using the Patient focused care language in your documentation?

2. Role of documentation in the delivery and quality of patient care at SHSC.

    i. How do you think other healthcare professionals perceive documentation by RT professionals?
    ii. What information about residents can RT professionals provide to other health care professionals?
    iii. Have you had experiences in which the documentation of other health professionals has enhanced your ability to offer leisure opportunities to the residents?
    iv. Do you have any examples of how your documentation (or the documentation of other RTs) can enhance the leisure opportunities provided to residents? Do you have any specific examples?

3. Experiences of the recreation therapy practitioners in hospital rounds, and in the communication of the residents' experiences in recreation therapy and leisure.

    i. Can you tell me about your experiences in rounds?
    ii. What type of information do you share during rounds?
    iii. Do you feel that the other healthcare professionals are interested in the information you share during rounds?
    iv. How do you feel you could improve your ability to share relevant and helpful information during rounds?

4. Perceptions of how documentation and communication of residents' experiences can be improved and enhanced.

    i. Are you satisfied with your documentation skills?

ii. Do you use the knowledge and skills you learned in school when documenting patient care?
iii. How do you think your personal documentation skills can be enhanced?
iv. How do you think the department's documentation practices can be enhanced?

Appendix 2:

Recreation Therapy Department Documentation Questionnaire:

1. Do you work in (please circle):

Cognitive support Physical support Other _____

2. How much time a week do you spent documenting patient care (excluding statistics)?

3. Do you think this is a realistic amount of time to spend documenting? Why?

4. How do you schedule the time you dedicate to the documentation of patient care?

5. What are the factors that may enhance the quality of your documentation of patient care?

6. What are the factors that may impede the quality of your documentation of patient care?

Appendix 3:

Information Letter

Dear Recreation Therapy Practitioners,

My name is Leahora Rotteau. I am a Masters of Arts candidate in the Recreation and Leisure Department at the University of Waterloo. As a requirement for my degree I will be conducting a research project on the documentation of recreation therapy and leisure opportunities at Sunnybrook and Women's College Health Sciences Centre. I would like to invite you all to participate in this study.

The Recreation Therapy Department at Sunnybrook has a long history of collaborative research with the department of Recreation and Leisure Studies at the University of Waterloo. This research has lead to a greater understanding of the residents' experience of patient-focused care and recreation therapy among the veteran residents at Sunnybrook. Continued research will allow this understanding to increase and impact the quality of practice of the Recreation Therapy practitioners.

Documentation is an important and required aspect of your practice, as it serves as a form of communication between healthcare practitioners and acts as a legal record of resident care. However, there has been little research of the documentation of leisure and recreation therapy. As a result little is known about the most effective and beneficial techniques to document leisure and recreation therapy experiences. The purpose of this study is twofold. The first is to develop an understanding of the recreation therapy practitioners' perceptions of the current recreation therapy documentation process at SHSC, as well as documentation within the field of therapeutic recreation in general. The second is to explore how the experiences of the residents participating in recreation therapy and leisure opportunities can be operationalized into meaningful language to effectively document and communicate those experiences. The desired outcome is a new effective documentation framework to be used by the Recreation Therapy department. This documentation framework will allow for an improvement in your ability to document and communicate the important service you provide to the residents.

As with past research collaborations, this project will follow an action research philosophy. As a result, participants will be viewed as co-researchers in this process. If you choose to participate you will have the opportunity to provide input in all aspects of research including the generation of focus group questions, the analysis of data and the creation of the new documentation framework. As well, you will be provided with all the findings generated by the lead researcher, and be asked to provide feedback on those findings.

This research project will involve a series of sessions, including focus groups, a workshop and finally an active application session. The focus group session will focus on your experiences with documentation and your feelings about the language used in

documentation. Each focus group session will take approximately 90 minutes and will be tape recorded. The workshop will involve a series of activities to examine and create language for the purposes of documenting the experiences of the residents. This session will take approximately 4 hours and will be video taped. The active application session will involve a collaborative effort to develop the new documentation framework from the findings of the previous phases of the research project. Finally, you will also be asked to provide some examples of documentation you have previously written in resident charts for analysis. The names of the residents and practitioners will not be included on these documents to protect anonymity.

Participation in this research project is voluntary. If you chose not to participate, there will be no professional repercussion towards your career. If you do choose to volunteer, you may participate in as many or as few of the session as you choose. You may also chose to withdraw from the project at any time, as well during any sessions you may chose not to answer questions you would prefer not to answer.

This project has been reviewed by, and has received ethics clearance through, the Office of Research Ethics at the University of Waterloo. If you have any questions regarding the project do not hesitate to contact the lead researcher, Leahora Rotteau at lrotteau@ahsmail.uwaterloo.ca. You may also contact the Director of the Office of Research Ethics, NAME, if you have an questions regarding any questions or concerns about participation in this project at (give contact info).

Thank you for your interest, I look forward to working with you on this important research collaboration.

Leahora Rotteau

Appendix 4

Workshop Exercises

Exercise 1: Understanding the Meaning of the Quality Indicators in Recreation Therapy and Leisure Experiences:

The purpose of this exercise is to explore and share how the quality indicators are experienced by the residents/patients and how as a practitioner you understand the experiences of the residents/patients.

In groups of 2 or 3 answer the following question:

Think of a time when a resident/patient experienced one of the quality indicators.

1. Briefly describe the event.
    a. Type of program
    b. Your role in the program
    c. Your relationship to the resident

2. Describe how the resident/patient reacted or what the resident/patient said during or after the event.

3. Describe why you made the connection between this event and the experience of that Quality Indicator?

Exercise 2: Development of Prompts and Probes associated with the Quality Indicators.

The purpose of this exercise is to develop a comprehensive list of prompts and probes for each of the quality indicators to be used with the DILE tool and in documentation.

Each group will be assigned a quality indicator. Brainstorm various key words that you associate wit the quality indicators.

- What leads to the QI
- What the QI represents
- What feelings are associated with the QI
- Benefits associated with the QI
- How is the QI expressed (actions/language)

Appendix 5

Recreation Therapy Sample Notes
-Developed June 16th 2006, by Documentation Framework Committee Working Group (Julie, Nora, Leanne, Leahora and Alison)

Cognitive Support Note

Resident seems more relaxed in one-on-one interactions with the RT and small groups as evidenced in his participation in small group music programs and the snozelen room. Noisy and busy environments seem to lead to increased agitation, as seen through chair rocking and teeth grinding. When interacting with the RT expressions of enjoyment are seen through smiling and apparent physical calmness. The resident also has the opportunity to be himself; he expresses his personhood in the presence of the RT through eye contact and attempts at verbalization. Resident will begin using the snozelen cart. This will enhance the calming and relaxing effects of the snozelen experience, by decreasing the stimulation from traveling, to and from the snozelen room, through the hallways.

Physical Support Note

Over the past quarter, the resident has increased his participation with recreation therapy. The resident appears to be motivated to continue his past leisure patterns and to develop new skills, despite his expressed concerns about the progress of his disease and his lack of control over the outcome. Recreation therapy has played an important role by providing the resident with the opportunity to choose his personal leisure experiences. The resident has told the RT that he tries to help others in the facility, because they are all

part of the community, and being part of that community is important to him. He is able to help others during his participation with the lunch group by suggesting menu choices and helping with preparation. The resident also expresses his sense of belonging with the group by offering experiences that reflect and express the group's common heritage. Resident will continue to be given the opportunity to choose the recreation and leisure opportunity which will allow him to maintain his personal leisure preferences.

Community Support Note

Based on his frequent attendance it seems the resident enjoys taking part in the music and evening programs provided by C.S. Though the resident has expressed concerns about other people's ability to understand his speech, due to a stroke, he continues to participate and meet new people. Meeting others, and being understood by an increasing number of residents and staff, seems to have helped the resident become more confident. He often initiates conversations, and expresses himself to others. The resident has also had the opportunity to develop himself; he has recently begun participating in the Life Long Journey Series, which can lead to the acquisition of new knowledge and skills. The RT will continue to make attempts to introduce the resident to others during the evening and music programs, and encourage participation in C.S. events.

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