

The experiences of new graduates learning to make intervention decisions in diverse paediatric workplace settings: A cross-case analysis

E. M. A. Moir, J. A. Copley & M. J. Turpin

Abstract

Introduction: New graduates commonly experience challenges making client-related decisions. Current occupational therapy literature has predominantly focused on new graduates' general experiences of commencing practice and experienced clinicians' perceptions of clinical decision making. This study aimed to explore new graduate occupational therapists' experiences of learning to make intervention decisions in paediatric practice.

Methods: A case study approach enabled exploration of the experiences and reflections of 18 new graduate and eight experienced occupational therapists working in three paediatric service delivery contexts—private practice, acute hospital and non-government settings. Data were collected using semi-structured interviews, observations, informal discussions, review of documents and reflective journal entries. Similarities and differences across the three cases were examined.

Results: Contextual influences, including time pressure, clinical risk and self-expectations, shaped new graduates' experiences of learning to make intervention decisions. These influences impacted new graduates' access to common support mechanisms, such as informal discussions with colleagues, formal workplace supervision and shared workplace resources, and prompted them to draw on supports and resources external to the workplace.

Conclusions: Understanding the contextual influences that shape new graduate allied health practitioners' experiences of learning to make intervention decisions assists professional bodies, workplaces and universities to better target the training and support provided to new graduates to ensure that their intervention decisions promote positive client outcomes. Furthermore, the research findings can increase new graduates' understanding of both workplace and external support mechanisms that assist clinical decision making and the possible impact of high self-expectations on their decision-making experiences.

Keywords: occupational therapy; graduate; decision making; paediatric; context; cross-case analysis

School of Health and Rehabilitation Sciences, The University of Queensland, Australia

Correspondence: Elizabeth Moir e.moir@uq.net.au

Introduction

Australian allied health professions are growing rapidly (Australian Government, 2020a, 2020b). Occupational therapy is one fast-growing health profession, with registration numbers increasing by 48% since July 2012 (Occupational Therapy Board of Australia, 2019). As increasing numbers of students are undertaking occupational therapy degrees (Gilbert Hunt, 2017), it is anticipated that many of these registrants are new graduates. In Australia, new graduates are defined as practitioners within their first 2 years of practice (Occupational Therapy Australia, 2021).

Recent workforce data (Australian Government, 2020a) identified paediatrics as the most common area of occupational therapy practice, with the media highlighting an increased demand for community-based paediatric occupational therapy services following the introduction of the National Disability Insurance Scheme (NDIS) (Fitzsimmons, 2019). Fay and Adamson (2017) suggested that new graduates may fulfil workforce demands as they are more likely to be employed in full-time roles compared to experienced clinicians. However, under the NDIS, service providers lack funding for clinical supervision (Hines & Lincoln, 2016). This contrasts with the government sector, where new graduates historically sought employment in hospital settings due to the availability of workplace support processes (Cusick et al., 2004). Differences between employment settings likely results in variable experiences of support upon commencing practice.

New graduate occupational therapists commonly experience challenges when entering the workforce (Murray et al., 2020; Toal-Sullivan, 2006). Moir et al. (2021) identified that feelings of self-doubt often underpin new graduate challenges, whether relating to clinical decision making or using skills and knowledge in practice. New graduate physiotherapists and speech pathologists also experience challenges with clinical decision making (Kenny et al., 2009; Wells et al., 2021). In paediatric practice, clinical decision making requires simultaneous consideration of wide-ranging factors relating to children and families (Copley et al., 2008). Experienced occupational therapists typically draw upon colleagues, their own personal and professional knowledge and experience, and professional literature when making clinical decisions (Copley et al., 2008; Copley et al., 2010).

New graduates find decision making laborious (Morrison & Robertson, 2011) and often want experienced colleagues to confirm their clinical decisions (Toal-Sullivan, 2006). Support for decision making is needed as clinical reasoning skills develop throughout an occupational therapist's career (Mattingly, 1991). Engagement with colleagues, sometimes referred to as "communities of practice", enables new graduates to learn clinical reasoning and decision making through modelling and explicit feedback (Ajjawi & Higgs, 2008). However, Murray et al. (2015) acknowledged that workplace support is not always available. This may be particularly prevalent in practice contexts facing a lack of funding for clinical supervision.

Current occupational therapy literature has primarily focused on new graduates' experiences of the overall transition to practice and experienced clinicians' perceptions of clinical decision making. New graduate occupational therapists' experiences of learning to make intervention decisions is under-researched. As well conceived intervention decisions underpin positive client outcomes, exploration of new graduates' experiences of learning to make intervention decisions requires attention. As some practice contexts are lacking funding for clinical supervision, consideration of other possible support mechanisms, such as new graduates' personal experiences and wider professional supports available outside the workplace, is needed.

This research explored the experiences of new graduate occupational therapists learning to make intervention decisions when working with children and families. The research questions were:

- What are the experiences of new graduate paediatric occupational therapists when learning to make intervention decisions with clients in practice?
- How do the organisational context, new graduates' personal resources and experiences, and their wider professional community influence their experiences of learning to make intervention decisions?

Method

Research design

Case studies assist in understanding particular phenomena in context (Patton, 2015). This research used an exploratory, multiple-case design (Yin, 2018) to gain an in-depth understanding of the phenomenon of new graduates' experiences of learning to make intervention decisions in the context of three paediatric service delivery models (cases)—private practice, acute hospital and non-government (not-for-profit) settings. Within case study research, cases are not limited to concrete entities such as individuals or organisations (Yin, 2018) but can include “bounded systems”, such as people working in particular service delivery contexts. The use of an exploratory multiple-case design enabled comparison of new graduates' experiences in the different cases, highlighting how different service delivery contexts shape their experiences. This paper presents a cross-case analysis of the findings from the three cases.

Ethical approval was granted by the University of Queensland Human Research Ethics Committee (2018001256) and Children's Health Queensland Human Research Ethics Committee (LNR/19/QCHQ/50651). A gatekeeper letter was signed by a representative from each purposefully selected workplace confirming permission to conduct case study research at the site.

The processes for initial participant recruitment, data collection and data analysis were similar across all cases. The aim of the first case, private practice, was to establish a

rich and detailed understanding of new graduates' experiences of learning to make intervention decisions. As there was some commonality in new graduates' experiences across the cases, subsequent cases were explored in a progressively more targeted manner to draw out differences among the contexts. Additionally, initial data collection revealed topics that warranted further exploration, such as new graduates' experiences in less supportive private practices.

Participant recruitment

Participant recruitment occurred in two stages. Initially, new graduate and experienced occupational therapists were recruited through purposive sampling (Patton, 2015) within the selected contexts. Experienced clinicians were included, as they could provide unique insights from having direct contact with new graduates in addition to reflections on their own new graduate experiences. The first author (EM) shared information about the research at a team meeting within a purposefully selected private practice and acute hospital. The practice/departmental director then circulated consent forms to staff. Within a purposefully selected non-government organisation (NGO), participant information was distributed by a contact person, and interested occupational therapists could email EM. To gain further insight into new graduates' experiences within the private practice and NGO contexts (i.e., cases), additional new graduates working in private practice and NGOs were later recruited using purposeful snowball sampling through the initial participants' and the authors' professional networks. This was prompted by difficulties recruiting new graduate participants within the NGO case and to explore emerging issues as data were collected. Twenty-six occupational therapists, 18 new graduates and eight experienced clinicians volunteered to participate. Written, informed consent was obtained from all participants.

Data collection

All data collection was undertaken by EM between October 2018 and February 2020. Data collection methods included observations, semi-structured interviews, informal discussions, review of documents and reflective journal entries to gain a rich understanding of the phenomenon. Table 1 outlines participant numbers and data collection methods used for each case. Data collection varied within each case according to organisational policies and workload demands and became more targeted over time as the authors were able to discern which provided the richest information and could draw out differences from previous cases.

An interview guide, developed and piloted by the authors, aimed to facilitate discussion regarding participants' experiences of commencing practice and learning to make intervention decisions (see Appendix). As the interviews progressed, minor adjustments were made to allow exploration of topics raised by previous participants. All interviews were audio-recorded and transcribed verbatim. Researcher reflections and descriptions from observations, informal discussions and review of documents were recorded in field notes.

Table 1*Participant Numbers and Data Collection Methods Used Within Each Case*

	Private Practice (n)	Acute Hospital (n)	NGO (n)
Number of participants	14	8	4
Number of sites	6	1	2
Instances of data collection	68	16	9
Semi-structured interviews	14	9	4
Participant observations	17	2	2
Informal discussions	22	4	3
General workplace observations	10	0	0
Document review	1	1	0
Reflective journal entries	4	0	0

Data analysis

A cross-case analysis enables comparison and synthesis of patterns across cases (Yin, 2018). Prior to commencing the cross-case analysis, data from each case were analysed separately using an inductive process, “working with your data from the ground up” (Yin, 2018, p. 169). Initially, the authors independently coded a sample of the data from each case and met to develop a coding strategy. EM then coded the remaining data using this coding strategy, meeting regularly with the other authors until consensus was reached. The authors identified overarching themes pervading the codes through repeated discussion and consensus. Member checking (Patton, 2015) was used to confirm the authors’ initial interpretations, whereby all participants were emailed a summary of the preliminary codes and themes pertaining to their workplace context and asked to confirm whether the summary reflected their experiences and to provide additional information if they wished. Twelve participants responded confirming the authors’ initial analysis, with two providing additional perspectives. Following this, the themes and codes were further reviewed and refined by the authors to assist the reporting of the findings. The cross-case analysis involved comparing and synthesising “any ‘within-case patterns’ across the cases” (Yin, 2018, p. 196). EM reviewed the codes and themes from the three cases in light of the research questions to identify patterns of similarities and differences. During an ongoing peer-review process, all authors reviewed and refined the patterns of similarities and differences through discussion and further interrogation of the data. The peer-review process continued during the development of the manuscript to reach consensus regarding the similarities and differences.

The cases

Case 1: Private practice

Fourteen occupational therapists, representing six practice organisations (see Table 2), were recruited for the private practice case. This included nine participants from the purposefully selected private practice and five new graduates recruited through purposeful snowball sampling. Some private practices were long-established paediatric or generalist practices, whilst others were newly established or had recently expanded to include paediatric clients following the introduction of the NDIS. All participants worked with at least one other occupational therapist, who was sometimes based in a different practice location, and some worked in multidisciplinary teams. Occupational therapy services were provided to children with a range of diagnoses in clinics, family homes and schools. Children were privately paying clients or NDIS participants.

Table 2

Breakdown of Practices Comprising the Private Practice Case

Practice	Participants	Caseload
1	New graduate (n = 6)	Paediatrics
	Experienced clinicians (n = 3)	
2	New graduate (n = 1)	Generalist
3	New graduate (n = 1)	Generalist
4	New graduate (n = 1)	Generalist
5	New graduate (n = 1)	Paediatrics
6	New graduate (n = 1)	Paediatrics

EM was an insider within the purposefully selected private practice. Despite being employed in this practice, she predominantly worked off-site and did not work alongside participants on a day-to-day basis or have a supervisory role. Her position as an insider appeared to support the depth of information shared by participants, to whom she was familiar. Interviews were conducted at the participants' workplace (n = 6) or convenient off-site locations (e.g., local cafes) (n = 6), with two conducted via phone or an online platform (e.g., Skype). Observations and informal discussions within the purposefully selected private practice took place on a part-time basis over several weeks. Most informal discussions occurred face-to-face, with two conducted via phone. Documents relating to the support of new graduates, such as one organisation's new employee orientation information, were provided for viewing. This information assisted in contextualising information obtained during the semi-structured interviews and informal discussions. Additionally, three new graduates provided a total of four single reflective journal entries based on stimulus questions.

Case 2: Acute hospital

Eight participants, four new graduates and four experienced occupational therapists were recruited from an acute paediatric hospital in metropolitan Australia. The occupational therapists worked in multidisciplinary teams and provided inpatient and outpatient services across caseloads including oncology, burns, palliative care and orthopaedics.

Data were collected through semi-structured interviews, observations of peer supervision sessions, informal discussions and review of documents. One experienced participant did not partake in a semi-structured interview and only engaged in informal discussions. Two interviews took place over two sessions due to time constraints, resulting in a total of nine semi-structured interviews. Four interviews were conducted at the participants' workplace and one via phone. The remaining four interviews took place at off-site locations. Documents provided for viewing included the department's new graduate handbook and peer supervision guidelines.

Case 3: NGO

Four occupational therapists, from two NGOs, were recruited for the NGO case. This included two new graduates and one experienced occupational therapist from the purposefully selected NGO, with one additional new graduate recruited through purposeful snowball sampling. Participant recruitment was challenging, as new graduates often stated that they had little time or were too stressed to participate. The NGOs provided services to individuals with a specific diagnosis, and participants worked in transdisciplinary allied health teams. Services were funded through the NDIS or, sometimes, a government grant for school-based services. Following the introduction of the NDIS, these organisations had moved to a predominantly "fee-for-service" funding model.

Data collection within this case included semi-structured interviews, observations and informal discussions. One interview was conducted via phone and the others at convenient off-site locations. Two observations took place at the purposefully selected NGO during which a new graduate facilitated a group program and engaged in informal discussions with EM. The other new graduate participant from that organisation engaged in an informal discussion via phone to reflect on their recent therapy sessions.

Findings

Twenty-five females and one male participated. The pronouns "they" and "their" are used to protect participant anonymity. The 18 new graduates had been employed for 1–24 months. Four worked with both children and adults, and the others worked with children only. Three had experience in other areas of practice, including aged care, aged care combined with community-based NDIS services and school-based services. Most worked in full-time positions, with two working in two part-time positions. At the

time of data collection, two had left their roles in paediatric practice but reflected on their experiences. The eight experienced participants had worked for 4–25 years, with a mean of 9.3 years' experience in paediatric practice. Six had experience in other areas of practice, including mental health, hand therapy, acute adult settings and aged care. Two had full-time positions, whilst the others had one or two part-time roles. Two worked only in managerial or supervisory positions with no clinical caseload.

Similarities and differences across the cases are presented first. Distinct identifiers are used for participant quotes (e.g., PP-NG6 or NGO-E1, denoting the case (PP—private practice, AH—Acute Hospital, NGO) and “new graduate” or “experienced” participant). Participants' recommendations regarding supporting new graduates' decision making are then presented.

Table 3

Common Support Mechanisms Across the Three Cases

Common Support Mechanisms	
Learning from others	Workplace-based: informal discussions with colleagues, work shadowing, access to previous documentation Personal networks: discussions with university staff and peers
Formal supervision sessions	Formal, scheduled time to meet with an experienced supervisor Participation in peer supervision facilitated by an experienced colleague
Physical resources	On-site resources: learning modules, intervention information, formal therapy programs External resources: university notes, online media
Knowledge and experience	Prior knowledge and experience (university): knowledge of contemporary occupational therapy practice, student placement experiences Practice knowledge and experience: translating intervention ideas between clients
Feedback and reflection	Reflecting on previous clients and approaches used, seeking feedback from colleagues, clients and families

Similarities across the cases

Participants commonly described challenges with clinical decision making upon commencing practice. They described making intervention decisions as “hard” (NGO-NG2), “daunting” (NGO-NG1), “overwhelming” (PP-NG2) and “time consuming” (PP-NG4), with one new graduate further describing how “there were definitely times where I would worry ... Did I do enough? Did I do the right thing?” (AH-NG1). Participants described a range of common support mechanisms within and external to the workplace that informed new graduates' intervention decisions (see Table 3). For example, informal discussions with colleagues and formal supervision sessions enabled opportunities to ask questions, seek advice, obtain validation and reassurance, and

gather intervention ideas. Many new graduates were initially reliant on work colleagues to help them make intervention decisions. Then, as practice experience was gained, new graduates, particularly those working with entirely paediatric caseloads, began translating intervention ideas to new clients presenting in similar ways to previous clients and mostly only sought support for unfamiliar or complex cases.

Two other common aspects that influenced new graduates' intervention decisions were identified across the cases: the need to be responsive to each child and family and new graduates' personal factors. Participants described needing to effectively engage children and families, which affected the intervention decisions they made both when planning upcoming sessions and moment-by-moment within sessions. This included considering family contextual factors when choosing interventions and ensuring therapy was motivating and engaging. "Because they are kids, it's so important to keep [therapy] exciting and fun" (PP-NG11). Personal factors further influenced new graduates' experiences. For example, workplace supports that aligned with their individual learning styles were seen as particularly beneficial. However, many described having high self-expectations when commencing practice, including a desire to always do the "right thing" and be an expert straight away. This resulted in challenges sharing openly with colleagues, negative self-perceptions when needing to seek support and "becoming stressed or worried about not knowing what to do" (NGO-NG3). Additionally, some new graduates found the provision of feedback challenging and "hard to take" (AH-NG3). The experienced occupational therapists perceived that high self-expectations and challenges receiving feedback were more prevalent among current new graduates. In general, new graduates' confidence in their decision making increased as they gained practice experience.

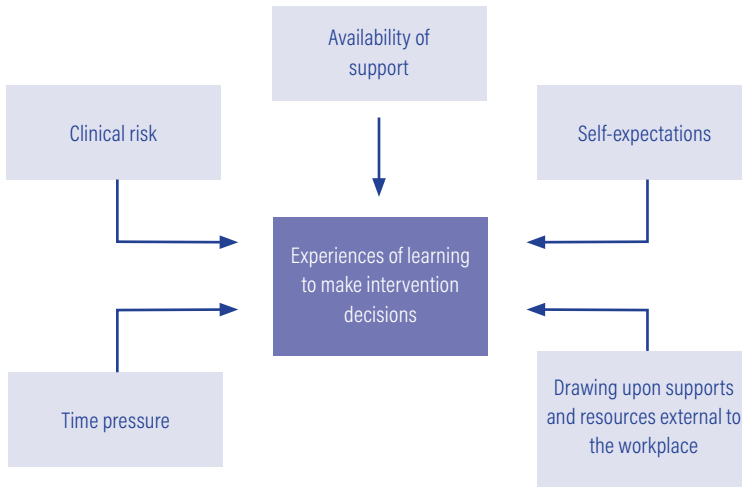
Another issue seen across the cases was varying descriptions of accessing external professional development to increase their skills and knowledge and inform their intervention decisions. Various factors impacted new graduates' engagement with external professional development, including the need to book leave in advance, the availability of workplace professional development allowances and limited awareness of professional development available outside of the workplace. Whilst common supports and influences shaped new graduates' decision-making experiences across the three cases, their access to support mechanisms and overall experiences of learning to make intervention decisions were further shaped by contextual influences that manifested in different ways between cases.

Differences between cases

A range of contextual influences shaped new graduates' experiences of learning to make intervention decisions. These contextual influences related to time pressure, clinical risk, availability of support, self-expectations and drawing upon supports and resources external to the workplace. Figure 1 summarises these contextual influences and each is explored in turn.

Figure 1

Contextual Influences Shaping New Graduates' Decision-Making Experiences



Time pressure

Time pressure manifested in different ways within each case. For hospital-based new graduates, the immediacy with which they needed to respond to referrals impacted their ability to draw on available support mechanisms. One new graduate described their experience:

It is very busy. And so, that can sometimes hinder maybe the amount of time you spend discussing a certain case or decision you need to make. Or ... you've gotten a referral and you immediately need to respond to that or do some kind of intervention. But you don't always have time to sit down and do an hour of learning. (AH-NG1)

Within the NGOs, the NDIS had contributed to increased demand for occupational therapy services and pressure to meet billable hours' targets. This requirement impacted supervision processes and opportunities to engage in informal discussions and made new graduates reluctant to "ask too much of other people" (NGO-NG2). The experienced NGO clinician further explained how opportunities to talk with colleagues are "slowly getting lost ... because the expectation is to have those five billable hours. So it's just go, go, go" (NGO-E1). In contrast, whilst new graduates in private practice described an awareness that their colleagues had their own caseloads to attend to, time pressure did not feature highly in their descriptions of seeking support for their intervention decisions.

Risk

Within the acute hospital, new graduates were very aware of the need to manage clinical risk, particularly in relation to there being "consequences for the intervention I select"

(AH-NG2) when providing medicalised interventions (e.g., splinting) and prescribing equipment. An experienced clinician further described this, saying, “Some interventions are potentially riskier than others in terms of ... the potential for things to go wrong if done wrong” (AH-E3). The awareness of clinical risk contributed to new graduates actively seeking support for their clinical decision making on an “as-needs” basis and feeling that it was not appropriate to learn through trial-and-error. Conversely, new graduates working in the NGO and private practice contexts did not discuss perceptions of clinical risk as influencing their decision making.

Availability of support

New graduates working in the paediatric-only private practices, acute hospital and NGOs frequently described drawing on support from experienced occupational therapists to assist their intervention decisions and accessing shared workplace resources. However, those working in generalist private practices described having limited access to experienced occupational therapy colleagues and not having “really any resources, ... no paper resources or anything like that” (PP-NG9). Having limited access to experienced work colleagues contributed to seeking support from less experienced colleagues or other professions within their workplace, experienced colleagues based in other locations or going without support.

Participants described variable experiences of engaging in “external” supervision as a support for their intervention decisions. One new graduate working in a generalist private practice described how they chose to “run [the plan for] all my cases” (PP-NG7) by their supervisor, who was wholly external to their workplace. However, an NGO new graduate felt that their off-site supervisor, who was employed by the same organisation but based in a different practice location, had less knowledge of the specific children with whom they were working compared to on-site colleagues, contributing to them prioritising broader topics for discussion. Some private practice new graduates providing off-site services described seeking information and therapy ideas from family members and university peers when not seeing work colleagues on a regular basis.

Self-expectations

Whilst new graduates across the three cases described having high self-expectations, an awareness that families were paying for services was evident among new graduates working in private practice. These new graduates also reported a desire to be seen as capable and competent by families, stakeholders, colleagues and their employers, particularly as families were paying for services. This fear of appearing incompetent also contributed to private practice new graduates seeking information from their family members and university peers rather than more experienced colleagues. One explained, “When I really didn’t know what I was doing, I would message my friends from my cohort, ... and they were really good in kind of helping me ... so I didn’t look like an

absolute fool” (PP-NG7). Additionally, many private practice participants were conscious of providing “financially worthwhile” services. This prompted high levels of collaboration with parents and teachers, a strong focus on goal achievement and a reluctance to experiment with strategies early on in practice. For example, one new graduate described how they felt it was important to provide feedback to parents about what had been worked on or achieved during the session “because they [parents] are paying” (PP-NG2).

Drawing upon supports and resources external to the workplace

New graduates described diverse experiences of drawing upon supports and resources external to the workplace across the three cases. Within the acute hospital case, new graduates described how knowledge regarding contemporary occupational therapy practice gained at university provided a general understanding of the focus of their practice within the various caseload areas. Similarly, new graduates within the NGOs described how they could “fall back on” (NGO-NG3) university coursework to support their familiarity with possible intervention approaches. In contrast, many private practice new graduates reported similarities not only between their clinical work and university training but also their personal experiences of developing the skills they were helping children master (i.e., drawing on the study skills they had developed during high school and university) and the knowledge of their personal contacts, such as friends or family members who were parents. This enabled them to use a variety of supports, resources and experiences external to the workplace, and sometimes outside of the profession, to inform their intervention decisions. One new graduate reflected on discussions with personal contacts, describing “definitely talking to people in my personal life about [the toilet training phase]. It’s not something I’ve personally dealt with, with a child” (PP-NG3).

Participant recommendations

All participants made recommendations regarding supporting new graduates’ confidence and competence in their clinical decision making. These recommendations encompassed both workplace and personal strategies, with some specifically suggested for new graduates in less supportive positions. Table 4 outlines the similar and different recommendations provided across the cases.

Discussion

The findings highlight new graduate occupational therapists’ experiences when learning to make intervention decisions in three paediatric service delivery contexts. Common support mechanisms informed new graduates’ intervention decisions across the cases. However, the extent and availability of these supports and resources varied within the different practice contexts, thereby contributing to variable experiences of learning to make intervention decisions. As new graduates from other allied health professions experience challenges with clinical decision making (Kenny et al., 2009; Wells et al., 2021) and also gain employment within these contexts, the findings provide considerations for many allied health professions.

Table 4*Participant Recommendations: Similar and Different Recommendations Provided Across the Three Cases*

Context of Support	Similar Across Cases	Different Across Cases
Workplace	<ul style="list-style-type: none"> Promote opportunities to learn from colleagues Allow time to learn and engage in reflective practice during working hours Scaffold caseload expectations Enable access to regular supervision Offer learning opportunities that align with new graduates' preferred learning style Offer support to identify, and financial assistance to attend, professional development events 	<ul style="list-style-type: none"> Provide specific induction, including background theory, information about caseload and what to expect and commonly used assessments and intervention approaches (Private) Enable supervision sessions to be used flexibly based on new graduates' needs (e.g., case discussions, reading a report) (NGO) Offer personal support (NGO)
Personal	<ul style="list-style-type: none"> Proactively seek support and information Become aware of where to access internal and external support Have confidence in knowledge learned at university Be open to learning and not needing to be an expert straightaway Maintain connections with university peers Accept job offers that are a good match to student placement experiences and/or provide opportunities for support 	<ul style="list-style-type: none"> Use social media to obtain peer-reviewed material (Private) Seek an individual they feel comfortable learning from (Acute hospital) Prioritise attending supervision (Acute hospital) Feel comfortable to jump in and have a go (Acute hospital) Prioritise learning needs and communicate learning goals (Acute hospital) Have a life outside of work (i.e., hobbies) to assist in switching off (NGO) Engage in reflective practice (NGO)
Less supportive positions	<ul style="list-style-type: none"> Draw on the knowledge and experiences of university cohort, lecturers and clinical educators Utilise external resources (i.e., social media, podcasts, textbooks, research articles) Proactively seek external mentors and professional networks 	<ul style="list-style-type: none"> Have faith in knowledge learned at university (Private) Request external supervision when needed (Private) Collaborate and problem solve with other new graduates (Private) Seek/utilise feedback from patients and families (Acute hospital)

The challenges with clinical decision making reported by participants align with previous research (e.g., Murray et al., 2020; Robertson & Griffiths, 2009; Toal-Sullivan, 2006), demonstrating that this is an ongoing difficulty upon commencing practice. Some support mechanisms identified in this research are similar to those identified in studies exploring experienced paediatric occupational therapists' clinical decision making (Copley et al., 2008; Copley et al., 2010) and experienced occupational therapists' perceptions of novice decision making (Jeffery et al., 2021). These include therapists' own knowledge

and experience, professional literature and the knowledge and expertise of clients and colleagues. However, the current research highlighted further supports for clinical decision making that have not previously been identified, including the influence of university professional networks and personal contacts outside of the profession and personal experiences of skill development and relating this to clients' skill development. These additional supports may be particularly beneficial for new graduates experiencing a lack of workplace support.

Service characteristics such as timing of service provision (Copley et al., 2008) have previously been identified as influencing occupational therapists' clinical decisions. However, the impact of contextual factors has not been explored in relation to new graduates' experiences of learning to make intervention decisions. The contextual influences identified as shaping new graduates' experiences in the current research included time pressure, perceptions of clinical risk, availability of experienced colleagues and shared workplace resources, self-expectations, and drawing upon supports and resources external to the workplace. Some contextual influences broadly coincide with findings within wider occupational therapy literature. For example, private practice new graduates' heightened awareness of services being funded by families coincides with Babic's (2016) study in which knowledge that clients were paying for services contributed to dilemmas faced by private practitioners. However, previous research has not identified the effect of this awareness on new graduates' experiences of engaging with families and seeking support. Similarly, whilst researchers have established that time pressure within acute hospital settings contributes to a need for rapid discharge decisions (Britton et al., 2016; Moats, 2006) and new graduates experience general concerns regarding taking risks (Leonard & Corr, 1998), the impact of these factors on new graduates' access to workplace supports to assist their intervention decisions has not previously been identified. Other influences on new graduates' decision-making experiences identified in this research, including the impact of billable hours requirements, differences in availability of support, high self-expectations and drawing upon supports and resources external to the workplace, have not been documented in occupational therapy literature to date. The research findings are valuable to new graduates as they highlight the wide-ranging support mechanisms that assist clinical decision making and the possible impact of high self-expectations on their decision-making experiences. Additionally, the findings allow a more nuanced understanding of changes to current new graduate supports required for safe and effective service provision. Consequently, the findings of this research have implications for allied health professional bodies, workplaces and universities.

As highlighted by Lave and Wenger (1991), engagement with a community of practice enables novices to learn accepted ways of working and thinking. Within the current research, being part of a workplace community of practice enabled new graduates to obtain intervention ideas and reassurance of their clinical decision making through

observing their colleagues and having formal supervision and informal discussions with more experienced therapists. Being part of a community of practice is important, as new graduates enter practice with limited context-specific knowledge and experience (Ajjawi & Higgs, 2008). However, their participation in workplace communities of practice was negatively impacted by time pressure, limited access to colleagues and high self-expectations. This demonstrates a possible need for more rigorous supervision requirements to support new graduates' access to experienced colleagues within the Australian occupational therapy profession and other professions without mandated supervision. While some Australian allied health professional bodies have developed guidelines and position statements regarding the expectations for participation in supervision (e.g., Occupational Therapy Australia, 2019; Speech Pathology Australia, 2022), mandatory supervision requirements for new graduates, such as those implemented by the Psychology Board of Australia (2022), are yet to be introduced by many Australian allied health registration authorities. The lack of formal requirements leaves the provision of supervision to the discretion of organisations. The introduction of mandated supervision requirements or competency frameworks by registration authorities, such as those used for new graduate occupational therapists in New Zealand (Occupational Therapy Board of New Zealand, 2020) or within Australian psychology practice (Psychology Board of Australia, 2022), may further prompt workplaces to ensure provision of appropriate levels of support and thereby benefit both professions' reputations and new graduates. Despite the benefits of supervision, possible costs and the practicalities of allocating time for engagement in supervision must be considered in light of workload and funding pressures.

A range of theoretical concepts emphasise the importance of skill development in context (Brown et al., 1989; Dreyfus & Dreyfus, 1986). This research reinforced the notion that new graduates gain knowledge and experience by being in the workplace and having caseload responsibilities. Through gaining practice experience and repeated exposure to cases, new graduates were able to identify patterns (Robertson, 2012), enabling them to translate intervention ideas between children that were presenting in similar ways. However, some of the contextual influences that impacted access to workplace communities of practice also impacted new graduates' ability to gain knowledge and experience through caseload responsibilities. For example, both self-expectations and perceptions of clinical risk contributed to reluctance to experiment with strategies and learn through trial-and-error. Ongoing professional socialisation assists the development of clinical reasoning (Ajjawi & Higgs, 2008) and may support new graduates in understanding trial-and-error as a process of "using action as reasoning" (Turpin & Hanson, 2018, p. 449). Additionally, new graduates working with entirely paediatric caseloads more frequently described translating knowledge and repeating similar activities, which demonstrates the benefit of scaffolding new graduates' caseloads initially to allow them to gain the repeated exposure required for drawing on previous experience.

This research also demonstrated the influence of university knowledge and personal resources and experiences on new graduate decision making. In contrast to other new graduate research, this study found that new graduates drew heavily on knowledge gained whilst at university and supplemented this with their personal networks and own experiences of developing the skills their clients were trying to master. Such findings highlight the importance of ongoing evaluation of university curricula (e.g., Sellar et al., 2018) to ensure soon-to-be graduates continue to have adequate opportunities for assessment and intervention planning as part of simulation activities and student placements to assist the development of confidence in their clinical decision making. Increased use of clinical or professional reasoning models (e.g., Jeffery et al., 2021) within coursework and student placements would also assist new graduates in understanding the wide-ranging evidence that contributes to well-informed intervention decisions. Additionally, further clarification regarding the skills gained at university and those acquired after entering the workforce (Hodgetts et al., 2007) will assist new graduates' understanding of the development of expertise and possibly moderate high self-expectations.

Limitations and recommendations for further research

Despite limited participant numbers within each case and fewer observations and informal discussions outside of the private practice case, the use of targeted data collection methods enabled a rich understanding of participants' experiences of learning to make intervention decisions within the included workplace contexts. However, this study only begins to explore experiences of new graduates learning to make intervention decisions in paediatric occupational therapy practice. Therefore, further research is needed to understand in more detail new graduates' experiences of learning to make intervention decisions. This may include the types of support provided in supervision and how new graduates' relationships with supervisors facilitate their experiences of learning to make intervention decisions.

Conclusion

This research explored new graduate occupational therapists' experiences of learning to make intervention decisions in three paediatric service delivery contexts—private practice, acute hospital and NGO settings. Contextual influences impacted new graduates' access to common workplace support mechanisms and their experiences of gaining skills and knowledge through caseload responsibilities while also prompting them to draw on supports and resources external to the workplace. The findings can assist new graduates' understanding of workplace and external support mechanisms that assist clinical decision making and the possible impact of high self-expectations on their decision-making experiences. Furthermore, as challenges with clinical decision making are common among new graduate allied health practitioners, such insights have implications for the training and support provided by professional bodies, workplaces and universities.

Conflicts of interest and funding

The authors declare no conflicts of interest and acknowledge the support of an Australian Government Research Training Program (RTP) scholarship.

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Appendix A

Finalised Semi-Structured Interview Guide

This interview guide is for both new graduate and experienced participants. The interviewer will choose which questions are relevant to each participant group and workplace setting.

Section 1: Demographic details

Interviewer to tick or record relevant answer.

What is your age?

18-24	25-34	35-44	45-54	55-64	65+
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What is your gender?

Male	Female	Other
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What year did you graduate from your occupational therapy degree?

Course Entry?

School entry	Previous degree (incomplete)	Please describe: _____	Mature aged
Gap year	Previous degree (postgraduate)	Please describe: _____	

Number of years [or months] employed as an occupational therapist?

Number of years [or months] working in paediatric practice?

If relevant, other areas of practice in which you've been employed as an occupational therapist (e.g., mental health, aged care)?

What is your highest level of occupational therapy qualifications?

Bachelor	Bachelor (Honours)	Graduate masters
Masters	PhD	

Any other relevant qualifications or certifications?

What is your employment status?

How would you describe the organisation in which you are employed?

Private practice	Non-government organisation	Acute hospital	Other
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Tell me about the practice/organisation and your work here.

Prompts

- *Clients you see, length and frequency of sessions*
- *Location of therapy, referral pathway, funding, diagnoses, variation/similarities in work being undertaken, intervention approaches used, decisions made*
- *Role: what do you do, what are your responsibilities?*
- *Perceptions of new graduate experiences within the workplace*
- *Differences over time?*
- *Support available to new graduate occupational therapists*

Section 2: New graduate transition to practice (description of their experience)

I want you to think back to when you started work as a new graduate occupational therapist. Tell me about your experience of finishing university, applying for jobs and being offered your first position.

Prompts:

- *What feelings did you have?*
- *How did they change in the weeks after graduating? What do you think made you feel differently?*

Tell me about your experience in your first job [or current role] (particularly the first few months or first 6 months).

Prompts:

- *What did your first few weeks/months of work look like?*
- *What supports were you receiving? How were they helping you?*
- *Nature of caseload (i.e., graduated or full). Was this a positive or negative experience?*
- *Aspects of your job/OT role that were easy or you felt confident to undertake. Why was it easy?*
- *Aspects of your job/OT role that you couldn't do or didn't feel confident to undertake. Why?*
- *Were there any events or experiences that were stressful or problematic?*
- *Influence of funding structures?*

Tell me about anything that changed [or has changed] over the first year [or specify other timeframe].

Prompts:

- *Nature of caseload?*
- *Aspects of your job/OT role that became easy? Why?*
- *Aspects of your job/OT role that were still challenging or difficult? Why? How did you overcome them?*
- *Nature/availability of supports?*
- *Events or experiences that were stressful or problematic?*

Section 3: Learning to make decisions

I'm interested in exploring how new graduates learn to make decisions about "what to do" in their practice, for example, choosing assessments or intervention activities. Tell me about your experience when first making decisions about "what to do" in your practice.

Prompts:

- *What did you draw upon to make decisions? How did this inform your decision making?*
- *What did you do to help you decide?*
- *How did you feel when first making decisions about "what to do"?*
- *What did you rely on to know you were making the "right" decisions?*

When you think back, what do you think helped (or hindered) your decision making during that time?

Prompts:

- *Supports available? (organisational, personal life, the profession)*
- *Is there anything else that would have helped? (personally, the environment)*

Now let's think about your decision making after [specify timeframe e.g., 12 months, 2 years]. Tell me about your experience.

Prompts:

- *What did you draw upon?*
- *How did you feel about making decisions?*
- *What do you think made you feel differently?*
- *Additional resources that you are now using?*
- *What did you rely on to know you were making the "right" decisions?*

What do you think helped you at that time?

Prompts:

- *Supports available? (organisational, personal life, the profession)*
- *Is there anything else that would have helped?*

Based on your experiences, what supports or experiences do you think current new graduates need to feel confident and competent in making decisions about “what to do”?

Prompts

- *Would the same things that helped you be relevant for everyone?*