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The Experiences Of An Occupational Therapist Delivering Occupation-Based Practice At A Skilled Nursing Facility

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By

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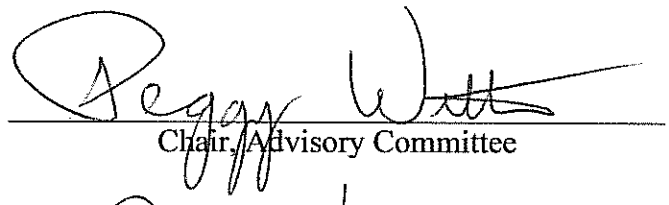

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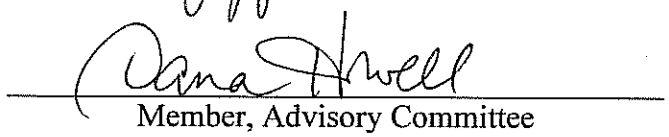

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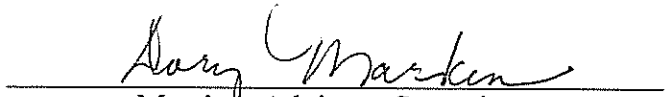

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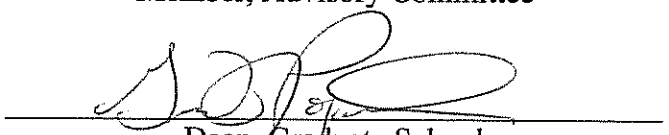

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By

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DEDICATION

This thesis is dedicated to my sweet mom, Debbie Mattingly, who completed her journey on this earth on May 12, 2001. I am grateful that you and dad chose to be co-creators with God and give me life. I am thankful that you instilled a foundation of faith in me at a very young age. I can still close my eyes and hear your voice singing Amazing Grace. You are a special lady, and I was fortunate to have the privilege of calling you Mom. I look forward to seeing you again one day.

ACKNOWLEDGMENTS

First and foremost, I want to thank my Father in Heaven for always fulfilling Your promise to take care of me. Not only have You given me the grace to persevere throughout this project but Your Providence has guided me every moment of my life. My completion of this research project is further proof that "I can do all things in Him who strengthens me" (Philippians 4:13, Revised Standard Version).

I would like to thank Dr. Wittman, Dr. Marken, and Dr. Howell for helping me through this process. Thank you for your time and patience with this girl who can be a bit high-strung at times. Thank you for helping me to discover the world of qualitative research. Through your guidance, I have grown as a writer, researcher, and professional.

I am thankful to my family and friends for being patient with me during the times when I locked myself in my room for days on end to submerge myself in this project. Thank you for your encouragement at the moments when I needed it most. You are a blessing to me.

Last but not least, I would like to thank Steven, my wonderful fiancé, for supporting and encouraging me throughout this process. You are a precious treasure, and I thank God for you every day. It is true that when you "take delight in the Lord, He will give you the desires of your heart" (Psalm 37:4). I look forward to being friends with you on the journey to Heaven. The next item on the agenda at the completion of this project is wedding planning!

ABSTRACT

This paper is a qualitative research study which seeks to explore the experiences of an occupational therapist in delivering occupation-based practice at a skilled nursing facility in Kentucky. Over a three month period, the subject participated in one email and two face-to-face semi-structured interviews. During these interviews, the researcher and therapist discussed topics such as the therapist's thoughts on reimbursement and documentation and her strategies for intervention planning and implementation.

During data analysis of interview transcriptions, three themes emerged and were titled with direct quotes from the participant: "The long-term goal is to increase my patient's level of functional ADL performance," "I'm constantly watching my little stopwatch," and "I like the bio-mechanical aspect of OT as well as the occupational aspect."

Results were congruent with previous conclusions drawn by scholars in the field regarding occupation-based practice. The results support the argument for further research of therapists' experiences in delivering occupation-based practice in real-world contexts. The findings of this research study are beneficial to the field of occupational therapy because they assist in profession's understanding of why a gap exists between theory and practice of occupational therapy.

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CHAPTER 1

INTRODUCTION

Background and Need

If your mind automatically goes to paid employment when you think of the word "occupation," you are definitely not alone. In fact, the first definition of occupation on Dictionary.com (n.d.) is "a person's usual or principal work or business, especially as means of earning a living; vocation: Her occupation was dentistry." Occupation to an occupational therapist (OT), however, is something quite different; the word encompasses so much more. The Occupational Therapy Practice Framework (American Occupational Therapy Association, 2008, p. 629) defines occupation as "activities that people engage in throughout their daily lives to fulfill their time and give life meaning."

I would like for you to think of your daily life for a moment. What does your daily routine look like? Is it important that you get a shower every day? What brings meaning to your day? Have you been entrusted with the care of another human being? What do you do with your free time? How do you unwind after a stressful day at work? Would you rather talk on the phone with a friend, or spend some time in solitude reading a book? Occupation means all of these things and more. It is complex and unfolds differently for every person.

Now, imagine for a moment that you are no longer able to engage in the things that bring most meaning to your life. I, for example, would be devastated if I were no longer able to practice my Catholic faith, to smell the incense, to feel the Holy Water, to genuflect before my Lord. What if you were told that you could no longer swing a golf

club, plant a garden, cook a meal, care for your child? All of a sudden, life would be less meaningful; it would be difficult to find the motivation to get through the day. When our valued occupations are interrupted, our lives are interrupted.

Occupational therapists are educated to see the world through the lens of occupation, understanding that the human is an occupational being. When a person is faced with challenges that interrupt his or her ability to engage in valued occupations, we help him or her to overcome those challenges and live life to it's fullest potential. Instead of seeing the person as a set of diagnoses and disabilities to be fixed, we are interested in the occupations that bring meaning to his or her life and help him or her to return to those occupations.

Because we take this stance on rehabilitation, we have found ourselves on the defense since the beginning of our profession. In the early 1900's, when occupational therapy was emerging, scientific methods were becoming the focus of American medicine. During this time, occupational therapists continued to voice the humanistic influence on the health and wellbeing of the person. We have struggled with "balancing the scientific and humanistic trends inherent in occupational therapy, of finding occupational therapy's place in American medicine, and of meeting the aims of scientific medicine" (Quiroga, 1995, p. 14).

Now, a century later, occupational therapists still have difficulty maintaining a unique identity and incorporating the profession's founding principles while practicing within the medical setting. Due to the complexity of occupational therapy, many therapists have found it difficult to articulate exactly what we do (Fisher, 1998). Incorporating occupation into practice is extremely challenging for many reasons.

Improvements in performance components are much easier to document for reimbursement purposes (Thomesen, 1996). Excessive documentation and productivity demands are taking therapists away from direct patient care (Walker, 2000). Many therapists in the medical-model setting are expected by their fellow therapists and supervisors to solely rely on preparatory methods, which simply prepare a patient for occupation and do not foster actual participation in that occupation (Rogers, 2007).

The scholars of the profession recognize that therapists have difficulty incorporating occupation into practice, and several solutions have been proposed to address this issue. One such solution is through the emergence of the academic discipline of occupational science. This discipline seeks to contribute to the knowledge base of occupational therapy, reflect the values of the field, and increase society's awareness of the potential of people with disabilities (Yerxa, 1993). Yerxa (2000) suggests that occupational therapists need not pull away from modern medicine. Rather, we are to "contribute to the relationship by developing and strengthening our own thought process, by focusing our detective work and practice on the occupational human within a physical and social context" (p.196). We must learn to incorporate our medical knowledge with our ability to engage clients in valuable occupations.

Fortune (2000) contends that occupational therapy practitioners who are neither recent graduates nor current postgraduates must also further their understanding of occupation to translate occupational ideas into practice. Pierce (2003) suggests that occupation-based programs must be established in every area, and program leaders must publish their experiences. All of these proposed solutions will assist practicing therapists in maintaining consistency between the profession's philosophy and practice.

My own lived experiences highlight this inconsistency between philosophy and practice. My training as an occupational therapist greatly emphasized occupation-based practice. This type of treatment involves a more humanistic, holistic approach than does a component-based treatment approach. It includes identifying those occupations that are important to the client, working with the client to set goals toward returning to these occupations, and structuring therapy sessions in such a way that will be meaningful and motivating to the client. On the other hand, component-based treatments that focus on remediating functional deficits were frowned upon in my education; the use of pegboards, upper extremity bicycles, arm arcs and clothes pins had no place in the occupational therapist's potential list of treatment tools.

In my second year of practice, I entered the long-term care setting. On my first day, I remember my supervisor encouraging me to look through the cabinets to become familiar with the therapy tools that were available to me. I was disappointed with what I saw. The very things that were frowned upon in my education were the tools that were stored in the cabinets, waiting for me to use. A clothespin tree, pegboard, arm arc, stacking cones and upper extremity bicycle were some of the tools that I observed. Within days, I was regularly using these very tools in practice. They were easy, and I could easily treat more than one patient at once. Besides, I reasoned, they had to benefit my patients at least somewhat. The residents of a nursing home are extremely weak and sedentary; any amount of movement must increase their strength which will then increase their ability to engage in occupation.

Deep down, however, I struggled daily with internal conflict. I was not providing the services that I was trained to provide. I did not feel as though I was providing quality

occupational therapy to my clients but did not know how to meet the conflicting demands that were placed upon me. Every day, I was faced with reimbursement, case overload, productivity, and the unique occupational needs of each client. Job satisfaction for me was less than desirable. In fact, many days I would go home in tears, feeling like a failure. I was not providing occupation-based therapy. I knew it but didn't know how to change it.

After working for a year in this setting, I finally decided to return to Eastern Kentucky University to obtain my master's degree. I had hopes to further my education in occupational therapy and to strengthen my foundation of knowledge of occupation-based practice. When deciding upon a topic for my master's thesis, I chose to face my struggles head-on and focus my research on occupation-based practice in long-term care. In so doing, I hoped that I would not only make sense of this topic for myself but to also shed light on this area for other struggling therapists.

Problem Statement

Scholars of the profession are well aware that a gap exists between the philosophy of occupational therapy and its implementation in everyday practice (Hasselkus, 2002; Kielhofner, 2005; Nelson, 1996; Pierce, 2001; Wu & Lin, 1999). However, literature which captures the voice of the therapist who encounters the demands of daily practice in regards to occupation-based practice (Estes & Pierce, 2012; Fortune, 2000; Wilding & Whiteford, 2007) is sparse. The literature appears to lack the perspective regarding occupation-based practice of the occupational therapist employed in the long-term care setting. Therefore, the proposed study provides a unique

perspective that may not yet have been explored and may help to provide an explanation for the gap between scholarship and practice.

Statement of Purpose

The purpose of this case study is to explore the experiences of an occupational therapist in delivering occupation-based practice at a skilled nursing facility in Kentucky. This will contribute to the knowledge of occupational therapists and to the profession as a whole by revealing the thoughts, actions and experiences of this therapist regarding occupation-based practice. This study may serve as the basis for future research studies. It may also provide food for thought for other therapists who are working in nursing homes throughout the United States.

Research Question

The research question for this study is:

What are the experiences of one occupational therapist delivering occupation-based practice (OBP) at a nursing home in Kentucky?

Sub-Questions

The research sub-questions for this study were:

How does the therapist plan intervention for the client?

Does physical environment play a role in the ability to provide OBP interventions?

What is the therapist's understanding of the views of her colleagues regarding OBP?

Does this therapist include the client in intervention planning?

How does this therapist view reimbursement in relation to OBP?

How would this therapist describe a treatment session that was successful? Unsuccessful?

How does this therapist feel at the end of a day of work at this skilled nursing facility?

Definition of Terms

Activities of Daily Living (ADLs): "activities oriented toward taking care of one's own body. ADL also is referred to as basic activities of daily living (BADL) and personal activities of daily living (PADL). These activities are 'fundamental to living in a social world; they enable basic survival and well-being'" (American Occupational Therapy Association, 2008, p. 669)

Areas of Occupation: "various kinds of life activities in which people engage, including the following categories: ADLs, IADLs, rest and sleep, education, work, play, leisure, and social participation" (American Occupational Therapy Association, 2008, p. 669)

Assessment: "specific tools or instruments that are used during the evaluation process" (American Occupational Therapy Association, 2008, p. 669)

Biomechanical Intervention Approach: a remediation or restoration approach; "the intervention is designed to restore or establish client-level factors of structural stability, tissue integrity, range of motion (ROM), strength, and endurance" (Rybski, 2012, p. 309)

Evaluation: "the process of obtaining and interpreting data necessary for intervention. This includes planning for and documenting the evaluation process and results" (American Occupational Therapy Association, 2008, p. 670)

Goals: "the result or achievement toward which effort is directed; aim; end" (American Occupational Therapy Association, 2008, p. 670)

Gerontology: "the scientific study of the process and problems of aging" (Stedman, 2005, p. 595)

Instrumental Activities of Daily Living (IADLs): "activities to support daily life within the home and community that often requires more complex interactions than self-care used in ADL" (American Occupational Therapy Association, 2008, p. 671)

Interests: "what one finds enjoyable or satisfying to do" (American Occupational Therapy Association, 2008, p. 671)

Intervention: "the process and skilled actions taken by occupational therapy practitioners in collaboration with the client to facilitate engagement in occupation related to health and participation. The intervention process includes the plan, implementation, and review" (American Occupational Therapy Association, 2008, p. 671)

Leisure: "activities or tasks done for enjoyment or renewal" (Sumsion and Blank, 2006, p. 110)

Occupation: "activities that people engage in throughout their daily lives to fulfill their time and give life meaning" (American Occupational Therapy Association, 2008, p. 672)

Occupation-Based Intervention (Practice): "a type of occupational therapy intervention - a client-centered intervention in which the occupational therapy practitioner and client collaboratively select and design activities that have specific relevance or meaning to the client and support the client's interests, need, health, and participation in daily life (American Occupational Therapy Association, 2008, p. 672).

Occupational Performance: "those skills/actions that result from the interaction of the body systems with specific reference to self-maintenance, leisure and productivity" (Sumsion and Blank, 2006, p. 339)

Occupational Science: "an interdisciplinary academic discipline in the social and behavioral sciences dedicated to the study of the form, the function, and the meaning of human occupations" (American Occupational Therapy Association, 2008, p. 673).

Occupational Therapy: "the practice of occupational therapy means the therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for the purpose of promoting health and wellness and to those who have or at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity, limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life" (American Occupational Therapy Association, 2008, p. 673)

Preparatory Methods: "methods and techniques that prepare the client for occupational performance. Used in preparation for or concurrently with purposeful and occupation-based activities" (American Occupational Therapy Association, 2008, p. 674)

Productivity: "activities or tasks done to enable the person to provide support to self and others" (Sumsion and Blank, 2006, p. 110)

Quality of Life: "a client's dynamic appraisal of life satisfactions (perceptions of progress toward identified goals), self-concept (the composite of beliefs and feelings about themselves), health and functioning (including health status, self-care capabilities), and socioeconomic factors (e.g., vocation, education, income)" (American Occupational Therapy Association, 2008, p. 674)

Self-Maintenance/Self-Care: "activities done to maintain the person's health and well being in the environment (Sumsion and Blank, 2006, p. 110)

Skilled Nursing Facility (SNF): "a nursing facility providing 24-hour non-acute nursing, medical, and rehabilitative care" (Stedman, 2005, p. 1349)

Social Participation: "organized patterns of behavior that are characteristic and expected of an individual in a given position within a social system" (American Occupational Therapy Association, 2008, p. 675)

Spirituality: "the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship with the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community" (American Occupational Therapy Association, 2008, p. 675)

Assumptions

It is assumed that the participant will try to the best of her ability to provide truthful responses to interview questions. It is also assumed that the participant will understand the occupational therapy terminology used throughout the interview process or will ask for clarification, if not.

Biases

As the primary researcher for this study, it is important for me to identify my biases regarding the topic at hand. Due to an education focused on occupation-based practice, I have a specific idea of what occupation-based practice should look like in everyday practice. When the client is evaluated, all valued occupations are identified, including work, self-care, and leisure occupations. Then, during occupational therapy

intervention, the therapist will gradually ease the client back into those occupations that he or she is no longer able to perform.

I believe that occupation-based practice is very difficult to implement in today's rehabilitation world and that the participant for this study will reveal this difficulty when describing her experiences. Because of my previous experience at a skilled nursing facility, it is assumed that the participant more than likely engages in component-based interventions that focus on remediating functional deficits. I have the bias that occupation-based intervention is more effective than component-based intervention. I also have the belief that because many of the clients in the geriatric population are retired, they will especially value leisure occupations. These preconceived ideas of occupation-based practice may have prevented me from maintaining complete objectivity during data analysis.

Limitations

This is the researcher's first experience with an in-depth qualitative research study so flaws may exist with the data collection and analysis. Gillham (2000) speaks of sub-methods within case study research. He specifically mentions interviews, observations, document and record analysis, and work samples. Using more than one method allows for triangulation of the data, which increases the likelihood that the results accurately represented the case. As Gillham points out, there is often a discrepancy between what people say about themselves and what they actually do. Because the present study only includes one method, it is difficult to say with confidence that this case is being thoroughly represented.

Although the interview times were chosen by the participant, they may have been less than optimal. During the first interview, she was interviewed at the end of a workday and may have been fatigued, as a result. This interview also took place right after her vacation, and she mentioned that she felt as though her memory had been erased. During the third interview, she was feeling sick and stated that she felt a little "foggy minded." These factors may have inhibited the participant from revealing a crisp, clear picture of her experiences.

The participant's responses may have been influenced by her desire to impress the researcher. This therapist knew that the researcher was a student who was affiliated with the local university. When discussing the use of formal assessments, she stated, "I'm almost embarrassed to say, you being an EKU student." She seemed to convey the belief that a student would not understand the pressures of real life practice and, as a result, may judge her job performance. Therefore, her ability to provide accurate responses may have been impeded by her desire to portray herself as a competent, successful therapist.

CHAPTER 2

LITERATURE REVIEW

The demand for occupational therapists in geriatrics is going to continually increase in the United States due to the expected growth of this population in the coming years. In 2005, the United States Census Bureau conducted a special study on the population of Americans who are age 65 and older due to its potential impact on policy makers, healthcare providers, businesses and families. In the twentieth century, the elderly population grew from 3.1 million to over 35 million and is projected to double to 72 million by 2030. By then, the older population is expected to make up 20 percent of the overall American population. This phenomenon is partially caused by an increased life expectancy; the average life expectancy rose from 47.3 in 1900 to 76.9 in 2000. Another cause of the aging population is the aging of the Baby Boom generation, which includes people born between 1946 and 1964 (He, Sengupta, Velkoff, & DeBarros, 2005).

This growth in the elderly population is going to continually provide opportunities for occupational therapy practice in geriatrics. The profession has much to offer; its focus on the balance of work, play, and self-care and their interaction with the health of the person contributes to the quality of life of this population.

Occupational Therapy and Gerontology

Gerontology is designated as a specialization in the field of occupational therapy. However, as Hasselkus and Kiernat (1989) point out, many occupational therapists working with older people do not take the initiative to explore the unique

developmental, health and occupational contexts of this population. This results in the elderly client being "deprived of services directed specifically to his or her contextual needs (p. 78)." One solution proposed by the authors of this article is an increase in research endeavors directed toward learning more about the geriatric population.

The well elderly study (Clark et al., 1997), a landmark study that evaluates the effectiveness of preventive occupational therapy treatment, highlights the potential benefits of occupational therapy intervention in the geriatric population. This was a randomized controlled trial, with the controls being a social activity group and a non-treatment group. Significant benefits attributable to OT treatment were found in the areas of quality of interaction, life satisfaction, Medical Outcomes Study Health Perceptions, bodily pain, physical functioning, the effects of health problems on role functioning, general health, social functioning, the effects of emotional problems on role functioning, and general mental health.

The researchers of this study conclude that it is not enough to simply engage in activity. Occupational therapists add special expertise to impact therapeutic outcomes. They have a deep understanding of the relationship of occupation to health, are trained to individualize treatment to meet the specific needs of each client, and have the ability to instruct clients on how to overcome barriers to successful daily living (Clark, Azen, Zemke, Jackson, Carlson, et al., 1997). Follow-up research to the well elderly study was conducted from 2004 to 2009. Again, the intervention group displayed significant improvements in lessening bodily pain and depression while improving vitality, social function, mental health, and overall life satisfaction (Waite, 2011).

Defining Occupation

One would be hard pressed to find a definitive, agreed upon definition of occupation. Hasselkus (2002) illustrates this fact by citing six different scholars with their own interpretation of the definition of occupation. In an attempt to provide a distinguishable definition of occupation, the American Occupational Therapy Association (1995) put forth a position paper. According to the authors of this position paper, the term has been used historically to refer to "an individual's active participation in self-maintenance, work, leisure, and play" (p. 1015). They assert, however, that the word "occupation" has been used interchangeably with other concepts within the profession's literature and, therefore, has been made ambiguous.

To clarify the differences between the meanings of occupation, function, and purposeful activities, position papers were written by the American Occupational Therapy Association for each topic. These papers state that "purposeful activity refers to the goal-directed behaviors or tasks that comprise occupations" (American Occupational Therapy Association, 1993, p. 1081). Because the OT profession's domain includes the function of a person in occupational roles, the word function is used interchangeably with performance and occupational performance. It can mean "role, use, activity, capacity, job, position, pursuit, or place" (American Occupational Therapy Association, 1995, p. 1019). The very fact that three position papers were written by the professional association to clarify three important terms in the profession illustrates the complexity of its theoretical foundations.

Wu and Lin (1999) discuss the ongoing struggle of occupational therapists and occupational scientists to satisfactorily define the concept of occupation. They then

compare the attempts of Nelson and Kielhofner, two scholars of the profession, to decrease the ambiguity of this concept. They hope that by identifying similarities and differences between the two attempts, further advancements may be made to develop and validate a clear definition of occupation.

In 1988, Nelson describes occupation as an ambiguous term and states that the ambiguity of the definition of occupation can inhibit the growth of the OT profession. He explains that occupational form is "the preexisting structure that elicits, guides, or structures subsequent human performance" while occupational performance "consists of the human actions take in response to an occupational form" (p. 633). He then states that the word occupation refers to the relationship between occupational form and occupational performance. It is the occupational performance of an occupational form; to put it simply, it is the doing of something or the engaging in something.

Nelson asserts that all occupation includes a sense of purposefulness. He furthers his definition of occupation by linking the relationship between occupational form and occupational performance with the meaning that occupational form and the purpose that occupational performance has to the individual. He states that meaning and purpose are dependent upon the individual's developmental structure. He then describes the dynamics of occupation and explains that "occupational performance influences subsequent occupational forms, and purposefulness and/or performance results in adaptations in the individual's developmental structures" (p. 637). Nelson provides an abbreviated real-life example of the relationship between occupational form and occupational performance.

In a later article, Nelson (1996) describes the term therapeutic occupation and how it relates to the terms that he previously defined. He introduces the term occupational synthesis which he claims is "the design of the occupational form by the occupational therapist in collaboration with the recipient of services to advance therapeutic assessment or achieve a therapeutic goal" (p. 777). He mentions that this is the primary aim of the occupational therapist and that the goal is to provide a just-right challenge given the individual's developmental structures. In order to further remove the ambiguity associated with his proposed definitions, Nelson provides diagrams of each.

In 1980, Kielhofner (2008) first proposed the Model of Human Occupation, the first contemporary model to express a focus on occupation in practice. He proposes that the basic concepts of human occupation are volition, habituation and performance capacity. "Volition refers to the motivation for occupation. Habituation refers to the process by which occupation is organized into patterns or routines. Performance capacity refers to the physical and mental abilities that underlie skilled occupational performance" (p. 12). Kielhofner notes the impact the environment has on the occupation and states that the environment must be taken into account when attempting to understand the person's occupational circumstances.

After comparing the works of Nelson and Kielhofner, Wu and Lin (1999) state that these scholars have successfully provided an important foundation in the attempt to clearly define occupation. They then propose several specific recommendations for future research that will continue this quest. They suggest that the typology of the three occupational forms described by Nelson may need to be expanded. They claim that a differentiation should be made between the "amount of materials afforded for task

performance, the way which the materials are utilised (e.g., consumed, used as a tool or transformed into something else), or the functional level of the goal of the task" (p. 10). They state that this differentiation may have an impact on therapeutic outcomes. They also suggest that the effect of changing occupational forms needs to be researched with a variety of populations since the focus of Nelson's research had been on neurologically impaired populations.

Wu and Lin also suggest that the concepts need to be investigated to reveal whether or not they are applicable across cultures. They mention that the concepts proposed by both Nelson and Kielhofner have only been researched in western civilization. Therefore, it may be difficult to generalize these concepts to other cultures. The final suggestion made by Wu and Lin is that instrument validation needs to continue for the Model of Human Occupation. They point out that most of the tools used to measure the effects of this model were developed before its creation and that some of the measures may not have corresponded to the intended variable.

In 2003, the American Occupational Therapy Association embarked on a quest to create a Centennial Vision, commemorating the profession's 100th anniversary which will take place in 2017 (American Occupational Therapy Association, 2007). During the planning phases, the committee identified that one barrier to achieving this vision was "unclear professional language and terminology (p. 614)." The very fact that one of the profession's leading organizations identified this barrier, and that the Centennial Vision was written to address this barrier, gives further recognition to the struggle of defining "occupation" and other important terms important to the profession. After three years of deliberation, the official Centennial Vision was released as follows: "We envision that

occupational therapy is a powerful, widely recognized, science-driven, and evidence-based profession with a globally connected and diverse workforce meeting society's occupational needs" (p. 613).

Top-Down versus Bottom-Up Therapeutic Approaches

Two practice approaches within occupational therapy which are inverse to one another are the top-down and bottom-up approaches. When a top-down approach is used, the therapist works with patients to assess whether or not meaningful roles and occupations have been disrupted. Then, therapy is focused on eliminating component deficits which hinder the patient from returning to those roles and occupations. A bottom-up approach, on the other hand, focuses assessment and treatment on the component deficits and assumes that barriers to occupational performance will automatically disappear once these deficits are addressed (Trombly, 1993).

A debate exists within the profession regarding the superiority of one treatment approach over the other. This debate prompted a discussion regarding the language used in the Occupational Therapy Practice Framework to describe the evaluation process. Weinstock-Zlotnick and Hinojosa (2004) assert that the language of the first edition of the Framework denotes superiority of top-down approaches by declaring that this type of approach should always be used during occupational therapy evaluation. They then explain their position that this decision should be left to the occupational therapist who will use clinical reasoning to determine which approach is best for the situation.

In an article which suggests revisions to the original Practice Framework (Gutman, Mortera, Hinojosa, & Kramer, 2007), an entire section is devoted to the "validity of multiple approaches for evaluation and intervention" (p. 121). In this section,

it is stated that three approaches should be deemed acceptable by the Practice Framework; these include top-down, bottom-up, and environment-first. The chosen approach should be based upon the therapist's judgment, demands of the therapist's practice area, and client need. Whatever the chosen approach, the occupational roles of clients must be addressed. Interestingly, the language of the second edition of the Practice Framework includes revisions to accommodate this position. This edition specifically mentions that the knowledge and skills of the occupational therapist influence the information which is collected during evaluation (American Occupational Therapy Association, 2008).

Gray (1998) argues that when a bottom-up approach is used, treatment goals are often reduced to components, and intervention includes exercises and purposeful or non-purposeful activity to improve balance, attention, strength, range of motion, etc. She proposes several problems associated with this approach. First off, component-focused treatment does not necessarily lead to increased engagement in occupation. Second, since component interventions are often decontextualized, transferability to a person's daily activities may be minimal. Third, the client has been deprived of the benefits of an occupational intervention which will perpetuate the lack of public knowledge regarding the contributions of occupational therapy.

Defining Occupation-Based Practice

In the Occupational Therapy Practice Framework (2008), occupation-based intervention is defined as "a type of occupational therapy intervention - a client-centered intervention in which the occupational therapy practitioner and client collaboratively select and design activities that have specific relevance or meaning to the client and

support the client's interests, need, health, and participation in daily life" (p. 672). When incorporated into therapeutic treatment, occupation can be used as a change agent. The founders of the profession of occupational therapy believed that when a person is engaged in purposeful and meaningful activity, that individual will experience health enhancement (Molineux, 2004).

Evidence-Based Practice and Occupation

Leaders of the profession of occupational therapy are aware of the importance of evidence-based practice. This is evident in the Centennial Vision of the American Occupational Therapy Association (2007), which states, "We envision that occupational therapy is a ... science-driven, and evidence-based profession..." (p. 613). Although the Centennial Vision was first implemented in 2006, the profession has been concerned with providing evidence of occupational therapy practices for many years.

Scholars of occupational therapy have demonstrated a substantial amount of interest in discovering the impact of occupationally embedded movement on therapeutic outcomes (Nelson, Cipriani, & Thomas, 2001). Occupational therapists often practice in settings which are less than optimal for addressing unique occupations due to unnatural treatment environments such as the hospital or clinic. Therefore, activities are enhanced by simulating the valued occupation as much as possible. One example of an activity of this nature is to have a patient stack one pound weights on a shelf while imagining that the weights are canned goods. Several research studies have been conducted to test these techniques (Ching-Lin, Nelson, Smith, & Peterson, 1996; Ferguson, & Trombly, 1997; Hoppe, Miller, & Rice, 2008; Nelson, Konosky, Fleharty, Webb, Newer, et al., 1996; Thomas, 1996). Two of these studies will be discussed in greater detail.

One study was conducted with adults with hemiplegia and compared task performance of two added-purpose activities with one rote exercise. The first added-purpose activity consisted of bending down to pick up a small ball with the unimpaired hand and then standing up to throw the ball at the target. For the second added-purpose activity, the subjects imagined picking up the ball from the ground with the impaired hand and throwing it at the target. The control group performed rote exercises which were the same motions as the first group but without a ball or target. It was found that the participants completed more repetitions of the first two activities than the rote exercises (Ching-Lin, Nelson, Smith, & Peterson, 1996).

In a similar study with well-elderly women, participants were assigned to one of three groups. Participants in the first group performed a materials-based activity of kicking a balloon. The second group performed an imagery-based activity of kicking an imaginary balloon. The third group performed a rote exercise of performing a kicking movement without a balloon or imagery prompt. It was found that participants in the first group performed significantly more repetitions and required longer self-perceived rest periods than participants in the second and third groups. The researchers concluded that the materials-based activity contained more meaning, which contributed to enhanced performance compared to the imagery-based and rote exercise groups (Thomas, 1996).

It is important to discover the difference in therapeutic outcomes when engaging patients in purposeful versus rote activity. However, research studies which measure outcomes of activities such as throwing a ball at a target or kicking a balloon do not capture the essence of returning patients to their meaningful occupations. Occupations are often as unique as the individual and affected by multiple external contexts, including

the social, cultural, physical, and temporal environments. Therefore, controlled research studies with multiple participants do not completely fulfill the objectives of the occupational therapy profession of finding the impact of unique occupations on health and wellness.

Tomlin and Borgetto (2011) note that the current, commonly used single-hierarchical evidence-based practice model is not sufficient when attempting to prove the effectiveness of occupational therapy intervention. First, research studies which are considered high in rigor in the current model take place in highly controlled environments; replication of these environments in real-world practice is virtually impossible. Therefore, the treatment methods used in these studies may be impractical for therapists to implement or may produce different results within everyday treatment environments.

Second, the holistic, person-centered nature of occupational therapy demands that therapists attempt to capture the lived experiences of clients and support their unique roles and occupations. This is incongruent with the one-size-fits-all interventions required for randomized clinical trials. In an effort to combat the weaknesses of the single-hierarchical model, Tomlin and Borgetto (2011) propose an alternative model, the Research Pyramid. This pyramid acknowledges the usefulness and value of not only experimental research but also qualitative and outcomes research. It recognizes that multiple types of research are needed to move toward achieving best practices in the medical, psychological, and educational communities.

Two single-case qualitative studies were found which explore the effects of occupation-based practice interventions on each subject. Both of these studies illustrate

the value and depth afforded by qualitative research. Both studies provide a unique glimpse into the lives of participants and capture the importance of valued occupation. True client-centered, occupation-based practice is showcased in these case studies which will now be explained in further detail.

A case study was conducted that explored the experiences of a musician who had survived a stroke (Earley, Herlache, & Skelton, 2010). This study analyzed the therapeutic outcomes of modified constraint-induced movement therapy used in conjunction with occupation-embedded interventions. At the beginning of the study, the participant was four years post-stroke and was experiencing a decrease in quality of her violin playing due to decreased motor control. Intervention included preparatory, purposeful, and occupation-based activities that were directed toward achieving the goal of an improved ability to play the violin. At the end of treatment, the participant demonstrated notable improvements in gross and fine motor coordination, upper-extremity strength, and spontaneous use of the affected extremity. The participant was also able to reach her goal of returning to playing her violin in a community symphony orchestra.

Jack and Estes (2010) describe a case report where the treatment approach was shifted from a biomechanical approach to an Occupational Adaptation approach after 10 weeks of therapy yielded minimal improvement. Treatment strategies used within the biomechanical approach were range of motion, scar management, edema reduction, a home exercise program, and splinting. When treatment interventions were shifted to reflect the Occupational Adaptation approach, the client achieved personally meaningful

goals of manipulating door knobs, producing a signature, independently paying for items at the grocery store, and controlling the car window were achieved.

Qualitative research studies, like the ones described above, should not be discounted from the scientific community. They provide rich data and reveal aspects of human behavior which may not otherwise be explored. Important specifically to occupational therapy, qualitative research grants the researcher the opportunity to explore the impact of unique occupations on persons in real-world settings. Experimental, outcome, and qualitative designs are all useful research methods and all have their place in scientific inquiry.

Incorporating Occupation in Occupational Therapy

Even though the substantial contributions of occupational therapy to clients have been demonstrated through several research studies, many occupational therapists have difficulty incorporating the specific therapeutic components that are unique to the profession of occupational therapy. Furthermore, many practitioners in the field have difficulty articulating their uniqueness. Based on her experiences with occupational therapists throughout the world, Fisher (1998) asserts that therapists "often use evaluation and intervention methods that are so similar to those of their colleagues in physical therapy, neuropsychology, social work, and nursing that any distinction between occupational therapy and these professions become blurred and even abolished" (p. 558).

A review of the published literature reveals similar observations among other occupational therapists practicing in the field. A study conducted in an acute setting in a hospital in Australia revealed several themes related to the experiences of the occupational therapists working there. The therapists had difficulty describing

occupational therapy. Their descriptions were lengthy and detailed due to the feeling that "a straightforward definition looked far too simple" (p. 189). There was also a "significant gap between what they intended to convey about occupational therapy and what was actually said" (p. 189). This study also revealed that in the hospital setting, therapists are immersed in a culture of professionals who classify patients based on medical conditions, rather than their occupational needs. The researchers came to the conclusion that occupational therapists do not fit well with medicine's philosophy, theory, and practice (Wilding & Whiteford, 2006). This study contributes to the rationale for the present study in that it highlights the challenges faced by practitioners when providing occupational therapy in a medical setting.

One study describes the experiences of two therapists implementing occupation-based practice at a newly opened center for independent and assisted living elders (Goldstein-Lohman, Kratz & Pierce, 2003). These therapists were on a 3-month clinical rotation so were free of the pressures of reimbursement and productivity. Even in this environment, however, the researcher identified that "distinct external forces are at work on both sides of the tug of war that goes on within the therapist's practice, especially between the occupation-based and component-focused approaches" (p. 250). The staff and administrator of the facility tended to more readily accept and understand component-focused practice because of their medically oriented backgrounds. The residents were limited in their occupational choices due to institutional policies. Also, the therapists reported that occupation-based practice was more difficult and required more creativity, custom design, and problem solving than component-based practice.

Another factor that often affects the ability of therapists to provide occupation-based practice is reimbursement. Thomesen (1996) found that federal and state reimbursement mechanisms in the United States "exerted substantial influence on occupational therapy practitioners and affected the selection, scheduling and treatment of patients" (p. 794). Based on the results of this study, the author speculates that therapists were influenced to prioritize the performance components that were addressed during treatment. She states that it is much more difficult to demonstrate functional improvement in leisure management and psychosocial skills than transfers and feeding.

In a later study, Walker (2000) identified that therapists respond to adjustments to managed health care by "pushing against it, going with it, and making the best of it" (p. 129). The therapists in the study express frustrations with no longer being able to use some types of therapy expertise in order to meet productivity. They also mention that excessive documentation decreases their ability to spend time specifically on patient care. Some ethical issues are identified, including over-referral to occupational therapy and the use of group treatment solely for reimbursement purposes. Some positives are identified, as well. Therapists in this environment were encouraged to defend and justify the importance of occupational therapy services. They were also held accountable for their services and encouraged to ensure quality care. These reimbursement issues often affect the ability to provide occupation-based practice; this is one specific environmental factor the researcher wishes to explore in this research study.

Several non-research articles were found that address the difficulties faced by occupational therapists when attempting to provide occupation-based practice. Yerxa (2000) describes her experience as a therapist of gradually moving from automated,

component-based therapy to becoming a sort of detective, attempting to uncover the power of occupation. Fisher (2003) authored a guest editorial entitled "Why is it so hard to practice as an occupational therapist" (p. 193)? In this article, she mentions several scenarios, such as, "A new graduate occupational therapist, well versed in occupational therapy theory, who frequently uses mat activities as therapeutic methods to develop postural control and balance of persons with neurological disorders" (p. 193). Fortune (2000) presents the idea that occupational therapists are "gap fillers" (p. 227). She states that many therapists feel as though the profession lacks a unique identity, and other professionals do not understand the contributions of occupational therapy.

The difficulty of incorporating occupation into occupational therapy is now at the forefront of the profession. Whiteford and Fossey (2002) state that there has been a renewed interest in occupation within the profession beginning in the 1990's. They support this statement by mentioning that there has been an increase in occupation-focused research, utilization of occupation-based treatment models and use of occupational concepts in the terminology used by occupational therapists. Pierce (2001) identifies three specific bridges that need to be built between research of occupation and the use of occupation in practice. The first bridge involves producing an active discourse on translating the theories and research involving occupation to application in daily practice. She notes that occupation is difficult to describe, and translating it into practice is "a demanding, theoretical, action-oriented, and fluid style of intervention" (p. 250).

The second bridge proposed by Pierce is the creation of practice demonstration sites. She describes the importance of these sites in showcasing how the knowledge of occupation can become a reality in practice in different types of settings. The third and

final bridge involves the use of education programs with the specific goal of preparing sophisticated practitioners who are proficient in providing effective occupation-based practice. She mentions the danger of sending new practitioners into a culture which values technical, medical knowledge more than the highly theoretical yet commonsense knowledge unique to the occupational therapy profession. She asserts that in order to combat this danger, there must be a curriculum shift within occupational therapy programs from component-focused, physiological knowledge to the knowledge of occupation (Pierce, 2001).

Wittman (1990) notes that the value placed on holistic treatment in the academic setting may not be carried over to the practice setting due to the demands of the "real world." Burke and Cassidy (1991) speak specifically of the "disparity between reimbursement-driven practice and humanistic values of occupational therapy" (p. 173).

Occupation in Long-Term Care

Occupational engagement in residents of long-term care facilities is necessary for their overall health and wellbeing. One study that examined the contribution of occupation to function in persons with Alzheimer's disease suggests that engagement in productive behaviors such as instrumental, leisure and social tasks may decrease disruptive behaviors in this population (Baum, 1995). A study that describes the occupational need of persons with severe dementia in nine different dementia care settings reveal that these residents had experienced a marked occupational poverty (Perrin, 1997). The results of the study show that these residents engaged in minimal social interaction and passive behaviors for a majority of the time. These studies

illustrate the importance of examining the occupational therapist's role in supporting the return of residents in long-term care facilities to engagement in occupation.

Occupation-based practice requires that the client be involved in the processes of intervention planning and goal setting. However, in the long-term care setting, residents are often dependent upon others to make decision for them. The Lazarus Project, conducted by two occupational therapists, was an attempt to restructure the hierarchical structure of authority in the participating nursing home (Kari & Michels, 1991). In the background information of this article, the authors discuss the effects of institutionalization on elderly residents. They mention that disease and functional loss are usually emphasized because of the medical perspective in these environments. The authors also state that many occupational therapists are "unable to develop a practice that reflects the broad, holistic philosophy of the profession, primarily because their practice has been narrowly redefined by parties outside the field" (p. 720).

Mitchell and Koch (1997) attempt to give a voice to residents by conducting a quality improvement research project in which the residents of a 32 bed nursing home in Australia were interviewed (Mitchell & Koch, 1997). The residents stated that they had a lack of adequate space and privacy and that their daily routines revolved around the schedules of the staff. Another study involves interviewing the matrons of several nursing homes in the United Kingdom (Green & Cooper, 2000). The researchers found that the occupational engagement of residents varied widely amongst the nursing homes participating in the study and was mainly influenced by the involvement of the matron. The researchers point out that the responsibility of setting up an occupationally focused day cannot fall completely on the shoulders of the occupational therapist. All staff

involved must be able to share in the vision of engaging residents in meaningful activity. These studies highlight that institutional environmental factors may be a challenge when attempting to provide client-centered, occupation-based practice.

Application of Theory

The Canadian Model of Occupational Performance (CMOP) was chosen at the outset of this project as the theoretical framework to guide the researcher's thinking throughout the research process. The CMOP highlights the interdependence between the person, environment, and occupation; if one aspect changes, then another aspect is affected. This model positions the person at its center which represents the client-centered focus of occupational therapy (Law, Polatajko, Baptiste, & Townsend, 1997).

The researcher initially chose the CMOP due to its focus on occupation and client-centeredness. However, as this research project progressed, the researcher discovered that the objectives of this project were more closely aligned with the theory of Ecology of Human Performance (EHP). This theory consists of three core constructs: person, task, and context. The relationship between these constructs assists one in understanding performance, a fourth construct. The person uses unique abilities and talents to engage in task performance. Context may influence the person's interests and either assist or impede the person's ability to engage in a task. Tasks refer to the objective sets of behaviors which are needed to accomplish a goal. Task demands determine the required behaviors that are needed by the person to fully participate in the task (Dunbar & Dunn, 2007).

Context includes both temporal and environmental aspects. The temporal aspect is made up of developmental stage, chronological age, life cycle, disability status, or the

span of time within which a task exists. The environmental aspect is divided into three aspects: physical, social, and cultural. The physical environment includes the nonhuman aspects such as tools, equipment, and the building. The social environment is made up of the norms, role expectations, and social routines associated with the person's significant relationships. Finally, the cultural environment refers to the person's associated group and includes activity patterns, behavioral standards, customs, and beliefs, as well as laws and politics (Cole & Tufano, 2008).

When EHP was first designed, the creators emphasized the construct of context because they believed that this construct had been neglected in occupational therapy practice. Context is still a critical part of this frame of reference because it plays a major role in determining possible behaviors and levels of participation. According to EHP, it is impossible to understand performance without discovering the influence of context. A person's performance range is determined by considering the person's skills and abilities along with the context's supports and barriers (Dunbar & Dunn, 2007).

Proof of the use of EHP in practice exists in the current literature. Stav, Justiss, Belchior, and Lanford (2006) describe using this theory to guide their practice of driving rehabilitation. In this instance, examples of contextual factors which may need to be considered are roadway design, driving responsibilities and expectations of each spouse, and season of the year. EHP assists the practitioner in this setting to determine whether or not driving lies in the person's performance range.

Myers (2006) describes the application of EHP to occupational therapy and early childhood transitions. When EHP is applied to this setting, the person construct is the child who will be transitioning. As the child transitions, the contexts will change,

requiring the child to adjust to new physical, social, and cultural environments. EHP guides the occupational therapist, child, and family toward identifying interventions which will assist the child in meeting performance needs for a successful transition. Intervention strategies will address the effect of context on the person and task.

EHP was a useful theory to guide the current research endeavor. During the process of data analysis, the influence of contextual factors on the participant's job performance began to come into focus. EHP provided the researcher a theoretical lens with which to view the data with a clearer perspective. The researcher developed a greater understanding of this therapist's job performance and a possible reason for the gap between occupational therapy scholarship and practice.

Conclusion

The existing literature provides strong support for the necessity of additional research regarding occupation-based practice. The proposed study provides a unique perspective that has not yet been explored. This study will explore the experiences of one occupational therapist who is currently employed at a nursing home in Kentucky. This will contribute to the knowledge of occupational therapists and to the profession as a whole by revealing the thoughts, actions and experiences of this therapist regarding occupation-based practice. This study may serve as the basis for future research studies. It may also facilitate the thinking process about occupation-based practice of other therapists who are working in nursing homes throughout the United States.

CHAPTER 3

METHODS

Research Design

A qualitative research design was used to accomplish the objectives of this project. This form of methodology is used when the study of a group or population is necessary to explore a problem or issue. Qualitative research allows the researcher to obtain a detailed, complex understanding of the issue by meeting people in their natural environments and allowing them to tell their stories; this form of inquiry considers the impact of context on the issue. Qualitative research highlights the uniqueness of individuals by exploring the deeper thoughts and behaviors guiding their actions (Cresswell, 2007).

Qualitative methods have many functions. They are used when other methods of investigation are not practical or ethically justifiable. When little is known about a situation, qualitative research may precede more formal research. Complexities that are beyond the scope of more controlled approaches may be explored using these methods. Another function of qualitative research is "to 'get under the skin' of a group or organization to find out what really happens - the informal reality which can only be perceived from the inside" (Gillham, 2000, p. 10).

The profession of occupational therapy has many formal theories of best practice. However, these theories often do not get translated into practice. The current study seeks to obtain an insider's perspective and find out what really goes on in the informal reality of daily practice as experienced by an occupational therapist. Qualitative research will

allow the researcher to view the case from the inside out and to see it from the perspective of those involved (Gillham, 2000). The unique perspective of this therapist may help to explain why a gap exists between theory and practice. This participant's perspective is significant because she is a practitioner who provides services in a real-life setting.

Qualitative research is founded upon three main philosophical bases. First, human behavior is influenced by context; a person must be studied in his or her context and in the way he or she operates in order to understand him or her in real life. Second, the artifacts that are produced in quantitative research do not always paint a true picture of people in the practice of real life. Third, one can only understand how people behave, think, and feel if one gets to know their world and what they are trying to do in it (Gillham, 2000).

Case study design was the research method chosen for this project. "A case study is a research approach that is used to generate an in-depth, multi-faceted understanding of a complex issue in its real-life context" (Crowe, Cresswell, Robertson, Huby, Avery, et al., 2011, p. 1). This form of research assists with answering the explanatory questions of 'how,' 'what,' and 'why.' Unlike experimental designs where the environment is deliberately manipulated, case studies allow the researcher to understand an issue in its natural context (Crowe, Cresswell, Robertson, Huby, et al., 2011). A case study design was chosen for this research project because the researcher wished to gain increased understanding of this therapist's daily delivery of occupation-based practice within the context of a skilled nursing facility.

More specifically, this type of research study is classified as an instrumental case study. Stake (1995) explains that instrumental case study research is used when there is "a research question, a puzzlement, a need for general understanding" (p. 3) and insight may be gained from studying a particular case. The researcher of the present study is puzzled by the gap which exists between the theories of occupational therapy and the actual implementation of occupational therapy. It is hoped that an exploration of this particular case will provide insight into this puzzlement.

Participant

When identifying the case to be explored, researchers engage in purposeful sampling. Cases may be chosen based on a particular perspective the researcher wishes to portray, or cases may be ordinary, accessible, or unusual (Creswell, 2007). The researcher of the current study used convenience sampling to choose an accessible case. This participant was referred by the occupational therapy fieldwork placement office at the university where the student researcher was enrolled.

Inclusion criteria were that the participant must be a licensed occupational therapist and working in a skilled nursing facility in Kentucky. Exclusion criteria were occupational therapists at settings other than a skilled nursing facility and therapists who were located more than 100 miles away. This study included one Caucasian female participant between the ages of 25 and 60. By giving informed consent, she willingly agreed to share her experiences through a series of interviews designed to collect information on her perspective of providing occupation-based practice in a skilled nursing facility.

Description of Facility

The participant was employed at a skilled nursing facility owned by an international, for-profit company. At the time of the interviews, the facility housed 86 patients and employed 115 staff members, including housekeeping, dietary, nurses, director of nursing, and administrator. The therapy department consisted of 10 staff members, including 3 full-time occupational therapists. The facility contained 93 beds, with 80 semi-private rooms and 13 private rooms. Patient services were covered by Medicare, Medicaid and private insurance.

The rehabilitation area in the facility was a large open room with several pieces of equipment placed throughout the room. Large, immovable equipment pieces included a large flatscreen television, parallel bars, two plinths, a recliner with an automatic lift, an exercise bike, and a treadmill. A movable weight storage rack contained free weights, wrist weights, and Theraband. Small equipment pieces included several arm bikes, cones, weight bars, weighted balls, balloons, overhead pulleys, and a target with velcro tennis balls.

Adjoining the rehabilitation room was a courtyard which could be seen through several windows and a glass door. The courtyard contained a gazebo, picnic tables, and several small square flowerbeds which were raised approximately two feet from the ground. Opposite the courtyard, the rehabilitation room opened up into a kitchen, equipped with a refrigerator, stove, microwave, cabinets, and a sink. A washer and dryer were also located in the kitchen area. A handicap accessible bathroom was attached to the rehabilitation room and contained a bathtub with handheld shower, two grab bars, and

a tub bench. The toilet was covered with a freestanding bedside commode. The bathroom sink was wheelchair accessible.

Interviews

Three semi-structured interviews were conducted to gather data for the purpose of this research project. The first interview was a face-to-face interview and was conducted at the skilled nursing facility where the participant was employed. This interview lasted for one hour and fifteen minutes and took place in a quiet area within the facility.

Questions during this first interview were asked with the aim of exploring the day-to-day experiences of this therapist as she provided treatment to clients (See Appendix A). Questions were asked about her strategies in regards to the different stages of treatment, including the development of a treatment plan, intervention planning and implementation, and stories of specific treatment sessions. The participant was also questioned on how occupation-based practice was affected by the physical environment, views of her colleagues, documentation, and reimbursement. She was also asked to describe how she felt at the end of a day of working at this skilled nursing facility.

The second interview was conducted via email and included three questions (See Appendix B). In this interview, three questions were asked. The purpose of the first question was to develop a deeper understanding of how the participant defined OBP. A second question was asked to explore what she learned in school about OBP and whether or not she used that knowledge in current practice. She was also asked whether or not she practiced within a frame of reference.

The third and final interview lasted for 32 minutes and was located in the same area as the first face-to-face interview. This was a follow up interview to obtain

clarification of previous interview responses and to ask additional questions with the intention of reaching saturation (See Appendix C). Also, since the previous interview, new policies and procedures had been implemented at the facility, and the researcher wished to get the participant's perspective on these changes. Additional questions were asked about assessment and documentation strategies, leisure occupations, and interaction between therapy disciplines.

Data Collection Procedure

This research project was approved by Eastern Kentucky University's Institutional Review Board. An informed consent form was signed by the participant (See Appendix D). All necessary precautions were taken to ensure confidentiality of this participant. All identifiable information was kept in a secure location. Initials only were used in the transcription of interviews and a pseudonym was used when referring to the participant within the text of this project.

The researcher contacted the participant to set up appointments for interviews at her convenience. Open-ended, semi-structured interviews were conducted. The two face-to-face interviews were audio recorded. Interviews were conducted until saturation was reached. The researcher transcribed interviews verbatim onto computer and printed the entire interview transcripts to have hard copies for organization of data analysis.

Data Analysis Procedure

Creswell (2007) describes data analysis as resembling a spiral, in which "the researcher engages in the process of moving in analytic circles rather than using a fixed linear approach" (p. 150). Throughout data analysis, the researcher moves in circles, touching on different facets of analysis again and again. The spiral begins with raw

collected data and ends when the researcher has produced an account or narrative of the data (Creswell, 2007).

In the present study, the first step completed by the researcher was to carefully read the transcription of the first interview. Then, the researcher completed first level coding by examining each individual response given by the participant and labeling significant phrases or excerpts with in vivo codes. A traditional coding technique was used, which involved cutting coded data from transcripts, and placing them in envelopes labeled with their assigned codes. First-level coding generated 24 codes.

Two more interviews were conducted with the participant to reach saturation. The researcher completed the same coding techniques described above with these interview transcriptions. Initially, the 24 codes were collapsed into 4 categories. During this process, the researcher completed several peer debriefing sessions with research advisors to verify the results. Within the course of several sessions, the researcher discovered that the original codes and categories did not adequately represent the case. Based on these peer debriefings and reflexivity notes, the researcher realized that previous coding attempts reflected the researcher's personal interpretations instead of a pure, unbiased depiction of the participant's experiences.

The researcher made a fresh attempt to bracket personal experiences and returned once more to the data. As the researcher again reflected upon the meaning of the data, codes were revised and the end result was 29 codes and 4 categories. Out of the 4 categories, three themes emerged from the data. To preserve the voice of the participant, exact quotes were used for themes: "The long-term goal is to increase my patient's level

of functional ADL performance," "I'm constantly watching my little stopwatch," and "I like the bio-mechanical aspect of OT as well as the occupational aspect."

Data Verification

As described above, several peer debriefings assisted the researcher in remaining true to the data and identifying biases which were clouding data analysis. These discussions also revealed that the researcher had certain expectations of how the participant would respond and struggled when these expectations were not realized. Several one-on-one debriefing sessions occurred in the offices of committee members. One debriefing session included the researcher and three committee members and was held at a time and place of convenience for all parties involved.

The researcher engaged in bracketing by writing thoughts, biases, and personal revelations in a digital journal and referencing them periodically throughout data analysis. One revelation which occurred through this process was that the researcher had a fear of offending the participant. In the beginning of data analysis, this fear prevented the researcher from fully delving into the data. The researcher realized, however, that this was an unfounded fear given the stipulation that data analysis was performed properly and the voice of the participant captured adequately.

The process of data analysis was documented through an audit trail. This strengthened verification by providing a record of the researcher's thought processes along the way. The audit trail contained the initial arrangement of codes into categories, as well as the original arrangement of four themes. The final compilation of codes and categories into the three themes was referenced multiple times as the researcher reported the findings within the results chapter of this project.

Member checking occurred two times within the process of data analysis. Once the initial four themes were identified, preliminary results were sent to the participant via email. She reviewed them and stated, "all sounds good to me." Final results were approved by the participant at the completion of the project.

CHAPTER 4

RESULTS

This case study sought to describe the experiences of an occupational therapist in delivering occupation-based practice at a nursing home in Kentucky. The occupational therapist chosen for this study was a credible source from which to collect information regarding this topic. She received her education in occupational therapy from a reputable university. At the time of the interviews, she had been a practicing therapist for over ten years and possessed previous experience as a rehabilitation coordinator of a skilled nursing facility. As a woman from a small town, she was representative of many occupational therapists.

Sarah was a dedicated worker and would often spend more than eight hours a day at her job. She strived to provide quality, client-centered care. Sarah enjoyed working with the geriatric population. Not only did she genuinely care about the patients on her caseload but she also went above and beyond by building relationships with other patients in the nursing home. She stated that some of the full-time residents had "become part of our family." One patient, in particular, would shave in the therapy bathroom, and Sarah would periodically clean his electric razor for him. Sarah also described having a good relationship among the therapists in the department. She stated, "We laugh, we joke, we really have a good rapport down there among all of us therapists."

Sarah's thoughtful responses to interview questions provided rich descriptions of her experiences in providing occupation-based practice in a nursing home. During a careful analysis of the data, three themes emerged and were identified as being pertinent

to the topic of this research study. Direct quotes from interview responses were chosen as theme titles as an attempt to fully capture the voice of the participant. These themes will now be identified and discussed in greater detail.

"The long-term goal is to increase my patient's level of functional ADL performance"

As the researcher carefully examined the interview transcriptions, a discovery was made that the topic of discussion often returned to activities of daily living and instrumental activities of daily living. This topic permeated the data and emerged as a major theme. This theme was woven throughout Sarah's interview responses. As topics such as evaluation techniques, intervention goals, professional relationships, and facility layout were discussed, Sarah revealed that her experiences with occupation-based practice mostly involved the areas of activities of daily living and instrumental activities of daily living.

Beginning with assessment, Sarah's primary concern was to identify the daily living activities which patients were having difficulty performing and return them to their prior level of functioning in those activities. Her primary method of obtaining this information upon evaluation was an informal interview with patients. She would ask them to describe their home environment and their performance in self-care activities before being admitted to the facility. She would also observe them while engaging in daily living activities to identify problem areas.

Sarah felt as though she was "in the business" of helping patients to safely and independently return home. She would identify the activities which made up patients' daily routines before entering the facility; these included activities such as dressing, bathing, shopping, or cooking. Then, she would formulate intervention plans to return

them to engaging in these activities. She perceived that her role as occupational therapist within the facility was to assist patients in returning to their activities of daily living and instrumental activities of daily living so that they could return home. Sarah's introduction of herself to a new patient best illustrates this point:

> "I'll say, 'My name is Sarah and I'm the occupational therapist here. It's my job to look at your prior level of function in and at home. It's my job to get you to that point again so I can get you back home. That requires me to look at your basic self-care.'"

Sarah believed that all of her treatment strategies needed to point to the overall goal of improving patients' skills in functional daily living activities. She would set a short-term goal of improving standing tolerance to ultimately achieve the goal of performing a home management task or lower body self-care. She felt most successful as a therapist when she was able to assist a person who had sustained a stroke to attend to the left side, pick up a fork or a glass, and begin to engage in feeding independently.

Many of the women who were at the facility for short-term rehabilitation desired to regain the ability to stand in the kitchen and cook. If they were unable to cook full-course meals, Sarah would modify the activity by purchasing TV dinners. Many of her patients enjoyed preparing fresh vegetables from the garden and eating them as a snack or simple meal. Sarah believed that she was performing occupation-based practice when addressing ADL skills of interest to patients.

Sarah perceived that the facility provided many opportunities for her to address the daily living skills of her patients. She mentioned that many patients enjoyed retrieving vegetables from the garden. She also described using patients' rooms to practice making the bed, retrieving clothes from the closet, and standing at the sink to

perform grooming activities. The following quote provides a rich description of the working environment from her point of view:

> We're very fortunate to have the therapy department that we do because we do have the kitchen area with the washer and dryer, which allows for opportunities for female and male patients, those getting near their prior level of function, going home, needing to prepare meals, needing to wash clothes. That's the perfect opportunity, and that setting provides that perfect opportunity for us to see how they would function in their home setting. Is it safe? Are they able to plan and prep and problem-solve? We do have the bathroom which I pointed out to you and that also provides us with opportunities to see how a patient can perform in that setting. Are they going to be able to do this when they get home? If not now, what do we need to work on so that we can get them home?

Of all of the areas of occupation described in the Occupational Therapy Practice Framework (American Occupational Therapy Association, 2008), activities of daily living and instrumental activities of daily living were Sarah's first priority. She felt as though this focus on daily living activities would ensure that her patients were ready to return home safely and independently by the time of discharge. She viewed ADL skills as "the basics" and wanted patients to achieve these goals before moving on to other areas, such as leisure. She believed that if a patient achieved independence in daily living activities, independence in leisure occupations would often fall into place.

As proven through a thorough description of the first theme, activities of daily living and instrumental activities of daily living were a major aspect of Sarah's experiences in providing occupation-based practice in a nursing home. Sarah believed that as long as she was addressing a daily living activity of patient interest, she was providing occupation-based practice. Improving these skills in patients was important to Sarah because it meant that they could return home, safely and independently.

"I'm constantly watching my little stopwatch"

Another theme which emerged during data analysis was that Sarah believed that time was the main barrier to providing occupation-based interventions. During her first interview, she stated that she had ten patients on her caseload, and those treatment minutes amounted to more than an eight hour day. Most of her day was governed by trying to stay ahead of treatment minutes and meet productivity requirements. She stated that time constraints prevented her from being the therapist that she wanted to be. This point is best illustrated by the following quote:

> "Knowing I've got to go see Mr. so and so for 50 minutes but then I still have a 60 minute treatment left here. I want to do this with them and I've got to get down here and do this with this person. Well, he's leaving for a doctor's appointment at 1:00 and I mean, again, it's just kind of juggling. Honestly, I don't want to be here at 6 o'clock every single night, so it's trying to do my job, take care of my patients the way that I want to and to keep my sanity."

Time constraints also prevented Sarah from using standardized assessments when evaluating a patient. She stated that she wished she were able to use them and acknowledged the usefulness of standardized evaluations as justification for reimbursement. She obtained the information she needed to formulate a plan of care through conversation and observation. She appeared to struggle with this reality, and said, "You know, I'm almost embarrassed to say, you being an EKU student, but I don't do a lot of standardized assessments."

Sarah stated that because she had a limited amount of time, it was not always possible to obtain all of the necessary information on the first evaluation. To adjust to this challenge, Sarah viewed patients' plans of care as an ongoing process and believed that it was never too late to add a goal. During subsequent treatment sessions, she would

converse with patients about their progress or any difficulties impeding their independence. Also, if she learned during a treatment session that a patient had a particular interest, she would try to incorporate that interest into a future session. When approaching discharge, she would ask patients if there were any areas they would like to work on before going home.

During the time of the interviews for this research project, Sarah's company was going through changes related to reimbursement due to new governmental regulations. After these changes took effect, the mandate for fulfilling the treatment minutes with each patient became even more rigid. Sarah was given an iPhone which she carried with her throughout the day. Before and after each treatment encounter, she was required to start and stop a timer on the iPhone which calculated her treatment sessions to the minute. She stated, "I'm constantly watching my little stopwatch here, as I was before, my watch, but now you have to make sure that you get those minutes every single day."

Sarah did identify one outcome to the reimbursement changes which she viewed as positive. Once the regulations took effect, therapists were no longer allowed to see patients within a group. Sarah stated that she did not mind the one-on-one treatments. In fact, she enjoyed them because she felt as though she was able to provide more individualized treatment.

In addition to the concern of productivity, Sarah was required to treat and discharge patients within a certain timeframe to ensure approval for reimbursement. Sarah sometimes found it challenging to address all of the necessary goals before discharging patients. Throughout the course of treatment, she would check with patients to see if anything needed to be addressed in preparation for a safe return to their home

environments. She described herself as sometimes scurrying around, trying to address one last goal so that she felt comfortable discharging a patient to independently return home.

Sarah's rehabilitation manager had the responsibility of keeping therapists productive and carrying a full caseload. To do so required shifting patients from one therapist to another. A patient would be evaluated by Sarah and then assigned to another therapist to carry out the treatment plan. Sarah stated that in these instances, it was difficult to develop a relationship with these patients and provide client-centered care.

Sarah also spoke about being responsible for a substantial amount of paperwork. For each patient, she had to complete daily notes, weekly notes, evaluations and discharge summaries. She described needing to be "strategic" throughout the day to avoid accumulation of paperwork. For example, she would attempt to write a note when her patient was having a rest break during a treatment session. As evidenced by the following quote, large amounts of paperwork contributed to an already hectic day:

> I've got 10 people right now and you've got daily notes and some days you have weekly notes. Some days you have to write up an eval. Some days you have a discharge summary to write up. So I think that from the moment you walk through this door, your mind is just going, going, going and so yes, I know there are times when I forget to maybe address something that I should have or maybe my patient told me something and I didn't write it down.

Sarah explained that she attempted to adjust to the pressures of daily practice in the best way she knew how. She tried to take full advantage of the time allotted for each patient. She said that flexibility was necessary for this job. Some days would run smooth, and other days would leave her physically and mentally exhausted.

Sarah was asked how her typical day would look if reimbursement, treatment space, and equipment were not an issue. She envisioned less stress, less focus on treatment minutes, more time spent with patients, and a greater focus on patients' needs and interests. She conveyed that she was frustrated with the current system. The following quote adequately captures her thoughts on this issue:

> "When you're on the clock and the time's ticking and maybe you wish you had a little bit more time with that patient that day ... What I would do differently? Do away with all the laws. I mean I know that's not possible and that's in a make believe world but I'm going to get on my soapbox for a minute. Sometimes I think that laws and regulations are set by people who are not therapists and it's very difficult for them to understand where we're coming from. I think we're the best judge of how things should be handled and you know you've got corporate business minded people who are interested in reimbursement."

Given all of these considerations, it is evident that Sarah had little time for treatment planning. Sarah often had to think on her feet. To address the meaningful occupations that are unique to every single patient is time-consuming. The time constraints that Sarah faced on a daily basis did not allow her to engage in the individualized planning of client-centered care. She considered her day a success when she was able to meet productivity expectations, get her patients seen for their allotted number of minutes, and complete all of the paperwork requirements.

"I like the bio-mechanical aspect of OT as well as the occupational aspect"

A third noteworthy theme which emerged during data analysis was that Sarah enjoyed performing occupation-based, as well as bio-mechanical, interventions. She believed that she could incorporate both intervention methods to perform occupation-based practice. Some of her treatment activities would include components such as standing tolerance, strengthening, progressive resistive exercises, activity tolerance, and

sensory stimulation. She stated that many patients were de-conditioned due to hospital stays and therapeutic interventions needed to begin at this level. In the following quote, she conveyed an awareness that disagreements exist within the occupational therapy profession regarding the use of bio-mechanical interventions:

> "I'll probably be shot for saying this. I know that there are a lot of OTs out there who are very against ther ex, but there are times when I feel like it's necessary. You know, it takes so little for someone to decondition. They can be very weak, very low activity tolerance, and so that's when I think it's important to maybe work on those areas"

One interesting phenomenon which Sarah spoke about was that occupational therapists often focused on patients' upper bodies and physical therapists focused on the patients' lower bodies. Sarah stated, "PT lower body, OT upper body, and I think that's been going on for so long. I don't think that will ever change." She then said, "I can't say that I mind that because I love shoulders and hands and fractures." She proposed a couple of reasons for this phenomenon. She stated that during her schooling for occupational therapy, her Advanced Anatomy class focused on the upper body, whereas the lower body was covered in a matter of a day. She also believed that physical therapists had more than enough lower extremities to deal with.

When describing her documentation, Sarah felt as though the use of component terminology was necessary for reimbursement. For instance, when writing a daily note, she would describe patients' standing balance, problem solving, sequencing, safety awareness, activity tolerance, etc. She referred to this terminology as "clinical" and believed that this language would make her services "sound skilled."

The third theme highlights that Sarah believed that the use of bio-mechanical interventions was an acceptable vehicle toward returning patients to valued occupations.

After acknowledging the difference of opinion in the field regarding this topic, Sarah remained steadfast in her belief that these interventions were useful and necessary within occupational therapy practice.

Conclusion

The research objective of this case study was to explore the experiences of an occupational therapist delivering occupation-based practice at a nursing home in Kentucky. The data from the three interview transcriptions yielded a wealth of information with which to achieve this objective. The three themes which emerged were that activities of daily living were a prominent part of this therapist's experiences, time was a factor affecting her job performance, and bio-mechanical interventions were an aspect of her therapeutic techniques.

CHAPTER 5

DISCUSSION

The aim of this study was to describe an occupational therapist's experiences of providing occupation-based practice at a skilled nursing facility in Kentucky. Results revealed some discrepancies between this therapist's thoughts and experiences of occupation-based practice and the definitions and theories put forth by occupational therapy scholars regarding this topic. This is a significant finding as it touches on a pertinent topic which has been the focus of debate and discussion within the occupational therapy profession (Hasselkus, 2002; Kielhofner, 2005; Nelson, 1996; Pierce, 2001; Wu & Lin, 1999). This study contributes to this discourse by providing a practitioner's experience of occupation-based practice within a real-world setting

Central concepts that emerged in the results were: a focus on activities of daily living, time constraints, and the use of bio-mechanical intervention strategies. The credibility of this study's findings is strengthened by the content of occupational therapy literature regarding this topic. In an effort to triangulate the data, the researcher will provide commentary of each theme and make connections with literature which already exists.

Ecology of Human Performance

As the researcher analyzed the data, it became apparent that Sarah's job performance was greatly influenced by context. This coincides with Ecology of Human Performance (EHP), a theory which already exists within the occupational therapy profession. As previously mentioned, EHP recognizes context as a major factor affecting

task performance (Cole & Tufano, 2008). EHP assisted with untangling the complexities associated with Sarah's provision of occupation-based practice in a skilled nursing facility by guiding the researcher to consider contextual aspects. Therefore, the effects of context on Sarah's job performance will be explored within the content of each theme.

"The long term goal is to increase my patient's level of functional ADL performance"

An analysis of research interviews revealed that this therapist's descriptions of the use of occupation in practice were concentrated in the areas of activities of daily living and instrumental activities of daily living. The Occupational Therapy Practice Framework (American Occupational Therapy Association, 2008) acknowledges that occupation encompasses several areas. These areas include activities of daily living (ADL), instrumental activities of daily living (IADL), rest and sleep, education, work, play, leisure, and social participation. The role of the occupational therapist is to discover those occupations that are important to each individual client. Sarah's focus on activities of daily living and instrumental activities of daily living is an important finding, as it reveals a narrow focus on two areas of occupation.

Similar findings have been reported in the literature. A study by Nelson and Glass (1999) identified occupational therapists' involvement in the Minimum Data Set, a comprehensive, federal assessment of residents in skilled nursing facilities who receive Medicare or Medicaid. A discovery was made that therapists were most involved with the items on the assessment pertaining to activities of daily living. Only a small percentage reported contributing to the section dealing with communication and

psychosocial well-being. The researchers note the discrepancy between the profession's claim to comprehensive, holistic care and the narrow scope of these therapists' practice.

This finding also coincides with an article by Gray (1998) who states that in many rehabilitation facilities, the focus of treatment planning is often on feeding, bathing, toileting, grooming, hygiene, and dressing. Gray acknowledges the importance of these skills but warns that therapists often use them reflexively and do not first analyze their therapeutic impact. In order for them to be truly therapeutic, these occupations must be identified by the patient as important and valuable. Gray states that all domains of occupation that are of interest to the person should be addressed.

The tools and equipment within Sarah's environment provided her with many opportunities to address activities of daily living and instrumental activities of daily living. Therefore, the physical environmental context within the facility prompted her to focus on these areas of occupation when planning interventions for patients. The impact of the physical environment on occupational therapy practice has been discussed in the literature. In a qualitative research study conducted by Skubik-Peplaski, Rowles, and Hunter (2012), occupational therapists from a rehabilitation hospital reported that their intervention strategies were greatly influenced by the equipment available in their environment.

Specht, King, Brown, and Foris (2002) state that although occupational therapists recognize the importance of a balance of self-care, productivity, and leisure, the occupation of leisure is addressed the least in practice and research. This statement is congruent with the findings of the present study. Sarah claimed that she usually did not

obtain information from patients regarding leisure during evaluation. She also had difficulty thinking of a time when she addressed a particular leisure interest of a patient.

This lack of focus on patients' leisure interests may be due, in part, to the environmental social context, which includes role expectations. Sarah seldom collaborated with the facility's activities staff, and the roles appeared to be clearly defined. Sarah's role was to address activities such as bathing, dressing, and cooking while the activities staff provided opportunities for the patients to engage in leisure activities such as Bingo, birthday parties, and spiritual activities. When providing a description of her role, Sarah stated "I'm the occupational therapist here. It's my job to look at your prior level of function in and at home. It's my job to get you to that point again so I can get you back home." Fortune (2000) claims that therapists often struggle with lack of a clear identity. Perhaps Sarah's claim to addressing activities of daily living provided her with a unique identity within the facility.

Another aspect of the social environmental context which influenced Sarah to focus on activities of daily living was her coworkers' expectations of her role. She felt as though they did not completely understand what she was trying to accomplish with patients. Since Sarah's coworkers believed she was responsible for patients' ADL function, they often relied on her when they needed assistance with patients. She would often involuntarily work on activities of daily living, at the request of coworkers, causing her to spend even more time on this particular area of occupation. A possible explanation for this is identified by Fortune (2000) who stated that "a lack of clear identity amongst occupational therapists can result in a tendency to accept the identity imposed upon them by their workplace colleagues" (p. 229).

When asked if she addressed patients' spirituality occupations, Sarah stated that she was not sure if she would know how to do this. Kirsh (1996) affirms this sentiment by stating, "methods of addressing and enhancing spirituality in occupational therapy practice remain relatively unexplored within the profession" (p. 55). Kirsh then proposes that a narrative approach may be used to incorporate spirituality into occupational therapy practice.

"I'm constantly watching my little stopwatch"

Another major theme which emerged during data analysis was that Sarah's job performance was influenced by the temporal context. This is a very important point to consider because it greatly affects a therapist's ability to provide the client-centered care required for occupation-based practice. Burke and Cassidy (1991) reiterate this point by stating that therapists "must spend considerable time and energy getting to know each patient as a person" in order to "create individually designed, personally meaningful treatment programs" (p. 173).

Reimbursement is a major factor contributing to these time constraints. In the words of Benjamin Franklin, "time is money" (Ketcham, 1965/2003, p. 51). This is no exception when referring to the current reimbursement-driven healthcare system. Like many therapists employed in skilled nursing facilities, Sarah worked for a for-profit organization. Therefore, her company was interested in maximizing the profit gained from her services.

Many of Sarah's company policies regarding documentation were written to ensure that Sarah's services would be reimbursed. These policies required Sarah to complete a substantial amount of paperwork, including daily notes, weekly notes,

evaluations and discharge summaries. This finding was similar to the findings of a study conducted by Thomesen (1996). The results revealed that the majority of nursing homes had formal written policies regarding documentation due to the impact of documentation review on government reimbursement.

The therapists in a qualitative study conducted by Walker (2001) reported that managed healthcare exerted substantial influence on their job performance. They had to utilize abbreviated assessments and complete excessive amounts of documentation. They were no longer able to use certain types of expertise, and the focus of treatment shifted to productivity demands and meeting treatment goals in a limited timeframe. Another qualitative research study explores the experiences of students related to their observations of ethical tensions during OT fieldwork education experiences (Kinsella, Park, Appiagyei, Chang, & Chow, 2008). The students observed that these therapists dealt with overly large caseloads and were given inadequate time to spend with patients.

Kielhofner (2005) writes about a gap between "the everyday practice of occupational therapy and the vision of occupation-focused practice articulated in the literature" (p. 232). He echoes the findings of the current study when he mentions that two factors contributing to this gap are the high productivity demands in everyday practice and specific expectations of reimbursement entities. Jack and Estes (2010) maintain that even in the face of productivity demands and limited treatment time, therapeutic relationships must be formed to provide the best patient care.

The temporal context greatly influenced Sarah's job performance. Productivity, excessive documentation, and pressures to discharge patients as soon as possible all contributed to the time constraints she experienced. In Sarah's words, "I feel like I can't

be the therapist that I want to be with those constraints." All of these demands left little time for Sarah to concentrate on the unique, individual needs of each patient which ultimately affected her ability to provide client-centered, occupation-based practice.

"I like the bio-mechanical aspect of OT as well as the occupational aspect"

Sarah's interview responses indicated her awareness of a debate which exists within the profession regarding the topic of bio-mechanical interventions; the occupational therapy literature provides ample evidence of this debate. When reviewing the practice models of the profession, Reed and Sanderson (1999) state "the biomechanical approach does not incorporate the strengths of occupational therapy service delivery" (p. 250). They mention, however, that many therapists believe that it is valuable for the acute phase of treatment and as a communication tool between health care team members.

In his book dedicated to the conceptual foundations of occupational therapy, Kielhofner (1997) states, "While the debates over occupational therapists' use of physical agents, exercise, and passive techniques have been heated, it seems that there are two legitimate sides to the argument" (p. 120). He explains that one risk in utilizing biomechanical interventions is that therapists may begin to rely solely on this treatment method and move away from the occupational aspects of treatment. On the other hand, Kielhofner (1997) states that this form of intervention may be useful when used in addition to treatment methods which focus on occupational functioning.

Jack and Estes (2010) assert that a biomechanical approach is valuable in many cases; however, they encourage using this approach in conjunction with an Occupational Adaptation approach to address the need for treatment strategies that are holistic and

client-centered. They recognize that the demands of today's health care system makes this endeavor challenging and that examples of how to shift to client-centered approaches have not yet been published. However, they believe that barriers to this type of practice must ultimately be overcome if the needs of patients are to be met in the best possible way.

A study conducted by Jackson and Schkade (2001) compared the Biomechanical-Rehabilitation Model with the Occupational Adaptation Model. This study was based on three hypotheses that the Occupational Adaptation approach would yield greater gains in functional independence outcomes, contribute to greater patient satisfaction with OT intervention, and result in more patients being discharged to a community setting instead of a more restrictive setting. Differences in functional independence outcomes between the two groups were not statistically significant and did not support the first hypothesis. The second hypothesis was supported as participants did report significantly more satisfaction with the Occupational Adaptation approach. The results failed to support the third hypothesis that the Occupational Adaptation approach would contribute to better discharge outcomes.

One point made by Gray (1998) which is congruent with the present study is that the treatment equipment available within the physical environment of the facility often influences therapists to use a component-focused approach. For example, pegs and cones are often "chosen for their potential to provide repetitive, structured practice of a specific component" (p. 355). This was similar to Sarah's experiences; when she described the specific interventions she used, she mentioned using the equipment available to her within the facility. She spoke about using the bicycle for cardiovascular workout and the

treadmill to increase endurance or activity tolerance. This is evidence that the physical environmental context contributed to Sarah's choice to include biomechanical interventions when planning treatment.

The cultural environment, which includes the politics and laws of the collective group (Cole & Tufano, 2008), may have influenced Sarah to provide component-focused treatment strategies. Within Sarah's work environment, certain laws existed in regards to reimbursement of therapy services. As Sarah talked about documentation, it became evident that her treatment plans were influenced by her view of reimbursable activities.

Sarah worried about the possibility of not getting reimbursed if she did not carefully choose her wording. For instance, when addressing a goal to cook a meal, she would document the activity by describing standing balance, problem solving, sequencing, safety awareness, rest breaks, etc. This same concern is faced by many other occupational therapists in the field. The current president of the American Occupational Therapy Association (Clark, 2011) states, "In talking with people whose work is to review Medicare claims, I'm told we hesitate to fully document the familial, cognitive, and occupation-based aspects of our interventions. Instead, we have a tendency to overemphasize motor-based components" (p. 620). She speculates that practitioners may lack confidence, feel intimidated, or doubt that they are able to get reimbursed for all that occupational therapists do.

Researcher's Conclusions

This case study fulfilled the researcher's quest to obtain the experiences of an occupational therapist in delivering occupation-based practice at a skilled nursing facility in Kentucky. The underlying objective of this project was to address the problem of a

gap which exists between the philosophy of occupational therapy and it's implementation in everyday practice. Therefore, at the conclusion of this project, a necessary question arises: "Does this gap exist between the philosophy of occupational therapy and the practice of this therapist?" The researcher has come to the conclusion that the answer to this question is "yes" and "no."

This therapist's actions of addressing daily living activities were in accordance with the philosophy of the profession. Activities of daily living and instrumental activities of daily living are two areas addressed by occupational therapists. Based on Sarah's interview responses, she addressed only those daily living activities which were meaningful and important to patients, which revealed that these treatment sessions were occupation-based. However, her narrow focus on two areas of occupation was not in keeping with the theories of occupation-based practice.

One possibility exists that, given the choice between every area of occupation, clients would indeed choose to address activities of daily living. This would be a probable scenario since the majority of patients receiving rehabilitation services at this skilled nursing facility were most interested in returning home as soon as possible. Achieving independence in activities of daily living would advance them toward this end.

However, Sarah indicated that during initial evaluations with clients, her description of services offered by the occupational therapist only included self-care. If patients were aware of the complete list of occupations addressed by occupational therapists, they may opt to focus on an occupation other than activities of daily living or instrumental activities of daily living. In order to provide occupation-based intervention, an occupational therapist must consider all areas of occupation during service delivery.

As previously stated, Kielhofner (1997) warns of the tendency of therapists to begin to rely solely on biomechanical interventions. Sarah may have practiced in this manner at times, as evidenced by the following description of a particular patient on caseload during the time of the interview, "He is independent with his total body dressing, toileting, but he could use some upper body strength." On the other hand, Sarah demonstrated that she made an attempt to combine biomechanical interventions with occupation-focused methods to achieve occupational functioning. The following statement spoken by Sarah illustrates this point: "...it's easy to incorporate it altogether and to make it work and to make it occupation-based."

An analysis of interview responses revealed that Sarah was a dedicated professional who took pride in her work as an occupational therapist. She maintained positive relationships with patients and colleagues. She demonstrated leadership capabilities within the field as evidenced by previous experience as rehabilitation coordinator of a long-term care facility. Therefore, it is concluded that the gap between the profession's scholarship and this particular therapist's practice speaks volumes; if this occupational therapist, who is an accomplished professional in the rehabilitation setting, exhibits difficulty aligning her actions with the values of the profession, it stands to reason that other therapists may have similar experiences.

The researcher has concluded that, in this particular case, the influence of the surrounding context may have contributed to the gap between scholarship and practice. Each of the four contexts identified in the theory of Ecology of Human Performance influenced Sarah's job performance. The first theme, "the long-term goal is to increase my patient's level of functional ADL performance," was affected by the physical and

social environmental contexts. The second theme, "I'm constantly watching my little stopwatch," demonstrated the effect of the temporal context on Sarah's delivery of occupation-based practice. The third theme, "I like the bio-mechanical aspect of OT as well as the occupational aspect," was influenced by the physical and cultural environmental contexts (See Table 1). This discovery may contribute to the profession of occupational therapy by providing the basis for future research which investigates if other therapists are similarly impacted by context. If it is discovered that context does, in fact, affect the therapist's ability to provide occupation-based practice, this finding may provide direction in moving toward the goal of uniting scholarship with practice.

Table 1
Ecology of Human Performance

	Environmental Context: Physical	Environmental Context: Cultural	Environmental Context: Social	Temporal Context
Theme #1	X		X	
Theme #2				X
Theme #3	X	X		

Source: Dunbar, S.B. & Dunn, W. (2007). Ecology of human performance model. In *Occupational therapy models for intervention with children and families* (127-155). Thorofare, NJ: SLACK, Inc.

Implications for the Profession of Occupational Therapy

Although a significant amount of the profession's thought, scholarly writing, and educational curriculum changes have been directed toward the goal of aligning scholarship and practice, much work is still to be done. The current study and other

scholarly work reflecting the perspectives of therapists in the field provide evidence that this goal has not yet been accomplished. All of the profession's members, scholars and practitioners alike, play an important role in achieving this ultimate goal. Several solutions have been proposed to surmount the barriers which stand in the way of realizing the potential of occupation within the profession of occupational therapy.

Kielhofner (2005) proposes that one explanation for the gap between scholarship and practice may partly be "technical rationality" (p. 232), the assumption that knowledge about something results in the ability to do something. Occupational therapy scholars often believe that advancement in theory and research will automatically result in advancement in occupational therapy practice. This has not proven to be the case, however. In fact, technical rationality may actually widen the gap between researcher and practitioner. Many occupational therapists practicing in real world settings have made the claim that theory and research were unimportant, did not inform their practice, and were often irrelevant. They have also stated that research findings were rarely presented in a way which fostered easy application within clinical practice (Kielhofner, 2005).

Kielhofner contends that the antidote to technical rationality is the partnership of occupational therapy scholars and practitioners within the profession. Therapist participation in research endeavors provides a unique perspective and may assist with solving the barriers to optimal occupational therapy practice. Kielhofner (2005) describes that this partnership requires an equal level of authority between scholar and practitioner. Power is shared throughout the research process and ensures that the

benefits of both the researcher's empirical knowledge and the therapist's experience contribute to practical, applicable, high-quality results (Kielhofner, 2005).

As mentioned in a previous chapter, Pierce recommends the building of three bridges toward translating the knowledge of occupation into occupation-based practice (Pierce, 2001). The profession must engage in an ongoing discussion to bridge the gap between theories and practice. Practice demonstration sites should be developed to showcase the use of occupation-based practice. The third and final bridge recommended by Pierce is the development of educational programs that are effective in preparing practitioners to implement occupation-based practice.

Gray (1998) claims that the profession needs to have a unique perspective of occupation as ends and occupation as means. Traditionally, in the occupational therapy literature, occupation as ends referred to specific treatment interventions which use activities, tasks, and roles to reach a functional goal. Gray cites Trombly (1995), one scholar of the field, as describing occupation as ends as not involving the use of occupation or meaningful activity. However, Gray presents a different perspective. She claims that occupation as ends should be viewed as the continual overarching goal of every intervention in occupational therapy instead of an intervention method; in other words, every occupational therapy endeavor, including evaluation and treatment, "should be directed toward the ultimate outcome of restoring client's 'occupational lives'" (p. 357).

Gray also challenges Trombly's description of occupation as means as the use of simple behaviors, including purposeful, repetitive activity. Gray suggests that Trombly's description sounds more like exercise or physical modalities. She proposes that

"occupation as means refers to the use of therapeutic occupation as the treatment modality to advance someone toward an occupational outcome" (p. 358). She then states that the components should not be ignored by therapists but that therapists need to remember that occupation is a very powerful tool in treating these components.

Implications for Occupational Therapy Practitioners

Occupational therapy practitioners play an important role in returning to the roots of the profession. A commitment to using occupation-based assessments in practice will assist with the therapist's ability to remain occupation-focused throughout service delivery. Therapists need to include more occupation-based aspects of interventions within documentation (Clark, 2011). Completing continuing education credits related to occupation-based practice will increase therapists' competence in incorporating occupation into practice. Practitioners should participate in research opportunities related to occupation-based practice to lessen the divide between scholars and practitioners. Remaining active in local and national occupational therapy organizations which advocate for the profession is very important.

Practitioners should be ready at every moment to provide a clear definition of occupation, infused with language which highlights the occupational therapist's role in returning patients to valued occupations; taking every available opportunity to share this definition with colleagues, patients, family members of patients, and the general public will assist with advocacy for the profession. Gray (1998) proposes that "the survival of the profession may seriously rest in each occupational therapist's ability to give coherent and attractive answers to the prevailing questions" (p. 363). These questions include:

"What is occupational therapy?" and "How do occupational therapists differ from other health care professionals?"

Florence Clark, current president of the American Occupational Therapy Association, makes several other recommendations to ensure that the benefits of occupational therapy continue to be recognized by the public as well as the healthcare industry (2011). Practitioners should not only be members of AOTA, but should also recruit and encourage coworkers to become members of the organization. Clark encourages practitioners to engage in political activity and form relationships with local, state, and national politicians. She also mentions that practitioners should be committed to contributing to the advancement of AOTA's Centennial Vision.

Recommendations for future research endeavors

As mentioned by Kielhofner (2005), in order to translate the ideals of occupation-based practice into real-world practice, a shift needs to take place in the research world. Scholars can no longer assume that knowing about occupation will automatically improve the delivery of occupation-based practice. Endeavors in participatory action research concerned with the advancement of both theory and practice need to be implemented. Researchers need to be concerned with solving real problems faced by therapists within their work contexts. Dialogue and collaboration among scholars and practitioners needs to fuel research projects. All of these solutions will help to bridge the gap between scholarship and practice.

Currently, minimal research exists which showcases the effects of the use of occupation-based practice on treatment outcomes. In a medical world fueled by evidence-based practice, it is imperative that proof of the positive impact of occupation

on health exists. Research endeavors should also show the cost effectiveness of occupation-based practice; the reimbursement-driven healthcare industry will be much more ready to accept this form of treatment when it is proven that occupation-based practice decreases healthcare costs.

Additional research is needed to discover the supports and barriers to occupation-based practice. The voice of the occupational therapy practitioner must be taken into account so that solutions may support their ability to provide occupation-based practice in real-world settings. If practitioners are not given the resources and practical information they need to engage in occupation-based practice, the profession is ultimately spinning its wheels and making no progress toward the advancement of occupation in occupational therapy.

Summary

It has now been over a year since I first set off on a journey to explore the experiences of an occupational therapist in delivering occupation-based practice at a nursing home in Kentucky. At the beginning of this project, I stated that my reason for choosing this topic was to face my struggles with occupation-based practice head-on. In my own words, "In so doing, I hoped that I would not only make sense of this topic for myself but to also shed light on this area for other struggling therapists."

This project has helped me to realize that this issue is bigger than me. It has existed for many years and has a long road ahead toward a complete resolution. The development of a distinct, unique professional identity is going to require the participation of all members of the profession of occupational therapy. If scholars and

practitioners become a unified front and work together to learn how to incorporate occupation-based philosophies into everyday practice, the profession will prosper.

Although I am only one small piece of the puzzle, I know that I must also do my part to bring occupation to the center of occupational therapy. I know that if I am to remain true to the roots of the profession, I have a challenging road ahead. My greatest fear as I complete graduate school and fully transition back into the role of occupational therapy practitioner is that I will have difficulty implementing all that I have learned throughout this project. It becomes very easy from the outside looking in to make many recommendations toward a solution. It is entirely different to be the one implementing these solutions in the context of the rehabilitation world.

I believe in the power of occupation. I have personally experienced moments when time seemed to pass at lightning speed as I lost myself in a valued occupation. I have witnessed the effects of the loss of a valued role. I know that engagement in valuable occupation truly does contribute to the health and wellbeing of a person. We, as occupational therapists, have a lot to contribute to this world. It is my hope that we learn to unleash the power of occupation so that we can assist others to become all that they were meant to be and fully enjoy the gift of this life.

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APPENDIX A:

Sample Questions – First Interview

- How do you decide what the treatment plan is for your client?
- Does physical environment play a role in your ability to provide OBP interventions? If so, how?
- What is your understanding of the views of your colleagues regarding OBP?
- Do you include the client in intervention planning and implementation? If so, how?
- How do you view reimbursement in relation to OBP (have you ever gotten denied? How do you document client-centered treatment? Do you hide the occupation and put components only, or do you come right out and describe it?)?
- How would you describe a treatment session that was successful? Unsuccessful?
- How do you feel at the end of a day of work at this skilled nursing facility? (Are all days the same?)

APPENDIX B:

Sample Questions – Second Interview

In your own words, define occupation-based practice.

Do you practice within a frame of reference? (Why or why not? If you do use a FOR, which one, and why? How does it guide your practice?)

What do you remember learning in school about occupation-based practice? (Do you use that information today? Why or why not?)

Of the seven areas of occupation mentioned in the OT Practice Framework (activities of daily living, instrumental activities of daily living, rest and sleep, education, work play, leisure, and social participation), are there any in particular that get addressed more in the long-term setting? Why or why not?

If reimbursement, treatment space and equipment were not an issue, what would your typical day look like?

APPENDIX B:

Sample Questions – Third Interview

- How is it going with the new Medicare Guidelines?

- "I feel like I can't be the therapist I want to be with those constraints." What are some things you might do differently if you didn't have these constraints?

- Do you ever feel as though there is an overlap between PT, OT, and ST treatment?

- "The long term goal is to increase my patient's level of functional ADL performance." In your own words, could you describe "functional ADL performance" for me?

- What year did you graduated OT school? Have you ever heard of The Canadian Occupational Performance Measure (originally published in 1991)? I'm just wondering if these kinds of assessments were around when you were in school. Do you remember being taught about formal assessments that address the client's valued occupations?

- Can you tell me a story about addressing a person's leisure interests?

- Do you address leisure interests in your evaluation? What questions do you ask? Do you write goals about leisure? Can you give me a specific example of a goal?

- Can I see the evaluation that you use?

APPENDIX D:

Copy of Informed Consent Form

Consent to Participate in a Research Study
A CASE STUDY OF ONE OCCUPATIONAL THERAPIST AT A SKILLED NURSING FACILITY IN KENTUCKY

You are being invited to take part in a research study about occcupation-based practice at a skilled nursing facility. The purpose of this case study will be to explore the experience of one occupational therapist in delivering occupation-based practice at a nursing home in Kentucky. The person in charge of this study is Shannon M. Mattingly at Eastern Kentucky University. She is being guided in this research by Dr. Wittman. There may be other people on the research team assisting at different times during the study.

You will be asked several questions regarding your delivery of occupational therapy at the skilled nursing facility with which you are currently employed. Answers to your questions will be based solely on your personal experiences and there are no "right" answers to these questions. You may be asked to participate in several interviews so that the researcher can gain greater insight into your experiences. The researcher will then attempt to interpret the information gathered from the interviews. You will then be asked to provide feedback regarding these interpretations. Each visit will take about 45 minutes to an hour. You may also be asked to answer questions via email. The total amount of time you will be asked to volunteer for this study is 5 hours over the next 4 months. To the best of our knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life. You will not get any personal benefit from taking part in this study.

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. f you decide to take part in the study, you still have the right to decide at any time that you no longer want to participate. You will not be treated differently if you decide to stop taking part in the study. You will not be identified in the written materials used during this study. We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. For example, your name will be kept separate from the information you give, and these two things will be stored in different places under lock and key.

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions about the study, you can contact the investigator, Shannon M. Mattingly at xxx-xxx-xxxx. If you have any questions about your rights as a research volunteer, contact the staff in the Division of Sponsored Programs at Eastern Kentucky University at 859-622-3636. We will give you a copy of this consent form to take with you. You will be told if any new information is learned which may affect your condition or influence your willingness to continue taking part in this study.

I have thoroughly read this document, understand its contents, have been given an opportunity to have my questions answered, and agree to participate in this research project.

_____ _____
Signature of person agreeing to take part in the study Date

_____
Printed name of person taking part in the study

_____
Name of person providing information to subject