Occupational Therapy Goals during Acute Discharge for Older Adults

Paige Waller

Master of Occupational Therapy
University of Sydney
2015

Research Supervisors:  Professor Lindy Clemson
                        Associate Professor Natasha Lannin
                        Associate Professor Lynette Mackenzie
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Acknowledgements

This research project is unfunded and there are no conflicts of interest to declare.

I would like to express my thanks and appreciation to my supervisors, Professor Lindy Clemson, Associate Professor Natasha Lannin and Associate Professor Lynette Mackenzie for their guidance, support, patience and feedback during the completion of this thesis.
Thesis Abstract

This thesis investigates the characteristics and nature of occupational therapy goals during acute discharge for older adults. The thesis is presented in two chapters:

1. Literature review
2. Journal manuscript

The literature review chapter presented first provides a background of older adults and their experiences with acute hospitalisation. The literature describes the role of goal setting during discharge from acute and rehabilitation settings. The review examines existing research on the types of goals set by clients of various ages within a range of clinical settings. From this review it was identified that there is limited research into the characteristics and nature of occupational therapy goals for older adults during discharge from acute hospitalisation.

The findings from the literature review were used to inform the design and completion of a parallel mixed methods study to identify the themes and categories of occupational goals and determine if there is an association between the goals and participant characteristics. The mixed methods study is presented as a journal manuscript in the second chapter of this thesis. The manuscript describes the methods, the results and implications of this research. The journal manuscript will be submitted to the Australian Occupational Therapy Journal.
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Introduction

This literature review provides an overview of research on the role of goal setting in discharge planning for older adults from acute hospitalisation. The topic was considered relevant because older adults make up a large proportion of all hospital admissions (Australian Institute of Health and Welfare, 2015) and, the number of older adults is expected to double in the next few decades (Australian Institute of Health and Welfare, 2015). Discharge planning has been proposed as a way to prevent negative outcomes following discharge. As part of discharge planning occupational therapists set goals, which are used to guide the therapy.

Search Strategy

The following search strategies were undertaken to identify relevant literature for the review. Science, medical and health databases were searched, including Medline, CINAHL, AMED, Web of Science, Scopus, OT Seeker and the Cochrane Library. The databases were searched using terms such as occupational therapy, allied health, goals, goal setting, set goals, hospital, acute, discharge, follow up, elderly, aged and older people. Boolean operators (AND, OR) and truncation were used to join terms into a search strategy. Example search: [(“occupational therapy” OR “allied health”) AND (“acute discharge” OR “hospital discharge” OR “patient discharge”) AND (“goal*” OR “goal* set*” OR “set* goal*”) AND (“old*” OR “elder*” OR “aged*)]. Search results excluded publications unavailable in English. From the identified articles, the references lists were reviewed to identify relevant publications that were not found through the database searches. A search of the website the Australian Institute for Health and Welfare was completed to obtain current statistics of the ageing Australian population and to determine the prevalence of hospital admission.

Definitions

For the purposes of this literature review the following definitions will be used:

- **Acute** – A hospital setting which is concerned with preventing the client from deteriorating (Bondoc et al., 2012) and stabilising medical issues that require immediate treatment (Robinson & Shotwell, 2013).
- **Goal** – A future-oriented aim or objective to be worked towards as the desired outcome (Trentham & Dunal, 2009). Goals can be written in lay terms or constructed using a specific-measurable-achievable-realistic-time frame (SMART) approach.
- **Discharge** – The transition process from hospital admission to returning home.
• Older Adults – Throughout the research and literature older adults have been defined using a variety of age ranges. The research reported in this literature review identifies older adults as age 65 years or older. However, the completed HOME study from which study data was obtained and analysed concerns adults aged 70 years or older.

Theoretical Framework

The ‘Occupational Therapy Practice Framework’ by the American Occupational Therapy Association (2014) was selected to guide this project. First, the framework summarises the main concepts that define occupational therapy practice, including definitions of each type of occupation. The definition of the types of occupations has been central to data collection and analysis for the current study. Using definitions set out in an established clinical and research framework allows findings to be relevant, applicable and consistent with current knowledge. The definitions of the occupations are outlined in Table 1. Second, the ‘Occupational Therapy Practice Framework’ (American Occupational Therapy Association, 2014) identifies the importance of goal setting to occupational therapy intervention. The practice framework identifies goal setting as the beginning, midpoint and end of the intervention plan. The goals are established early in therapy and give direction to the intervention. The goals are then used during the midpoint and the end of therapy to evaluate the intervention. Based on this the goals can be achieved or re-evaluated, including modifying the intervention. Third, this framework describes the importance of occupational participation and performance to the health and wellbeing of an individual. The framework defines engagement as the completion of occupations, and participation as the active engagement in roles, habits and routines (American Occupational Therapy Association, 2014). The framework argues that through occupational engagement individuals participate in meaningful and necessary life roles.
Table 1.  
*Type of Occupations and Definitions (American Occupational Therapy Association, 2014, pp. S19-S21)*

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<tr>
<th>Occupation</th>
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<tr>
<td>Activities of Daily Living</td>
<td>Required for survival and wellbeing (e.g., bathing, toileting, dressing, eating, feeding, functional mobility, personal device care, personal hygiene and grooming, sexual activity).</td>
</tr>
<tr>
<td>Instrumental Activities of Daily Living</td>
<td>Activities that support living in the home and community (e.g., care of others/pets, child rearing, communication management, driving and community mobility, financial management, health management and maintenance, home establishment and management, meal preparation, religious/spiritual activities, safety and emergency maintenance, shopping).</td>
</tr>
<tr>
<td>Rest and Sleep</td>
<td>Rest, sleep preparation, sleeping.</td>
</tr>
<tr>
<td>Education</td>
<td>Activities for learning and participation in learning environment (e.g., formal and informal education).</td>
</tr>
<tr>
<td>Work</td>
<td>Productivity (e.g., employment, voluntary, retirement preparation and adjustment).</td>
</tr>
<tr>
<td>Leisure</td>
<td>Activity that is completed without obligation.</td>
</tr>
<tr>
<td>Social Participation</td>
<td>Engagement in community, family, peer and/or friend activities.</td>
</tr>
</tbody>
</table>
Background

In 2013-14 nearly half (40%) of Australian hospital admissions were older adults aged 65 years or older (Australian Institute of Health and Welfare, 2015). Every year, the proportion of older adults admitted to Australian hospitals has increased (Australian Institute of Health and Welfare, 2015). Further, increased average life expectancy has resulted in a greater number of older Australians alive today (Australian Institute of Health and Welfare, 2014). By the year 2054-55, the number of Australians aged 65 years or older is predicted to double (Commonwealth of Australia, 2015). Although an increase in life expectancy has been perceived as a great achievement, it creates new challenges to health services caring for this population (Hughes et al., 2011). An increase in hospital admissions is expected in line with the ageing population (McMurdo, 2000). When admitted to hospital, older inpatients consume a higher amount of resources compared to other age groups (Macaulay, Dingwall, & Preyde, 2009), and so returning older adults to their home following a hospital admission is cost effective for the health service and beneficial for the older adult (Taylor, Kurytnik, & Pain, 2007). If an older adult ages in their own home, rather than in a hospital or supported accommodation/nursing home setting, this is known as ageing in place (Fänge, Oswald, & Clemson, 2012). However, returning an older adult to their home can be difficult as older adults face different issues compared to younger age groups, including increased experience of disability, mobility limitations (Fried & Guralnik, 1997), social/economic exclusion (Fänge et al., 2012) and decreased activities of daily living (ADL) engagement (Wales, Clemson, Lannin, & Cameron, 2012). The additional issues faced by older adults could be due to the decline in physical, cognitive and/or sensory functioning that occurs with ageing (Hoy, Wagner, & Hall, 2007; Wales, Clemson, Lannin, & Cameron, 2012). All of these factors make efficient and safe hospital discharge important as we move towards an aged care model that aims to facilitate aging in place. Efficient and safe discharge will enable ageing in place to continue after a hospital admission.

Acute Hospital Care

Occupational Therapy

When an older person is admitted to hospital they can be placed in an acute ward. Acute hospital care aims to prevent the client from deteriorating (Bondoc et al., 2012) and stabilise medical issues requiring immediate treatment (Robinson & Shotwell, 2013). Occupational therapists in acute care aim to restore function, prevent further decline and encourage mobilisation (Bondoc et al., 2012). Following this medical phase, acute wards then
organise for the client to be discharged home, or to another setting (Robinson & Shotwell, 2013), including referral to community-based services (Welch & Lowes, 2005). An occupational therapist works within an acute setting to assess the occupational performance of the client and use the information obtained from assessment to enable safe and timely discharge (Welch & Lowes, 2005). This definition of an occupational therapist aligns well with the physical, cultural and social environment of acute hospital care. Multiple qualitative research studies have established that the high pressure and fast-paced hospital environment can result in occupational therapists focusing on safe and fast discharge (Macauley et al., 2009; Moats, 2006; Thomson & Black, 2008; Welch & Lowes, 2005). Within this environment the therapist has limited time to interact with the client due to high patient turnover (Hamby, 2013; Thomson & Black, 2008), which can prevent the therapist from gaining a thorough understanding of the needs and wants of the client and their family. Pressure to quickly discharge in acute care results in discharge plans not being thoroughly carried out and places the client at risk of re-admission and difficulties post-discharge (Kinsella, Park, Appiagyei, Chang, & Chow, 2008). Further, occupational therapists have identified time and cost constraints as contributing to a focus on self-care and safety during discharge from hospital to home (Craig, Robertson, & Milligan, 2004; Griffin, 2002). A focus on self-care and safety does not ensure older adults are able to resume their pre-admission roles and daily occupations outside of self-care, and such a focus may not be adequate when older adults return to living in the community. A final issue raised in the literature is that therapists may feel unable to advocate for clients being discharged who are not ready (Craig et al., 2004). If a therapist believes a client is not ready to function independently in the community post-discharge, then going ahead with a discharge could result in increased re-admission rates and difficulties post-discharge. The above environmental factors encountered by occupational therapists working in acute care can therefore influence the quality of care clients receive.

**Older Adults**

Hospital admission for older adults frequently results in deconditioning (O'Brien, Bynon, Morarty, & Presnell, 2011). During hospital admission older adults are not as active as other age groups (Eyres & Unsworth, 2005). Following discharge older adults often do not regain their pre-admission function (Lakhan et al., 2011) or mobility (Fried & Guralnik, 1997). Lakhan et al. (2011) compared self-reported pre-admission to post-discharge function and found decreases in both ADL performance and cognition and increased incontinence at discharge in older adults. Decreased function is detrimental to older adults and has been
correlated with increased prevalence of depression (Dunne, Wrosch, & Miller, 2011). The decrease in cognitive and physical function makes older adults vulnerable at discharge, as they may be unable to recommence their pre-admission lifestyle. When decreased physical function is combined with acute discharge plans not being thoroughly carried out (Kinsella et al., 2008), older adults can be returned to the community without suitable services to remediate their decreased function.

Several factors have been identified to contribute to positive outcomes for older adults during the acute discharge process. Encouraging the older person to do as much as they can throughout their admission can reduce the severity of physical and cognitive deconditioning during hospitalisation (McMurdo, 2000). Maintaining physical and cognitive function during a hospital stay is beneficial as it leads to decreased rates of re-admission and death in the two years following discharge (Inouye et al., 1998). Further, shorter hospital admissions are favourable as older adults with shorter hospital stays score higher on functional and cognitive assessments and have an increased likelihood of remaining in their homes in the 18 months post discharge (Neufeld, Lysack, Macneill, & Lichtenberg, 2004). However, Neufeld et al. (2004) found these results to be strongest for participants who returned home immediately following discharge. Another supportive environmental factor related to successful discharge home is living with a spouse prior to hospital admission (Huck, Penrod, Reinardy, & Kane, 1999; Stineman et al., 2014). Living with a partner before admission may increase motivation to return home and once home the spouse can assist their partner. Differences were also found in equipment use based on living arrangement. Individuals living alone are more likely to use bathroom equipment than those living with a partner (Hoffmann & McKenna, 2004). This suggests older adults living alone post-discharge are vulnerable during discharge as they do not have the same care and support available within their home environment, compared to those living with a partner. The above research identifies maintaining physical fitness during admission, shorter hospital stays, discharging immediately to the home and living with others as strengths and strategies to be used during the discharge process for older adults.

Other factors contribute to the vulnerability experienced by older adults when discharged home. First, the high incidence of difficulties with self-care activities, higher risk of falls, increased risk of hospital re-admission and decreased function in the home and community (Cummings et al., 2010; Dossa, Bokhour, & Hoenig, 2012) make it difficult to re-adapt to living independently following a hospital admission. Second, acute discharge is perceived as challenging for older adults. Older adults are frequently concerned about losing independence, control and fear of failure when discharged from acute hospital care (Atwal, McIntyre, Craik, & Hunt, 2008; Bowman, 2001; Ramsdell, Jackson, Guy, & Renvall, 2004).
These concerns can make older adults hesitant to seek and accept services during discharge. Lastly, the high prevalence of disability (Fried & Guralnik, 1997), increased social and economic exclusion (Fänge et al., 2012) and limited ability to engage in occupations (Wales, Clemson, Lannin, & Cameron, 2012) make older adults vulnerable when discharged into the community. The psychological, physical, medical, environmental and occupational factors listed above contribute to challenging cases during acute discharge for older adults. These cases require comprehensive individualised discharge planning to adequately address the needs of older adults.

**Discharge Planning**

Discharge planning is used to reduce length of hospital admission, prepare a person for discharge home and prevent hospital re-admission following discharge (Chow & Wong, 2014; Shepperd et al., 2013). Discharge planning aims to achieve this by addressing the needs of clients and minimise the risks associated with hospital discharge (Crennan & MacRae, 2010). A multi-disciplinary team typically completes discharge planning to decrease the dependence of the client on others and promotes a safe transition home. Occupational therapists are a member of this team who work from a client-centred perspective throughout discharge planning. Occupational therapists look at what the person needs and wants to do (Moats & Doble, 2006) and provide intervention to facilitate engagement in meaningful occupations (Hamby, 2013; Taylor et al., 2007). Occupational therapists in an acute hospital help older adults to re-develop functional ability and skills required for safe discharge (Bondoc et al., 2012; Duxbury, DePaul, Alderson, Moreland, & Wilkins, 2012). As part of discharge planning, occupational therapists may complete a pre-discharge home visit to assess and make recommendations on the home environment (Horowitz, 2002; Wales, Clemson, Lannin, Cameron, et al., 2012). Most commonly, discharge recommendations from an occupational therapist involve safety in the home and equipment prescription (Harris, James, & Snow, 2008), however skill retraining and development can also result in functional improvements for older adults (Winkel, Langberg, & Wæhrens, 2015). The above duties are carried out within the fast-paced, discharge-focused environment of an acute hospital setting (Macaulay et al., 2009; Moats, 2006; Thomson & Black, 2008; Welch & Lowes, 2005), which can place pressure on the way discharge planning is completed (Kinsella et al., 2008).

Discharge planning can be beneficial to older adults when it addresses common problems they experience following discharge home. These problems include difficulty returning to pre-admission occupations, concerns of caregiver burden, difficulty readjusting to change, problems with home and community services, issues coordinating care between
different care providers, problems understanding the plan for follow-up care and medication management (Altfeld et al., 2013; Söderback, 2008). A Cochrane review by Shepperd et al. (2013) found discharge planning for older adults was related to decreased length of hospital admission and reduced re-admission rates in the three months following discharge. However, the review identified no strong evidence for differences in mortality rates or increased rates of discharge home (Shepperd et al., 2013). Despite no difference in mortality rates or rates of discharge home, Shepperd et al. (2013) concluded that decreased lengths of hospital admission and reduced re-admission rates would reduce hospital bed blockages and improve client flow through the hospital system. Other benefits of discharge planning include improving mental health and lowering anxiety during discharge (Wressle et al., 2006). These findings support discharge planning in acute hospital care for older adults.

Goal Setting

As part of discharge planning, occupational therapists collaborate with clients to set discharge goals. Goal setting is currently considered best practice throughout all areas of occupational therapy to improve and maintain performance in occupations (Jackson, 2013). Goal setting enables the client and other health professionals to communicate about the focus of treatment during a hospital admission (Bovend'Eerdt, Botell, & Wade, 2009; Turner-Stokes, 2009; Turner-Stokes & Williams, 2010). Through goal setting clients are able to plan for the future, which can build a sense of hope surrounding discharge (Brown et al., 2014; Spencer, Davidson, & White, 1997), and is associated with increased quality of life (Parsons, Rouse, Robinson, Sheridan, & Connolly, 2012). Goal setting theory (Locke & Latham, 1990; 2002) argues that goals can also increase individual motivation, performance and persistence towards goal attainment. The importance of goal setting to occupational therapy is identified in the ‘Occupational Performance Process Model’ (Fearing, Law, & Clark, 1997). This model highlights goals as emerging from assessment and being central to intervention, evaluation and achievement in therapy. The goals set determine the types of intervention and should reflect each client’s own goal priorities (Dyer et al., 2004; Timmer, Unsworth, & Taylor, 2015). Within occupational therapy, occupational performance issues are often identified first and then goals are set to address the occupational performance issues (Trentham & Dunal, 2009). The goals identified with the client and the therapist can also be used to evaluate the effect of intervention based on goal achievement (Gagne, 2001; Gagne & Hoppes, 2003; Turner-Stokes, 2009).

Within acute hospital care goals are often set during the initial interview and are used throughout occupational therapy as a measure of therapy outcomes and intervention.
effectiveness (Melville, Baltic, Bettcher, & Nelson, 2002; Welch & Forster, 2003). Many goal setting processes have been discussed in the literature, however a framework or approach to goal setting is yet to be established as best practice (Scobie, Duncan, Brady, & Wyke, 2015). Scobie, Dixon, and Wyke (2011) identified four steps of goal setting including: goal negotiation; goal identification; planning or intervention; and goal appraisal and feedback. This goal setting method is consistent with other literature on client-centred goals (Park, 2011). Tang Yan, Clemson, Jarvis & Laver (2014) identified six prominent features of collaborative goal setting: rapport building; identification of client needs or concerns; incorporation of the clients priorities; client involvement in problem solving to identify strategies; clearly defined goals; and client engagement in monitoring progress towards goal achievement. Other goal setting approaches are less specific, with Holliday, Antoun, and Playford (2005) suggesting goals are set in response to a client’s problem. Despite different processes to goal setting, the above papers are all consistent with the ‘Occupational Performance Process Model’ (Fearing et al., 1997). This model highlights the centrality of goals to all stages of therapy intervention.

In addition to methods of goal setting, the research has also identified what the goal should contain. Occupational therapy students learn to write goals using the specific-measurable-achievable-realistic-time based (SMART) approach (Bovend'Eerdt et al., 2009), and this approach is sometimes used in practice. SMART goals are consistent with goal setting theory (Locke & Latham, 1990, 2002), which argues goals should be specific, measurable, difficult, meaningful promote self-efficacy, time-framed and involve strategies for goal achievement. Varying qualities of SMART goals are observed in research and clinical practice. Research has found goals frequently address the specific component, but less than half of goals are measurable (Hassett et al., 2015). However, it is difficult for studies to evaluate achievable and realistic components of SMART goals without detailed client and context information. Writing SMART goals in therapy can result in increased goal achievement, compared to non-SMART goals (Welch & Forster, 2003). The increased goal achievement for SMART goals could be due therapists considering the achievable and realistic nature of the goal and working within the resources and limitations of acute hospital environment.

The goals for the current study were set using the ‘easy’ Goal Attainment Scaling (GAS) (Turner-Stokes, 2009; Turner-Stokes & Williams, 2010). The ‘easy’ GAS is a practical method for goal setting and evaluation through four steps. First, goals are identified with the client, their family and the therapist. Throughout goal identification the therapist assists the client on achievable and realistic goals and outcomes. These goals are recorded as
client-stated goals. Second, the therapist defines the expected outcomes from the client-stated goal by generating therapist SMART goals. Third, the therapist assesses the clients’ baseline performance in the goal activity. This is scored as some or no function. Fourth, the therapist scores the clients performance at the end of a therapy. Performance is scored on a 5-point scale, (1) much better than expected, (2) better than expected, (3) expected outcome, (4) less than expected, (5) much less than expected. The ‘easy’ GAS allows client-centred goals to be developed that can be used to evaluate therapeutic outcomes.

**Successful Goal Setting**

Research has identified many factors that contribute to successful goal setting for older adults during acute discharge. Two factors are clear communication and collaboration between the client and therapist. Communication allows the therapist and client to have the same expectations and streamlines the goal setting process. Communication can contribute to reduced re-admission and increased quality of life for clients following discharge (Dossa et al., 2012). Communication can be achieved through therapist and client collaboration during goal setting, which aligns with the healthcare paradigm shift to client-centred healthcare (Palisano, 2014). Collaboration during goal setting can decrease anxiety by giving older adults control of their circumstances (Brown, Craddock, & Greenyer, 2012), create a sense of empowerment (Chow & Wong, 2014), improve satisfaction with care (McAndrew, McDermott, Vitzakovitch, Warunek, & Holm, 1999) and promote active involvement in therapy (Welch & Forster, 2003). Collaborative goal setting allows the client to identify what is important to them and increases motivation to work towards and achieve therapy goals (Bogardus et al., 2001; Brown et al., 2014; Winkel et al., 2015). Another factor is setting realistic and achievable goals as they create feelings of success and increase motivation for older adults (Melville et al., 2002). Realistic and achievable goals can improve the therapeutic alliance (Alaszewski, Alaszewski, & Potter, 2004), promote behaviour change (Prochaska, 2008) and goal achievement (Potempa, Butterworth, Flaherty-Robb, & Gaynor, 2010). An occupational therapist can work with clients to guide realistic and achievable goals and ensure intervention is tailored towards goal achievement (Bovend'Eerdt et al., 2009; Turner-Stokes & Williams, 2010).

A final factor is consideration of goal achievement in the natural environment. Harris et al. (2008) identified understanding the older adults function in the hospital and their home as necessary for returning and remaining at home following discharge. This suggests home visits are important for discharge planning. Specific to goals, home visits could be used to promote generalisation and transfer of goal outcomes from hospital to the home. Research
discusses the benefit of home visits to safe and timely discharge (Atwal et al., 2008), but is yet to conclusively determine the effect of home visits on discharge outcomes (Lannin et al., 2007; McKye, Naglie, Tierney, & Jaglal, 2009; Taylor et al., 2007). However, due to the high cost of home visits occupational therapists have reported pressure to decrease the number of home visits completed (Lannin, Clemson, & McCluskey, 2011). The factors of communication, collaboration, realistic and achievable goal components and the performance environment during goal setting have been argued to promote successful hospital discharge for older adults.

**Barriers to Goal Setting**

Despite the benefits of collaborative goal setting, environmental barriers can hinder this in an acute hospital. The high pressure, fast-paced discharge environment (Macaulay et al., 2009; Moats, 2006; Thomson & Black, 2008; Welch & Lowes, 2005) can prevent therapists from comprehensively understanding the client (Hamby, 2013) and completing thorough discharge planning (Kinsella et al., 2008). Without a complete understanding of the client and their context occupational therapists could incorrectly identify goal priorities. Occupational therapists may also focus on self-care and safety goals (Craig et al., 2004), without consideration of each person’s individual goals from a client-centred perspective. The focus on fast discharge in acute care can take away from collaborative and holistic, client-centred goal setting. Consistent with the time restrictions of an acute hospital Welch and Forster (2003) found goals were often identified by the therapist and then communicated to the client. This can result in clients feeling uninvolved in goal setting and intervention planning (Almborg, Ulander, Thulin, & Berg, 2009; Atwal, Spiliotopoulou, Plastow, McIntyre, & McKay, 2012; Eschenfelder, 2005). Although goals set by therapists may be considered time effective, this approach conflicts with the Occupational Therapy Australia (2014) code of ethics to respect clients’ autonomy if the goals are not consistent with the clients’. Another factor influencing goal setting is the clients’ health. Maitra and Erway (2006) argued it was difficult for therapists to set collaborative goals within an acute setting when clients are unable to participate due illness. Therapists need to work within the limitations of acute care to collaboratively set goals to promote active engagement and achievement in therapy (Melville et al., 2002). Crennan (2010) highlight how occupational therapy discharge assessment and decision making in acute care is a complex issue that is unique to each individual and that training should be provided to ensure the process is client-centred.
Rehabilitation Goals

Levack, Dean, Siegert, and McPherson (2006) acknowledge that goal setting research has mainly been completed in rehabilitation settings compared to acute care. The literature is clearer on the characteristics and nature of goals within rehabilitation. Goals are more commonly achieved in rehabilitation when they are set over a short time frame, are realistic, achievable, measurable, client identified and based on improving physical function (Barclay, 2002; Custer, Huebner, & Howell, 2015; Levack, Dean, Siegert, & McPherson, 2011). Client goals in rehabilitation are generally broad compared to therapist goals (Brown et al., 2014; Laver, Halbert, Stewart, & Crotty, 2010). When negotiating rehabilitation goals, differences between the client and therapist in what is achievable lead to difficulty reaching agreement during goal setting (Barnard, Cruice, & Playford, 2010; Glazier, Schuman, Keltz, Vally, & Glazier, 2004). Research for clients with spinal cord injury has found no differences in the goals set by males and females, however differences were found in the types of goals set based on the severity of the injury (Wallace & Kendall, 2014). Adults with quadriplegia were more likely to set personal care and ADL goals, while community access was often identified by adults with paraplegia (Wallace & Kendall, 2014). In outpatient adult rehabilitation, driving goals were identified most frequently, followed by employment, pain management, leisure, personal and instrumental ADL (Custer, Huebner, Freudenberger, & Nichols, 2013). Despite a variety of diagnoses it was found participants with a neurological diagnosis or functional limitations, selected ADL goals more often (Custer et al., 2013). Participants with a non-neurological diagnosis and fewer functional limitations selected employment-based goals (Custer et al., 2013). The above rehabilitation literature suggests personal characteristics and experience of illness or disability, not demographics, are related to the types of goals.

Acute Discharge Goals

There is limited research on the characteristics and nature of occupational therapy goals set by older adults during acute discharge. Melville et al. (2002) identified older adults set acute discharge goals with consideration of four elements: i) what is required for discharge; ii) activities that are difficult, painful or requiring independence; iii) therapist suggestions; and iv) personally valued occupations. Most goal setting studies have examined the types of occupations in goals for older adults in acute and sub-acute settings. Within a sub-acute setting older adults most frequently set personal and instrumental ADL goals, and less frequently identified leisure and employment goals (Melville et al., 2002). This aligns with other research that has found acute hospital therapists focused on self-care, safety (Craig et al., 2004) and functional mobility goals (Welch & Forster, 2003). The high prevalence of
functional mobility goals identified by Welch and Forster (2003) could be due to the aim of the study to audit functional assessment procedures in acute care, and so the focus on functional assessment may have resulted in greater identification of mobility or function goals. An increased prevalence of personal and instrumental ADL goals for older adults has also been found in community (Fisher, Atler, & Potts, 2007; Kuluski et al., 2013) and inpatient rehabilitation (Timmer et al., 2015). Although the methods used by Melville et al. (2002) and Welch and Forster (2003) facilitated collaborative goal setting for the client, the purpose of these studies was to look at the perspectives of the client during the goal setting process and focused on occupation elements of the goal. Additionally, these studies did not identify other characteristics of the goals set during the discharge process.

Conclusion

As we move towards an ageing population, new and effective ways need to be considered to economically meet the health demands of the ageing population. This includes looking at the discharge process for older adults, due to their high admission rates and vulnerability following discharge. Despite the benefits of successful discharge for older adults, there has been little investigation into the types of occupational therapy goals set by older adults and therapists during discharge from an acute hospital. Discharge goals are used to guide recommendations and intervention, and so are vital to the outcomes experienced by older adults during the transition home. Being able to set effective goals to promote positive discharge outcomes will reduce the healthcare cost of the ageing population. Therefore, the current study addresses the research question, what are the characteristics and nature of occupational therapy goals set by older adults during and immediately following discharge from an acute hospital setting? To achieve this, categories and themes will be identified within each goal, goals set by occupational therapists and clients will be compared, and tests for associations between the types of goals set and participant characteristics will be applied. Gaining this knowledge will contribute to improving discharge for older adults.
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Occupational Therapy Goals during Acute Discharge for Older Adults

Authors: Paige Waller
BSc.(Psych.)
Final year student – M. Occupational Therapy

Research Supervisors: Professor Lindy Clemson
Associate Professor Natasha Lannin
Associate Professor Lynette Mackenzie

Research Locations: University of Sydney
Cumberland Campus
Lidcombe, NSW 2006

Correspondence: Paige Waller pwal5089@uni.sydney.edu.au
7/14 Victoria Ave
Woollahra, NSW, 2025

Running Head: Acute Discharge Goals for Older Adults

Target Journal: Australian Occupational Therapy Journal (see Author Guidelines, Appendix III)

Key Words: Aged; aged, 80 and over; patient discharge

Total Word Length: 4644

Number of References: 32

Number of Tables 2

Number of Figures 2
Abstract

Background: As the population ages, the number of older adults admitted to hospital can be expected to increase. Efficient and safe discharge planning, including goal setting, needs to be achieved to effectively manage this.

Aim: To describe the characteristics and nature of occupational therapy goals set by older adults during and immediately following discharge from an acute hospital. Exploration of the characteristics and nature of goals and associations with specific characteristics of the sample can identify the needs of the older adult population during discharge.

Methods: A parallel mixed-methods study design was conducted using secondary analysis of data from a randomised trial. Content analysis was used to identify key themes and categories within the goals. Descriptive statistics were used to describe characteristics of the participants. Chi-square was used to determine associations between participant characteristics and goal themes.

Results: From a random sample of 50 participant files, 414 goals were identified. Two key themes, (a) ‘desire to get back to doing’, and (b) ‘engaging in doing’ emerged from the goals. Four sub-themes were identified describing the ‘what’, ‘how’, ‘who’ and ‘where’ components of goals. Instrumental activities of daily living goals were identified most frequently. An association was found between type of goals and living arrangement, participation, comorbidities and functional independence.

Conclusion: Older adults set goals based on their desire or want to engage in occupations. The high frequency of instrumental activities of daily living goals needs to be considered in delivering health services to effectively meet the needs of older people during discharge from acute and medical wards.

Key words: Aged; aged, 80 and over; patient discharge
Introduction

Nearly half (40%) of all Australian hospital admissions are older adults aged 65 years or older (Australian Institute of Health and Welfare, 2015). Every year, there is a proportional increase in the number of older adults admitted to Australian hospitals (Australian Institute of Health and Welfare, 2015). By the year 2054-55, the number of older Australians is predicted to double (Commonwealth of Australia, 2015), and an increase in hospital admissions is expected in line with this ageing population. This increase in numbers will pose a greater challenge to Australian health services. In addition to the projected increase in numbers, older adults face different issues compared to younger age groups, including increased experience of disability, mobility limitations (Fried & Guralnik, 1997), decreased social support (Fänge, Oswald, & Clemson, 2012) and decreased engagement in activities of daily living (ADL) (Wales, Clemson, Lannin, & Cameron, 2012). These factors need to be considered when understanding the experience that older adults have during hospitalisation and discharge.

Older adults are vulnerable after discharge from acute hospitalisation. Older adults frequently experience deconditioning during hospitalisation (O'Brien, Bynon, Morarty, & Presnell, 2011), which is not regained following discharge (Lakhan et al., 2011). Post-discharge, older adults have high incidences of difficulties with self-care, increased rates of falls and high hospital re-admissions rates (Dossa, Bokhour, & Hoenig, 2012). Further, older adults have identified feeling vulnerable during discharge with concerns about losing independence and fear of failure (Atwal, McIntyre, Craik, & Hunt, 2008). Discharge from hospital can be more challenging for adults living alone (Stineman et al., 2014), as those living alone have less support available than those living with others. These challenges make it difficult for older adults to resume their pre-admission function after discharge.

In attempting to address challenges experienced during and after acute discharge for older adults, discharge planning is necessary to reduce length of hospital admission, prepare a person for discharge home, and to prevent re-admission following discharge (Shepperd et al., 2013). As part of discharge planning, occupational therapists set goals with clients. Occupational therapy theory identifies therapy goals as arising from the therapists’ assessment with the client, as exemplified in the ‘Occupational Performance Process Model’ (Fearing, Law, & Clark, 1997). Goal theory identifies setting goals as beneficial to improve collaborative agreement and understanding about the focus of treatment (Turner-Stokes & Williams, 2010) and to increase motivation and persistence towards goal attainment (Locke & Latham, 2002).

Within rehabilitation, client goals are broad (Brown et al., 2014) and therapist goals are specific, but rarely measurable (Hassett et al., 2015). Differences in rehabilitation goals
are observed based on type of disability, diagnosis and the clients’ age (Custer, Huebner, Freudenberg, & Nichols, 2013), but no differences based on gender (Wallace & Kendall, 2014). In a sub-acute setting, older adults have been shown to identify goals considering their discharge requirements; activities that are painful, difficult or require independence; therapist recommendations; and personally valued occupations (Melville, Baltic, Bettcher, & Nelson, 2002). Research in sub-acute care has also shown that older adults and therapists frequently set goals to improve their performance of self-care and ADL (Craig, Robertson, & Milligan, 2004; Welch & Forster, 2003). While research has studied the occupational components of goals, there is limited research identifying and describing occupational therapy goals set by older adults during hospital discharge from acute care or medical wards.

Therefore, the current study addresses the research question, what are the characteristics and nature of occupational therapy goals set by older adults during and immediately following discharge from an acute hospital setting? To achieve this, categories and themes will be identified within each goal, goals set by occupational therapists and clients will be compared, and tests for associations between the types of goals set and participant characteristics will be applied. It is hypothesised there will be a significant difference in the types of goals between participants based on: age, living arrangement, comorbidities, and levels of functional independence and participation. It is hypothesised their will be no significant differences in the types of goals set between males or females.

Methods

Study Design

Fifty intervention case notes were analysed from data collected in a large randomised trial (HOME) (Clemson et al., in press). A parallel mixed-method study design was used (Morse, 2010). Qualitative methods were used to analyse the content of goals and identify key themes. Quantitative methods were used to identify participant demographics, comorbidities, and levels of functional independence and participation. The qualitative and quantitative results were analysed together to investigate the association between the content of the goals and characteristics of the participants.

Data Source

Secondary data from the HOME trial was used in the current study. The HOME trial evaluated the efficacy of a discharge planning intervention compared to an in hospital consultation during discharge from acute care and medical wards for older adults (Clemson et al., in press). Participants were recruited from six metropolitan hospitals in Sydney and
Melbourne, Australia. Participants were eligible for inclusion if they were aged 70 years or older, living in the community prior to admission and expected to return to the community after discharge, were conversational in English, and had no severe cognitive impairment. Participants were excluded from the HOME trial if they had received an occupational therapy home assessment in the past six months, had significant comorbidities, were expected to require a wheelchair during discharge, or scored less than five on the locomotion subscale of the Functional Independence Measure (Uniform Data System for Medical Rehabilitation, 2008). Participants were recruited from acute hospital wards and randomly allocated to control or intervention groups. As the control group did not complete goal setting, only data from the intervention group was used in the current study. The intervention group received an occupational therapy discharge planning intervention (HOME) that focused on rapport and client-centred practice, including collaborative goal setting. The participant and their family set goals with occupational therapists trained in the ‘easy’ Goal Attainment Scaling (GAS) method (Turner-Stokes, 2009; Turner-Stokes & Williams, 2010) which involved four steps: (1) identify goals with the client, (2) define expected outcomes to be achieved at the end of the intervention period, (3) score current baseline performance and then (4) score final performance at 3 months follow-up. The goals set using this protocol were recorded on an ‘Occupational Therapy Goal’ table (Appendix I) and this was the main source of qualitative data for the current study.

Quantitative data was obtained from clinical assessments completed as part of the HOME trial and outlined in the protocol paper (Wales, xxxx ref):

**Baseline questionnaire.** The questionnaire was completed using a semi-structured interview to collect participant demographics.

**Charlson Comorbidity Index (Charlson, Pompei, Ales, & MacKenzie, 1987).** The Charlson Comorbidity Index is a 16-item questionnaire used to identify if participants have comorbidities known to influence health state. Comorbidities are given different weightings depending on how they influence ten-year mortality. As the score increases, the individual has an increased risk of mortality in the next ten years.

**Late Life Disability Index (LLDI): Frequency Dimension (Jette et al., 2002).** The LLDI is a 16-item self-report questionnaire asking participants how often they participate in certain activities. Responses are given on a 5-point Likert scale; (1) very often, (2) often, (3) once in a while, (4) almost never, (5) never. The LLDI was used as a measure of participation.

**Nottingham Extended Activities of Daily Living (NEADL) (Nouri & Lincoln, 1987).** The NEADL is a 22-item self-report scale that was used to assess functional independence.
Participants are asked about their ADL performance in the past week. Participants score 0 for answers ‘no’ or ‘with help’ and 1 for ‘on my own with difficulty’ or ‘on my own’.

Current Study

Sampling method. Fifty participant files were sampled from the total possible participant files in the HOME intervention group ($N=198$). The intervention group files were first stratified by gender to maintain equivalent male to female ratio, and then every fourth file was systematically selected and de-identified.

Data collection. Written data was extracted from the ‘Occupational Therapy Goals’ table (Appendix I) and clinical notes of each participant file into an Excel spreadsheet (Appendix II). Participant and therapist goals were entered into the database exactly as they had been recorded in the notes, to keep authenticity to the participants/therapist goals and prevent researcher interpretation of the goals during data collection. Additional demographic and assessment data was obtained from the HOME trial database.

Ethical considerations. The Human Research Ethics Committee at the University of Sydney granted ethical approval for the HOME trial (HREC/09/RRCS/07); individualised written consent for the HOME trial included consent for data being used in future research provided data were de-identified.

Data Analysis

Descriptive statistics. The data was quantitatively analysed using SPSS 22. Descriptive statistics were applied to define the sample, including frequency, range, median and mean of different variables. The variables of interest in the current study are gender, age, living arrangements, participation level (LLDI), functional independence (NEADL), and comorbidities. Obtaining the mean age, participation level, functional independence and comorbidities allowed variables to be split into high and low categories in preparation for mixed method analysis. The total count of goals, and frequencies of client and therapist goals were identified.

Content analysis. The characteristics and nature of the goals was analysed using inductive content analysis (Elo & Kyngäs, 2008). Content analysis was selected as it is appropriate for analysing short qualitative data sources, such as single words or phrases (Braun & Clarke, 2006). Content analysis places the broad data into fewer categories to describe and quantify the goals (Elo & Kyngäs, 2008). First, a broad understanding the goals and initial codes were developed by investigators from the raw data goal sheets and supported by reading and reflecting on therapist notes from 10 participant files. Second, using the excel
spreadsheet of goals, two of the researchers [PW and LC] together coded 20 participant goals to check and refine these initial codes. Third, researchers independently coded 100 goals to determine if the initial codes were representative of the larger data set. Fourth, PW, LC & NL met to again check, refine and suggest additional codes, and reach consensus on codes. Then one researcher [PW] applied the codes to all goals. Several meetings were conducted to review field notes and to continue consensus coding. Final categories were identified by all researchers at completion of coding through in-depth discussion and mapping of themes and sub-themes.

**Mixed Methods.** Descriptive statistics and the final thematic findings were used to determine if an association existed between the participant characteristics (gender, age, living arrangements, participation level, functional independence and comorbidities) or the goal author (client or therapist goal) and the types of goals. Independent sample chi-square tests were used to determine significance.

**Results**

**Participants and Goals**

From the 50 participant files sampled, 414 goals were identified. On average, each file contained 9 goals set by the client or therapist.

Characteristics of participants and goals are presented in Table 1. The sample was aged from 70 to 96 years with average age 80 years. Just over half of the participants were female, received assistance from their family, and had previous hospital admissions in the past year. Less than half were married and living alone in the community. Most participants’ income was a pension or similar benefit.

**Goal Nature and Characteristics**

A number of themes emerged from the content analysis of written goals. The two main themes were (a) desire to get back to ‘doing’ and (b) engaging in ‘doing’. The four sub-themes present in both of the main themes were (a) what ‘doing’, (b) how to ‘do’, (c) who ‘doing’ and (d) where ‘doing’. Goals often had each of the sub-themes and had one or more components within the sub-themes. Table 2 lists the themes and categories. The main themes of desire to get back to ‘doing’ and engaging in ‘doing’ have been mapped in Figures 1 and 2 respectively. These two figures show the relationship between the sub-themes and categories within the themes. The quoted goals presented below are labeled as therapist (OT) or client (CT) to identify the differences between the goals set by different authors.

**Major Themes**

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1. Desire to get back to ‘doing’

Expressing the desire to get back to previous lifestyle or function was present in 36 (72%) of the participant files ($N = 50$). Goals captured the participants’ general wish to return to something about their pre-admission life and included words such as ‘resume’, ‘usual’, ‘get back’ and ‘return’. The goals stated participation in their pre-admission lifestyle, returning to their prior health or going home:

- Get back to doing everything. (OT)
- To return home. (OT)

2. Engaging in ‘doing’

Engaging in ‘doing’ involved goals that were based in activity, task or occupation. This theme was present 379 times from the 50 participant files. Engaging in ‘doing’ goals had an increase in the number and variety of sub-themes included, compared to desire to get back to ‘doing’ goals. Goals expressed a specific activity that participants wanted or needed to engage in:

- Within one week client will return to cooking a simple meal for herself. (OT)
- Independent with showering and dressing. (CT)

Sub-themes

What ‘doing’: Goals could be grouped based on the different types of ‘doings’, or occupations. The types of occupations found throughout the analysis are located in the ‘doing’ box of both figures. The most frequent goal occupations were instrumental ADL, leisure and community mobility. What ‘doing’ goals were in both themes, but were more frequent and specific within the theme engaging in ‘doing’:

- To be able to do what I was doing before I went into hospital. (Desire to get back to ‘doing’) (PT)
- Walking Ollie her dog to park. (Engaging in ‘doing’) (CT)

The above goals also highlight the different activities. The first is a health management goal. The second goal is leisure and community mobility, demonstrating how goals can be grouped in to two different categories within the one sub-theme.

How to ‘do’: Goals stated the level of performance the participant would need to achieve the goal. Achievement was most frequently participation or resumptions of pre-admission lifestyle:
Return to fitness and social activities as able. (OT)

Some goals had multiple levels of achievement within the goal. The below example describes achievement as participation, independence and use of strategy, modification or equipment:

*Within one week of discharge have vacuumed flat with three rest breaks (seated) with nil assistance.* (OT)

Other goals involved the participant’s attainment of a capability or skill development, whether or not this skill was used functionally in a task:

*To increase activity tolerance.* (OT)

*Increase physical endurance post discharge.* (CT)

The above two capability goals demonstrate improvement, but goal improvement was also observed in relation to specific task performance:

*Improve walking.* (CT)

Some goals identified goal achievement as making arrangements in preparation for engagement in a task:

*Client to look up local men’s sheds on the internet.* (OT)

Goal achievement was also demonstrated by upgrading the demands of a previously set goal:

*Be able to write cards to family and friends again.* (CT)

*Write five thank you cards to friends and family.* (OT) (Upgrade)

**Who ‘doing’**: Goals included whether the goal would be completed alone or with others. Goals were more frequently completed alone. Alone was used as a default category. Goals that were identified as alone often included words such as, independent, by myself and without help/assistance:

*Be able to walk by myself with no assistance.* (CT)

If the goal was to be completed with others it included to what level the other person would be involved. Some goals had another person involved for assistance or supervision:

*Prepare meat and 3 veg meal and husband to put in oven.* (OT)
Able to shower, dress, toilet & feed self with supervision from son-in-law. (CT)

Other goals involved the inclusion of others for social engagement rather than support: 
Celebrate Christmas with whole family. (CT)

*Where ‘doing’:* Goals contained reference to an environment for goal performance. The environment of goals was most frequently inside the home. Inside the home was used as a default category. Goals inside and outside of the home frequently included personal ADL, instrumental ADL and mobility:

*Within 2 weeks negotiate stairs independently and use extra four wheeled walker to collect mail.* (OT)

*Be safe using the shower.* (CT)

Community goals identified various locations within the community, such as, clubs, shopping centres and restaurants. Community goals included public and private transport:

*To complete own grocery shopping with assistance from community transport to carry items to bus by 28/4/13.* (OT)

A small group of goals defined the performance environment as in the hospital before the client was discharged:

*Shower self while in hospital.* (CT)

**Association between Goals and Participant Characteristics**

These results are presented in Table 2. Overall, there was little association between goals and age or gender. The only differences in these groups were increased skill and ability development goals in the older group compared to the younger, and increased personal ADL goals for males compared to females.

Greater differences were observed based on living arrangement, participation and comorbidities. The living alone group had more goals involving health management and making arrangements, while participants living with others had increased personal ADL, home mobility, independence and participation goals. Participants with high participation scores had increased goals involving home mobility, personal ADL, skill and ability development, independence, and within the home, compared to the low participation. The low participation group had more leisure, and community-based goals. Participants with high comorbidities had increased personal ADL, home mobility, independence and alone goals.
compared to low comorbidities. The low comorbidity group had an increase in leisure, resumption of previous lifestyle and goals completed socially with others.

The greatest differences in goals was observed based on functional independence. The high functional independence group had more desire to get back to ‘doing’, leisure, community mobility, resumption of previous lifestyle, making arrangements, and goals completed in the community, compared to the low functional group. The low functional independence group had an increase in engaging in ‘doing’, personal ADL, home mobility, independence and strategy, modification or equipment goals that were completed within the home.

Client and Therapist Goals

Client goals were more often completed alone. Therapist goals frequently were completed with others for assistance or supervision, or using a strategy, modification or equipment or requiring independence. There were no significant differences between client and therapist goals for where ‘doing’ or the major themes, desire to get back to ‘doing’ and engaging in ‘doing’.

Informal observation of the quality of therapist SMART goals throughout the content analysis revealed most goals satisfied the specific SMART goal component. Measurable and time-based components were included less frequently in therapist SMART goals. Therapist goals included more SMART components than client goals, for example:

*Weed front lawn.* (CT)

_In 2 weeks client will spend 1/2hr weeding front lawn from kneeling position 2x /week._

(OT)

**Discussion**

The purpose of the current study was to explore the characteristic and nature of occupational therapy goals set during discharge from acute hospital for older adults. The findings suggest that central to all goals was a ‘desire to get back to doing’ or ‘engage in doing’. The characteristics of goals were the goal components of what, who, where and how. The secondary aims were to investigate the association between goals and participant characteristics and to compare therapist and client goals. Generally, therapist goals were more specific than client goals. There was little association found between goals and age or gender. However goals were associated with living arrangements, functional independence, participation and comorbidities suggesting that clinicians ought to pay greater attention to these factors when goal setting for older adults during discharge from acute care.
Identifying that client and therapist goals could be grouped based on ‘desire to get back to doing’ and ‘engaging in doing’ contained a broader range with both overall goals and specific goals. Most participant files had one ‘desire to get back to a doing’ goal, and each participant had multiple ‘engaging in doing’ goals. Brown et al. (2014) found adults in a rehabilitation ward set broad goals to plan to be able to resume their pre-admission lifestyle. This finding from Brown et al. (2014) has similarities with the ‘desire to get back to doing’ theme identified in the current study. The results of the current study differ to Brown et al. (2014) as clients also identified specific occupation-based goals. As clients identified both types of goals this suggests the older adults in the current study were informed about the scope of therapy goals and actively participated in goal setting.

The sub-themes of the current study were the what, who, where, and how components of goals. The sub-themes provided more goal specificity and identified the requirements for goal achievement. Within the subthemes, instrumental ADL goals completed alone and involving client participation within the home were identified most frequently. This finding of the current study contrasts the typical acute hospital care focus on personal ADLs (Craig et al., 2004; Welch & Forster, 2003). The high prevalence of instrumental ADL goals shows the impact of the client-centered HOME intervention on goal setting. ‘What doing’ was present in most goals and shows how goals could be grouped according to the categories of occupation in occupational therapy models; the ‘who doing’ part of goals stated whether another person would be present for the goal. Throughout analysis it became clear that goals could involve another person for assistance, supervision or social reasons. During acute hospital discharge goals within the home are expected, so it was interesting the goals in the current study were split evenly between the home and community. This demonstrates the impact of the HOME intervention on issues beyond ‘safe for discharge’. The ‘how to do’ subtheme was an unexpected finding as the researchers expected goals to involve client improvement. However a wider range of outcomes was observed, including, making arrangements towards a larger goal, taking part in an activity, resuming previous lifestyle and using new strategies or equipment.

The what, who, where and how of goals is new to research literature, however, has been described previously in a physiotherapy goal setting guide. Randall and McEwen (2000) described goals as including a general outcome, who, what, under what circumstances, how well and by when. The components ‘how well’ and ‘by when’ described by Randall and McEwen (2000) in their American study, were not consistently found in the current study, and this may be due to international or inter-disciplinary differences in goal setting. ‘How well’ allows goals to be measureable and ‘by when’ makes goals time-limited. Not including
the measurable component of goals was common in the current study and has been found in
other research (Hassett et al., 2015). Generally, therapists could improve goal setting by
ensuring goals are measurable and time-limited.

The results of the current study revealed similarities in the content of therapist and
client goals. This is unusual as acute therapists focus on safety and self-care (Craig et al.,
2004) and clients in the current study identified instrumental ADL goals most frequently. This
likely shows the influence of the HOME intervention on goal setting. The ‘easy’ GAS
resulted in paired goals as therapist goals came from the client-stated goal. From this it can be
concluded that the goals show older adults in the current study were able to identify needs
beyond self-care and safety and have these reflected in the therapists’ goals. Some differences
were observed in therapist and client goals. Overall, therapist goals were more specific than
client goals. Therapists included independence and strategy, equipment or modification
within goals more than clients, which aligns with equipment prescription and home safety
being the most frequent discharge recommendations (Harris, James, & Snow, 2008).

Rehabilitation literature has identified participant characteristics are more predictive
of goals (Custer et al., 2013) than demographics (Wallace & Kendall, 2014). The current
study was consistent with this and so while an association was found between living
arrangement, functional independence, participation and comorbidities, an association was not
found between goals and gender or age. Although discharge could be considered more
challenging for individuals living alone due to reduced social support and need for
independent occupational performance (Stineman et al., 2014), clients returning to live with
others set more goals. Clients living with others had greater desire to participate and complete
goals independently, suggesting client living with others set more goals to prevent them
burdening others they live with. This conclusion is comparable to that drawn by Hoffmann
and McKenna (2004) who found living with others was predictive of low use of bathroom
equipment and suggested this could be because of the inconvenience they felt this caused
others in the house. Overall clients with high functional independence and participation had a
greater number of goals compared to low counterparts. Those participants who were already
participating in community activities appeared to set goals to further increase their
occupational engagement. In regards to functional independence, high and low participants
seemed to demonstrate insight into their own abilities and incorporated this into their goals.
Client with high functional independence set more goals overall, with an increase in
community and leisure goals; clients with low functional independence focused on home-
Based goals relating to personal ADL. Despite poorer health, the high comorbidity group set
more goals than the low comorbidity group. However the goals set by the high comorbidity
group focused on personal ADL tasks, home mobility and independence. This result shows insight into realistic goals given the clients health. Similar results have been found in adult spinal cord injury rehabilitation, where clients with quadriplegia set self-care goals, while client with paraplegia identified community mobility goals (Wallace & Kendall, 2014). When the association between personal characteristics and goals is considered in relation to existing goal research, it suggests older adults set goals in the same way as other age groups.

Implications

This study shows older adults have broader goals than the traditional self-care and safety focus of acute discharge planning. This has implications for clinical practice, particularly when planning to work with the ageing population in acute hospital care. Identifying goals to address all of the needs of older adults will provide holistic intervention to meet the demands of returning to live in the community following an acute admission. Identifying the broad scope of goals set when older adults are discharged home is vital to increase community participation and decrease functional difficulties during and after discharge.

Limitations and Future Research

One of the main limitations of this study was the use of secondary data. This prevented member checking and the opportunity for in depth interpretation of goals with therapists or participants. Further, missing data from the HOME trial therapist files (not necessary as major outcomes to the trial and limited by therapist time for reporting additional to usual care) prevented evaluation of goal achievement and therapist goals, as what was achievable and realistic from the client’s and therapist’s perspectives was unknown. Although a primary investigation into acute discharge goals for older adults would have had greater reliability, secondary analysis was selected as it is a cost and time effective way to investigate additional hypotheses identified during the primary investigation. The limitations of secondary analysis were acknowledged during the design phase and methodologically addressed by evaluating the dataset to ensure the research questions could be answered with the existing data. Despite this, we recommend completion of a primary investigation in the future to enable greater depth in knowledge regarding goal setting during acute discharge for older adults. In particular, we recommend improving the accuracy of goal interpretation and exploring the components of goal setting.

Conclusion
The research findings highlight the variety of occupational therapy goals older adults identified during discharge from acute care and medical hospital wards. The variety of goals identified shows that older adults have needs beyond the self-care and safety goals that are commonly addressed during discharge. This study has shown older adults set different types of goals based on their functional independence, participation levels, living arrangement and comorbidities. This information needs to be considered for health services to effectively meet the needs of this group during the crucial time of discharge home from hospital. Effectively addressing the occupational therapy goals of older adults during discharge aims to enable older adults to return to their pre-admission lifestyle and prevent re-admission.

Acknowledgements
The HOME trial was funded by an NHMRC project grant.
There are no conflicts of interest to declare.
The researchers would like to thank the occupational therapists at the Melbourne and Sydney hospitals involved in the HOME trial for providing the data source for the current study.
References


Tables

Table 1.  
*Participant and Goal Characteristics*

Table 2.  
*Associations between Goals and Participant Characteristics*
Table 1.

*Participant and Goal Characteristics*

<table>
<thead>
<tr>
<th>Participants (N = 50)</th>
<th>n (%)</th>
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<tr>
<td>Gender (female)</td>
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<td>Married</td>
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<td>Lives alone</td>
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<td>Receives support from family</td>
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<td>Education: Completed year 11 or 12</td>
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<td>Previous hospital admission in past year</td>
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<tr>
<td>Age (years) (range: 70-96)</td>
</tr>
<tr>
<td>Charlson Comorbidity Index†</td>
</tr>
<tr>
<td>NEADL‡</td>
</tr>
<tr>
<td>Frequency Component LLDI§</td>
</tr>
</tbody>
</table>

| Number of goals (range: 3-22) | 8.9 (3.4) |

<table>
<thead>
<tr>
<th>Goals (N = 414)</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>≤ 79 years</td>
<td>217 (52.4)</td>
</tr>
<tr>
<td>≥ 80 years</td>
<td>197 (47.6)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>164 (39.6)</td>
</tr>
<tr>
<td>Female</td>
<td>250 (60.4)</td>
</tr>
<tr>
<td>Goal Author</td>
<td></td>
</tr>
<tr>
<td>Client Goals</td>
<td>182 (44)</td>
</tr>
<tr>
<td>Therapist Goals</td>
<td>232 (56)</td>
</tr>
<tr>
<td>Living Arrangements</td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>174 (42)</td>
</tr>
<tr>
<td>With others</td>
<td>240 (58)</td>
</tr>
<tr>
<td>Charlson Comorbidity Index¶§</td>
<td></td>
</tr>
<tr>
<td>Low Comorbidities</td>
<td>190 (50)</td>
</tr>
<tr>
<td>High Comorbidities</td>
<td>190 (50)</td>
</tr>
</tbody>
</table>
ACUTE DISCHARGE GOALS FOR OLDER ADULTS

Function al Independence: NEADL

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Functional Independence</td>
<td>166 (40.1)</td>
</tr>
<tr>
<td>High Functional Independence</td>
<td>248 (59.9)</td>
</tr>
</tbody>
</table>

Participation: LLDI

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Participation</td>
<td>239 (57.7)</td>
</tr>
<tr>
<td>High Participation</td>
<td>175 (42.3)</td>
</tr>
</tbody>
</table>

Note.

†Charlson Comorbidity Index. Score 0-37, scores >3 are rare, scores ≥5 have increase 3-month mortality.
‡NEADL, Nottingham Extended Activities of Daily Living. Score 0-22, higher scores = greater independence.
§LLDI, Late Life Disability Index. Score 16-80, lower scores = higher participation. ¶Groups were divided into high/low based on the mean. ∆Charlson Comorbidity (N = 390; 34 missing).
Table 2.
Associations between Goals and Participant Characteristics

<table>
<thead>
<tr>
<th>Goal Themes/Sub-themes/Categories</th>
<th>Age</th>
<th>Gender</th>
<th>Living Arrangement</th>
<th>Functional Independence</th>
<th>Participation</th>
<th>Comorbidity</th>
<th>Goal Author</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>79</td>
<td>80</td>
<td>Male</td>
<td>Female</td>
<td>Alone</td>
<td>With others</td>
<td>High (n)</td>
</tr>
<tr>
<td>(N = 414)</td>
<td></td>
<td></td>
<td>(n = 23)</td>
<td>(n = 27)</td>
<td>(n = 20)</td>
<td>(n = 30)</td>
<td>30</td>
</tr>
<tr>
<td>Desire to get back to ‘doing’</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>28*</td>
</tr>
<tr>
<td>Engaging in ‘doing’</td>
<td>15</td>
<td>21</td>
<td>15</td>
<td>21</td>
<td>19</td>
<td>17</td>
<td>221*</td>
</tr>
<tr>
<td>What ‘doing’</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal ADL</td>
<td>19</td>
<td>17</td>
<td>20*</td>
<td>16*</td>
<td>5**</td>
<td>31***</td>
<td>4***</td>
</tr>
<tr>
<td>Instrumental ADL</td>
<td>62</td>
<td>49</td>
<td>37</td>
<td>74</td>
<td>46</td>
<td>65</td>
<td>63</td>
</tr>
<tr>
<td>Home Mobility</td>
<td>17</td>
<td>17</td>
<td>12</td>
<td>22</td>
<td>5**</td>
<td>29**</td>
<td>8***</td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobility</td>
<td>40</td>
<td>48</td>
<td>35</td>
<td>53</td>
<td>34</td>
<td>54</td>
<td>61*</td>
</tr>
<tr>
<td>Leisure</td>
<td>56</td>
<td>46</td>
<td>42</td>
<td>60</td>
<td>48</td>
<td>54</td>
<td>78***</td>
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<td>Social</td>
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<td>12</td>
<td>29</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteering</td>
<td>3†</td>
<td>2†</td>
<td>0†</td>
<td>5†</td>
<td>4†</td>
<td>1†</td>
<td>3†</td>
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<tr>
<td>Health</td>
<td>20</td>
<td>12</td>
<td>17</td>
<td>15</td>
<td>21**</td>
<td>11**</td>
<td>17</td>
</tr>
</tbody>
</table>
## Participant Characteristics (N = 50)

<table>
<thead>
<tr>
<th>Goal Themes/Sub-themes/Categories (N = 414)</th>
<th>Age</th>
<th>Gender</th>
<th>Living Arrangement</th>
<th>Function Independence</th>
<th>Participation</th>
<th>Comorbidity</th>
<th>Goal Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How to ‘do’</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation</td>
<td>139</td>
<td>115</td>
<td>98</td>
<td>156</td>
<td>93**</td>
<td>161**</td>
<td>144</td>
</tr>
<tr>
<td>Independence</td>
<td>31</td>
<td>27</td>
<td>20</td>
<td>38</td>
<td>10***</td>
<td>48***</td>
<td>13***</td>
</tr>
<tr>
<td>Make</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrangements</td>
<td>34</td>
<td>35</td>
<td>28</td>
<td>41</td>
<td>40**</td>
<td>29**</td>
<td>53**</td>
</tr>
<tr>
<td>Strategy, Modification or Equipment</td>
<td>39</td>
<td>38</td>
<td>32</td>
<td>45</td>
<td>26</td>
<td>51</td>
<td>38*</td>
</tr>
<tr>
<td>Skill &amp; Ability</td>
<td>31*</td>
<td>43*</td>
<td>35</td>
<td>39</td>
<td>27</td>
<td>47</td>
<td>37</td>
</tr>
<tr>
<td>Upgrade on Previous Goal</td>
<td>10</td>
<td>4</td>
<td>3</td>
<td>11</td>
<td>6</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Improvement</td>
<td>12</td>
<td>12</td>
<td>13</td>
<td>11</td>
<td>10</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>Resume Previous Lifestyle</td>
<td>66</td>
<td>50</td>
<td>43</td>
<td>73</td>
<td>53</td>
<td>63</td>
<td>84**</td>
</tr>
</tbody>
</table>
## Participant Characteristics (N = 50)

<table>
<thead>
<tr>
<th>Goal Themes/Sub-themes/Categories (N = 414)</th>
<th>Age</th>
<th>Gender</th>
<th>Living Arrangement</th>
<th>Functional Independence</th>
<th>Participation</th>
<th>Comorbidity</th>
<th>Goal Author</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>≤ 79</td>
<td>≥ 80</td>
<td>Male</td>
<td>Female</td>
<td>Alone</td>
<td>With others</td>
<td>High (n = 30)</td>
</tr>
<tr>
<td>Who ‘doing’</td>
<td></td>
<td></td>
<td>(n = 23)</td>
<td>(n = 27)</td>
<td>(n = 20)</td>
<td>(n = 30)</td>
<td>(n = 28)</td>
</tr>
<tr>
<td>Alone</td>
<td>165</td>
<td>150</td>
<td>124</td>
<td>191</td>
<td>129</td>
<td>186</td>
<td>186</td>
</tr>
<tr>
<td>Supervision</td>
<td>10</td>
<td>10</td>
<td>9</td>
<td>11</td>
<td>7</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Assistance</td>
<td>26</td>
<td>18</td>
<td>16</td>
<td>28</td>
<td>21</td>
<td>23</td>
<td>25</td>
</tr>
<tr>
<td>Socially</td>
<td>21</td>
<td>23</td>
<td>18</td>
<td>26</td>
<td>24</td>
<td>20</td>
<td>31</td>
</tr>
</tbody>
</table>

Where ‘doing’

| Inside Home | 111 | 114 | 93 | 132 | 89 | 136 | 118** | 107** | 106* | 119* | 96  | 110 | 101  | 124  |
| Outside Home| 9   | 9   | 11 | 7   | 7  | 11  | 9    | 9    | 9    | 9    | 7   | 10  | 6    | 12    |
| In the Community | 92 | 79  | 65 | 106 | 81 | 90  | 127*** | 44**  | 57** | 114** | 85  | 70  | 74   | 97    |
| In Hospital  | 7†  | 1†  | 1† | 7†  | 0† | 8†  | 0†   | 8†   | 7†  | 1†  | 4†  | 4†  | 1†   | 7†    |

*Expected frequencies < 5, chi-square could not be used.

* p < .05. ** p < .01. *** p < .001
Figures

Figure Legends

*Figure 1.* Theme Map of Desire to Get Back to ‘Doing’ \((N = 414)\). Percentages do not sum to 100% as goals were coded into more than one code.

*Figure 2.* Theme Map of Engaging in ‘Doing’ \((N = 414)\). Percentages do not sum to 100% as goals were coded into more than one code.
Figure 1.
Figure 2.
Appendices

Appendix I: ‘Occupational Therapy Goal’ Table from HOME trial 62

Appendix II: Data Collection Table from Current Study 63

Appendix III: Author Guidelines – Australian Occupational Therapy Journal 64
### Appendix I: ‘Occupational Therapy Goal’ Table from HOME Trial

<table>
<thead>
<tr>
<th>Client Stated goal</th>
<th>SMART goal</th>
<th>Baseline</th>
<th>Review Date</th>
<th>Achieved</th>
<th>Level of Attainment</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Some Function</td>
<td>☐ No Function</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Much better than expected</td>
<td></td>
</tr>
<tr>
<td>☐ Some Function</td>
<td>☐ No Function</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Much better than expected</td>
<td></td>
</tr>
<tr>
<td>☐ Some Function</td>
<td>☐ No Function</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Much better than expected</td>
<td></td>
</tr>
<tr>
<td>☐ Some Function</td>
<td>☐ No Function</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Much better than expected</td>
<td></td>
</tr>
<tr>
<td>☐ Some Function</td>
<td>☐ No Function</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Much better than expected</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix II: Data Collection Table from Current Study

<table>
<thead>
<tr>
<th>Participant ID</th>
<th>Goal Number</th>
<th>Goal Source</th>
<th>Client Stated Goal</th>
<th>SMART Goal</th>
<th>Additional Goal</th>
<th>Review Time</th>
<th>Achieved</th>
<th>Review Time 2</th>
<th>Achieved 2</th>
<th>Level of Attainment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix III: Author Guidelines – Australian Occupational Therapy Journal

The Australian Occupational Therapy Journal is the official journal of Occupational Therapy Australia. The journal publishes original articles dealing with theory, research, practice and education in occupational therapy. Papers in any of the following forms will be considered: Feature Articles, Research Articles, Reviews, Viewpoints, Critically Appraised Papers, and Letters to the Editor.

Research Articles

Research Articles should contain the following:

Structured abstract: 250 word limit.

Introduction: The aims of the article should be clearly stated and a theoretical framework (if applicable) should be presented with reference to established theoretical model(s) and background literature. A succinct review of current literature should set the work in context. The introduction should not contain findings or conclusions.

Methods: This should provide a description of the method (including subjects, procedures and data analysis) in sufficient detail to allow the work to be repeated by others.

Results: Results should be presented in a logical sequence in the text, tables and figures. The same data should not be presented repetitively in different forms.

Conclusion: The conclusion should consider the results in relation to the purpose of the article advanced in the introduction. The relationship of your results to the work of others and relevant methodological points could also be discussed. Implications for future research and practice should be considered. The conclusion section of your structured abstract should contain the key messages/take home points of your article.

Research Article manuscripts should not exceed 5000 words, and have no more than 35 references.

For manuscripts that report on randomised controlled trials, please include all the information required by the CONSORT checklist. All manuscripts must include a flow chart showing the progress of participants during the trial. Where applicable, reference should be made to the extension to the CONSORT statement for non-pharmacological treatment and the CLEAR NPT. When restrictions on word length make this difficult, this information may be provided in a separate document submitted with the manuscript.
EDITORIAL REVIEW AND ACCEPTANCE
The acceptance criteria for all papers are quality, originality and significance to our readership. Except where otherwise stated, Feature Articles, Research Articles, Reviews and Viewpoint manuscripts are blind peer reviewed by two anonymous reviewers. Final acceptance or rejection rests with the Editorial Board or the editor, who reserves the right to refuse any material for publication.
Manuscripts should be written so that they are intelligible to the professional reader who is not a specialist in the particular field. They should be written in a clear, concise, direct style. Where contributions are judged as acceptable for publication on the basis of scientific content, the Editor and the Publisher reserve the right to modify typescripts to eliminate ambiguity and repetition and improve communication between author and reader. If extensive alterations are required, the manuscript will be returned to the author for revision.

COVER LETTER AND ETHICAL CONSIDERATIONS
Papers are accepted for publication in the journal on the understanding that the content has not been published or submitted for publication elsewhere, and this must be stated in the covering letter. The covering letter must contain an acknowledgement that all authors have contributed significantly, and that all authors are in agreement with the content of the manuscript.
 Authors must also state that the protocol for the research project has been approved by a suitably constituted Human Research Ethics Committee of the institution within which the work was undertaken and that it conforms to the provisions of the Declaration of Helsinki (as revised in 2008). All investigations involving humans must include a statement about the ethical review process. It is expected that most investigations will seek review by a Human Ethics Review Committee. Where ethical review has not been sought or obtained, justification must be provided. It is expected that most investigations involving humans will require informed consent for participant data to be collected and/or used; this process should be described. A statement is also required about preserving participant anonymity.
The Australian Occupational Therapy Journal retains the right to reject manuscripts which do not describe these processes, or which describe unethical conduct related to human or animal studies.

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Paige Waller – University of Sydney
the options. All services are paid for and arranged by the author. Please note using the Wiley English Language Editing Service does not guarantee that your paper will be accepted by this journal.

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*Spelling.* The Journal uses Australian spelling and authors should therefore follow the latest edition of the Macquarie Dictionary.

*Units.* All measurements must be given in SI or SI-derived units.

*Abbreviations.* Abbreviations should be used sparingly - only where they ease the reader's task by reducing repetition of long, technical terms. Initially use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only. The abbreviation of OT is not allowed in the manuscript.

**PARTS OF THE MANUSCRIPT**
Manuscripts should be presented in the following order: (i) title page, (ii) abstract and key words, (iii) text, (iv) acknowledgements, (v) references, (vi) appendices, (vii) figure legends, (viii) tables (each table complete with title and footnotes) and (ix) figures. Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

**Title page**
The title page should contain (i) the title of the paper, (ii) the full names, qualifications and designations of the authors and (iii) the addresses of the institutions at which the work was carried out together with (iv) the full postal and email address, plus facsimile and telephone numbers, of the author to whom correspondence about the manuscript should be sent. The present address of any author, if different from that where the work was carried out, should be supplied in a footnote.

The title should be short, informative and contain the major key words and consider including the study design for research articles. Do not use abbreviations in the title. A short running title (less than 40 characters) should also be provided.

All submitted manuscripts must indicate the total word length for the manuscript, word length of the abstract, number of references, figures and tables on the title page of the manuscript.
Abstract and key words
Research, Feature and Review articles must have a structured abstract that states in 250 words or fewer the purpose, basic procedures, main findings and principal conclusions of the study. Divide the abstract with the headings: Background/Aim, Methods, Results, Conclusions and significance of the study. Viewpoint articles should have an unstructured abstract of 150 words or fewer. Abstracts should not contain abbreviations or references.

Key words
Three to five key words must be supplied. They are required to index the content of the paper and should be selected from the US National Library of Medicine's Medical Subject Headings (MeSH) browser list. Key words should be arranged in alphabetical order. Please do not use words already written in your title or abstract.

Text
Authors should use the following subheadings to divide the sections of their manuscript: Introduction, Methods, Results and Conclusion. All articles should include an introduction that provide a background to the article, describes its purpose and outlines its relevance to occupational therapy. References should be made to an established theoretical background and/or background literature. The implications of the work for occupational therapy practice, and further research and/or conceptual development, should be clearly described.

Acknowledgements
The source of financial grants and other funding must be acknowledged, including a frank declaration of the authors' industrial links and affiliations. Authors should state any potential conflicts of interest. The contribution of colleagues or institutions should also be acknowledged. Personal thanks and thanks to anonymous reviewers are not appropriate.

References
The American Psychological Association (author, date, title, source) system of referencing is used (examples are given below). In the text give the author's name followed by the year in parentheses: Smith (2000). If there are two authors use 'and': Smith and Jones (2001), but if cited within parentheses use '&': (Smith & Jones, 2001). When reference is made to a work by three to five authors, cite all the authors the first time: (Davis, Jones, Wilson, Smith, & Lee, 2000); and in subsequent citations, include only the name of the first author followed by et al.: (Davis et al., 2000). When reference is made to a work by six or more authors, the first
name followed by et al. should be used in all instances: Law et al. (1997). If several papers by the same author(s) from the same year are cited, a, b, c, etc. should be inserted after the year of publication. Within parentheses, groups of authors should be listed alphabetically. In the reference list, references should be listed in alphabetical order.

In the reference list, cite the names of all authors when there are six or fewer; when seven or more, list only the first six followed by et al. Do not use ibid. or op cit. Reference to unpublished data and personal communications should not appear in the list but should be cited in the text only (e.g. A. Smith, unpublished data, 2000). All citations mentioned in the text, tables or figures must be listed in the reference list.

Authors are responsible for the accuracy of the references.

We recommend the use of a tool such as Reference Manager for reference management and formatting.

**Journal article**


**Advanced online publication of journal article with DOI**


**Book**


**Chapter in a book**


**Electronic media**


**Appendices**

These should be placed at the end of the paper, numbered in Roman numerals and referred to.
in the text. If written by a person other than the author of the main text, the writer's name should be included below the title.

Tables
There is a limit of four tables or figures per manuscript. Tables should be self-contained and complement, but not duplicate, information contained in the text. Number tables consecutively in the text in Arabic numerals. Type tables on a separate sheet with the legend above. Legends should be concise but comprehensive - the table, legend and footnotes must be understandable without reference to the text. Vertical lines should not be used to separate columns. Column headings should be brief, with units of measurement in parentheses; all abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures
There is a limit of four tables or figures per manuscript. All illustrations (line drawings and photographs) are classified as figures. Figures should be cited in consecutive order in the text. Each figure should be labelled on the back in very soft marker or chinagraph pencil, indicating name of author(s), figure number and orientation. Do not use adhesive labels as this prohibits electronic scanning. Figures should be sized to fit within the column (80 mm), intermediate (114 mm) or the full text width (171 mm).
Line figures should be supplied as sharp, black and white graphs or diagrams, drawn professionally or with a computer graphics package. Lettering must be included and should be sized to be no larger than the journal text. Photographs should be supplied as sharp, glossy, black-and-white or colour photographic prints and must be unmounted. Individual photographs forming a composite figure should be of equal contrast, to facilitate printing, and should be accurately squared.
Magnifications should be indicated using a scale bar on the illustration.
If supplied electronically, graphics must be supplied as high resolution (at least 300 d.p.i.) files, saved as .eps or .tif. A high-resolution print-out must also be provided. Digital images supplied only as low-resolution print-outs and/or files cannot be used.

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A charge of A$1000/US$530/¥64000 for the first three colour figures and A$500/US$265/¥32000 for each extra colour figure thereafter will be charged to the author.
Figure legends
Type figure legends on a separate sheet. Legends should be concise but comprehensive - the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

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