Goal setting with older people in acute care before and after discharge: Occupational therapists perspectives

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I declare that this report is my own work and that the contributions of have been fully acknowledged.

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Literature review

In 2012-13, there were 5.5 million acute admissions to hospital in Australia (Australian Institute of Health and Welfare [AIHW], 2015). Of these acute admissions, 40% were accounted for by persons aged 65 years of age or older (AIHW, 2015). The World Health Organisation commissioned report by Parker (2005) identified that persons aged 65 and over face increased risks upon discharge from hospital due to deconditioning and loss of functionality, loss of independence, negative affect, lowered well-being and interruptions to formal and informal care.

Due to a combination of these increased risks and a push for swift discharge, the readmission rates for those over 65 have been reported at rates as high as 20% across a number of studies (Courtney et al., 2009; Mahoney, Eisner, Havighurst, Gray & Plata, 2000). As such, discharge planning has received increased attention as a strategy to minimise readmissions and increase functioning and participation of older patients upon discharge (Wales et al, 2012). However, despite this, there has been limited exploration of the goal setting processes of occupational therapists in discharge planning in Acute Aged Care [AAC] when no consistent goal setting practice is known to exist (Holm & Mu, 2012).

Background

The number of persons over 65 in Australia is estimated to rise from the current 15.4% to 22.6% by 2054 (ABS, 2014). The Australian Bureau of Statistics [ABS] (2014) has reported that the rate of those aged over 65 in Australia is increasing at approximately 6.3% annually. Internationally, rates are similar with the United Nations (2013) forecasting exponential growth of the percentage of individuals over 60 years of age across all regions of the world. With those aged over 65 already overrepresented in acute hospital admissions, the

number of admissions and readmissions are set to continue to rise (AIHW, 2015; The Treasury, 2015).

Acute hospital admissions accounted for $40.2 billion spent on hospital care in 2011-12 in Australia (AIHW, 2014). The AIHW's (2014) report on Australia's healthcare noted that the cost of acute healthcare is growing at a similar rate to the rate of increase of older adults, at approximately 7% growth annually. Concerns around the rising cost of healthcare have been addressed by an increased focus of researchers and institutions on the role of discharge planning in the effective return of older persons to the community to minimise readmissions and additional preventable costs (Parker, Peet, McPherson, Cannaby & Abrams, 2002; Shepperd et al., 2013; Wales et al., 2012).

Discharge planning refers to collaborative problem solving between patients, carers and a range of treating professionals to identify and manage care needs during their current admission and transition home (Wales et al., 2012). Effective discharge planning is generally multidisciplinary and incorporates an assessment of the individual, development of a care plan, implementation of the plan, follow-up and evaluation post discharge (DHS, 1998). Two systematic reviews of discharge planning have reported some effectiveness of the process, with evidence of shortened hospital stays, lowered readmission rates, minimised carer burden and improved communication resulting in enhanced coordination of services (Parker et al., 2002; Shepperd et al., 2013).

However, although results suggest that some effectiveness could be attributed to discharge planning, little is known as to why results have not been bigger given that the principles of discharge planning theoretically facilitate improved outcomes (Courtney et al., 2009; Shepperd et al., 2013; Wales et al., 2012). One suggestion for these results is the lack of structured discharge planning framework or consistency across institutions (Courtney et al,

2009; Wales et al., 2012). Therefore, further investigation into current discharge planning processes is needed.

Occupational therapists are one of the specialist disciplines that contribute to discharge planning (Wales et al., 2012). The occupational therapist's role in discharge planning is to consider the ability of older adults to independently and safely function within their own environment upon discharge (Parker et al., 2002; Wales et al., 2012). As such, occupational therapists evaluate the patient's current level of functioning, the social and physical environment that they will be returning to on discharge, and the occupations and roles that will be required of them (Wales et al., 2012). From this information, they construct a plan for the patient to overcome any challenges in their Person-Environment-Occupation fit that may arise (Sheppard et al., 2013).

One aspect of the discharge planning process for occupational therapy is setting treatment goals with clients (Atwal & Caldwell, 2003). Goal setting is a key aspect of the care plan development during discharge planning (Holm & Mu, 2012; Wales et al., 2012). Goal setting outlines the intended outcomes of the care plan, directing future interventions and services (Holm & Mu, 2012). Once the therapist has thoroughly assessed the needs, wants and circumstances of the patient, they negotiate with them to construct suitable goals for therapy (Park, 2011). Occupational therapists believe that effective goal setting is important for improved patient outcomes and patient satisfaction (Holm & Mu, 2012).

However, although effective goal setting is pivotal in the occupational therapy process and discharge planning, there is no known consistent goal setting practice or procedure in acute aged care (Holm & Mu, 2012). This lack of framework for goal setting has been reported across a number of countries with westernised health systems such as Canada, the United Kingdom and the United States (Atwal & Caldwell, 2003; Holm & Mu, 2012). Furthermore, little is known about what goal setting looks like across a variety of settings and

institutions and whether goal setting practices are sufficient to meet patient needs (Holm & Mu, 2012).

Defining Acute Aged Care

Acute aged care is initial care given to those over 65 in a hospital setting following admission (AIHW, 2015). Acute care is intended to cure or reduce severity of an injury or illness, alleviate current symptoms of an injury or illness or protect against exacerbation of a current condition (AIHW, 2015). The average length of stay in acute aged care is approximately 4.2 bed days, with treatment focused on swift discharge to minimise costs and the detrimental effects of hospitalisation (AIHW, 2015; Parker 2005).

It has been estimated that each hospital bed day for a person over 65 results in a 5% loss of muscle mass (Palmer, Counsell & Landefield 1998). This means that five bed days will require a patient approximately two months to recover (Palmer et al., 1998). When hospitalised, older persons are also prone to higher rates of under-nutrition, falls, medication errors, depression and infections (Palmer et al., 1998, Victoria Department of Health [VDOH], 2012). It has been recognized that acute aged care has a unique set of challenges due to the nature of complex and compounding illnesses (Moats & Doble, 2006).

Defining Goal Setting

Goal-directed behavior is a general characteristic of human behaviour and as such setting goals motivates individuals to meet intended outcomes (Playford et al., 2000). A goal is defined in occupational therapy as a measurable, narrowly defined end result of therapy to be achieved in a specified time (Bryant, 1995). Park (2011) expanded on this, defining a goal as an intent statement, collaboratively formulated with the client that outlines the intended measurable outcome to be achieved through therapy and a time frame for attainment. As such, goal setting is therefore taken to mean the formulation of goals or targets that will be the aim of all further therapy (Polatajko, Craik, Davis & Townsend, 2007).

The Australian Minimum Standards for New Graduate Occupational Therapists defines goal setting as the determination of priorities for intervention, developed collaboratively with the patient through complex problem solving, professional reasoning, and consideration of the person and their environment (Occupational Therapy Australia [OTA], 2010). All students must achieve proficiency in goal setting through fieldwork evaluation to be registered as an occupational therapist in Australia (OTA, 2010). Throughout the literature, definitions of goal setting appear to share the main aspects of this definition; collaboration with the patient, professional reasoning and determining priorities for further intervention (Custer, Huebner, Freudenberger, & Nichols, 2013; Moats & Doble, 2006).

Search Process

Using the keywords and MeSH terms *goal, goal setting, occupational therapy, discharge planning and aged care, acute aged care, elderly and hospital*, a number of databases were searched. Databases searched included: OT Seeker, Cochrane Library, CINAHL, Medline, Ageline, PubMed, Scopus and AMED. This search resulted in over one thousand results. To reduce this number, publications prior to 2000 and not in English were excluded. Although measures were taken to reduce results, the search still wielded over 700 articles. Effort was taken to screen all available articles or their abstract if the article was not available, however, some articles or their abstracts were unable to be obtained. Although the search was limited to articles published after 2000, articles found to be pivotal but published before 2000 were still included. A review of the literature illustrated that little review of goal setting practices in acute aged care had been done with a majority of articles focusing on goal setting in rehabilitation settings, aged care facilities or the community. Similarly, there were few studies that focused specifically on older adults. However, studies that reviewed goal setting in acute care that included participants over 65 were also included as their results were consistent across all age ranges (Maitra & Erway, 2006; Thomson & Black, 2008).

‘Best practice’ for goal setting

Autonomous Decision-Making

Traditionally, professionals alone made health care decisions, including goals, for patients in their ‘best interest’ (Moats & Doble, 2006). Taking a paternalistic approach acknowledged therapists as the experts with the education and experience to determine appropriate goals for therapy (Moats & Doble, 2006). This approach was consistent to the medical model of treatment most commonly found in acute care (Atwal & Caldwell, 2003; Moats & Doble, 2006). However, due to the changing nature of disability and the human rights movement, there has been a shift towards anti-paternalistic or autonomous approaches to health care decision-making (Hofland, 1988).

An autonomy approach dictates that patients should have the final say in decisions made about their healthcare that will affect their well-being (Moats & Doble, 2006). It has often been misinterpreted in health care that autonomy equates to giving informed consent (Huby, Brook, Thompson & Tierney, 2007; Moats & Doble, 2006). However, autonomous care planning involves the patient making decisions as well as being informed (Moats & Doble, 2006). It is argued that once a patient is informed of all options and the potential risk associated with choices, they should be given the final say in all health care decisions, including goal setting (Hofland, 1988). Moats & Doble (2006) proposed that if a client identifies that they have no current issues that they would like to work on, that therapists should respect that and further care planning decisions should align with this.

Consistent with the autonomy approach, the Australian Human Rights Commission [AHRC] (2013) Aged Care Reform Agenda emphasised the freedom of older adults to make decisions in regard to their healthcare. They asserted that older adults should be supported and respected in these decisions, with therapists acting as educated advisors and supports to enable self-directed care (AHRC, 2013).

Playford et al. (2000) further argued that autonomy should be not only plan related, but also task related. Patients should be able to select not only how they reach their goals but which tasks to focus their goals on (Playford et al, 2000). However, providing complete freedom to patients in decision-making often contradicts principle of beneficence in providing health care and although patients wishes should be respected, there is a requirement of the therapist to also minimise potential risk (Moats & Doble, 2006). Researchers have therefore proposed that a more collaborative approach should be taken (Moats & Doble, 2006).

Client-Centredness and Collaborative Goal Setting

Collaboration between therapists and their patients is a central theme of goal setting throughout the literature (Holm & Mu, 2012). Goal setting should create a means for therapists and patients to discuss treatment priorities and enable them to create goals that meet both the patient's perceived needs and wants as well as measurable occupational outcomes (Smith, 2013). Frameworks of occupational therapy practice such as the Canadian Practice Process Framework [CPPF] highlight the importance of the role of the patient in the occupational therapy process (Polatajko et al., 2007). Such practice frameworks incorporate the knowledge, experience and personal values of both the patient and therapist in the occupational therapy process (Polatajko et al., 2007).

Collaborating with older patients has been found to create increased ownership, accountability and responsibility of goals, increased feelings of participation in healthcare choices, and increased empowerment to self-manage care (Armstrong, 2008). Developing goals that are meaningful to clients has resulted in increased participation and engagement in therapy, improved outcomes, increased goal attainment and shorter hospital stays (Eschenfelder, 2005; Wressle, Öberg, & Henriksson, 1999; Thomson & Black, 2008). Client-centred practices have further been found to improve health outcomes, result in increased

patient satisfaction, and increased feelings of worth for therapists (Playford et al., 2000; Wressle, et al., 1999).

The Occupational Therapy Board of Australia: Code of Conduct (2014) outlines the requirement of occupational therapists to practice client-centred care which aims to engage the client and their chosen carers/family in the care planning and decision making process and respect the decisions of the client. Similarly, recent initiatives by the Agency for Clinical Innovation (2014) in NSW and the Victorian Department of Health (2012) on the treatment of older adults have emphasised the importance of enabling older persons through educating them in health literacy and involving them in the development of care plans in order to achieve improved outcomes and increased satisfaction.

Victoria Department of Health [VDOH] (2012) identified that older adults have complex health care needs due to the chronic and compounding nature of illnesses. Accordingly, it has been identified that older persons have different priorities than other patient groups and often value well-being and social functioning over physical functioning (Atwal et al., 2007). As such, they should have the opportunity to advocate for intervention to return to activities that are meaningful to them (Eschenfelder, 2005; Moats, 2006). For therapists, this means that they may be required to build an intricate therapeutic relationship in order to collaborate effectively with older patients to determine goals that engage patients and improve outcomes (Moats & Doble, 2006).

The Goal Setting Process

There is no gold standard for goal setting in occupational therapy. Occupational therapy practice frameworks such as the CPPF, a highly used practice framework, outline the role of goal setting in the OT process (Polatajko et al., 2007). The CPPF guides therapists through the steps of initiating practice, assessment, agreeing on objectives/plan, implementation of the plan, monitoring and modifying, evaluation and service exit (Polatajko

et al., 2007). Agreeing on objectives or goal setting is the fourth step in the CPPF, and is pivotal for determining the direction and implementation of further treatment (Polatajko et al., 2007). Completing in-depth assessments prior to setting goals enables therapists to understand the patient, their environment and their occupations to develop goals that meet the patients identified needs (Polatajko et al., 2007).

The content of goals should be participation and occupation focused as opposed to illness or symptom focus (Eschenfelder, 2005). Developing both long- and short-term goals enables therapists to guide patients towards the resumption of roles and return to functional tasks (Smith, 2013). Creating long-term goals provides meaning and motivation for the patient to participate in therapy (Eschenfelder, 2005). Short-term goals can then be developed based on expected improvements or incremental steps towards broader functional tasks (Smith, 2013). The Canadian Measure of Occupational Performance [CMOP] and Goal Attainment Scale [GAS] have been highlighted as effective tools in identifying meaningful patient goals and monitoring and modifying goals to reach greater outcomes (Custer et al., 2013; Turner-Stokes, 2009).

Although there appears to be a consensus about the role and nature of goal setting in the occupational therapy process, there is limited agreement on a structure or formula for setting goals (Custer et al., 2013). A highly utilized structure of goals set in occupational therapy is the SMART goal model (Thomson & Black, 2008). SMART goals require goals to be specific, measurable, achievable, realistic and have clear time frames (Thomson & Black, 2008). These goals create tangible and achievable targets for the client and therapist to enable progress (Thomson & Black, 2008). Therapists have reported that using the SMART goals framework has made them more confident in goal setting and enabled improved transition of care (Custer et al., 2013). Welch & Forster (2003) found that using SMART goals as opposed to unstructured goals showed improved goal attainment with 91% attainment for SMART

goals and 46% attainment for non-SMART goals. This suggests that structured goal setting may improve patient satisfaction and functional outcomes (Custer et al., 2013). However, despite indications that structured goal setting may improve the occupational therapy process, there is no known requirement for any specific goal structure to be used in the acute setting.

Current Goal Setting Practice

Recent observational studies and reviews of current goal setting practice have begun to shape an objective picture of the goal setting process (Atwal & Caldwell, 2003; Huby et al., 2007; Thomson & Black, 2008; Playford et al., 2000). These studies have illustrated that although occupational therapy is directed by theories of client-centred goal setting practice, in action, goal setting is often ruled by organisational procedures and the dominance of the medical model in the acute setting (Atwal & Caldwell, 2003; Huby et al., 2007; Playford et al., 2000; Thomson & Black, 2008). As a result, goals set by therapists are often short term, only meeting the patients acute needs and not working towards larger more meaningful goals (Huby et al., 2007).

Studies by Huby et al. (2007), Maitra & Erway (2006) & Moats (2006) found that it was rare that patients were consulted or their needs considered, with most goals professionally-set, based on self-care tasks and activities of daily living, and given to patients as opposed to negotiated. Thomson and Black (2008) identified that multidisciplinary goals received almost no input from clients and were set without their presence, which did not enable them to play a role in managing their complex care needs.

A comparison of goal setting for older adults across four of heath care settings in Canada found that patients in the inpatient setting were least likely to be involved in client-centred goal setting when compared to outpatient, residential care and long-term care or rehabilitation (Maitra & Erway, 2006). Atwal et al. (2007) suggested that failure to work with older adults to identify their problems or perceived problems resulted in a majority of patients

being discharged with unmet occupational goals. Furthermore, Atwal et al. (2007) also identified that not only were current goal setting practices ineffective for returning adequate functioning, but patients were often unable even identify goals set by the occupational therapist or rationale for those goals. From this, it was concluded that limited time and resources faced by therapists in acute aged care resulted in failure of professionals to involve clients and develop effective goals for improved outcomes (Atwal et al., 2007).

Recent studies have not only highlighted the lack of client-centred practice in goal setting, but also the lack of consistent method of goal setting and subsequent impact of this on client care (Custer et al., 2013; Huby et al., 2007; Thomson & Black, 2008). Observations and reports of goal setting methods have shown that goal setting generally involves the therapist completing standardised and non-standardised assessments and having an informal conversation with the patient. From this, therapists are able to understand the patient's level of ability, needs for discharge, and available resources on discharge (Huby et al., 2007). This information gathering process leads to occupational therapists to formulate goals for the patient, with or without their involvement (Huby et al., 2007). Therapists have reported that these unorthodox methods have been consistent in the acute setting over the past 15 years (Custer et al., 2013). However, older patients have reported that the current goal setting practices that they have been exposed to often resulted in goals that are often vague or confusing to patients (Huby et al., 2007). Health care professionals have suggested that failure to provide clearly defined goals that meet patient needs may result in confusion for the patient around their goals and decreased levels of engagement in therapy (Huby et al., 2007).

The apparent inconsistency between goal setting theory and practice suggests that there are a number of factors influencing goal setting for older adults and acting as a barrier to providing client-centred care (Maitra & Erway, 2006). As such, researchers have begun

exploring the lived experience of therapists practicing goal setting in acute aged care to better understand the incongruence between theory and practice (Maitra & Erway, 2006).

The Misaligned View of Client-Centredness

A review of qualitative studies that explore therapists experiences of goal setting exemplifies the current misalignment of theory and practice (Holm & Mu, 2012; Huby et al, 2007; Moats, 2006; Atwal & Caldwell, 2003). A reoccurring trend throughout these studies is the incongruence between therapists perceived client-centredness during goal setting and the patients feelings of limited participation in the process (Holm & Mu, 2012). Holm & Mu (2012) explored the experiences of seven OT's participating in discharge planning in acute aged care in Northern Colorado, USA. All therapists in this study identified the importance of their patients' values and beliefs in setting goals for them and stressed the importance of prioritising these to engage the patient (Holm & Mu, 2012). However, similar studies that compared occupational therapists experiences to their patients experience have found that this does not always translate to practice (Maitra & Erway, 2006).

Atwal & Caldwell (2003), Maitra & Erway (2006) & McAndrew et al., (2000) found in their studies that a majority of therapists felt they were acting in a client-centred manner. However, this directly contradicted patients reports that they often felt that they were unable to participate in the goal setting process, felt unheard when discussing their goals or were unsure of their goals (Atwal & Caldwell, 2003; Maitra & Erway, 2006; McAndrew et al., 2000). Furthermore, researchers observed that therapists often yielded to the medical model when goal setting, putting procedural requirements before clients needs and wants (Atwal & Caldwell, 2003; McAndrew et al., 2000).

These findings have highlighted a clear disparity between the experience of goal setting for patients and therapists (Atwal & Caldwell, 2003). Some have suggested that the reason for this is the definition of participation in regards to the goal setting process, with therapists

potentially interpreting participating as the patient's involvement in the care planning discussion, even if the problems and resulting goals were professional-set (Huby et al., 2007). Others suggest that therapists interpret a patients lack of complaint or input to mean satisfaction with the decision making or goal setting process, which is often not the case (Huby et al., 2007). Researchers have identified that there are a number of barriers to providing client-centred goal setting that fall outside of the control of the therapist and as such, therapists may be unaware of that they are impacting on goal setting practices (Holm & Mu, 2012).

Challenges to Providing Client-Centred Goal Setting

The Acute Setting

The acute hospital setting has been identified as a barrier to goal setting through out the literature (Thomson & Black, 2008). The acute setting is aimed at minimizing the impact of disease or illness on a person to a point where they are stable to return home and can transition from hospital care to community based health care or treatment (AIHW, 2015). Due to the aims of acute care, there is a dominance of the medical model over other models of practice (Moats, 2006; Welch & Forster, 2003). This dominance often impedes on occupational therapist's ability to practice client-centred care as they receive pressure from other members of the multidisciplinary team to follow their medical approach (Moats, 2006). The dominance of the medical model has also been noted to lead to a procedurally-based method of care, whereby many assessments and treatment decisions are based on procedural requirements of the hospital or institution as opposed to the clinical reasoning of the therapist (Huby et al., 2007; Moats, 2006; Polatajko at al., 2007). An example of this is the superficial nature of procedural assessments that do not enable therapists to assess the true needs and wants of their patients (Huby et al., 2007).

The acute setting also has a focus on timely discharge with high bed turnover and heavy caseloads (Welch & Forster, 2003). This puts pressure on therapists to complete assessments and set goals without the adequate time necessary for complex negotiations with patients around goals and treatment options (Welch & Forster, 2003). Therapists have reported taking a non-standardised approach in order to meet the demands of the acute setting (Holm & Mu, 2003). Research suggests that therapists feel that the change in approach needed in acute care is so large scale that they feel unable to impact it (Moats, 2006)

The Impact of the Acute Setting on the Patient

A number of studies have made note of the increased difficulties in goal setting caused by the impact of the acute setting on patients (Moats, 2007; Struhkamp, 2004; Maitra & Erway, 2006). Struhkamp (2004) suggested that it is hard for patients in acute settings to identify and articulate goal areas because they are unable to anticipate future functional abilities and skills needed for home that are not required of them in the acute settings. Similarly, it has been suggested by Maitra and Erway (2006) that patients in hospital become very passive with additional support to complete activities of daily living and limited requirements to complete tasks. This lack of activity, combined with poor insight may lead older adults to take on the sick role which may make it hard for them to picture themselves returning to their previous level of functioning and actively participating in goal setting (Maitra & Erway, 2006; Playford et al., 2000).

Goal setting also requires patients to feel secure in revealing their fears and concerns for their return home and the foreign clinical hospital setting may not provide the warm environment that elicits rapport building and complex conversations between patients and therapists (Playford et al., 2000). Furthermore, due to a traditional paternalistic approaches to acute care, older patients report feeling uncomfortable participating in decision-making,

including goal setting, as they believe in the knowledge of the educated professional or fear their input would be interpreted as criticism and (Huby, Stewart, Tierney & Rogers, 2004).

The Language of Goal Setting

Another identified challenge to client-centred goal setting is the use of the taxonomy of the language of goal setting (Custer et al., 2013; Playford et al., 2007). It has been found that patients often connect the word "goal" to the idea of something to strive for, an unachievable target to drive one to work harder (Playford et al., 2007). Therapists across a variety of settings have reported that when asked what goals they would like to work on, patients often respond with a perplexed look and are unsure of what they are being asked (Playford et al., 2000). Experienced therapists have suggested using more simple terms such as "problems", "solutions" or "issues" to reach a wider audience (Holm & Mu, 2012; Playford et al., 2000). Training has been recommended in changing terminology around goal setting and helping therapists to write goals from the patients perspective to ensure that they are understandable for the client to increase participation in goal setting and allow for ownership of their goals (Custer et al., 2013; Wressle et al., 1999).

Overcoming Challenges to Client-Centred Goal Setting

A number of suggestions have been made as to how to close the gap between the theory and practice of goal setting. Some researchers have suggested that the hospital setting should be utilized as a learning facility with increased training in collaborative goal setting (Custer et al., 2013; Wressle et al., 1999). It has also been posited that providing patients with a list of potential goals and having them chose the ones that they would like to prioritise may be effective and has shown some improvement in patients perceptions of participation as it provides them with autonomy in decision making within the scope of practice (Custer et al., 2013). Others argue that without higher-level government changes that place emphasis on client-centred care over quick discharge and available resources, occupational therapists are

limited in their professional capacity to provide client-centred goal setting (Moats, 2006). However, little exploration has been done on how to improve goal setting with older adults in the acute setting (Custer et al., 2013).

Conclusion

A review of the current literature available on goal setting in acute aged care has revealed that this is a relatively unexplored area of practice. From available research, it has been noted that therapists should aim for meaningful client-centred goals that look to address problems identified by patients during assessment to increase their participation and satisfaction (Playford et al., 2000). However, this does not match with observations of goal setting in acute care and patients perceptions of the process (Maitra & Erway, 2006). Goal setting in acute aged care has traditionally been procedurally driven with a focus on therapist priorities (Moats & Doble, 2006). Although researchers have identified a number of potential barriers to providing goal setting consistent with theories of best practice, further research is needed to identify not only barriers but also potential improvements that can be made (Custer et al., 2013). Further research is also needed to explore goal setting in acute aged care in Australia to determine if the same limitations exist so that attempts can be made to minimise healthcare costs.

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Goal setting with older people in acute care before and after discharge:

Occupational therapists perspectives

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Abstract

Background: The World Health Organisation identified that there is an increased risk to elderly of readmission to hospital following an acute hospital admission due to decreased function and deconditioning during hospitalisation. As such, researchers have reviewed the discharge process of older adults to identify areas for potential improvement. The aim of this study was to explore the experiences of occupational therapists during goal setting in acute aged care in Australia and to determine whether implementing training and a structured goal setting procedure such as the HOME protocol is feasible and beneficial.

Method: This study used a phenomenological study design and semi-structured interviews. Four therapists who participated in the HOME trial were recruited from New South Wales and Victoria. Interviews were conducted by telephone and focused on the therapist experiences of goal setting before, during and after the HOME study. Interviews were recorded and transcribed verbatim. Thematic analysis of the interview data was conducted and involved coding, data reduction, categorisation and determining themes and relationships.

Results: Results suggested three themes related to goal setting in acute aged care: (a) developing client-centred goals, (b) the therapist experience and training and (c) the ideal goal setting practice. However, therapists perceived that the reality of practice puts a number of pressures on them when setting goals in order to manage the return home for older persons – as such, some elements of best practice in goal setting must be forfeited.

Conclusions: Goal setting in acute aged care in Australia is complex and therapists face many of the same challenges as those in other western countries. Furthermore, therapists found structured goal setting frameworks to be beneficial, however, felt that they are not feasible in the current context of practice.

Key words: Elderly, Discharge planning, in-patient, geriatric

Introduction

In 2012-13, there were 5.5 million acute admissions to hospital in Australia (Australian Institute of Health and Welfare [AIHW], 2015). Of these acute admissions, 40% were accounted for by persons aged 65 years of age or older (AIHW, 2015). The World Health Organisation commissioned a report by Parker (2005) who identified an increased risk to older people of readmission to hospital following an acute admission due to decreased function and deconditioning, interruptions to formal and informal care, and service gaps during the transition from the acute to community care (Mahoney, Eisner, Havighurst, Gray & Plata, 2000). Due to a combination of these increased risks and a push for swift discharge, the readmission rates for those over 65 have been reported at rates as high as 20% across a number of studies (Courtney et al., 2009). With the United Nations (2013) forecasting exponential growth of the percentage of individuals over 65 across all regions of the world, the number of admissions and readmissions are set to continue to rise (The Treasury, 2015; AIHW, 2015).

Concerns around the subsequent rising cost of healthcare have been addressed by an increased focus on the role of discharge planning in the effective return of older persons to the community (Parker, Peet, McPherson, Cannaby & Abrams, 2002; Shepperd et al., 2013; Wales et al., 2012). Discharge planning is defined as collaborative problem solving between patients and carers and a range of treating professionals to identify and manage care needs for older people during their current admission and their transition to home (Wales et al., 2012). Two systematic reviews of discharge planning have reported its effectiveness, providing evidence of shortened hospital stays, lowered readmission rates, minimised carer burden and improved communication resulting in enhanced coordination of services (Parker et al., 2002; Shepperd et al., 2013). However, although some effectiveness could be attributed to discharge planning, better results were expected, considering that the principles and aspects of discharge

planning theoretically facilitate improved outcomes (Courtney et al., 2009). One potential reason for this is the lack of a structured evidence-based framework or consistency across institutions of discharge planning processes (Courtney et al, 2009; Wales et al., 2012).

Occupational therapists are one of the specialist disciplines that contribute to discharge planning (Wales et al., 2012). The occupational therapy role in discharge planning is to consider the ability of older adults to independently and safely function within their environment upon discharge (Parker et al., 2002; Wales et al., 2012). As such, occupational therapists evaluate the patient's current level of functioning, the social and physical environment that they will be returning to on discharge home and the occupations and roles that will be required of them (Wales et al., 2012). One aspect of the discharge planning process for occupational therapy is setting treatment goals with clients to determine the direction and aims of interventions that will follow (Atwal & Caldwell, 2003; Holm & Mu, 2012).

Goal setting is a key aspect of care plan development during discharge planning (Holm & Mu, 2012; Wales et al., 2012). Once the therapist has thoroughly assessed the needs, wants and circumstances of the patient, they negotiate with them to construct suitable goals for their care plan (Park, 2011). Effectively developing goals that are meaningful to clients has resulted in increased participation and engagement in therapy, improved outcomes, and shorter hospital stays (Eschenfelder, 2005; Thomson & Black, 2008).

However, although effective goal setting is pivotal in the occupational therapy process and discharge planning, there is no consistent goal setting method or procedure in acute aged care (Holm & Mu, 2012). This lack of a framework for goal setting has been reported across a number of health systems in developed countries such as Canada, the United Kingdom and the United States (Atwal & Caldwell, 2003; Holm & Mu, 2012). Ideally, goals should be occupation-focused, clearly stated, developed in negotiation with the patient and based on

patient priorities (Custer, Huebner, Freudenberger & Nichols, 2013). However, recent observational studies of current goal setting practice in acute aged care has revealed that in reality, goal setting is often ruled by organisational procedures and the dominance of the medical model in the acute setting (Atwal & Caldwell, 2003; Huby, Brook, Thompson & Tierney, 2007). As a result, goals set by therapists are often short term, not set in collaboration with patients and only meet the patient's acute needs and are not working towards larger more meaningful goals (Huby et al., 2007).

Further research to explore this phenomenon has investigated patient and therapists perceptions of goal setting and discharge planning. Studies in the US, UK and Canada have highlighted the incongruence between therapist and patient experiences of goal setting (Holm & Mu, 2012, McAndrew, McDermott, Vitzakovitch, Warunek & Holm, 1999). Atwal & Caldwell (2003), Maitra & Erway (2006), and McAndrew et al. (1999) found in their studies that a majority of therapists felt they were acting in a collaborative client-centred manner, involving clients in care plan decision-making. However, in these studies patients reported that they often felt that they were unable to participate in the goal setting process, felt unheard when discussing their goals or were confused about their final goals (Atwal & Caldwell, 2003; Maitra & Erway, 2006; McAndrew et al., 1999). These results suggest that further investigation is required to explore experiences of goal setting in Australian acute aged care to determine if similar phenomena exist and any potential areas for improvement in goal setting.

Some improved outcomes have been found with implementing a structured discharge plan in acute aged care settings (Harris, James & Snow, 2008; Wales et al., 2012). The HOME study implemented a structured pre- and post discharge protocol in AAC across a number of NSW and Victorian public hospitals (Clemson et al., 2011). One aspect of the protocol was goal setting which involved training participating therapists in the importance of setting collaborative client-centred goals using the SMART framework (Turner-Stokes,

2009). Therapists received guided training on the process of goal setting and implementation of SMART goals on the commencement of their participation in the HOME study. It was hoped that the training and framework would result in more effective goals and as such play a role in improved discharge outcomes.

This study aimed to explore and understand the clinical reasoning processes used by occupational therapists when setting goals during discharge planning in acute aged care settings. The secondary aim of this study was to explore how occupational therapists perceive goal setting training and or a structured goal setting framework such as the HOME protocol to have influenced or changed their goal setting practice.

Method

Subjects

The subjects in this study consisted of four registered occupational therapists, two practicing in Victoria and two practicing in NSW. To meet the inclusion criteria, subjects had to have received training in and administered the HOME protocol at a Sydney or Melbourne hospital during the HOME study. One participant had also been a recruiter for the HOME study as well as a therapist administering the protocol. Participants were all female, reflective of occupational therapy demographics (Occupational Therapy Board of Australia [OTBA], 2015). Therapists in this qualitative study were considered 'experienced' with varying levels of experience; two therapists having seven years of practice experience, one having 16 years and one having 20 years (Atwal & Caldwell, 2003). Therapists also had varied backgrounds having practiced in a range of settings and client groups prior to the HOME study. Therapists were recruited via email from HOME study contact lists and participated voluntarily, receiving no incentives for participation. Individual emails were sent to recruit therapists to protect their identity from other participants, due to the small sample group available.

Procedures

Therapists who consented to participate in the study notified the researcher by email and returned their informed consent form. The participant was then sent a copy of the interview questions and asked to select a time to be contacted to complete a 30-45 minute interview. Participating therapists were contacted by telephone at a convenient time to complete a semi-structured goal-setting interview exploring their experiences of goal setting during and following the HOME trial (Appendix A). The interview was recorded on a digital device, as outlined in the participant information statement. Participants were also reminded verbally at the start of the interview that they were able to withdraw at any point or choose not to answer any questions, and they also had an opportunity to ask questions of the researcher. Following the interview, the researcher transcribed the interview, and de-identified the responses with pseudonyms (e.g. Participant A, Participant B).

Data Analysis

This study was a qualitative study using a phenomenological approach (Carpenter & Suto, 2008). This method enabled researchers to explore the lived experiences of occupational therapists during the goal setting process (Carpenter & Suto, 2008). As this study was qualitative, a small sample size was adequate and enabled the researcher to reach data saturation with no new information revealed in the fourth interview (Carpenter & Suto, 2008). Thematic analysis was used to analyse and report patterns within the data (Guest, 2012). The thematic analysis involved a number of steps. Firstly the researcher reviewed the data before coding or analysis to ensure familiarity. Next, two researchers completed line-by-line coding of the transcripts to identify an extensive collection of codes and themes. Consensus coding was completed to enhance rigour of the study and codes were consistent between researchers. Following this, codes were reviewed and sorted into themes, sub-themes and outliers.

Themes were then evaluated by reviewing the data extracts that corresponded with each theme to ensure consistency and coherency (Braun & Clark, 2006). Once themes and their relationships were determined, two researchers reviewed each theme and its narrative to create theme names that captured the essence of each theme and sub-theme (Carpenter & Suto, 2008; Guest, 2012).

Results

Participants in this study had a range of experience and professional backgrounds. Table 1 outlines the therapist's location of practice and professional experience. Four key themes emerged from the data relating to how participants set goals to manage the return home for older adults in acute care: (a) developing client centred goals, (b) the therapists training and experience, (c) the ideal goal setting practice, and (d) the reality of practice. Figure 1 represents the theoretical model of the relationship between themes.

Developing Client-Centred Goals

One factor that influenced goal setting was the focus of therapists on developing client-centred goals. Therapists reported that they perceived the purpose of goal setting to be enabling client-directed services, determining client needs and wants, and making them achievable. One therapist highlighted this stating:

> *"... it's about what the person wants to do, what the person wants to achieve and any perceived barriers and limitations in getting back to that".* (Participant C)

As such, therapists reported establishing client-centred goals by asking patients what they did pre-discharge and what they wanted to do post-discharge. Therapists reported targeting interests and leisure to increase patient motivation. Broad goals were developed based on client needs and wants, which could be broken into smaller SMART goals that could be graded:

> *"I tried to target what their interests were and their leisure. Say they want to walk to the shops, well then they need to be able to walk to at least the letterbox this week and then next week we're going to walk to the corner up the road."* (Participant A)

Therapists perceived setting client-centred goals were important as they were often associated with increased motivation.

However, focusing on client-centred goals was reported as both beneficial and problematic. For patients who knew what they wanted, goal setting was perceived as easier for therapists:

> *"…easy because she had things that she clearly knew that she wanted to do and she was really motivated to get back to doing them".* (Participant B)

However, for patients who did not know what they wanted or were disengaged with the goal setting process, therapists reported finding extreme difficulty with setting goals, as they struggled to set goals that they felt would motivate patients.

Therapists' Experience and Training

All therapists reported limited prior formal training in goal setting. They were unable to remember the extent of goal setting training completed in their formal education and stated they had received minimal informal training in supervision and in service education:

> *"I can't really remember if we did goal setting at uni… between then and the HOME trial I hadn't really received any formal goal setting training, only informal training in supervision".* (Participant B)

Similarly although therapists reported a mixture of previous goal setting experience across a wide domain of fields, they still had little experience of goal setting during professional practice. Those that had participated in goal setting in previous roles noted a lack of consistency across fields:

> *"It's been very ad hoc, very here and there in different places that I've worked depending on the framework of practice of goal setting that's in place…".* (Participant C)

Some therapists had reported using goal setting in rehabilitation and community as an outcome measure, however still perceived their experience as limited.

Even for those who had reported previous goal setting experience, this was limited. Therapists stated that during previous goal setting they had prioritised issues and set goals for patients with or without their presence:

> *"… the team has generally set the goals for the patient in a case conference or a team meeting".* (Participant C)

This suggests that therapists may have developed these habits through clinical experience. Therefore, when therapists were in challenging situations when developing client-centred goals because the patient was not clear about their needs and wants, therapists appeared to revert back to the habit of setting goals for patients or setting goals *'for the sake of it'* (Participant A). The goals reported in these situations tended to be superficial and professionally set:

> *"Falls safety, a lot of that. Medication management. There were a lot of like "go see your doctor about this" or "go to the pharmacy" '* (Participant A)

The Ideal

Therapists in this study were applying the HOME protocol when goal setting. This was considered best practice or ideal goal setting practice with therapists noting a number of benefits when implementing the protocol. Therapists reported that in-depth specific skills-based training on goal setting and applied practice was helpful in improving their goal setting.

> *"I: Was there anything else you found helpful when setting goals in the HOME trial?*
>
> *P: … some brief training on setting goals. I was also given a few articles about*

SMART goals to read. I think we received some feedback on some goals at the start" (Participant B)

"it was great to be part of something where I had more practice in the process of goal setting… it has helped me to be a better goal setter now" (Participant C)

Therapists also reported that being able to complete the full occupational therapy process of assessment, including home-visits, goal setting, monitoring and modification, enabled more effective goal setting. For instance:

"I think actually having the ability to review it a week later and to actually mark it off and see if we set the challenge correctly… whether we could fine tune that further… so I think that having that review was really beneficial as well because it's easy to set a goal but it's hard to get it going and to maintain it" (Participant D)

This longer term process allowed therapists to check if the goals set were in fact still what the older person was wanting to achieve following discharge and to determine if goals could be extended.

Therapists perceived working collaboratively with clients over time to be more beneficial and more satisfying:

"I've worked in acute for a fair time and it was a real privilege to actually sit down with people and have that conversation about goals rather than us imposing in an acute setting". (Participant D)

This collaborative approach appeared to foster more meaningful client-centred goals that and gave the therapists more meaning in their role:

"I can remember on a number of pre-discharge home visits literally just sitting down over a cup of coffee or tea and having a chat about "well now that we're here, what's

something that you'd really, really like to do and how can we progress you with that?". So it was a good opportunity to really help these people." (Participant D)

The Reality of Practice

Although many factors contributed to goal setting, the reality of practice put pressure on therapists to manage these factors to create goals that effectively managed the return home. Therapists identified that the acute aged care setting added additional complexity due to the pragmatics of the setting and its impact on patient care. Therapists identified time and resource limitations in the acute setting affected goal setting. Despite being given additional time as part of the HOME study protocol, there were still a number of aspects that were hard to complete:

"there were a lot of other pressures on us as a part of the HOME trial, goal setting was just one of the things that we had to do". (Participant B)

Similarly, the nature of the acute setting and the completion of the service on discharge was highlighted as a barrier to implementing best practice goal setting that should involve evaluation and modification of goals:

"in terms of process it's very hard because we don't really see people after discharge so our goals are very much about what do you want to achieve while you're here in hospital what do you want to do by the time you leave hospital so we don't get that follow up". (Participant C)

Setting goals focused on long-term outcomes were difficult for therapists due to the nature of the client group. Therapists reported that patients were focused on just getting home, when setting goals pre-discharge. Therapist suggested that this may have been because patients may have still been acutely ill and could not see the bigger picture needed to develop more long-term client-centred goals.

Therapists reported finding it difficult to prioritise goals, especially when therapist and patient goals did not match. For instance, older adults may not have, or be interested in long-term goals, instead expressing a preference for comfort and enjoyment over safety or independence. Therapists perceived that their role was to educate about falls prevention and to ensure safe discharge home, however, older Australians may not be as concerned about this. This brought up some conflicts for therapists who were concerned about minimising risks. For instance:

> *"I think there is dignity in risk and if they're cognitively able they should be able to make that decision that they maybe don't want the things that we're recommending and that they might prefer to work on more enjoyable things."* (Participant C)

Whilst the importance of safety was recognised, some therapists acknowledged that individual aspirations were also important for older people, and that a focus on safety alone might be *"at the detriment of them living the life they want to live."* (Participant C). Therapists described the conflict between the key performance indicators they were expected to adhere to – such as discharging people within a certain number of days, and no re-admissions within a certain time period – and the goals of older people. For instance:

> *"There is a real conflict around what we do as acute therapists versus what the older Australians would prefer to be doing… so were going "come on you've got to have your shower and you've got to do this and blah blah"… and the older Australians are going "yeah but I just want to be able to enjoy my life"…"* (Participant D)

Managing the Return Home

As a result of the pressure on therapists to produce goals that effectively manage the return home, therapists reported that they produced a range of goals on a continuum of complex and meaningful to superficial and short term. When they were able to effectively manage and get a good balance of experience in goal setting, being client-centred and

incorporating best practice, they were able to develop good goals. However, when they were unable to do so, this resulted in more token goals that were less meaningful. For instance poor timing, lack of therapist experience in setting goals with patients, the use of more standardised and less individual goals, and the limitations of the occupational therapy role in the acute setting, resulted in goals which were safety-focused or superficial, that may not be effective in minimising readmissions. This may have led to less collaborative goals, for instance:

> *"... Like even when you did talk about re-engaging in those daily routines doing things or improving their safety… They weren't really identified by them, they were more what I as a therapist thought. This is going to be good if you do this because then you won't come back into hospital."* (Participant A)

Therapists indicated that knowledge of the ideal is not enough, and practice is required to develop the necessary skills of the therapist to implement client-centred goal setting:

> *"Looking back on it now using the SMART goals it was really difficult to put it into specific, measurable… the whole thing it was really tricky"* (Participant D)

> *"… Learn about SMART goals, that's nice, you can apply those principles. But how do you motivate someone to do it?"* (Participant A)

Therapists further acknowledged that although the process of managing the return home is hard, if done correctly it can be very beneficial for older people:

> *"… it was literally just so hard, it was really hard"* (Participant D)

> *"But it's hard, I know I find it hard and I think patients find it hard. But it can be very good for them if it's done well"* (Participant A)

Discussion

This study provided an insight into goal setting in the acute aged care setting in Australia. With little previous exploration of this topic, researchers were able to gain an insight into the processes and practices of occupational therapists working in this area of practice. This study also provided a unique perspective as therapists had received training on the best practice of goal setting using the HOME protocol. Therefore, they could reflect on barriers to implementing best practice while practising in the acute aged care context. Results indicated that goal setting is a complex process that is influenced by a number of factors including the individual therapist, the patient, the theory, and the setting. These findings suggest that goal setting challenges in Australia align with those faced by therapists in the US, UK, and Canada (Custer et al., 2013; Huby, 2007).

Unlike previous studies, therapists were able to reflect on their practices and identify that although being client-centred was important, they were not always able to provide best practice collaborative goal setting (Holm & Mu, 2012; Atwal & Caldwell, 2003; McAndrew et al., 2000). The goal setting training participants received prior to implementing the HOME protocol aimed to develop best practice goal setting practices. This meant that therapists could identify when they were not able to apply ideal practice and what was impeding them from doing so. This insight into their personal limitations enabled therapists to give a unique perspective on their capacity to set client-centred goals and what their limitations were.

This study also highlighted the limited training and experience of goal setting for experienced therapists. As a cornerstone to practice and an essential element of the occupational therapy process, it could be assumed that goal setting would receive a lot of attention (Custer et al., 2013; Polatajko, Craik, Davis & Townsend, 2007). However, therapists all reported no formal training post-university and limited goal setting with patients as part of their clinical practice. For participants, the HOME study was the first time they

were explicitly exposed to collaborative goal setting processes. It is concerning that these therapists have been registered and practicing for at least seven years and have self-reported that they have not previously participated in any goal setting, especially when goal setting is a fundamental component of occupational therapy practice frameworks such as the Canadian Practice Process Framework (Polatajko et al., 2007). This may also explain why less experienced therapists have previously reported limited confidence in goal setting and experienced occupational therapists have reported continued difficulties (Custer et al., 2013; Holm & Mu, 2012; Thomson & Black, 2008). As such, employers of occupational therapists and professional associations should provide adequate learning opportunities for staff to enable effective goal setting skills (Welch & Forster, 2003; Wressle, Öberg, & Henriksson, 1999).

The challenging nature of the acute hospital setting is consistent with previous research with limitations of time and the role of the occupational therapist placing increased pressure on therapists when determining goals (Custer et al., 2013; Holm & Mu, 2012). Therapists have previously reported feeling pressure to develop effective, motivating goals for the patient, that aim to overcome complex health challenges faced by older adults on discharge (Moats & Doble, 2006). The HOME study provided therapists with additional time and continuation of care into the community, and participants in this study indicated that these were helpful factors for higher quality goal setting. However, participants stated that they would be unable to do this in reality, due to the short-term and fast paced nature of acute care.

Similarly therapists reported difficulty prioritising issues and identifying goals with patients because often the therapist-generated priorities did not match those set by the patient. It has been found that older adults have complex care needs and place higher value on participation in social and leisure activities than independence (Atwal et al., 2007; Custer et al., 2013; Moats & Doble, 2006). This was mirrored by the results, with therapists identifying

that therapists and patient views were misaligned, and patient goals being less realistic to implement in an acute setting. Therapists reported that dealing with this inconsistency resulted in them setting more superficial goals unrelated to client preferences, for the sake of setting a goal. This may explain why goals for older adults in acute care are generally set by health professionals and are focused on safety (Atwal & Caldwell, 2003; Welch & Forster, 2003).

This study had a number of limitations including study design and small sample size. A qualitative approach was chosen for this study to explore occupational therapists perceptions of the goal setting process. Although qualitative research is not generalisable, results from this study added to the understanding of goal setting in Australian acute aged care (Carpenter & Suto, 2008). This study also provided insight on potential limitations of implementing a structured goal setting protocol. Another limitation of this study was the small sample size. Although qualitative research does not require large sample sizes, increased participant numbers may have provided a more comprehensive view of goal setting practices (Carpenter & Suto, 2008). The choice to use purposive sampling may have limited participant numbers, however, it was important that participants had participated in the HOME study to compare their experience of best practice using the HOME protocol to their usual practice in acute care and data saturation was achieved. Some aspects of the study also added rigour including consultation with field experts and key informants to develop appropriate and in-depth interview questions, consensus coding, use of a reflexivity journal and ongoing peer review (Carpenter & Suto, 2008).

Future research should aim to further investigate goal setting in acute aged care in Australia. Observational studies may assist researcher to identify additional factors influencing the goal setting process. Similarly, qualitative review of patients experiences of the process may give additional insight to the level of client-centredness perceived by patients

in this setting. To determine the effectiveness of having a structured goal setting framework, quantitative investigation should be completed to determine whether structured goal setting results in the improvement of quality of goals or outcomes.

Conclusion

Goal setting in acute aged care in Australia is a complex process that involves therapists trying to manage a number of factors in order to manage patients to return home. Trying to facilitate client-centred goals with limited training and experience is challenging for therapists when faced with the pressure of the acute setting and working with older adults. Although a structured goal setting framework was perceived to be beneficial by therapists, further development is needed to enable feasibility of implementation of such a framework in the acute setting.

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Appendices

Appendix A

Interview questions - Revised

Background information

- How many years have you been working as an occupational therapist?
- Could you please tell me about the clinical areas that you have worked in?
- Could you describe any previous experience that you had with goal setting, prior to your involvement with the HOME Trial?
- Tell me about any goal setting training that you had undergone prior to the HOME Trial

Goal setting questions 1

- What do you remember about goal setting as part of the HOME Trial?
- Why do you think that goals were included in the discharge planning process?
- Please take me through the thinking processes that you used when setting goals
- How did you know when you had set a high quality goal?

Goal setting questions 2

- Could you please take me through the thinking processes that you used when reviewing the goals? (E.g. models, goal setting frameworks, considerations)
- Please tell me about someone that it was easy to set goals with
    - What goals did you set?
    - How did you get to them?
    - Why do you think it was easy this time?
- Now can you tell me about someone that it was difficult to set goals with

  - Why do you think it was difficult?
  - What questions did you ask yourself?
  - What questions did you ask the participant?
  - What were your thinking processes?
  - What did you do?
  - What goals did you come up with in the end?

- What did you find difficult about the goal setting process?
- Tell me about any parts of the HOME discharge planning process that was helpful in the goal setting process. It might help to think about the green folder
- Please describe for me anything else that you found helpful when setting goals during the HOME Trial
- What do you think would be best practice for goal setting when we are discharge planning?
- Did participation in the HOME trial change the way you set goals? Are you able to utilize the training from the HOME study or is it unrealistic in the AAC setting?

Appendix B

Australian Occupational Therapy Journal

Author Guidelines

Author Guidelines

Thank you for your interest in *Australian Occupational Therapy Journal*. Please read the complete Author Guidelines carefully prior to submission, including the section on copyright. To ensure fast peer review and publication, manuscripts that do not adhere to the following instructions will be returned to the corresponding author for technical revision before undergoing peer review. Note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium. Once you have prepared your submission in accordance with the Guidelines, manuscripts should be submitted online at https://mc.manuscriptcentral.com/aotj
For help with submissions, please contact the Editorial Assistant: aot.eo@wiley.com

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.

ARTICLE TYPES

Type of Article	Word limit	Number of references	Figure files	Abstract required - word limit
Feature Articles	5000	35	4	250
Review Articles	5000	-	4	250
Research Articles	5000	35	4	250
Viewpoints	2000	15	4	150
Critically Appraised Papers	800	10	0	
Letters to the Editor	500			

Feature Articles

Feature Articles can be in the form of research studies, theoretical papers, case reports or descriptive articles. Descriptive articles involve descriptions of interesting clinical, administrative, educational or technological innovations in occupational therapy. Single or multiple case reports may be used to illustrate the application of such innovations. Feature 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 discussion 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.
Feature Article manuscripts should not exceed 5000 words, and have no more than 35 references.

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.

Reviews
Narrative reviews, systematic reviews and meta-analyses are included in this category. Recommendations for clinical practice and further research should be included. A structured abstract is required of 250 words. Manuscripts should not exceed 5,000 words (not including references).
Viewpoints
Viewpoints provide a forum for the debate and discussion of occupational therapy issues and related concerns. The discussion should highlight the author's opinion and the views presented should be linked, where possible, with an established literature base. Authors are encouraged to discuss topical and controversial issues, and to do so in a manner that sheds light on or challenges established practices and beliefs. In many cases, discussion will require attention to varying opinions.
Viewpoint may be an appropriate avenue for readers to debate the content of previous Viewpoints or other articles that have appeared in the Journal. Authors of articles commented on will be invited to respond in a Letter to the Editor which, where possible, will be published in the same issue as the Viewpoint.
Viewpoint manuscripts should not exceed 2000 words, include a 150 word abstract and have no more than 15 references. A title page, abstract, keywords and references should be included.
A Viewpoint abstract should, in 150 words, clearly articulate the significance of the professional/practice/theoretical issue you will address, your proposition/contention and an overview of how you will support your case.
Letters to the Editor
The Journal welcomes letters from readers who wish to comment on previous articles in the Journal or on any topic relating to occupational therapy theory, research, practice or education. Letters should not exceed 500 words.
A longer letter may be considered as a Commentary if it is a comment on a specific article; however, it should not exceed 800 words. The author(s) of the original article will be given a right of reply to the Commentary. The reply should also not exceed 800 words.
Critically Appraised Papers
Critically Appraised Papers are usually solicited by the Editorial Office. If a submission is planned, please contact the Editorial Office for specific guidelines.
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.
Pre-submission English-language editing
Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. Visit our site to learn about 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.
STYLE OF THE MANUSCRIPT
Manuscripts should follow the style of the Publication Manual of the American Psychological Association, 6th ed. (2009)**.**

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

Bennett, S., & Bennett, J. W. (2000). The process of evidence-based practice in occupational therapy: Informing clinical decisions. *Australian Occupational Therapy Journal*, *47*, 171-180. doi: 10.1046/j.1440-1630.2000.00237.x.

Advanced online publication of journal article with DOI

Rodger, S., Clark, M., Banks, R., O'Brien, M., & Martinez, K. (2009a). A national evaluation of the Australian Occupational Therapy Competency Standards (1994): A multistakeholder perspective.*Australian Occupational Therapy Journal.* Advanced online publication. doi: 10.1111/j.1440-1630.2009.00794.x.

Book

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Newbury Park, CA: Sage.

Chapter in a book

Law, M., Cooper, B. A., Strong, S., Stewart, D., Rigby, P., & Letts, L. (1997). Theoretical context for the practice of occupational therapy. In: C. Christiansen & C. Baum (Eds.), *Occupational therapy: Enabling function and well-being* (2nd ed., pp. 72-102). Thorofare, NJ: Slack Inc.

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Occupational Therapy Australia. (2003). *Australian Occupational Therapy Journal author guidelines*. Retrieved from http://www.blackwell-publishing.com/journals/aot/submiss.htm.

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.
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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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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.

Figure Legends

Figure 1. When setting goals for patients, therapists try to balance and incorporate developing client centred goals, their level of training and experience with the ideal goal setting practices. However, in the reality of practice, it is not always possible to combine these factors and as such one factor may become dominant or be forfeited to enable managing the patients return home.

Tables

Table 1

Participant demographics and professional background

Pseudonym	Gender	City	Years practising	Areas of practice
Participant A	Female	Sydney, NSW	7	• Inpatient or clinical rehabilitation • Acute
Participant B	Female	Sydney, NSW	7	• Brain & spinal cord injury – Private Practice • Community based rehabilitation • Acute orthopaedic • Community Health
Participant C	Female	Melbourne, Vic	20	• Aged care • Acute - neurological disability, general medicine, orthopaedics, respiratory, heart and lung transplants • Rehabilitation
Participant D	Female	Melbourne, Vic	16	• In-patient psychiatry • Out-patient psychiatry • State HIV service • Aged care

Figures

Figure 1. Model of goal setting in acute aged care