

HOW DO HEALTH PROFESSIONALS' PERCEPTIONS OF THE ROLES OF
OCCUPATIONAL THERAPISTS AFFECT OCCUPATIONAL THERAPY PRACTICE
IN INTERPROFESSIONAL HOME HEALTH TEAMS?

by

Sze Kei Irene Cheung

Submitted in partial fulfilment of the requirements
for the degree of Master of Science

at

Dalhousie University
Halifax, Nova Scotia
August 2013

© Copyright by Sze Kei Irene Cheung, 2013

TABLE OF CONTENTS

LIST OF TABLES.....	vi
ABSTRACT.....	vii
LIST OF ABBREVIATIONS USED.....	viii
ACKNOWLEDGEMENTS.....	ix
CHAPTER 1 INTRODUCTION.....	1
1.1 Key Definitions.....	2
1.2 Research Questions.....	3
1.2 Impacts on the Personal, Professional and System Level.....	4
1.2.1 Impact on the Personal Level.....	4
1.2.2 Impact on the Professional Level.....	5
1.2.3 Impact on the System Level.....	5
CHAPTER 2 REVIEW OF LITERATURE.....	7
2.1 The Roles of Occupational Therapists in Home Health.....	7
2.1.1 Enabling Occupation.....	10
2.1.2 Prevention.....	12
2.1.3 Facilitating Hospital Discharge.....	12
2.1.4 Educating Clients and their Caregivers.....	13
2.1.5 Coordinating Clients' Care.....	13
2.1.6 Rehabilitation.....	14
2.2 Health Care Professionals' Perspectives about the Roles of Occupational Therapists in Interprofessional Home Health Teams.....	15
2.3 Challenges of Understanding the Roles of Occupational Therapists in Interprofessional Teams.....	16
2.3.1 The Difference between the Philosophies of Occupational Therapy and Medicine.....	17
2.3.2 Health Care Professionals' Attitude toward Learning Each Others' Roles.....	18
2.3.3 Difficulty with Articulating the Roles of Occupational Therapists.....	19
2.4 Impact of Role Perceptions on Occupational Therapy Practice.....	20
2.4.1 Implementation of Occupational Goals.....	20
2.4.2 Communication with Other Team Members.....	23

2.4.3 Job Satisfaction for the Occupational Therapists.....	25
2.4.4 Utilization of Occupational Therapy Service.....	26
2.5 Summary of Literature Review	27
CHAPTER 3 RESEARCH METHODOLOGY.....	28
3.1 Qualitative Approach	28
3.2 Research Sampling.....	29
3.3 Recruitment Strategies	31
3.4 Data Collection.....	32
3.4.1 Interview Process	34
3.4.2 Transcription.....	37
3.5 Data Analysis	37
3.5.1 Immersion	37
3.5.2 Coding.....	38
3.5.3 Categorizing.....	38
3.5.4 Generation of Themes.....	38
3.6 Trustworthiness and Ethics Considerations	39
CHAPTER 4 FINDINGS.....	41
4.1 Theme 1: Occupational Therapists are Experts in Assessing Clients’ Needs.....	45
4.1.1. Sub-Theme 1A: Occupational Therapists can Accurately Assess Clients’ Needs.....	45
4.1.2 Sub-Theme 1B: Occupational Therapists Assess the Interrelationships of all Performance Components.....	53
4.1.3 Sub-Theme 1C: Current Scope of Practice is Often Limited to Self Care	56
4.1.4 Sub-Theme 1D: Occupational Therapists are Experts on Assessing Cognition but are Limited to Focusing on the Physical Status	58
4.2 Theme 2: Occupational Therapists are Excellent Collaborators.....	60
4.2.1 Sub-Theme 2A: Occupational Therapists Partner with the Clients in Providing Health Services.....	60
4.2.2 Sub-Theme 2B: Occupational Therapists are Great Collaborators with Other Health Care Providers.....	62
4.3 Theme 3: Occupational Therapists are Good at Rehabilitation; despite being Limited to Using Equipment as their Major Interventions.	63
4.3.1 Sub-Theme 3A: Occupational Therapists are Good at Rehabilitation.....	64

4.3.2 Sub-Theme 3B: Current Interventions are Limited to Equipment Interventions.....	65
4.4 Theme 4: Non-Occupational Therapists Have Difficulties Understanding the Role of Occupational Therapists	70
4.4.1 Sub-Theme 4A: Limited Insight about Role Perception Discrepancies	71
4.4.2 Sub-Theme 4B: Role Overlaps with Physiotherapists.....	73
4.4.3 Sub-Theme 4C: Nursing Hierarchy in the Interprofessional Home Health Practice Context	74
4.4.4 Sub-Theme 4D: Challenges in Advocating for Occupational Therapy Service	75
4.5 Impact of Role Perceptions of Occupational Therapists on Occupational Therapy Practice in Home Health	77
4.5.1 The Perceived Expertise in Assessment and Collaboration Supports Home Health Occupational Therapists to Expand Their Roles to Include the Role of Care Coordinator.....	78
4.5.2 The Perceived Association with Equipment Generates Inappropriate Occupational Therapy Referrals in Home Health	81
4.5.3 Role Overlaps with Physiotherapists Cause Strong Collaboration with Physiotherapists, but also Inappropriate and Inefficient Use of the Occupational Therapy Service and Missed Occupational Therapy Referrals.....	82
4.6 Summary of Findings.....	90
CHAPTER 5 DISCUSSION.....	92
5.1 Role Perceptions Affect Home Health Occupational Therapy Practice	92
5.1.1 Focusing on Self Care could Limit Practice and lead to Poor Client Outcomes.....	93
5.1.2 Role Confusion can lead to Inefficient Practice and Inappropriate Client Services	95
5.1.3. Strong Associations between Equipment and Occupational Therapists might lead to Practice Inefficiencies and Client Dependence on Health Care	97
5.2 Proposed Expanded Roles for Occupational Therapists in Home Health.....	100
5.2.1 Care Coordination.....	100
5.2.2 Rehabilitation	102
5.2.3 Cognitive Assessment.....	104
5.3 Potential Barriers to Occupational Therapists' Role Expansion.....	106

5.3.1 Nursing Hierarchy.....	106
5.3.2 Difficulty with Articulating Occupational Therapy.....	110
CHAPTER 6 LIMITATIONS.....	112
CHAPTER 7 CONCLUSION.....	115
REFERENCES	117
APPENDIX I- Matrix for Recruitment.....	126
APPENDIX II – Determination of Home Health Team Size	127
APPENDIX III – Email Invitation.....	128
APPENDIX IV – Telephone Screening Tool	129
APPENDIX V – Written Consent Form.....	131
APPENDIX VI – Considerations for the Interviewing Process	138
APPENDIX VII – Interview Guide	139
APPENDIX VIII – Basic Questions Used for Coding Strategies.....	144
APPENDIX IX – Transcriber Confidentiality Agreement.....	145
APPENDIX X – Strategies to Improve Trustworthiness.....	146
APPENDIX XI – Ethics Considerations.....	152

LIST OF TABLES

Table 1: Participants' Profile.....	41
Table 2: Themes and Sub-Themes.....	43

ABSTRACT

Evidence shows that occupational therapists who work within interprofessional health teams sometimes have challenges delivering care to clients because other health professionals on the team have differing perceptions of their role. However, none of this research has been conducted in home health in Canada. Qualitative interviews with three non-occupational therapists and three occupational therapists were conducted to understand how role perceptions of occupational therapists affect occupational therapy practice in home health. The findings showed that occupational therapists were perceived to be experts in assessments and excellent collaborators. Also, they were perceived to be good at rehabilitation; however, their interventions were often limited to recommending equipment. Non-occupational therapists had difficulties understanding the roles of occupational therapists in home health, which could create practice challenges for occupational therapists. Educating team members about the role of occupational therapists could facilitate occupational therapists' ability to use their full range of skills in home health.

LIST OF ABBREVIATIONS USED

ADL	Activities of Daily Living
IADL	Instrumental Activities of Daily Living
FTE	Full Time Employees
NOT	Non-Occupational Therapy participants
OT	Occupational Therapy participants
PT	Physiotherapist
MMSE	Mini-Mental State Examination
CHW	Community Health Worker
BCNU	British Columbia Nursing Union
CAOT	Canadian Association of Occupational Therapists
EFAP	Employee and Family Assistance Program

ACKNOWLEDGEMENTS

I am grateful to have Dr. Grace Warner for guiding me through the thesis. Your encouraging and supportive approach was exactly what I needed throughout my graduate school journey.

Many thanks to Dr. Robin Stadnyk for your additional feedback and perspective that always challenge me to think from a different perspective to improve the quality of my work.

Thank you to all the Home Health Professionals who work in Fraser Health Authority, BC. I appreciate all the great work that you are doing that inspires me to do this project.

Thank you to my colleague, Pat Cottingham, who has edited numerous drafts of the thesis and always provides me with encouragement. Thank you to my uncle, Dr. Tom Culham, who helped me with final edits. You are an uncle whom I am proud of and always admire.

Thank you to all brothers and sisters in Westwood Alliance Church. Every single greeting, hug and prayer counts!

Thank you to my beautiful children, Curtis and Cleo. You are wonderful kids who understand that mommy needs to “go to school” and allow me to be distracted at times! One day, I hope you will be like mommy to know what your dream is and pursue it with no fear.

Thank you, mom, dad, Stephanie and May, who provided countless hours of support and encouragement. Your unconditional love and prayer support are treasures in my life.

I cannot use words to describe how appreciative I am to my dearest husband, David, who is also my best friend and cheerleader. God is so good to me that He gave me a wise and loving man beyond what I could have expected. Thank you for trusting me when I didn't trust myself. Thank you for loving me when I can't think of why I should be loved. I owe you a lot and I commit myself to you for the rest of my life. I love you!

CHAPTER 1 INTRODUCTION

In the western health care systems, it is believed that interprofessional practice can best match the client's needs (Miller, 2008; Strasser et al., 2005). However, evidence shows that occupational therapists experience significant challenges in practicing within interprofessional teams (Egan, Kubina, Lidstone, Macdougall, & Raudoy, 2010; Fortune & Fitzgerald, 2009; Wilding & Whiteford, 2007). In many settings, the challenges appear to be closely related to the role perceptions of occupational therapists by themselves and other health professionals (Caldwell & Atwal, 2003; Simpson, Bowers, Alexander, Ridley, & Warren, 2005). Despite the significance of role perceptions, there has been limited research conducted in this area. The demand for home health service has been steadily increasing over time due to the shortened length of hospital stays and growing proportion of older individuals in the population. An improved understanding of each others' roles in interprofessional teams could improve occupational therapy practice in home health. Home health is a practice context that offers less structure and more autonomy than many other facility-based settings; therefore, role overlap and joint practice are more likely to happen in home health. Although role overlap and joint practice may enhance practice, they may also create confusion, frustration and tension within the team (Gantert & McWilliam, 2004; Smith & Roberts, 2005). It is important to further investigate different health care professionals' perspectives of the roles of occupational therapists to understand how these perspectives influence occupational therapy practice in home health.

1.1 Key Definitions

Allied health professionals are all health professionals other than the medical professionals in home health teams. Examples of allied health professional include dietitians, physiotherapists, social workers and occupational therapists.

Health care professionals are defined as individuals who, by certification or licensure, are qualified to provide health care service after an intensive education and training in a specialized area (Farlex, 2013; Merriam Webster Dictionary, 2013). Health care professionals usually include medical professionals and allied health professionals, but not support personnel.

Home health is a collection of services provided by health care professionals and support workers within a home, to enable clients to live at home as independently as possible to prevent, postpone or substitute for the use of long term care or acute care services (Thome, Dykes, & Hallberg, 2003; Canadian Association of Occupational Therapy, 2000). In some literature, the term “*home health*” is used interchangeably with “*home care*”, “*community care*”, and “*home service*” (Barnes & Frock, 2003; DePalma, 2006; Egan et al., 2010). In this thesis, “*home health*” is used in order to maintain language consistency.

Interprofessional practice is a practice context in which various health care professionals and support personnel contribute their skills and knowledge to achieve clients’ goals of care in a collaborative manner (Miller, 2008).

Interprofessional team is a group that comprises various health professionals who strive for collaborative, interprofessional practice when providing health care services to clients. Some literature uses the term “*interprofessional*”

interchangeably with “*multidisciplinary*”, “*interdisciplinary*” and “*multiprofessional*” (McCallin, 2001). In this thesis, the term “*interprofessional*” is used because this study focuses on learning from a group of health professionals based on their experience of interacting with each other.

Medical professionals refer to the professionals with primarily medical or nursing backgrounds in home health such as doctors, nurse practitioners and nurses.

Rehabilitation is a process that facilitates clients to achieve the highest level of independence and quality of life through addressing their physical, emotional, cognitive and spiritual needs. It restores clients to the optimal health, functioning and well-being (The Ohio State University, 2013).

Roles are functions and expected behaviours associated with a particular status or position (Merriam Webster Dictionary, 2013; Business Dictionary, 2012).

1.2 Research Questions

This qualitative study investigated how health professionals’ perceptions of occupational therapists’ roles in home health impact occupational therapy service in interprofessional home health teams. Six interviews were conducted to answer the following research question:

How do health professionals’ perceptions of the roles of occupational therapists affect occupational therapy practice in interprofessional home health teams?

In addition to the main research question, the following sub-questions were explored in this study:

1. What are the role perceptions of occupational therapists by

(a) the occupational therapists working within interprofessional home health teams?

(b) the other health care professionals working within interprofessional home health teams?

2. How do the perceptions of occupational therapists' roles affect occupational therapists' practice in home health?

1.2 Impacts on the Personal, Professional and System Level

The topic of role perceptions of occupational therapists in home health had significant impacts on a personal, professional and societal level.

1.2.1 Impact on the Personal Level

The principal investigator had personally experienced both benefits and frustrations within multiple interprofessional practice contexts. Being a strong believer in teamwork, the principal investigator was passionate about studying how health care professionals can complement each other's work to optimize clients' care.

Understanding the role perceptions of occupational therapists by different health professionals including occupational therapists provided an insight into occupational therapy practice in interprofessional teams. This study aimed to explore how the role perceptions affect occupational therapy practice, and to make suggestions for strengthening interprofessional practice in home health. The results from this study are relevant to frontline clinicians and management who work in interprofessional practices in clinical settings.

1.2.2 Impact on the Professional Level

This study facilitated an understanding of the roles of occupational therapists in home health. Gaining awareness of the roles of occupational therapists was the first step to assisting occupational therapists in developing their professional identity. The study helped to identify potential barriers for occupational therapy practice in home health. This information could help occupational therapists strategize ways to deal with these issues and increase the effectiveness of their practice.

Most of the research studies identified in the literature review related to role perceptions of health professions other than occupational therapist. Very few of the studies located were specifically related to occupational therapy (Harr, Openshaw, & Moore, 2010; Pullon, 2008). The studies that focused on occupational therapists were mostly conducted in acute and mental health settings (Egan et al., 2010; Fortune & Fitzgerald, 2009; Wilding & Whiteford, 2007). Minimal studies have been conducted in home health to investigate the role of occupational therapists; however, home health is a growing area of practice so an improved understanding of role perceptions could have a significant impact on client care. In addition, studies conducted on role perceptions of occupational therapists were lacking in Canada. There had not been any recent research study exploring how occupational therapists and other health care professionals perceive the role of occupational therapists in home health. This research study was intended to build on the existing knowledge and fill in the knowledge gap.

1.2.3 Impact on the System Level

The findings from this study make a crucial contribution to the health care system. Research evidence has shown health care professionals in general report

struggles in interprofessional practice (Smith & Mackenzie, 2011; Suter et al., 2009). This study facilitates different health professionals' understanding of the roles of occupational therapists in home health. The current employer of the principal investigator, Fraser Health Authority in British Columbia, had recently implemented two new initiatives: "Home is Best" and "Pull Plans". The "Home is Best" initiative was designed to encourage clients to receive care at home; the "Pull Plans" recommended that health providers in each care delivery setting assume an active role in identifying the appropriate clients for their programs and work at "pulling" clients into the most appropriate care setting. These two strategies were created mainly to facilitate hospital decongestion. The implementation of these initiatives, together with the increase in the aging population, regionalization of services, client advocacy and consumer demand had exponentially increased the need for home health service (Finlayson, 2000; Randall, 2007). The occupational therapy literature had shown that enabling occupation can enhance people's physical, mental and social well-being and lessen the demand on the hospital system (Townsend & Polatajko, 2007; Wilcock, 2006). Therefore, it was important to understand the role of occupational therapists and their contributions to clients' care with the aim of maximizing the benefits of occupational therapy practice in home health.

CHAPTER 2 REVIEW OF LITERATURE

A literature search was conducted focusing on three topics: the roles of occupational therapists in home health, how their roles are perceived in the interprofessional teams and the impact of the role perceptions of occupational therapists on home health occupational therapy practice. Four databases were searched including CINAHL with Full Text (1982 – present), ProQuest Nursing and Allied Health Source, PubMed (1950's – present) and Google Scholar. Keywords used included multidisciplinary, interprofessional, collaboration, roles, role perception, home health, home care, community and occupational therapy. Article titles and abstracts were scanned to identify review articles, written in English, which addressed the role perceptions of occupational therapists in interprofessional settings. Articles that addressed interprofessional education for students were excluded.

In the following section, the roles of home health occupational therapists and how different health professionals perceive the roles of occupational therapists in home health will be discussed.

2.1 The Roles of Occupational Therapists in Home Health

Several factors determine the roles of occupational therapists in a practice setting. The roles of occupational therapists are driven by the professional education that the therapists receive. In Canada, the standard of occupational therapy practice is guided by the provincial regulatory body, which often differs from one province to another. In addition, health authorities may have their own practice guidelines to support occupational therapists to achieve best practice. The actual function of occupational therapists in a specific practice setting is significantly affected by the perceptions of the

employers. Based on the employers' understanding of health professionals' roles as well as their values and beliefs, the health employers make decisions about resource allocation that can affect health service delivery to their clients. How different health professionals' and occupational therapists' perceive the role of occupational therapists can also shape the day to day practice context, and have a significant impact on the daily functions of an occupational therapist.

Despite the importance of learning about the roles of different health professionals to facilitate a collaborative practice, it is surprising that very minimal research has been done to explore what the roles of occupational therapists are in home health (Ramsey, 2011; Suter et al., 2009). Yet, there are a substantial number of research studies addressing the roles of nurses, social workers, case managers and pharmacists in home health (Ayalon & Baum, 2010; Cesta, 2011; Deitrick et al., 2011; Kesselman, 2010; Lawson, 2007; McGarry, 2009; Traynor, 2011; Zarbock, 1996). Occupational therapists are important and valuable members in home health interprofessional teams; therefore, there needs to be more investigation into their roles as well.

The roles of occupational therapists vary in home health depending on the models of service delivery and funding availability. Different countries have various systems to determine how to provide health care services to their citizens; therefore, home health services can look very different from one country to another. Even within Canada, home health services vary tremendously from one province to another. According to the Canada Health Act, health authorities in each Canadian province are responsible to their own provincial government for the administration and operation of services. The act does not require provinces and territories to provide publicly funded

health services outside of hospital and physician care. Furthermore, there is a lack of federal criteria for allocating Canada Health and Social Transfer payments to the provinces that has led to inequities in accessing home health occupational therapy services across the country (Rappolt, Williams, Polatajko, Cott, & Soever, 2003). Currently in Canada home health occupational therapy services can be accessed through a complex system of public and private funding such as extended health insurance, auto insurance, workers compensation and the Department of Veterans Affairs. Depending on the resources available in each particular home health setting, the function of occupational therapists and the frequency and duration of their service differ tremendously (McKinnon, Townsend, & Maconachie, 1990). To obtain an accurate picture of the roles of home health occupational therapists in the public sector in Canada, it is best to refer to the research studies conducted in Canada.

As a result of the literature search, 14 articles were found on this topic: 10 of them were research studies and 4 were literature reviews. The 10 research studies explored different aspects of home health occupational therapists' functions (Barnes & Frock, 2003b; Boutin-Lester & Gibson, 2002; Furååker & Nilsson, 2011; Hoffmann & Cantoni, 2008; R. Mitchell & Unsworth, 2004; Moulton, 1997; Quick, Harman, Morgan, & Stagnitti, 2010; S. Smith & Roberts, 2005; Stalker, Jones, & Ritchie, 1996). All of these studies were conducted in different countries including the United States, United Kingdom, Australia and Sweden. None of them were conducted in Canada. Only one out of the four literature reviews found was conducted in Vancouver Canada (Altman, 1991; DePalma, 2006; Toto, 2006; Vance & Siebert, 2009). In this literature review, Altman (1991) summarized the functions of occupational therapists and the areas of services

provided by home health occupational therapists in Vancouver Canada. For the current study which took place in Greater Vancouver, British Columbia, this literature formed a foundation to study the roles of occupational therapists in home health in Vancouver British Columbia. Since health care is a rapidly changing field, the roles identified by Altman (1991) have very likely been changed. Altman's article did not reference other research and therefore might have only represented his perspective on home health occupational therapy services. Consequently, an updated and rigorous research study was needed to consider the home health occupational therapists' roles in Canada.

The 14 articles revealed the diversity of home health occupational therapists' functioning roles and their possible growth. Some of the possible functions of home health occupational therapists could include enabling occupation, prevention, facilitating hospital discharges, educating clients and their family members, supervising support personnel, coordinating clients' care and rehabilitation.

2.1.1 Enabling Occupation

One of the commonly identified roles of the occupational therapists in home health is to enable clients' occupation so that they can continue to live at home as safely and independently as possible (DePalma, 2006; Finlayson, 2000; Quick et al., 2010; Toto, 2006). Occupational therapists enhance clients' performance in three major types of occupations including self care, productivity and leisure. Among the three occupations, home health occupational therapists seem to concentrate mainly on self care, in which Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) are addressed (DePalma, 2006; Flowers, Siebert, & Zahoransky, 2011; Mitchell & Unsworth, 2004; Toto, 2006; Vance & Siebert, 2009); whereas leisure and

productivity are less frequently addressed (Hoffmann & Cantoni, 2008). Some possible areas addressed by home health occupational therapists are personal hygiene, dressing, toileting, pressure sore management, medication management, positioning, transfers, mobility and community accessibility (Altman, 1991; DePalma, 2006; Flowers et al., 2011; Mitchell & Unsworth, 2004; Moulton, 1997; Toto, 2006; Vance & Siebert, 2009).

Occupational therapists assess clients' daily occupations and determine the cause of occupational issues, which can be related to physical, cognitive, emotional and spiritual components of the person or physical, social, cultural and institutional aspects of the environment (Toto, 2006; Townsend & Polatajko, 2007). In home health, occupational therapists usually use informal checklists and their clinical reasoning for assessments (Mitchell & Unsworth, 2004). A major emphasis of home health is to assess clients in their "*real*" natural environments to ensure the feasibility of an intervention. In addition to the physical environment, occupational therapists observe clients interacting with their family members and pets during home visits. Such observations provide insights into the clients' social context and their daily routine. The environmental cues such as pictures and decorations at a home provide valuable information about clients' values, cultures and beliefs and their impact on clients' occupation (O'Sullivan & Siebert, 2004; Vance & Siebert, 2009).

In home health, various intervention strategies are used for enabling clients' occupation. Home health occupational therapy interventions may include activities of daily living (ADL) and instrumental activities of daily living (IADL) training, compensatory strategies such as equipment and environmental adaptations, energy conservation and joint protection, home support service and client and family education

(Altman, 1991; Barnes & Frock, 2003; Borell, 2008; Hoffmann & Cantoni, 2008; Mitchell & Unsworth, 2004; Vance & Siebert, 2009). Newer intervention strategies such as chronic care management and innovative technology have been recently introduced to home health (Borell, 2008; Vance & Siebert, 2009). Due to an increased demand for home health and global shortage of occupational therapists, in some settings the roles of occupational therapists have been limited to consultation. Instead of implementing hands-on treatments, some home health occupational therapists can only assist clients to identify and analyze their occupational issues, provide information and advice, and develop strategies that may resolve the issues (Altman, 1991; Furååker & Nilsson, 2011)

2.1.2 Prevention

Another role of home health occupational therapists is to prevent injury to clients and caregivers. Many home health occupational therapists evaluate clients' ability to live at home safely (Mitchell & Cody, 1993; Mitchell & Unsworth, 2004). They may provide strategies for falls prevention, chronic care management, and caregivers' support to prevent their burnout (Flowers et al., 2011; Mitchell & Unsworth, 2004; Quick et al., 2010; Vance & Siebert, 2009). These strategies may reduce clients' need to access acute hospital services or can delay residential care admissions.

2.1.3 Facilitating Hospital Discharge

As the pressure to shorten hospital stays increases, some home health occupational therapists take on the role of negotiating with their hospital counterpart in regards to clients' hospital discharge plans. Pre-discharge assessments are usually completed by occupational therapists at client's home to identify clients' readiness for discharge, provide recommendations for home adaptation and recommend the most

suitable discharge destination. Depending on the settings, pre-discharge assessments can be completed by hospital occupational therapists and home health occupational therapists. Some evidence questions the effectiveness of pre-discharge assessments completed by hospital occupational therapists (Atwal, McIntyre, Craik, & Hunt, 2008; Patterson, Viner, Saville, & Mulley, 2001). Limited evidence was found about the effectiveness of pre-discharge assessments completed by home health occupational therapists.

2.1.4 Educating Clients and their Caregivers

Another possible function of occupational therapists in home health is to provide education to clients and their caregivers (Furååker & Nilsson, 2011; Hoffmann & Cantoni, 2008; Mitchell & Unsworth, 2004; O'Sullivan & Siebert, 2004). Due to the aging population, the number of clients with more severe disability and complex living conditions is increasing. Occupational therapists have greater opportunity to work with family members or support personnel to educate them how to support clients living in the community (Barnes & Frock, 2003; O'Sullivan & Siebert, 2004). Home health occupational therapists are skilled in coaching caregivers to perform activities “*with*” rather than “*for*” the clients. Tasks can be modified according to the caregivers’ needs so that it is easier and safer for both clients and caregivers to perform. In other words, occupational therapists take care of the health of the caregivers and prevent them from burnout and injury (Borell, 2008).

2.1.5 Coordinating Clients’ Care

Clients’ care coordination can be part of the occupational therapists’ roles in some home health settings. Care coordination may include identifying clients’ needs,

liaising with different health care providers and linking clients' needs with appropriate resources. Occupational therapists are able to link all health professions' interventions together through focusing on the occupational outcomes (Barnes & Frock, 2003; Toto, 2006). Since occupational therapists are good at maximizing clients' occupational potentials, they are often the appropriate health professional to determine the amount of care required by the clients and estimate the cost of care (Barnes & Frock, 2003; Mitchell & Unsworth, 2004).

2.1.6 Rehabilitation

Some home health teams recognize the need to empower clients to be as independent as possible; thereby they expect occupational therapists to provide rehabilitation services. Rehabilitation is a type of interventions provided by occupational therapists to assist clients with improving specific physical, cognitive or sensory skills so they can improve their overall occupational performance (Barnes & Frock, 2003; DePalma, 2006). In some settings, occupational therapists supervise rehabilitation assistants or support personnel for implementing treatment plans to ensure clients' goals of independence in occupations are achieved (Barnes & Frock, 2003).

The roles of occupational therapy in home health vary depending on the practice context. Possible functions of home health occupational therapists are numerous. In order to gain a comprehensive understanding of the roles of occupational therapists in home health in Canada, it was important to conduct a rigorous research study to consider different health professionals' perspectives about the home health occupational therapists' roles at a local level.

2.2 Health Care Professionals' Perspectives about the Roles of Occupational Therapists in Interprofessional Home Health Teams

While it is acknowledged that occupational therapists can satisfy various functions in home health, the role they play may not be well understood by the occupational therapists themselves and by other health professionals working in home health. Only two research studies were found exploring the perspectives of the interprofessional team members in relation to the roles of home health occupational therapists (Boutin-Lester & Gibson, 2002; Smith & Roberts, 2005). Both studies revealed some confusion regarding the roles of occupational therapists and role overlap between occupational therapists and physiotherapists in home health. In addition, clients can also be confused about what a home health occupational therapist does. Boutin-Lester & Gibson (2002) investigated the clients' perception of occupational therapy in home health in the United States. During the interviews, some clients reported difficulty with distinguishing between occupational therapy and physiotherapy. Although clients are considered to be important members of the interprofessional team, their perspectives with regards to the roles of occupational therapists can be very different from those of the health care professionals. Smith & Roberts (2005) interviewed occupational therapists, physiotherapists, rehabilitation managers and clients regarding the roles of occupational therapists and physiotherapists within home health in the United Kingdom. Their results confirmed that there is a perceived role overlap between the two professions. The study found that clients believed both occupational therapists and physiotherapists maximize clients' physical status and function and increase their quality of life; however, they were not able to pinpoint the specific role of each profession. In the study, the rehabilitation managers and therapists acknowledged the importance of

differentiating between the two professional roles. Yet they admitted that role overlap is inevitable as both professions share many common skills and aspects of training. Professional differentiation can be a very complex task as it is a negotiation between individuals who have different perspectives (MacDonald et al., 2010). The study conducted by Smith and Roberts explored the perspectives of some health professionals; however, it did not investigate the perspectives of other important members of the interprofessional teams such as nurses and case managers. It is likely that other health professions may have varying perceptions of home health occupational therapists, based on their professional scope of practice and level of interaction with occupational therapists. The perceptions of the entire interprofessional team are worthwhile to explore. Even though it is important to learn about the managers' and leaders' perspectives, this study focused only on health care professionals' perspectives. This is the first step toward a better understanding of how the role perceptions of occupational therapists affect occupational therapy practice in home health.

2.3 Challenges of Understanding the Roles of Occupational Therapists in Interprofessional Teams

The challenges of learning the roles of occupational therapists are not isolated to home health; they could also happen in interprofessional teams who work in a variety of care settings. Although there were no studies examining the role perception of occupational therapists in home health, studies have been conducted in other settings. Six studies were found exploring the roles of occupational therapists in interprofessional teams, five of them were conducted in mental health settings and one was conducted in a spinal cord injury rehabilitation unit (Egan et al., 2010; Fortune & Fitzgerald, 2009; Pellatt, 2005; Simpson et al., 2005; Smith & McKenzie, 2011; Smith & Roberts, 2005).

Only one study was done in Canada, the other studies were done in either United Kingdom or Australia. All studies concluded that health professionals have limited understanding of the roles of occupational therapists in their particular settings. Some of the reasons appeared to be related to the lack of understanding of the differences between the philosophies of occupational therapy and medicine, a lack of motivation in learning each others' roles and the difficulty of occupational therapists have in articulating their roles. In order to increase our understanding of how health professionals perceive the roles of occupational therapists in home health, we needed to have a closer look at the research studies that were conducted in other care settings.

2.3.1 The Difference between the Philosophies of Occupational Therapy and Medicine

Fortune & Fitzgerald (2009) found that some nurses in acute mental health in Australia had difficulty with understanding the significance of occupation due to their lack of understanding of the philosophy behind occupational therapy. Similar to Fortune & Fitzgerald, (2009), Simpson et al. (2005) found the same result when interviewing occupational therapists in an acute mental health setting in United Kingdom. A nurse in the Smith & Mackenzie (2011) study reported that she felt occupational therapists and nurses take a different focus when assessing a client. Occupational therapists were more concerned about rehabilitation; meanwhile, nurses were concentrated on stabilizing clients' mental health symptoms. Wilding & Whiteford (2007) explored challenges in interprofessional practice in hospitals and they framed this ideological difference as care versus cure. Many occupational therapy scholars believe medical professionals, which include nursing focus on "*bottom-up reasoning*" whereas occupational therapists apply a "*top down approach*". With "*bottom-up reasoning*", the emphasis is on diagnosis and

impairment. When occupational therapists apply a “*top-down approach*”, they emphasize on occupational issues before examining the cause of the problem. The difference between the two approaches might create barriers for medical professionals to understand occupational therapy.

2.3.2 Health Care Professionals’ Attitude toward Learning Each Others’ Roles

Role clarity can possibly be improved if the areas of professional overlap are identified. Even if the professional roles overlap and continue to be vaguely defined, interprofessional teams may still work well together when the benefits of collaborative team efforts are valued (MacDonald et al., 2010). Unfortunately, many health professionals have a lack of insight into their need to learn about each others’ roles in interprofessional teams (Larkin & Callaghan, 2005; Pellatt, 2005). An ethnographic research study conducted by Pellatt (2005, P.143) with 27 health care professionals in a rehabilitation team indicated that there was a “*knowing paradox*” among health care professionals. All health care professionals perceived that other health care professionals had a lack of understanding of their roles, yet they believed that they understood their colleagues’ roles. Larkin & Callaghan (2005) discovered the same phenomenon in a mental health community team. Professional defensiveness is another barrier that blocks health care professionals from learning about each others’ roles, sharing their professional boundaries and working collaboratively. When health care professionals perceive a role conflict with other health professionals, they might become protective of their scope of practice and show resistance to collaboration (Smith & Roberts, 2005; Suter et al., 2009).

2.3.3 Difficulty with Articulating the Roles of Occupational Therapists

The occupational therapists' issues with their professional identity and the limited articulation of their roles have a major impact on how other health professionals perceive the roles of occupational therapists. In Smith & Mackenzie (2011), a nurse reported that the occupational therapists who she worked with seldom promoted the role of occupational therapists. In Edwards & Dirette (2010), the occupational therapists reported a lack of confidence in defining their roles. Some occupational therapists acknowledged difficulty with articulating the definition of occupational therapy and what services the profession can offer. Wilding & Whiteford (2007) reported that occupational therapists' explanations of their profession ranged from process-related to philosophical belief-based definitions. The illustrations were lengthy, problematic, over-inclusive and hard to understand. Egan et al. (2010) agreed with Wilding & Whiteford that the unarticulated occupational theory could be a concern for practice within an interprofessional setting. Fisher (2001) observed that different terminologies such as occupation, function and activities used interchangeably by occupational therapists can be confusing to others.

The professional differences and role perceptions could be very different and significantly influenced by various patient groups and practice contexts (Baxter & Brumfitt, 2008). The evidence suggested that the nature of occupational therapy and interprofessional settings can contribute to a limited understanding of the roles of occupational therapists in some practice contexts. Therefore, a study was needed to further explore the role perceptions in the home health settings.

2.4 Impact of Role Perceptions on Occupational Therapy Practice

It is critical to have a comprehensive understanding of how various health professionals perceive the role of occupational therapists, as these perceptions could have significant influences on occupational therapy practice. The research examining health professionals' perceptions of occupational therapists' roles in settings like mental health and rehabilitation has shown that these perceptions could lead to practice challenges in occupational therapy (Fortune & Fitzgerald, 2009; Norman & Peck, 1999; Simpson et al., 2005; Smith & Mackenzie, 2011). This is the first study exploring this relationship in home health. The perception of occupational therapists' roles by different health professionals can have the following implications for practice: implementation of occupational goals; communication with other health professionals; job satisfaction for occupational therapists; and utilization of occupational therapy service.

2.4.1 Implementation of Occupational Goals

Many practice contexts that occupational therapists work in are dominated by more medically oriented professions, such as physicians or nurses. This means that sometimes the roles of occupational therapists are considered to be secondary to medical roles and occupation-based goals are not always valued (Caldwell & Atwal, 2003). How occupational therapists perceive their roles within their practice setting can have a tremendous influence on how they practice. For example, 15 occupational therapists interviewed in an acute setting in Australia identified their roles to be facilitation of effective hospital discharges rather than enabling occupation (Wilding & Whiteford, 2009). As a result, they only minimally attended to occupational goals. In summary,

professional identity and the value that occupation brings to health could possibly be diminished in a medically-dominated environment, and clients' health could be compromised.

The implementation of occupational goals may also be affected by how other health care professionals perceived occupational therapists in interprofessional practice (Caldwell & Atwal, 2003; Fortune & Fitzgerald, 2009). Egan et al. (2010) explored occupational therapy practice in mental health settings and found that occupational goals were compromised due to the limited understanding or misunderstanding of occupational therapists' roles. Egan et al. (2010) reported that the community mental health team believed that the roles of health care professionals were to cure or decrease the related symptoms. Since the occupational goals did not fit with the team's values and beliefs, they were considered as lower priorities. In Fortune & Fitzgerald (2009, P.84), the acute mental health nurses acknowledged that occupational therapists were their "worst enemies". The nurses believed that occupational therapists' contribution was minimal and insignificant. The implementation of occupational therapy programs was not supported. This led to limited opportunities for clients to be engaged in occupations. Clients' occupational needs might be minimized when the contributions of occupational therapists in the interprofessional team are not recognized.

The different operational structure of home health may have a different impact on the occupational therapists' abilities to implement occupational goals. In home health physicians are not usually located in the same geographical location as the rest of the health care professionals. The physicians' and medical specialists' services are usually accessed by telephone or fax. This different way of accessing the physicians' services

may shift the system to be less hierarchical and medically-focused. Evidence showed that interprofessional teams in the community are more collaborative than those in acute care settings (Nugus, Greenfield, Travaglia, Westbrook, & Braithwaite, 2010). A more collaborative practice environment might affect how occupational therapists perceive themselves and how they are perceived by other health professionals. It could possibly facilitate a more occupation-focused practice. When interviewed, occupational therapists working in the community in the United States expressed a sense of autonomy (Ramsey, 2011). In contrast to hospital based therapists, therapists working in the community indicated that their program was more supportive and flexible and more conducive to a creative practice that focused on assisting clients in achieving their personalized goals. Gantert & McWilliam (2004) also found high levels of professional autonomy within home health organizations in Ontario. The team members reported that they are able to develop their own goals and intervention plans although the team goals are lacking.

Home health is different from traditional care settings, in that clients' care is provided within their own homes. The familiar environment may provide clients with more power and control over their treatment goals (Mortenson & Dyck, 2006). If clients were given more power, it is unclear if they would focus more on medical goals or occupational goals, or treat the two aspects equally. If clients could contribute more to their own intervention plans, they might be able to implement occupational goals even if the occupational therapists' role of enabling occupations is undermined. There are conflicting opinions on this in the literature. Ramsey (2011) interviewed 10 community occupational therapists in the United States who believed that their roles were to motivate clients to achieve their own life goals. Meanwhile, Boutin-Lester & Gibson (2002)

interviewed clients who believed they were engaged only in the goal setting processes and the actual intervention goals were determined by occupational therapists. Some clients reported that the interventions concentrated on exercises rather than on occupational outcomes.

The literature indicates that role perceptions can significantly affect the implementation of occupational therapy goals. Furthermore, role perceptions are influenced by practice settings. The differences between home health and traditional inpatient settings may affect the involvement of medical professionals and collaboration between occupational therapists and clients in implementing occupational goals. Thus occupational therapy practice in home health and quality of client care are likely to differ from other practice settings.

2.4.2 Communication with Other Team Members

A collaborative team requires effective communication among its team members (Suter et al., 2009). Communication is a two-way channel for conveying and receiving information between two or more parties, which can be facilitated within interprofessional teams when the members show trust and respect to each other (Xyrichis & Lowton, 2008). Research evidence indicates that interprofessional settings that are dominated by the values of medicine and nursing perceive the roles of occupational therapists to be secondary to those of medical professionals. This appears to result in a lack of listening and respect towards the occupational therapists (Simpson et al., 2005). One of the reasons might be the physicians' belief that they have the ultimate liability and responsibility for all aspects of patients' care. This belief may limit occupational therapists' ability to contribute to the decision making process related to

clients' care (Nugus et al., 2010; Wright, Lockyer, Fidler, & Hofmeister, 2007). The discounting of occupational therapists' contribution can be shown through an example of how a physician determined clients' eligibility for admission to group homes. Rather than requesting an occupational therapy functional assessment, the physician interviewed the group home staff (Egan et al., 2010). Simpson et al. (2005) conducted individual interviews with 47 multidisciplinary staff from 14 acute psychiatric wards in London to explore interprofessional relations between occupational therapists and other team members. One occupational therapist expressed feeling of being "out of the loop" and another therapist indicated not having pertinent clients' information from the team for her daily practice (Simpson et al., 2005, P.549).

In home health, health care professionals have fewer opportunities for face-to-face interprofessional communication, as they rarely provide care concurrently in the home. Communication among home health staff is often done "on the fly" and through a voicemail (Ehrlich, 2006). Instead of having regular ward rounds, most home health teams call for a client-specific case conference when needed. This may contribute to other home health professionals not understanding the roles of occupational therapists. Practice challenges can result due to the limited opportunities for communication (Thome, Dykes, & Hallberg, 2003). Lack of communication or miscommunication can negatively affect quality and safety of client service. Stalker et al. (1996) did a study in Scotland and reported that contacts among home health colleagues were informal and underdeveloped and the relationship with general physicians was variable. Gantert & McWilliam (2004) completed a recent study in Ontario Canada to examine the interprofessional process in an in-home service delivery organization. The eight health

care professionals who were interviewed in the study included home support workers, nurses, case managers, occupational therapists and physiotherapists. All participants reported limited knowledge regarding the roles and scope of other team members, and that they often relied on their previous knowledge gained in other contexts. These studies reveal the gap of knowledge regarding the roles of health professionals in home health and how the current communication among team members in home health settings is not adequate to fill the gap. Improved communication technology such as emails and cell phones, may improve or lessen communication among team members. Unfortunately, no study has been found to prove that technology can fill the communication gap.

2.4.3 Job Satisfaction for the Occupational Therapists

If occupational therapists can clearly identify their own roles and their roles are understood and supported by their colleagues, it might lead to an increase in job satisfaction. Wilding & Whiteford (2009) investigated how to change occupational therapy practice in acute settings to be more occupation-focused. These changes led to an increase in job satisfaction in occupational therapists. The variability of roles fulfilled by occupational therapists can lead to feelings of frustration and stress. In addition, difficulty with articulating a definition of occupational therapy increases their frustration, uncertainty, embarrassment, and dissatisfaction (Egan et al., 2010; Fisher, 2001; Townsend & Polatajko, 2007). In a study conducted by Edwards & Durette (2010), 126 occupational therapists across various practice settings, who reported a lower level of professional identity, expressed a higher level of burnout. Considering the issues of recruitment and retention in health care nowadays, occupational therapists' level of

satisfaction can influence their practice in health teams. As occupational therapists often use themselves as a tool in a therapeutic relationship, any negative emotions from the occupational therapists may directly affect client care.

2.4.4 Utilization of Occupational Therapy Service

Without a mutual understanding of each others' roles and responsibilities, it is challenging to develop a good working relationship among team members and work collaboratively when delivering client care. One of the key competencies identified in interprofessional practice is the ability to describe different professional perspectives and their scope of practice (MacDonald et al., 2010). When interprofessional team members do not have a clear understanding of each other's roles and their own roles, they may reduce interaction with each other or interact based on misconceptions (Pellatt, 2005). The health professionals may lose trust in each other and the amount of collaboration may be compromised as a result (Gantert & McWilliam, 2004).

A lack of knowledge regarding occupational therapy practice can possibly lead to inappropriate use or underuse of occupational therapy service. It can possibly prevent other health care professionals from generating appropriate occupational therapy referrals. Inappropriate referrals can lead to a long and unnecessary wait for people who truly require home health occupational therapy services. Health professionals may struggle with recommending occupational therapy service to clients when they are unsure what occupational therapists can offer (Smith & Mackenzie, 2011). DePalma (2006) reported that clients' family members expressed confusion due to the lack of information and practical expectation given to them about the range of services offered by home health occupational therapists. This could result in compromised client care.

2.5 Summary of Literature Review

In many practice contexts, health professionals expressed challenges in understanding the roles of occupational therapists. The challenges could lead to significant issues in occupation therapy practice. Currently, no research study has considered the role perceptions of occupational therapists in home health, although the same practice challenge could be present in home health occupational therapy. Therefore, this research was designed to fill the knowledge gap by studying how the roles of occupational therapists were perceived by different health professionals in home health and what the impact of these perceptions on home health occupational therapy practice.

CHAPTER 3 RESEARCH METHODOLOGY

3.1 Qualitative Approach

The research question was “How do health professionals’ perceptions of the roles of occupational therapists affect occupational therapy practice in interprofessional home health teams?” A qualitative approach was employed to answer this question. The purpose of this study was to explore the role perceptions of occupational therapists from different health professionals’ perspectives, including the occupational therapists’ perspectives, to understand how role perceptions affect occupational therapy practice in home health. The intention of this study was to inform health care decision makers and clinicians about home health occupational therapy clinical practice. Therefore, this study focused on a simple design to produce findings that could be applied fairly rapidly to practice (Kelly, 2010) while using methodological rigour to ensure a trustworthy study (Caelli, Ray, & Mill, 2003; Patton, 2002).

A qualitative approach was appropriate for this study because it used an inductive methodology that could reflect different health professionals’ perspectives. The results from this study can be used to develop new knowledge in a poorly understood and complicated area of health care such as role perceptions in interprofessional teams (Fossey, Harvey, McDermott, & Davidson, 2002). The qualitative approach fitted the primary goal of this study, which was to discover and describe the realities that health professionals are currently experiencing in home health (Kielhofner, 2006; Meadows, 2003). It allowed us to explore meanings and processes experienced by the participants (Kelly, 2010). In addition, a qualitative approach let us

collect deep and detailed data to further understand “the complex world of human experience and behaviour from the point-of-view of those involved in the situation of interest” (Krauss, 2005, P. 764; Patton, 2002). It was an effective approach for investigating a particular phenomenon when there is not much known about a situation (Kielhofner, 2006). Since there was minimal research evidence exploring the role perceptions of occupational therapists in home health and no research study had been done exploring the perspectives of occupational therapists with that of other health care professionals in Canada, a qualitative study was the most appropriate methodology to conduct the research.

3.2 Research Sampling

Purposive sampling was used to identify six health professionals to participate in this study. The aim of the study was to elicit a deeper understanding of the role perceptions of occupational therapists within home health from the perspective of occupational therapists and other health professionals who work in home health; therefore, a small number of participants was included to ensure a comprehensive investigation on each individual’s experience (Higginbottom, 2004). Considering that process of gaining a deeper understanding of everyone’s story could be an intense and time-consuming experience (Kearney, 2007), interviewing six participants appeared to be feasible and reasonable.

A matrix was created to keep track of details on participants from different professions, sized offices and professions (refer to Appendix I – Matrix for Recruitment).

The selection criteria for the participants included:

1. Frontline health care professionals working in clinical roles in home health including three occupational therapists and three non-occupational therapy health professionals (For instance, one from at least three of the following professional roles: nursing, case management, physiotherapy and social work) were recruited. The health professionals, who worked in managerial, supervisory or support roles such as managers, team leaders and clinical resource nurses, were excluded. Although each home health team in Fraser Health had a slightly different combination of health care professionals, most teams included nurses, case managers, occupational therapists, physiotherapists and social workers.
2. Health professionals who had worked in any home health teams for three to ten years.
3. In order to avoid coercion in participants' recruitment, participants were not recruited from the home health team where the principal investigator was clinically practicing at the time of recruitment.
4. Participants from different sized teams were preferred. There were 14 home health teams in the health authority with different team sizes. The total number of Full Time Employees (FTE) of frontline professional staff in each office was used to define the size of each team. Office sizes were compared with the size of the largest office and categorized as small, medium and large (refer to Appendix II – Determination of Home Health Team Sizes).

The key attributes that can affect role perceptions and should be addressed when sampling participants are: the type of profession, years of experience and team sizes (Xyrichis & Lowton, 2008). Six health professionals, including three occupational

therapists and three non-occupational therapists, were recruited. The three occupational therapists' opinions helped us understand occupational therapists' perspectives; the other health professionals' opinions were useful for understanding non-occupational therapists' perceptions. The differing opinions allowed the study to better describe a broad array of themes in the interviews. The number of years of home health experience could be a factor affecting role perceptions. Novice and expert health professionals might have different levels of understanding about the roles of occupational therapists. In order to rule out the influence of the years of home health experience, only health professionals with a range of 3 to 10 years of experience were recruited to ensure participants had adequate knowledge in home health and were capable of articulating that knowledge. The differences in team sizes could also possibly affect the team culture and means of communication that might affect interprofessional communications and role perceptions. By selecting a small sample of participants with different characteristics and obtaining rich descriptions in each interview, important patterns could be identified to create a broad understanding of the phenomena (Kearney, 2007; Patton, 2002).

3.3 Recruitment Strategies

This research proposal was approved by a director from a home health program as per the health authority guideline. The home health program director granted time for their staff members to participate in this research during work hours. The research was promoted at the profession-specific clinical practice committees. All committees assisted with recruitment by making announcements during meetings and forwarding an email invitation to their members (refer to Appendix III – Email Invitation). The email

invitation included the title of the study, researcher's information, expectations of participants, a brief description of eligibility and information regarding how to contact the principle investigator if interested. After receiving an email invitation, interested professionals contacted the principal investigator via emails.

The principal investigator used a checklist to guide the conversation and screen potential participants for their eligibility to participate in this study (refer to Appendix IV - Telephone Screening Tool). Information obtained from each potential participant was entered into the matrix (refer to Appendix I – Matrix for Recruitment). The first 6 eligible participants, whose attributes fit the sampling strategy, were invited to participate in the study. Consent to participate was obtained from the eligible participants (refer to Appendix V – Written Consent Form). After completion of the study, the participants were offered a \$20 visa gift card in recognition of their time spent in participating in the research.

3.4 Data Collection

A semi-structured interview was conducted with each participant in order to understand different participants' perspectives towards the roles of occupational therapists and how their perspectives impact occupational therapy practice in home health. The interviews were conducted by the principle investigator, who worked as an occupational therapist in one of the home health offices. The principal investigator had met some of the participants through regional educational events, so she might have been seen by the participants as an "insider". Having an "insider" as an interviewer might have made participants feel more comfortable because of the shared culture and technical language developed from exposure to a common practice environment. There

might also have been a pre-established rapport that could have made it easier for participants to discuss sensitive issues or provide a deviant view or richer and more personal information (Coar & Sim, 2006). In addition, having a clinician to conduct this research in a clinical setting provided a great example of integrating research into practice. It also made this project more financially feasible as no external researcher needed to be hired.

The semi-structured interviews were guided by a set of pre-established open-ended questions. Probing questions were used to obtain more in-depth and trustworthy information. During the interviews, the principal investigator expressed a different perspective from time to time to challenge participants to enrich data collection (Kielhofner, 2006). Unlike questionnaires, interviews provided opportunities for two-way communications to enable data construction between the interviewer and participants. Participants could clarify questions to ensure the information collected was relevant and trustworthy. The interviewer could facilitate conversations so that the participants could feel more comfortable with sharing more and deeper information. Participants' non-verbal communication skills such as gestures, facial expressions, tone and speed of voice were observed and noted at the interviews. The notes were helpful to understanding the participants' expressions during the interviews.

Timing and location of the interviews were important factors that might affect the quality of the interviews. Participants were consulted to select a venue that was relaxing, quiet, comfortable, private and convenient and offered no interruption (McDougall, 2000). Three out of the six interviews occurred in a coffee shop; the other three interviews occurred in an interviewing room in an art centre, library and office

building. The principal investigator left adequate time during the interviews to deal with any emotional distress and recovery from the distress created by answering some of the sensitive questions. She also attempted to arrange the interviews during a less stressful time so that the participants could be more focused on the research topic during the interviews (Hutchinson & Wilson, 1992). All six interviews were conducted between October and December of 2012 with from three days to two weeks apart.

To prepare for the interviews, the principle investigator developed a note page to remind herself about the details of the interviewing preparation and process (refer to Appendix VI - Considerations for the Interviewing Process). A semi-structured interview guide was developed and used to help participants to provide relevant information in a structured manner (Kielhofner, 2006) (Refer to Appendix VII - Interview Guide). The interview guide could ensure that all information was collected in a similar way to increase trustworthiness and creditability. It also helped the interviewer to cover all the points that might otherwise have been easily missed and could have a significant impact on the research study. Having an interview guide could also help other researchers replicate the study in the future. It ensured that the interview process was carefully planned and evidence-based.

3.4.1 Interview Process

The whole interview process was clearly stated in the interview guide. At the beginning of the interview, adequate time was devoted to greeting and establishing rapport with participants. General information regarding the research purpose, process and duration of the interview were provided. The consent form was reviewed with the

participants. Before the interview commenced, a written consent was obtained (Refer to Appendix V – Written Consent Form).

During the interviews, the interviewer asked questions based on the interview guide (Refer to Appendix VII – Interview Guide). The interviewer used a relaxing conversational style to conduct the interviews. She was flexible and adjusted the wordings of specific questions to ensure that the research question was addressed.

The interview questions were developed based on the research literature in the following three areas (Baxter & Brumfitt, 2008; Caldwell & Atwal, 2003; Egan et al., 2010; Fortune & Fitzgerald, 2009a; Nugus et al., 2010; Simpson et al., 2005).

- a. Perception of home health occupational therapists' functions
- b. Role overlap between occupational therapists and other health professionals
- c. Impact of the perceived roles of occupational therapists on occupational therapy practice in home health

The questions in the interview guide were structured, using four interviewing phases to maximize positive dynamics between the interviewer and participants to encourage participants' sharing of their stories. The use of the four interviewing phases helped with rapport development, which was crucial in this study when discussing personal experiences and potentially sensitive subjects such as interprofessional relationship (McDougall, 2000). The four major phases of interview included:

Apprehension.

At this initial phase, broad and non-threatening questions such as description of the roles of occupational therapists in home health were presented. The goal of this phase was to encourage participants to talk.

Exploration.

During the second phase, exploration, role overlap was explored. Both interviewer and participants continued to develop bonding and sharing at this stage.

Cooperation.

At this stage, participants started to feel more comfortable in discussing potentially sensitive topics. They were asked about the impact of role perception of occupational therapists on home health occupational therapy practice.

Participation.

During the participation phase, participants took on a guiding role to teach their experiences to the interviewer (Conneeley, 2002; DiCicco-Bloom, 2006). This was when participants were asked about how role perceptions impact occupational therapy practice such as implementation of occupational goals, communication with other health professionals, job satisfaction and utilization of occupational therapy service. At the end of the interviews, participants were asked with an easy open-ended question so that they could leave the interview with a positive feeling.

To ensure all relevant information had been captured, the entire interviewing process was voice-recorded by an MP3 player. The principle investigator recorded the non-verbal communication and paralanguages, which were observed from the participants throughout the interviews. It was important to record the non-verbal communication but not to interpret it at the time of the interviews. If needed, the principal investigator made reflective comments to participants and asked for clarification during the interviews.

3.4.2 Transcription

The data obtained from the interviews was transcribed within two weeks. An experienced transcriber was hired with consultation of the research service from the health authority. The transcriber transcribed the MP3 files to six written documents. The principal investigator organized and typed the handwritten field notes taken from the interview within two days after the completion of each interview and used it as a reference for data analysis.

3.5 Data Analysis

Thematic analysis was employed for data analysis. Thematic analysis is “a method for identifying, analyzing and reporting patterns or themes within the data (Liamputtong, 2009, P.135). The data analysis process started as soon as the first interview was completed and transcribed to ensure a better understanding of the data, follow up on ambiguous data and to help with theoretical sampling. This also made data analysis more manageable than waiting to commence the analysis upon the completion of data collection. The analysis was a back and forth process that involved the following four steps: immersion, coding, categorizing, and generation of themes (Green et al., 2007; Kielhofner, 2006; Liamputtong, 2009)

3.5.1 Immersion

The principal investigator read through the initial set of transcripts and interviewing notes without an attempt to make any interpretation. Repeated reading and re-reading of the transcripts and contextual data allowed her to conduct a detailed examination of what had been said. This initiated a process of incubating ideas about

possible themes. Data immersion provided a foundation for connecting the disjointed elements into a clearer picture of issues.

3.5.2 Coding

Coding involved examining and organizing information contained in each interview and the whole dataset. It provided the principal investigator with a clear sense of the context of the interview and allowed her to make judgments when coding different blocks of transcript. The principal investigator followed a set of basic questions to strategize coding (Liamputtong, 2009) (refer to Appendix VIII – Basic Questions Used for Coding Strategies). She made notes in the transcript margins and used colour-codes on the transcripts. A word, phrase or paragraph was attributed to each block of transcripts in this sorting process. As more information was discovered through the analysis, more codes were added and the meaning of each code was refined. When this happened, the previously coded transcripts were revisited in order to verify whether the codes still applied or the older transcripts might need re-coding.

3.5.3 Categorizing

At this stage, a detailed examination of data was conducted so that common categories could be created to link the codes together.

3.5.4 Generation of Themes

Generation of themes involved connecting the results of interviews with what was known about role perceptions of home health occupational therapists. Once themes were identified, the principal investigator tested them by linking the interview generated themes with themes identified in the literature review until an overriding explanation

was produced that made sense of various patterns that had emerged at a descriptive level (Green et al., 2007; Liamputtong, 2009). The principal investigator linked the themes generated from the findings with current practice and identified any implications for practice.

3.6 Trustworthiness and Ethics Considerations

The principal investigator highly valued trustworthiness and ethics throughout the study. Different procedures and strategies were employed to ensure a trustworthy and ethically sound study. The colleagues who worked in the same office as the principal investigator were excluded from the study to minimize participants' bias and conflict of interest. Some participants might view the principal investigator as an "insider", this may cause them to omit details from their responses to the interview questions. In order to minimize participants' bias, principal investigator explained the focus of the study at the beginning of the interview and constantly reminded participants during the interviews that there was no right or wrong answers so that they could express their opinions freely. The principal investigator used a reflexive research diary to identify her perceptions and bias. She also debriefed with her supervisor after the interviews so that she could identify barriers to drawing a trustworthy conclusion (Connelley, 2002; Hutchinson & Wilson, 1992). Since the relevancy and presentation of the interview questions could have a significant influence on the study outcome, the interview questions were forwarded to three identified key individuals in the field for review prior to conducting the interviews (Hutchinson & Wilson, 1992; McDougall, 2000). In order to enhance interviewing skills to guarantee quality data collection, the principal investigator did a mock interview and collected feedback from a colleague

before interviewing any participants (Bulpitt & Martin, 2010). The interviewing context was carefully selected to ensure a quiet venue with minimal distractions so that the sound file could be transcribed accurately (Easton, McComish, & Greenberg, 2000). In terms of data analysis, both principal investigator and her research supervisor worked as a team to analyze some of the data by using coding and constant comparative analysis (Coar & Sim, 2006; Curtin & Fossey, 2007; Ryan-Nicholls & Will, 2009). For more detailed information, refer to Appendix IX – Strategies to Improve Trustworthiness and Appendix X - Ethics Consideration.

CHAPTER 4 FINDINGS

In total, six participants were interviewed in this study. Three of the participants provided non-occupational therapists' viewpoints and their professions were social worker, case manager with a nursing background and home care nurse in home health. Two participants were occupational therapists who were currently practicing in home health. One participant had a combined physiotherapy/occupational therapy degree and was currently practicing in a case management role in home health. Her experience of being a case manager with an occupational therapy background provided a unique viewpoint that could be a significant contribution to answering this research question. This case manager's perspective was incorporated in the occupational therapy participant's findings because most of her viewpoints align with the other two occupational therapists' perspective. All participants were recruited from a variety of home health offices that were different from the one where the principal investigator previously practiced. Two participants came from a large office while four participants came from a medium sized office (See Table 1: Participants' Profile).

Table 1: Participants' Profile

Participant	Professions	Years of experience	Size	Brief description of the participants' professional background
NOT1	A social worker	7 years	Medium	Had previous experience of working in a mental health setting with occupational therapists in the interprofessional teams.
NOT 2	A case manager with nursing background	6 years	Medium	Had been working in the same home health office as a case manager for about 6 years. Had previous experience as a home care nurse

NOT = Non-occupational therapy participants

OT = Occupational Therapy participants

Participant	Professions	Years of experience	Size	Brief description of the participants' professional background
NOT 3	A nurse	5 years	Medium	Had been working in the same office as a home care nurse for 5 years. Previously worked as a client coordinator in a hospital for about 3 years.
OT1	A case manager with a combined physiotherapy/occupational therapy degree	7 years	Large	Graduated with a combined Physical/Occupational Therapy degree. Had been working as a case manager in the same home health office for 7 years. Practiced as an occupational therapist for 17 years before taking on the case management role.
OT2	An occupational therapist	7 years	Large	Had been practicing in the same home health office for 7 years. Worked in a mental health setting prior to home health.
OT 3	An occupational therapist	7 years	Medium	Had been practicing as an occupational therapist in two different home health offices in the past 7 years. Had experiences of working in different practice settings including neurology and rehabilitation.

NOT = Non-occupational therapy participants

OT = Occupational Therapy participants

The above description of the participants helps to provide the context for four main themes identified from the analysis of transcripts of all six participants. In order to answer the research question, *“How do health professionals’ perceptions of the roles of occupational therapists affect occupational therapy practice in interprofessional home health teams?”*. To answer the sub-question, *“what are the role perceptions of occupational therapists by the occupational therapists and other health care professionals within the interprofessional health teams?”*, four themes are identified. Each theme includes several subthemes. Table 2 lists these themes and subthemes which

will be further explained with supporting data below. To answer the sub-question, “*how do the perceptions of occupational therapists’ roles affect occupational therapists’ practice in home health?*”, four major themes are identified and revealed in the last column of Table 2.

Table 2: Themes and Sub-Themes

Role perceptions of occupational therapists in home health		Impact of role perceptions of occupational therapists on occupational therapy practice in home health
Themes	Sub-Themes	
1. Occupational therapists are experts in assessing clients’ needs	1A: Occupational therapists can accurately assess the clients’ needs	1. The perceived expertise in assessment and collaboration supports home health occupational therapists to expand their roles to include the role of care coordinator
	1B: Occupational therapists assess the interrelationships of all performance components	
	1C: Current scope of practice is often limited to self care	
	1D: Occupational therapists are experts on assessing cognition, but are limited to focusing on the physical status	
2. Occupational therapists are excellent collaborators	2A: Occupational therapists partner with the clients in providing health service	
	2B: Occupational therapists are great collaborators with other health care providers	
3. Occupational therapists are good at rehabilitation; despite being limited to using equipment as their major interventions	3A: Occupational therapists are good at rehabilitation	2. The perceived association with equipment could generate inappropriate occupational therapy referrals in home health
	3B: Current interventions are limited to equipment interventions	

Role perceptions of occupational therapists in home health		Impact of role perceptions of occupational therapists on occupational therapy practice in home health
Themes	Sub-themes	
4. Non-occupational therapists have difficulties understanding the role of occupational therapists	4A: Limited insight about the role perception discrepancies	3. Role overlap with physiotherapists cause strong collaboration with physiotherapists, but also inappropriate and inefficient use of occupational therapy service and missed occupational therapy referrals. 4. Nursing hierarchy and limited understanding of occupational therapy in home health hinders the implementation of occupational therapy recommendations, resources allocation to occupational therapy and occupational therapists' role expansion
	4B: Role overlaps with physiotherapists	
	4C: Nursing hierarchy in the interprofessional home health practice context	
	4D: Challenges in advocating for occupational therapy service	

In this chapter, we will share the findings theme by theme and compare and contrast the responses from the non-occupational therapy participants and the occupational therapy participants. The impact of role perceptions on occupational therapy practice will also be discussed in this chapter. Direct quotations from the participants will be used to illustrate the points. Direct quotes are *italicized*; **the bolded part** of the quotes is to highlight the important messages delivered while the other content provides the context.

4.1 Theme 1: Occupational Therapists are Experts in Assessing Clients' Needs.

All participants, both non-occupational therapy and occupational therapy participants, commented that occupational therapists are experts in assessing the needs of clients. They recognized that occupational therapists assess the physical, cognitive and emotional aspects of the person and environment. The non-occupational therapy participants did not realize that occupational therapists assess the interactions between the person, environment and occupation. All participants reported that home health occupational therapists' practice is limited to self care. Although occupational therapists are good at cognitive assessments, they are limited to focusing on clients' physical needs in home health.

4.1.1. Sub-Theme 1A: Occupational Therapists can Accurately Assess Clients' Needs

Both non-occupational therapy and occupational therapy participants recognized that home health occupational therapists have effective assessment skills that can inform the interprofessional team members and ensure resources are used appropriately and efficiently in the health care system. They perceived occupational therapists have specialties particularly in transfers and power mobility.

A non-occupational therapy participant provided an example of how an occupational therapist uses time-task analysis as a tool to provide valuable information about the efficient use of home support hours.

***NOT2:** ...Like **time-task analysis** (one kind of assessments conducted by occupational therapists), if you're having to plan care with the home support and the clients are only allowed a certain amount of time per month, then I think that (the time task analysis) has a huge impact as far as being **efficient with the home support time**...*

An occupational therapy participant stated how occupational therapists can recommend the appropriate amount of home support and the most effective and efficient way to assist clients in their care. These two examples illustrate how the occupational therapists' effective assessment skills can result in efficient use of resources.

OT1: We (The case managers) provide home support inefficiently until an OT (occupational therapist) gets in there to re-evaluate how things... (such as) transfers are done... I find (that) OTs are getting in there faster now so we are more efficient now but still there's the odd situation where ... a referral to OT has been missed and we've been doing things quite inefficiently.

OT1: They (the occupational therapists) find the most effective transfers that work and they teach the home support workers to do it. I found years ago when OTs just started going in, we had home support workers doing all kinds of work where the right piece of equipment would have saved a whole bunch of work, so the OTs get it right the first time so we start off being efficient in terms of delivering service, not only efficient but safe ...

Both non-occupational therapy and occupational therapy participants provided the following examples of why occupational therapy assessments are outstanding: occupational therapists have an extensive knowledge base, they use a holistic approach, they have a strength-focused approach and they have excellent observational skills.

Non-occupational therapy participants perceived that home health occupational therapists have an extensive knowledge base that contains knowledge such as psychosocial studies, environments, human rights, anatomy, physiology and medicine. This wide knowledge base equips occupational therapists well to use a broad view for considering their clients' needs during the assessments.

NOT1: OTs are very complementary in some of the training with social work but they go beyond it because of their medical knowledge, which the social worker doesn't...get formally trained on. So both occupational therapists and social workers have the psychosocial perspective and ...also the Person In Environment which is similar, we have models looking at the systems, those principles of human rights...

NOT3: ...this is how your body normally works, and with this disease, this is the difficulty you're having. And so these are the things you can do to make it easier 'cause our (the nurses') knowledge is very basic but of course the OT (occupational therapists) have a lot more of that (such as) **anatomy, physiology ...that help them to understand how their (the clients') body functions...**

Non-occupational therapy and occupational therapy participants expressed that occupational therapists adopt a holistic approach when assessing their clients.

NOT 1: OT is not a disease based model whereas, the nursing is a disease based model and they're treating a disease where OTs are like social workers that treating is like unpeeling an onion...**we're looking at that underlying wholeness and taking away what's restricting that wholeness.** Whereas, the nurses are treating the disease and, and they can't really ever fully become whole when they're looking at (the) disease...

OT1: The funders trust their (the occupational therapists') assessments because they are **thorough** and they are **looking at everything not just physical ability, not just access** but they do... **the cognitive assessments** to support both the... health and safety of (the) clients... I think if the OTs are given their space... it's recognized that they (the occupational therapists) can address **a broader perspective** of a... **the whole person...**

The non-occupational therapy participants recognized home health occupational therapists incorporate different aspects in assessing a client's ability to manage a medication dispenser.

NOT 3: The occupational therapists have been doing **cognitive screening** for all of the clients (who are referred for possibly using medication dispensers)...if someone had identified that there was a physical limitation to **open the containers...** but ... the cognitive assessment information will be compiled at the end ... to see... (if)... people are fitting in this medication dispensing project and (or) what difficulties they're having...

According to non-occupational therapy participants, occupational therapists usually analyze an issue deeply to get at the root of the problem so they can pinpoint the exact issue that prevents clients from performing the activities they would like to do.

NOT1: Well... in their (the occupational therapists') problem solving, they take the problem and then **they break it down into smaller pieces** and they

*deconstruct it **and they look at interventions that can be used to help the clients.***

NOT2:** I (a Case Manager) can go in (to assess the client)...but if I ask an OT to go in, I know that they're going to do something **very thorough** ...they're able to **focus on something** where I'm trying to get all the generals and **they can narrow it (the issue) down to something

A comment by one of the occupational therapy participants explained the complexity of an occupational therapy assessment that assists in pinpointing clients' issues with mobilizing around the home.

***OT3:** what I do is (that) I assess **how a person moves**. I look at how they're **physically and cognitively**...I also look at the **environment**...and I also look at the environment for safety...If someone has difficulty say, **getting up and down from the toilet** because they're weak or they've got lots of **pain**...(I will) make appropriate recommendations **considering the person, their height, their size, their weight** and how they move but also the environment, so considering the **space, the toilet, equipment considerations** that need to be taken into place and then making my recommendations to the client and their family...*

The non-occupational therapy participants expressed views that occupational therapists can usually recommend the most appropriate interventions targeting on the exact challenge that a client is experiencing.

***NOT3:** ... for our medication management clients that we see ... very often the occupational therapists can help with determining **which clients would benefit from having somebody administer the medications for them or do they just need a reminder system**...*

***NOT3:** ... their (the occupational therapists') cognitive screening helped to assess client safety as far as them (the clients) staying in their current environment. I think it would be a help to the case managers as well (when)... they are...doing their RAI assessments and knowing...**at what point does this person requires a higher level of care**... it would **help the case manager in making a decision about placement or which level of care**... is required...*

Occupational therapy participants reported that they focus on clients' strength and resources in their assessments. Since home health occupational therapists can see the potentials in clients and they have the skills to empower clients to actively

participate in the activities of daily living as much as they can, occupational therapists can determine just the right amount of support that the clients require. Based on the application of empowerment and activity analysis, occupational therapists can recommend appropriate interventions. Health care resources can be used in a more efficient and effective manner as a result.

***OT2:** I'm just thinking about our assessment... we **look at what supports a client has in place already**, we look at...their diagnoses, medical history and then we look at (their) physical (status)...and cognition...*

An occupational therapy participant was asked about the difference between the assessments conducted by a case manager and an occupational therapist. The occupational therapy participant explained that occupational therapists usually do more in enabling the clients to participate in their daily activities.

OT3:** We (the occupational therapists) do have different eyes. We assess the clients differently. **Our training is different. The skill set we have is different so our recommendations will be a little different. My recommendations are not just going to be on education, home support... mine may also involve recommendations that may help the client function, enable them to participate, looking at the equipment... there's recommendations for the client, the environment, the setup that help the client at home to perform their daily activities.

OT3:** There was a client who has a daughter then I'll identify what their interests are, what their goals are and then try and develop a plan with the client. So I might start (the interventions for cooking) out with something simple...like a...plan which includes things... (that) do not require any electrical appliances... looking at a simple task of doing one thing, maybe it's buttering bread, then **breaking down to a simple level that the client can be successful at and then to try and gradually develop complexity.

All participants indicated that home health occupational therapists' assess clients by observing clients in action, which is different from how some other health professionals assess clients in a verbal manner. Since occupational therapists assess by observations, together with their nature of practicing holistically, every client's

encounter becomes an opportunity for a re-assessment according to the occupational therapy participants. Occupational therapists address the clients' needs as a whole rather than isolating and addressing an individual problem.

A non-occupational therapy participant shared her experience of observing an occupational therapist evaluate a client's cognitive function at a joint home visit. She realized that the occupational therapist requested the client to "do" things to assess the client's cognition.

NOT2:** The occupational therapists was using yarn and trying **to get them (the clients) to do things in steps**, to follow steps in a concise way that will determine whether or not the clients can follow instruction...**asking them to use the microwave, do some other things like that.

Another non-occupational therapy participant confirmed the uniqueness of occupational therapy assessment by asking clients to do things instead of just interviewing them. The non-occupational therapy participant differentiated the occupational therapy assessment from the case management assessment based on occupational therapists' unique observational skills in their assessments.

***NOT3:** It's different... **(the assessment conducted by) the case manager is more a discussion- it's not an assessment.** It's a **discussion** with the client and the family and **gathering information** but the case managers do not have that additional knowledge to necessarily assess the problem, provide extra information or intervention...*

Occupational therapy participants confirmed that occupational therapists assess by observation. An occupational therapy participant reported that she assesses her clients by requesting them to demonstrate different activities at a home visit.

***OT2:** Ask them (the clients) questions and **ask them to demonstrate...**
Interviewer: I am curious to know about the demonstration. Are there any specific things that you are looking for when you ask them to demonstrate?
OT2: Looking at their **safety**, (we would consider) **if they can manage** stepping into a shower, into the tub, on and off a toilet, managing the stairs, if they can go*

*up and down the stairs safely, whether they have mobility aid that they're using or if not... also look ..If they're having problems in the kitchen cooking...and eating. So it's...**looking at the whole picture.***

Since occupational therapists assess by observation, occupational therapy assessments usually occur during each interaction with the clients according to an occupational therapy participant.

OT3: There's an initial assessment for the first time visit, but honestly a therapist does not stop assessing at that point... whenever I have another interaction with a client again I am reassessing to make sure whatever the equipment that I recommended is appropriate...

Non-occupational therapy participants and occupational therapy participants stated that home health occupational therapists have the most effective assessment skills compared to other health care professionals particularly in assessing self care. Among all self care activities, the non-occupational therapy participants believed that occupational therapists are specialized in transfers and power mobility.

A non-occupational therapy participant and an occupational therapy participant stated that several different home health professionals (for instance case managers, physiotherapists and occupational therapists) are capable of assessing clients' general personal care needs.

NOT3: I guess the only thing (referring to **role overlap between case managers and occupational therapists in home health**) would be their assessment of clients' living situation... and the cognitive (status) and **their ADLs**...

OT2: Yes there's quite a bit of overlap with everyone (every home health professional) because... all the disciplines do a bit of case management, especially if you're the only discipline involved. So...when the **case managers or physios (physiotherapists)** go out..., they **also ask the same type of questions for assessing client's personal care.**

Among all self care activities, non-occupational therapy participants perceived that home health occupational therapists are experts in assessing transfers and power

mobility management. A non-occupational therapy participant shared how she would only believe the findings from an occupational therapy assessment regarding the amount of help that a client requires for his transfers.

***NOT2:** I'm a nurse and... I have a lot more experience than some other people, (but)... I would only trust an OT and a PT (for assessing transfers) because that is what... they're skilled in or trained in. They have much more knowledge on that than I do and so if you say I need two (persons to assist for transfers), I believe you.*

Occupational therapy participants confirmed that home health occupational therapists spend a lot of time in addressing clients' mobility needs.

***OT2:** We (both the home health occupational therapists and physiotherapists) can prescribe the same type of equipment and maybe we (the occupational therapists) do a bit more of the lifts and the power chairs, wheelchairs, that type of thing.*

***OT3:** Both OTs and PTs may assess... for transfers, basic mobility, equipment needs...*

Although occupational therapy participants stated that occupational therapists are experts in assessing clients' ability to manage power mobility devices, they had different opinions about whether power mobility should be addressed by publically funded home health occupational therapists. One occupational therapy participant acknowledged the importance of addressing clients' needs of power mobility, but believed that the service can be provided by the funding agencies instead of the publicly funded home health occupational therapy. Due to the limited resources, the occupational therapy participant reported that the power mobility assessment is often seen as a lower priority for occupational therapists in home health.

***OT1:** I wish the extended health funding agencies would fund OTs (occupational therapists) so that private OTs can go in and do this work. Instead, home health OTs are asked to do a lot of mundane things like simple scooter assessment. They (the scooter assessments)... are way low on the priority scale... if these*

other funders have their own OTs we wouldn't be overloaded with those requests.

A non-occupational therapy participant expressed what she heard from some occupational therapy colleagues who said about the time they spent on scooter assessments. The occupational therapists expressed that the time could have been better used with other clients.

NOT3: ...I know they (the occupational therapists) get a lot of referrals from people for scooters. ... I've heard a couple of the OTs say that the referrals for scooters are taking up their time that could probably be better used with other clients...

Home health occupational therapists were perceived to be experts in assessing clients' needs due to their extensive knowledge base, holistic approach, strength-focused approach and the excellent observation skills. In home health, they were seen as experts particularly in the area of transfers and power mobility management.

4.1.2 Sub-Theme 1B: Occupational Therapists Assess the Interrelationships of all Performance Components

Both non-occupational therapy and occupational therapy participants stated that occupational therapists assess clients' performance components such as physical, cognitive and emotional status and their physical environment; however, non-occupational therapy participants did not seem to be aware that occupational therapists assess the interactions among different performance components. Examples provided by non-occupational therapy participants revealed that they recognized occupational therapists for assessing different components as separate entities.

Assessing the clients' physical status

NOT2: ... (the occupational therapists) going out and assessing **physical needs...and** determine if they (the clients) need certain devices in regards to...**strengthen their upper body.**

Assessing the clients' cognitive status

NOT2: ... what I really appreciate as a case manager is their (the occupational therapists') ability to look at a **client's mental capacity** ...

NOT3: ... I think they (the occupational therapists) have a huge role in just the **cognitive assessment skills...** as nurses, we don't have that expertise in assessing cognitive deficits...

Assessing the clients' emotional status:

NOT1: it's also **psychosocial factors that they look at...** they're **looking less at psychiatric tools** that might be used in mental health is a different thing...

Assessing the clients' physical environment:

NOT3: We can authorize a sponge bath but the OT (occupational therapist) has to make sure that **it's (the environment is) actually safe** for that home support worker to be providing that, that task...

NOT1: ...looking at the **environment, making it suitable** for the client based on their needs...

NOT2: Do they (the clients) have insight into their care needs or, you know, if the clients can deal with the **"what-ifs" (situation) in a home environment...**

Occupational therapy participants also expressed opinions that occupational therapists assess clients' physical and cognitive status, yet they pointed out that occupational therapists usually assess clients' physical and cognitive status in relation to their environment and occupation. Although the non-occupational therapy participants showed appreciation of occupational therapy assessment, they did not seem to be aware of its complexity.

A non-occupational therapy participant attempted to explain the complexity of an occupational therapy assessment yet his explanation appeared to be abstract and lacking details.

***NOT 1:** the OT was assessing an actual client... she had taken **the details of the situation and applied theory direct(ly) to it (.)** By citing it(the client's situation) and the model and how it fit in there (the model) and then moving it along through the therapeutic intervention, it... flowed very smoothly **which was what was so impressive about it (the occupational therapy assessment)**...*

Occupational therapy participants explained how they assess the relationships of the person, environment and occupation. An occupational therapy participant stated how she assessed a client's physical ability in relation his function.

***OT2:** We (The occupational therapists) look at... transfers and mobility but... where our expertise comes in is the equipment for one thing and.. **just being able to...see how the physical abilities of a client affect the function** (is another thing)"*

Another occupational therapy participant provided an extensive amount of details in her clinical reasoning process. During her assessment, she evaluated the interrelationships among all aspects of a client, the client's environment and the activities that the client performed.

***OT3:** Ok so what I do is (that) I assess **how a person moves**. I look at them if they're **physically, cognitively**, in terms of how they're thinking, decision making. I look at how their energy levels and other physical aspects. I also look at the **environment**, so there's a number of things. I look at the **person**...whether it's their physical, their vision, their cognitive, their thinking, decision making...I also look at the environment for safety, if there's fall hazards, if there's carpet, other things or if nightlights are needed in places, you know,(for) fall prevention...If someone has difficulty with... getting up and down from the toilet because they're weak, they've got lots of pain...(I will)...**make appropriate recommendations considering the person**...(such as) their height, their size, their weight and **how they move but also the environment**, so considering the space, the toilet and...equipment considerations that need to be taken into place and then making my recommendations to the client and their family...*

The same occupational therapy participant also provided another example of how the same clinical skill of analyzing the relationships among the person, environment and occupation was applied in a power mobility assessment.

OT3: To assess some person's power mobility, (the occupational therapists consider) the client... in their own residence... we assess (if) this person can use a power wheelchair safely and appropriately to get to meals...we look at people, their vision, their thinking...we test a person's cognition or visual, perceptual or their physical skills...

While all participants appreciated the occupational therapy assessment, non-occupational therapy participants did not seem to be aware of how the occupational therapists evaluate the interrelationships between the person, environment and occupations during the assessments.

4.1.3 Sub-Theme 1C: Current Scope of Practice is Often Limited to Self Care

Although occupational therapy participants claimed that they address all aspects of occupation in home health, examples provided by both groups of participants indicated that home health occupational therapists mainly focused on self care in their practice.

Non-occupational therapy participants used the terms “*function*” and “*ADLs*” (Activities of Daily Living) when they explained what home health occupational therapists assessed. From the examples provided by the non-occupational therapy participants, they appeared to refer to mainly self care, which is one of the three main occupations that occupational therapists address.

NOT1: They (The occupational therapists in Home Health) do functional assessments and seating assessments.

*NOT2: Doing **assessments** and whether or not they're able to manage how **they function**...how do they manage to **run their home**...Help them with **their daily livings** as well as, you know, can they **manage a cheque book**?*

*NOT 3: ...**mouth care**, that kind of thing, you know, enabling them to **brush their own teeth**, something as simple as that or **brush their own hair**...*

Compared to the non-occupational therapy participants, occupational therapy participants used more terminology to express what they assess. The terms included functions, Activities of Daily Living, Instrumental Activities of Daily Living, self care, productivity and leisure. One of the occupational therapy participants articulated that home health occupational therapists practice in all three major occupations including self care, productivity and leisure.

Interviewer: So when you say model of practice, what are the things that the OTs would look at in home health? ...What are the main areas that they would consider in their practice?

*OT3: There's the **self-care, productivity, leisure**...**They're applied in our practice** in how we assess, how we look at things, our interpretation (and) our recommendations.*

Although the occupational therapy participants' language indicated that they perceived home health occupational therapists address all three aspects of occupations, all examples given by the occupational therapy participants were related only to self care.

*OT1: Their primary role...is **ensuring safety in the home**. So there's a lot of bathroom assessments, equipment assessments in the home to make sure that clients can **safely carry out their ADLs** and that **community health workers can safely assist them doing their ADLs**...*

*OT2: Well we (the occupational therapists) start off with **our functional assessment** and we look at...**the personal care** aspect like if the client can manage their **bathing, toileting, dressing, grooming**...and then I actually see the client do the **transfers**...(I assess) all the transfers and **mobility** in the home, look at the stairs and ... their **IADLs** meaning the **instrumental activities of daily living** (such as)... **house cleaning, laundry, financials, grocery shopping, transportation**... just making sure that they can manage the day to day activities.*

Despite occupational therapists' scope in self care, productivity and leisure, all participants stated that the current scope of occupational therapists' practice is limited to self care in home health.

4.1.4 Sub-Theme 1D: Occupational Therapists are Experts on Assessing Cognition but are Limited to Focusing on Physical Status

Non-occupational therapy participants stated that occupational therapists are experts in cognitive assessments; however, occupational therapists are usually limited by the system to assessing physical aspects of clients' function only. The non-occupational therapy participants expressed that occupational therapists' cognitive assessments are helpful for the non-occupational therapy professional practice and would like to see occupational therapists conducting more cognitive assessments.

***NOT1:** Cognitive assessment is a useful thing for the teams to have the OTs do that and then it becomes...a formalized thing as they actually go through each factor in the cognitive test and explain what they(the clients) did in each one and ...why they did poorly on it.*

***NOT3:** ... their (the occupational therapists') cognitive screening would help to assess client safety as far as them (the clients) staying in their current environment. I think it would... help the case managers in making a decision about placement or which level of care the client is required*

A non-occupational therapy participant reported that occupational therapists are good at conducting cognitive assessments, yet he perceived that the occupational therapists do not do them in home health.

***NOT1:** I've talked with adult guardianship people (people who help clients with the adult guardianship investigation)... that in the hospital...they (the occupational therapists) do these cognitive assessments and they don't do them typically in the community... The social workers do them but OTs (occupational therapists) have actually had some specific training on it, I believe.*

Another non-occupational therapy participant stated that the priority for home health occupational therapists is usually provided to clients' physical needs rather than their emotional or cognitive needs.

NOT3: I think... it's...within home health... the immediate priority is ... falls risk, making sure ...it's (the environment's) safe and looking at ... more the physical aspect and not...the... emotional or the mental aspect.

Occupational therapy participants also perceived that occupational therapists are the most appropriate professionals to assess clients' cognition. They recognized the importance of cognitive assessments for providing a comprehensive understanding of clients' cognitive status to the interprofessional teams. They were also aware of the increased need of cognitive assessments in home health as the population ages.

Unfortunately, due to the time constraints, occupational therapists in home health are limited to conducting cognitive screens only as opposed to cognitive assessments.

OT 1: Well the funders trust OT's assessments... Their cognitive assessments are critical to support both ... the health and safety of clients. Case managers, the doctors and funders rely on that cognitive assessment... I don't know anyone else who does such a thorough cognitive assessment. Their cognitive assessments really help us to know how to manage the client better, so they're a real asset to the team as we (the case managers) try to figure out how best to create an effective care plan for a client.

OT2: I think that part (cognitive assessment) is critical. We see a lot of aging clients, (clients with) dementia or (with)... cognitive issues like memory issues... we don't know if... what and how significant it is, how and how much it is impacting...their functions. So if we get more concrete idea of where they're at cognitively, I think it would be helpful in terms of helping the family ... (or)... the client (to) understand where they're at and planning for the future.

OT2: ...(the home health occupational therapists) we look at cognition such as orientation, comprehension, insight. It's not like a formal cognitive assessment that we do... sometimes I do the MMSE which is a mini-mental. It's quick and it gives us an idea where the client is at in terms of cognitive functioning...

OT2: *it was my interest ...to actually have a bit more time to do cognitive assessments... I think that's a valuable part of assessment that we kind of skim over 'cause we **don't have enough time** usually, right, **to go into more depth...***

Although all participants recognized the clients' need for cognitive assessments and the occupational therapists' expertise in fulfilling the needs, the home health occupational therapists' scope of practice was sometimes limited to addressing mainly the physical needs of clients.

4.2 Theme 2: Occupational Therapists are Excellent Collaborators

Participants reported that occupational therapists are good at collaborating with clients and interprofessional teams to provide health services. The occupational therapists' strong collaboration skills are important assets in identifying clients' needs.

4.2.1 Sub-Theme 2A: Occupational Therapists Partner with the Clients in Providing Health Services

Participants perceived that occupational therapists are able to practice client-centredness in home health. The non-occupational therapy participants acknowledged that home health occupational therapists focus on clients' goals and empower clients to make decisions in regards to their care.

NOT2: *Yea... I do think (that) they (referring to the occupational therapists) are client-centred... (They consider) what's best for the client and... **what are the client's goals... what is it they want?** The clients may want to live at risk so how do they (the occupational therapists) help (to) support them so they're not at a greater risk to themselves and/or to others... how do we **mitigate some of the risk...***

A non-occupational therapy participant with a nursing background shared her observations that occupational therapists in home health are more effective in implementing client-centredness than nursing professionals. She shared her personal struggle with "letting go" to allow clients to live at risk and acknowledged that this

struggle may have come from her professional background which is nursing. She reported that occupational therapists are usually better with allowing clients to make decisions about their care even though their choice may put their health at risk.

***NOT3:** Well I think OTs probably grasp... client-centred practice extremely well as far as allowing the client to direct their care 'cause... sometimes I get... frustrated by people (clients) and seeing that they... may not be necessarily getting better or they may not be... following through with recommendations so I get frustrated by that...But I find with **any of the rehab (including occupational therapists)**, it seems like they're a **little more ok with letting go** of that and maybe... saying to the client, these are your options, this is...what I can do for you, what I can't do for you...I don't know if it's (because I am) a nurse, (and) it's different...or maybe it's just me...I've had a harder time of letting go of the ... control of the situation as far as seeing that things could be better for them but it's...ultimately their choice to make"*

Occupational therapy participants acknowledged that occupational therapists implement client-centred practice in home health. They reported that occupational therapists are good at empowering clients to self manage their health conditions.

***OT1:** OTs have the skill set to... empower clients to engaged in **chronic care management, self-management of chronic care** but they don't... I don't think they (the occupational therapists) maximize their skills. **They don't have an opportunity** to exercise that because of workload.*

Occupational therapy participants reported that they partner with clients to identify the clients' goals and provide them with resources to make decisions about their own care.

***OT1:** They (the occupational therapists) look at **what's important to the client**, not what we (the health care professionals) think is important. So they look at the client's values and match it up with their needs.*

One occupational therapy participant stated that home health occupational therapists tend to respect clients' decision about their health even though the decision may conflict with the occupational therapists' recommendations.

OT2:** In home health, respecting the client's choice is important. You know, we make **recommendations and sometimes they (the clients) tend not to follow through** and it's **respecting** that they're in their home that they have the **right to

choose ultimately. You can make your recommendations but they don't always have to follow through. So it's kind of letting go.

In home health, occupational therapists were observed to practice client-centredness by engaging clients in identifying their care needs and respecting the choices they make for their care.

4.2.2 Sub-Theme 2B: Occupational Therapists are Great Collaborators with Other Health Care Providers

Not only occupational therapists were seen to be good at collaborating with clients, they were also perceived as being strong team players who work closely with other health care professionals according to the non-occupational therapy and occupational therapy participants.

The non-occupational therapy participants expressed that home health occupational therapists have an extensive knowledge background and a holistic perspective that allow them to understand other health professionals' practice. A non-occupational therapy participant expressed her perception that home health occupational therapists are well-positioned to liaise with other members within the interprofessional health teams.

***NOT1:** they're well positioned to be able to communicate with everyone because they've had the same kind of medical training (with the nurses) and ...they're part of...the rehab team with PT (physiotherapists)...*

The occupational therapy participants reported that occupational therapists are trained to be collaborators. One of the occupational therapy participants emphasized that client-centred practice and care management approach have long been in the school curriculum for those who were educated to be occupational therapists.

***OT1:** OTs are trained to be client-centred and they're trained to be collaborators. They look at the whole picture... That (client-centred practice)*

was the training way back when I graduated in 1981 and yet it's coming out that client-centred practice or care management is like a new idea for the other health care professions ... we've been there for a long time and I think the OT's potential hasn't been tapped yet.

Two other occupational therapy participants provided examples of how they have been collaborating with different parties internally and externally for coordinating clients' care in their daily practice.

OT2: Well, we liaise with a lot of people. Our internal team, we liaise with the hospital, vendors, clients of course, family members...so we spend a lot of time talking with people... and of course we see the client in the home too

OT3: We liaise with other health professionals whether they're in our own home health office, hospital, in care facilities such as assisted living, the clients, their families, we provide recommendations...

According to the participants, occupational therapists' education together with their understanding of other professions made it easier for them to liaise with other health providers in their daily practice.

4.3 Theme 3: Occupational Therapists are Good at Rehabilitation, Despite being Limited to Using Equipment as their Major Interventions.

Occupational therapists are good at rehabilitation; despite being limited to using equipment as their major interventions.

Both the non-occupational therapy and occupational therapy participants perceived that occupational therapists have the expertise in providing rehabilitation to remediate clients' health conditions; however, in the current home health practice context, occupational therapists are often limited to equipment interventions that compensate for clients' disabilities.

4.3.1 Sub-Theme 3A: Occupational Therapists are Good at Rehabilitation

All participants expressed that occupational therapists should use their expertise in rehabilitation to remediate clients' physical and cognitive status and maximize their potential. The non-occupational therapy participants acknowledged the importance of occupational therapists providing rehabilitation to the clients in home health. Through rehabilitation, occupational therapists can help clients relearn, or enhance, the skills that are lost or deteriorated. Rehabilitation can increase clients' confidence and skills in performing the activities and prevent them from further deterioration.

***NOT1:** I like **the rehab (rehabilitation) focus**. I think there's not enough done on it (by the occupational therapists in home health)...sometimes people get older and they're just left to stay at a certain level of immobility...they need to learn how to improve their mobility... Some people have to **relearn how to swallow** after they've been on different feeding (interventions). (The support to assist clients') adapting new ways (of feeding) are limited ...*

***NOT2:** I think being able to go and see the client on a regular basis for a while in order to help the client **to build confidence in what's been given to them**, whether it be **an exercise or a cognitive exercise is important**.*

Occupational therapy participants stated that occupational therapists in home health would like to increase their involvement in rehabilitation. According to an occupational therapy participant, occupational therapists currently provide a certain degree of rehabilitation in home health; however, the amount of rehabilitation is very minimal due to limited time and resources. Before the introduction of rehabilitation assistants, only those clients who had family support could receive rehabilitation.

***OT3:** There was a client who has a daughter then I might... do the initial assessment... and develop a plan with the client. What I might suggest is that the person start out with something simple (like) making (something), which...does not require any electrical appliances...maybe it's buttering bread...**breaking down to a simple level that the client can be successful at and then to try and gradually develop complexity**. So ... I'll make suggestions to the client and the daughter... for this week (to) trial this and this and I may make*

*recommendations as to how the daughter can help the mother but this... works well if someone has a daughter. If it's just the client on their own, sometimes there's home support services but they are designed to help set up the meals. **They're not there to provide rehabilitation or help a person relearn or... that is very difficult to do that (provide rehabilitation)...***

Occupational therapy participants acknowledged that rehabilitation assistants are great resources to support home health occupational therapists for providing rehabilitation service in a home setting.

***OT2:** I would like to see more clinical time (for)... more intervention. **I do a lot of assessment but there's not a lot of time sometimes to do the intervention...** if we see a stroke client we don't have a lot of time to practice, now that we have a **rehab assistant** that's different but we... previously... didn't have a lot of time to **practice dressing, life skills and power wheelchair training.** Like I said, **now it's a bit different that we have an assistant** which is very helpful...*

OT3:** Looking ahead as you are probably aware that rehab (rehabilitation) assistants are coming. So that's a...role change opportunity for occupational therapists. So **what can you do more** when you have rehab assistants come into our practice depending on the funding. Our scope of practice may be able to **expand to include rehab (rehabilitation) services.

Both non-occupational therapy and occupational therapy participants stated that home health occupational therapists are good at remediating clients' health conditions but are currently not doing enough in this area. With the introduction of rehabilitation assistants in home health, occupational therapy participants stated that they may be able to provide more skill training to maximize clients' potential.

4.3.2 Sub-Theme 3B: Current Interventions are Limited to Equipment Interventions

Although rehabilitation was perceived to be an important intervention strategy, all participants identified equipment to be the most frequently used occupational therapy intervention in home health amongst all strategies. During the interviews, both groups of

participants often mentioned equipment when they talked about the roles of home health occupational therapists.

When participants were asked what occupational therapists do in home health, responses from both the non-occupational therapy participants and occupational therapy participants were very similar. They stated that equipment intervention is the major part of what home health occupational therapists do.

***Interviewer:** What do you think the occupational therapists do in home health?*

***NOT3:** ...do in home health? Ok, yeah...so **equipment needs**... yeah I think that covers it.*

***Interviewer:** ...can you tell me what the OT (occupational therapists) in home health do...?*

OT2:** Oh...**equipment is a big part of it.

Non-occupational therapy participants strongly associated equipment with the occupational therapists in home health. They stated that a key role of the home health occupational therapists is to determine clients' needs of equipment and make sure they obtain the equipment.

***NOT2:** ... (the occupational therapists) **determine if they (the clients) need certain devices** in regards to eat or exercise to strengthen their upper body... they also **assess for wheelchair**... for skin integrity, they (the occupational therapists) are determining if they (the clients) **need certain cushions, air mattresses**...*

***NOT3:** ...**making sure that they've (the clients have) got equipment** in the shower and in some situations...*

These examples show that non-occupational therapists might see equipment intervention as the only one type of intervention strategy offered by the occupational therapists.

Another great example provided by a non-occupational therapy participant further confirmed the strong perceived association between equipment and occupational therapists in home health. Even though the non-occupational therapy participant was not

completely aware of how the roles of occupational therapists related to footwear, she still related footwear to the occupational therapists' practice simply because footwear is a piece of equipment.

NOT3: Someone with diabetic foot ulcers will be referred to the OT for assessment of proper footwear... I really don't know as far as OTs and footwear and that I really don't know what their scope is on that...

While non-occupational therapy participants stated that home health occupational therapists assess clients' need of equipment, occupational therapy participants emphasized that they assess clients' function and only use equipment as one of the intervention strategies. Due to the lack of therapeutic time, home health occupational therapists are limited to recommending equipment as a quick solution for clients' issues.

The occupational therapy participants stated that home health occupational therapists analyze clients' function before offering clients any equipment.

OT2: I know that when the case managers, physios (physiotherapists) go out... they also ask the same type of questions and look at transfers and mobility, but I guess where our (the occupational therapists') expertise comes in is the equipment for one thing and being able... to see how the physical abilities of a client affect the function is another thing...

Some occupational therapy participants expressed that even though occupational therapists have diverse intervention strategies, they often have very limited time for interventions in home health. They could only apply a quick compensatory approach, which is to recommend equipment for clients.

OT2: I do a lot of assessment but there's not a lot of time sometimes to do the intervention...So we look at equipment that can remediate some of the problems

OT3: What we (the occupational therapists) do now is (to) identify what the problem is, what they're able to do, not able to do... we may see a person a

couple of times, maybe make some visual reminders in the kitchen and things like that but we don't spend weeks with that person. We can't spend three times a week...for two weeks or six weeks to help a person gradually (regain their function). .. We're not able to spend that amount of time.

OTI:** Clients are sent home but they can't get out of bed on their own so they've got to get in there quickly and provide bedrails or they've got to get a handy-pole in place or a lift in place. They have to teach the community health workers how to use the lift so that transfers can be happening from day one. They set up Red Cross temporary loan equipment and then do the paper work to apply for funding for longer term equipment, the purchase of equipment. Their **real skill set is education around energy conservation and doing things in a different way but they often don't have the time to get to that... it's primarily that quick intervention upfront.

The non-occupational therapy and occupational therapy participants had a different level of understanding about the home health occupational therapists' roles with clients in regards to equipment interventions. Both expressed views that occupational therapists assist clients with acquiring equipment and educating clients and caregivers about the use of equipment; however, the two groups of participants had a different understanding about whose role it is for installing equipment for clients.

One of the non-occupational therapy participants explained how occupational therapists advocate for clients' equipment needs by searching funding and writing justification letters to the funding agencies to support the clients' needs.

***NOTI:** they've helped link the client with those things (equipment) and **looking for funding through the Ministry** or different things. I've seen examples where the OTs have **written letters to Rotary club** and that for funding for something that wasn't covered by other funding agencies.*

Some non-occupational therapy participants were unclear on whether occupational therapists in home health actually install equipment for clients. One of the non-occupational therapy participants thought that home health occupational therapists actually install equipment at home while the other one was unsure.

NOT1: *They (The occupational therapists) regularly put in grab bars and I've seen quite elaborate ones that have been put in where they've put in **big tracks to move clients** around through the apartment... I've seen that they put in the actual grab bar. I know that they've **actually taken a screwdriver and then installed it onto the wall...***

NOT3: *...I'm not sure...**who installs it (the equipment)**. Is it **our OT** or is it the supplier who installs the equipment? That I don't know.*

An occupational therapy participant articulated occupational therapists' roles in equipment intervention in home health upon completion of a functional assessment. She also confirmed that occupational therapists in home health do not install equipment. In fact, the vendors install equipment for clients in home health.

OT3: *Equipment considerations need to be taken into account and then **making my recommendations** to the client and their family, if there's a family, explaining what it is, then **trying to get the resources as to how to obtain that equipment**. So it might be through a program (to obtain the)...equipment on a loan basis ...if there is a vendor... I send paper work off ...to the contracted vendor, **the vendor will provide that equipment and deliver it and set it up, install it safely for the family** and... I will do **follow-up** after the equipment has been delivered to make sure that it fits and works correctly.*

In home health, personal care may not always be managed by clients and their family members. Some clients require support from the home support workers who provide personal care assistance to clients in a home setting. There are many opportunities for home health occupational therapists to work with home support workers. All participants recognized that occupational therapists have an important role to teach home support workers how to properly use equipment with the clients.

NOT3: *For clients who are non-weight bearing and need special lifts, they (the occupational therapists) **train the home support workers how to use that equipment** whether it's a ceiling lift or a transfer board.*

OT2: *Like **training the CHWs**, the occupational therapists **train the family on how to use a lift, applying the sling**, showing them how to use the correct loops and positioning the wheelchair.*

4.4 Theme 4: Non-Occupational Therapists Have Difficulties Understanding the Role of Occupational Therapists

All participants expressed that the non-occupational therapists in the team have challenges in fully understanding occupational therapy service. During the interviews, both groups of participants reported that there are discrepancies between the perceived role of occupational therapists from the occupational therapists' perspective and that from the non-occupational therapists' perspective. The non-occupational therapy participants expressed opinions that occupational therapists' roles are not completely understood by other health professionals within the team. This finding is supported by Theme 1 which reveals that non-occupational therapists are not aware of the complexity of the occupational therapy assessments. They may not understand that occupational therapy assessments involve evaluation of the interrelationships between different aspects of the person, environment and occupation. One of the non-occupational therapy participants admitted that she is not fully aware of the roles of occupational therapists and there is no time to learn more about it.

***NOT3:** I think we really do not understand each other's roles or us not understanding OT role and I'm sure their role has changed over the years too cause I know there's lots of talk about working to full scope in the health authority with all disciplines...I hear it all the time with nursing but I'm sure that's true of OT..., historically they're expected to have a certain role and that's changed... I just find that there's **no time for discussion** (about each others' roles)*

According to the non-occupational therapy and occupational therapy participants, some of the reasons that contributed to the difficulties in understanding occupational therapy include decreased insight about the discrepancies in the role perception; role overlap with other health professionals, nursing dominated practice context and the occupational therapists' difficulties with articulating their service.

4.4.1 Sub-Theme 4A: Limited Insight about Role Perception Discrepancies

Non-occupational therapy participants reported that some of the non-occupational therapists have a lack of insight about the discrepancies in the perception of occupational therapists' roles between the non-occupational therapy participants' perspective and the occupational therapy participants' perspective. Even if they are truly aware of the knowledge gap, they may not know how to gain the knowledge that they miss to help them to better understand occupational therapy practice.

The perceptions of knowing what each other does in the interprofessional health teams can become a barrier for health professionals to get to know each others' roles. One of the non-occupational therapy participants perceived that occupational therapists perceive their roles the same way she does.

Interviewer: So...do you think the home health OTs perceive their roles the same way as you do?

NOT2: I would not know that.

Interviewer: Take a guess.

NOT2: I think they would...

An occupational therapy participant stated that some health professionals are aware of their roles and some are not.

Interviewer: Do you think other health professionals in your team perceive home health OTs' roles the same that you do?

OT2: I think some do and some don't but I think sometimes it comes down to the person as well... It's a personal connection with that team member... (if) you have a good relationship then I think there's a lot more respect and...cooperation.

Even if the home health professionals stated that they know other members' roles, whether they truly understand the roles is a question. A non-occupational therapy participant who was a social worker explained that most home health professionals think that they know other peoples' roles but they do not truly understand them. He used

social work as an example and explained how their roles always get misunderstood. He expressed that occupational therapists are like social workers in home health whose roles are not fully understood by others in interprofessional home health teams.

***NOT 1:** We're all provided a superficial explanation on what each discipline knows and ...during committee meetings, there was this thing that came up, people thought: well we don't need to include social work 'cause everyone knows what social work does but everyone doesn't know what social work does... there's a famous expression used by one nurse that we often cite: What I want from social work is housing and finance, housing and finance, nothing else. Those are not our roles at all, that's what a perceived role is...*

The social worker explained that the assumption of knowing each others' roles can become a barrier for interprofessional team members to take the initiatives to learn more about other peoples' roles.

***NOT1:** I can also imagine that the perception of us knowing what other people do but we might not. It can also be a barrier for us to get to know exactly what each other is doing and working in an interprofessional team in an efficient manner.*

Even if some of the health professionals are aware of the knowledge gap regarding the roles of occupational therapists, they may not know how to learn more about the occupational therapists' scope of practice. One non-occupational therapy participant confirmed this by expressing "you don't know what you don't know".

***NOT2:** I think OTs are probably are capable of doing more but we don't know what they are capable of, what they can do... or we don't ever ask... We don't even know how to explore asking the questions...*

The non-occupational therapists' lack of insight about their limited knowledge in the roles of occupational therapists can be a barrier for them to further understand the scope of occupational therapy practice in home health.

4.4.2 Sub-Theme 4B: Role Overlap with Physiotherapists

All participants stated that in home health the roles of occupational therapists sometimes overlap with the roles of other home health professionals. Amongst all health professionals, the roles of physiotherapists appeared to be the most similar to that of the occupational therapists. All participants acknowledged that this overlap can cause confusion for the non-occupational therapy participants that they came up with their own way of distinguishing the two practices. Their methods of differentiating occupational therapy and physiotherapy might not always be accurate.

Both groups of participants indicated that the roles of occupational therapists overlap with that of the physiotherapists in home health. They described that both professions assess clients' physical status and recommend equipment that may be confusing for other health professionals to differentiate the two practices. One of the non-occupational therapy participants stated:

***NOT2:** They (both physiotherapists and occupational therapists) do **assess physical functions** so... in that way there's an overlapping in regards to physical function... they both **order equipment** and that sort of thing.*

However, this non-occupational therapy participant perceived that physiotherapists can better address client's physical status and the reason for occupational therapists to address the clients' physical status was to add variety in their practice.

***NOT2:** Maybe it (**addressing physical function**) helps to **keep their (occupational therapists') practice more current** and.. in ways that they **normal wouldn't have been...** if you only had PTs... running out and doing it and... OTs just doing cognitive, then... and some OTs don't like to do cognitive..., I'm sure that could be quite boring after a while. So it **adds diversity** in what they can do for a client...and keeps... their practice current*

Even occupational therapists themselves admitted the overlap. An occupational therapy participant pointed out the similarities between occupational therapy and physiotherapy practice in home health.

***OT2:** (With) the physio (physiotherapists)... there's a...closer overlap... what we look at is... quite similar in terms of **our functional assessments...** but what they(the physiotherapists) do is **prescribing the exercises and looking more specifically at getting the client better with their balance or mobility...** but our overlap is that we can prescribe the same type of equipment and **we do a bit more of the special (equipment like)...** the lifts and the power chairs, wheelchairs, that type of thing.*

The similarity between the roles of occupational therapists and physiotherapists create confusion and difficulties for the interprofessional team members to understand the occupational therapists' roles.

4.4.3 Sub-Theme 4C: Nursing Hierarchy in Interprofessional Home Health Practice Context

The non-occupational therapy participants reported that home health is a nursing dominated practice context in which most of the health professionals are nurses who appear to hold more power than the allied health professionals do. The occupational therapy participants did not particularly mention about the hierarchy but had provided some examples of challenging situations in practice that appeared to be related to the nursing hierarchy. The details of those examples will be found in Section 4.5.4.

The reported role overlap between occupational therapists and case managers by the non-occupational therapy participants can create some tension and frustrations that lead to power struggle between the two groups of health professionals.

***NOT2:** We both (the case managers and occupational therapists) **put in home support, we both do some sort of care plan, referrals, ... home visits...**Some case managers are all about, **this is mine, (and ask the occupational therapists to get their) ... hands off...**If they (the occupational therapists) authorized some extra hours or they've actually altered a care plan...and some case managers*

feel... an ownership... it can create some barriers for ...a more collaborative practice between an OT and a case manager, you can see ...a bit of a power play.

Non-occupational therapy participants perceived that in a nursing dominated context allied health professionals such as occupational therapists are perceived as having less power. One of the non-occupational therapy participants expressed his perspective on how nurses are perceived to have a higher status than the allied health professionals do. He advised the occupational therapist to “*be a professional, not an allied health professional*”.

NOT1: *You know, from a nursing perspective they're the dominant kind of health thing. OTs are considered only paraprofessionals so they are only called allied health, they're not true health, from that medical... model...which is largely a nursing and a medical model. So from a nursing perspective you might see OT as a subset of nursing because they're a dominant role but that may not be true in how it would function best...It's almost like you're the allied health person or the assistant or, or a servant for another discipline.*

Home health was perceived to be a nursing dominated practice environment in which the occupational therapists appeared to have less power.

4.4.4 Sub-Theme 4D: Challenges in Advocating for Occupational Therapy Service

Both groups of participants perceived that home health occupational therapists have difficulties in advocating for themselves and their services. The reasons were related to the occupational therapists' difficulty with articulating their services to others and the limited opportunities for home health professionals to learn about each others' roles.

In Section 4.4.3, one of the non-occupational therapy participants mentioned that occupational therapists in home health need to advocate for themselves. The

occupational therapy participants also agreed that occupational therapists need to better advocate for themselves to management.

OT1: I think they (the occupational therapists) need to do a better selling job with management. I don't think that the leadership team appreciates them and their skill set well enough.

While recognizing the importance of marketing to management, another occupational therapy participant raised the importance of educating their colleagues and leaders about what occupational therapists need for their practice.

OT3: What words would I say to my fellow OTs to help us encourage good practice? Hmm... education, education, education....education to our colleagues or team leaders. Not to be afraid to ask for things... also ask for education for us as practitioners...

During the interviews, some occupational therapy participants appeared to have challenges in explaining their roles to others. One occupational therapy participant attempted to use different equipment recommendations to explain how the clients' issues defined by an occupational therapist would be different from those defined by a physiotherapist. The explanation was somewhat lengthy and difficult to understand. As she continued to explain how occupational therapy assessments different from others', the explanation was vague and might be difficult for other professionals to understand.

Non-occupational therapy participants perceived that they have limited opportunity to learn about each others' roles in home health due to time constraints and limited interprofessional collaborative opportunities. One of the non-occupational therapy participants stated that home health is a fast-paced practice context and the home health professionals may not see each other all the time. This may limit the opportunities for them to learn about each others' practice.

***NOT 1:** Well...we're all focused... in our areas, we're not always aware of what everyone is doing. We're in a very fast paced reality, you know, it's getting faster all the time. And people are out there... engaged in their own business in the community so you're not seeing them all the time.*

Another non-occupational therapy participant reported not only that the home health professionals have limited time to learn about each others' practice; they also have limited opportunity to collaborate. The participant emphasized that electronic documentation cannot replace face-to-face discussion to facilitate understanding of interprofessional roles.

***Interviewer:** Do you talk... with the OT about what their roles are and what your roles are?*

NOT3:** No... not a lot. I just find there's no time for discussion. I know we used to have team meetings years back and I thought it was great that we could all just talk about clients and... (who) maybe a bit more complex and all disciplines were there just to contribute so I found that was really helpful and, and that doesn't happen at all so that would be an area of improvement. I know **PARIS (the community electronic charting system) is a system that is intended for having that ability to communicate, I know we're not there yet but again, you can't always put everything in documentation, there's always so much outside of that...

Occupational therapists have difficulties articulating their service and this limits their ability to advocate for their service. Since home health is a fast-paced practice context and home health professionals do not have many opportunities to collaborate with each other, other health professionals have limited opportunities to learn about the roles of occupational therapists in home health.

4.5 Impact of Role Perceptions of Occupational Therapists on Occupational Therapy Practice in Home Health

In the previous sections, we reviewed different role perceptions of home health occupational therapists by occupational therapy and non-occupational therapy participants. In this section, we will learn about how the perceptions of occupational

therapists' roles affect home health occupational therapists' practice in interprofessional teams, which answers the second part of the research question. Four major key points are identified and will be discussed below:

1. The perceived expertise in assessment and collaboration supports an expansion of the home health occupational therapists role to include the role of care coordinators.
2. The perceived association with equipment generates inappropriate occupational therapy referrals in home health.
3. Role overlaps with physiotherapists cause strong collaboration with physiotherapists, but also inappropriate and inefficient use of occupational therapy service and missed occupational therapy referrals.
4. Nursing hierarchy and limited understanding of occupational therapy in home health hinder the implementation of occupational therapy recommendations, resources allocation to occupational therapy and occupational therapists' role expansion.

4.5.1 The Perceived Expertise in Assessment and Collaboration Supports Home Health Occupational Therapists to Expand Their Roles to Include the Role of Care Coordinator

As all participants perceived home health occupational therapists to be experts in assessing clients' needs, practicing client-centredness and collaborating with different health providers, they recommended occupational therapists expand their roles to be formal care coordinators. In the current home health setting, there are some formal care coordinating roles such as home health case managers, hospital liaisons and care coordinators. Non-occupational therapy participants suggested that home health

occupational therapists should be provided with opportunities to take on these formal roles for coordinating clients' care in home health.

NOT1:** I think they're (the leaders in home health care) going to **consider having OTs in the central intake (team) and also having them as case managers instead of just specialized as OTs because they bring their perspective into the job.

***NOT2:** This is great because we know that there's another health care professional (referring to an occupational therapist) in there who is **much more equipped on handling the clients who have just been discharged from the hospital.** For example, (for) people who have **musculoskeletal issues**, they've (occupational therapists) already set up a care plan...*

The occupational therapy participants reported that home health occupational therapists have been informally coordinating care for clients. One of the occupational therapy participants reported that home health occupational therapists have been informally practicing as "Quick Response Case Managers" for clients transitioning from hospital to home. The occupational therapists' involvement for client care coordination has been providing a relief to the case managers' workload in home health.

***OT1:** Well the unwritten (role) is that they're (the occupational therapists are) also the **quick response case managers** when people get home from hospital. So they are able to get in there quickly and set up short term home support hours before the case managers can look at the long term picture... We (the case managers) can't provide service till things are set up and the client can't get home and, and carry on function without the proper equipment in place.*

***OT1:** ...they (the occupational therapists) really **reduce the workload of case managers.** They **...really improve our (the case managers') efficiency,** they **make our job easier...** they have the right equipment in place for putting home support so **more effective** than the care that we put in... it is **more effective respite** to the caregivers. It's easier on the home support worker to provide care.*

***OT2:** You know, like really **we do a bit of case managing** as well, you know, referring clients to appropriate disciplines, professionals (such as) social work, case management, home care nursing or external agencies as well like volunteer services or a senior centre... so I feel like we do...a bit of everything*

All participants reported that home health occupational therapists should coordinate care particularly for clients transitioning from hospital to home because home health occupational therapists can conduct pre-discharge assessments. Pre-discharge assessments are functional assessments at the clients' home prior to the hospital discharge with an aim to ensure smooth clients' transitions and prevent hospital readmissions.

NOT3: *I think there needs to be **more of the OTs (occupational therapists) making those home visits prior to discharge to making sure things are set up even before the clients get home because I think then the clients will have more confidence in their ability to manage once they are home and probably prevent readmission to the hospital***

One of the occupational therapy participants also expressed that home health occupational therapists are the most qualified professionals to facilitate hospital discharge as they can appropriately identify the clients' needs.

OT1: *Well they (the occupational therapists) are **the most critical person in getting people home from the hospital... more than the case manager or the home care nurse or the physio (physiotherapist) or any discharge planning people because they're in the home. So the home health liaisons are the people in the hospital (who) are just guessing (the client's needs). It's the home OT that ensures the plan is realistic and appropriate for the client... I think in the hospitals with all this push for home, there's not nearly enough physio and OTs and I think there's way too much nursing.***

The amount of details involved in a home health occupational therapy pre-discharge assessment made a strong argument for the occupational therapists to be the most appropriate professionals to facilitate the hospital discharge plan. One of the occupational therapy participants described how she usually conducts a pre-discharge assessment.

OT2: *I usually talk with the hospital OT a bit before going out there just to get a sense of where the client is at in the hospital, what diagnosis they have, what (the) mobility is like... then we set up a time to meet with a client in the home*

*and...do the ... **functional assessment**... after the assessment, I make that **determination whether...it'll be safe or not (for the clients) coming home** and then from there I would recommend **what type of equipment** is needed, **how much home support** and **whatever else that needs to be followed up** on like med management and the meds need to be blister-packed and all ready to go, you know, or the client needs a med management program like all that needs to be sorted out before the client comes home.*

In addition to the occupational therapists' expertise in assessment, occupational therapists' proficiency in collaborating with clients and other health care team members well-positions them for a formal care coordinator role. The occupational therapists' use of client-centred approach allows them to better understand clients' needs. The holistic nature of occupational therapy practice provides them with a deeper level of understanding of other interprofessional team members' practice. The increased understanding of other health professionals' practice can probably make it easier for home health occupational therapists to refer clients to appropriate health services according to the clients' needs. Home health occupational therapists should be provided with formal opportunities to be care coordinators.

4.5.2 The Perceived Association with Equipment Generates Inappropriate Occupational Therapy Referrals in Home Health

Participants reported that the perceived association between equipment and occupational therapy creates some inappropriate occupational therapy referrals. The non-occupational therapy participants acknowledged that the main reasons for referrals to home health occupational therapy from the non-occupational therapy professionals are for assisting clients to acquire equipment.

***NOT3:** ... a lot of our (nurses') referrals (to occupational therapy) are more so for equipment. Equipment and safety, that's the bulk of our referrals to OTs.*

Occupational therapy participants stated that clients' needs related to equipment may not necessarily transcribe into a need for the occupational therapy service. Inappropriate referrals may be generated and as a result may negatively affect the efficiency of occupational therapy practice and the use of health authority's resources. An occupational therapy participant raised an example of an inappropriate occupational therapy referral received from a nurse, which was related to the maintenance of an air cushion. She expressed that equipment maintenance can be addressed by any home health professionals, not just occupational therapists.

OT3: With the nurses I might get a referral for... just going to check a ROHO cushion (referring to a type of air cushions) whereas the nurses (are) involved daily with a client. So looking at efficient use of OT's time, if the nurse is there already and they already know how to... check the inflation of a ROHO cushion, it just makes a lot more sense (to have them checking it) in terms of what the health authority's dollars in terms of time, mileage to go in...

The strong association between equipment and occupational therapy can lead to inappropriate occupational therapy referrals that may create inefficiency in the health care system and affect the quality of clients' care.

4.5.3 Role Overlaps with Physiotherapists Cause Strong Collaboration with Physiotherapists, but also Inappropriate and Inefficient Use of the Occupational Therapy Service and Missed Occupational Therapy Referrals

The perceived role overlap between occupational therapists and physiotherapists in home health leads to situations where occupational therapists work closely with physiotherapists; however, they can also lead to inappropriate and inefficient use of occupational therapy service. In home health, occupational therapists work with physiotherapists to provide services to meet the clients' needs. A non-occupational

therapy participant observed that the occupational therapists provide coverage for the physiotherapists in her office.

NOT2:** Even though that's (the referral is) with PT but because we're short in our office sometimes ... **the OTs are having to do some PT stuff.

An occupational therapy participant expressed that the overlaps of roles could enhance the collaboration between occupational therapists and physiotherapists that could possibly benefit occupational therapy practice.

OT2:** Particularly in our office , we **support each other a lot** - if one discipline (between the occupational therapy and physiotherapy) is quite swamped then we say "can you see this client?" like if there's that much overlap that if it's simple equipment, putting in home support... they (the physiotherapists) can do that as well. So, I think **that overlap in that sense is beneficial to us.

Not all referrals sent to the occupational therapists are appropriate. Some of the ways that the non-occupational therapy participants used to distinguish physiotherapy and occupational therapy service in home health brought up concerns about the appropriateness of referrals generated for occupational therapy. One of the non-occupational therapy participants reported how he distinguishes the services between occupational therapy and physiotherapy.

***NOT1:** if the OT has done an assessment of the needs of the client, the needs will be rehabilitated. The **physiotherapist may implement those** and see what kind of **exercises** are needed or support and encouragement and that.*

Another non-occupational therapy participant shared her way of distinguishing the two services:

NOT2:** PTs don't go out and do cognitive but they do assess... **physical functions...**in our office because we're so short, **whoever (between the occupational therapists and physiotherapists) can pick up that client('s referral) would pick up that client ('s referral).. I know that occupational therapists do the "hands up" /// and they (Physiotherapists) do the "waist down"

Due to the role overlap between physiotherapy and occupational therapy, some clients may be referred to one profession due to certain needs, which can actually be better served by another profession. As a result, inefficient occupational therapy practice can result when referrals are made to occupational therapy for clients who do not need the service. Missed occupational therapy referrals can result when the clients require occupational therapy service but are referred to physiotherapy instead. One of the occupational therapy participants provided an example of how a client's physical needs could be better addressed by the physiotherapists, but was inappropriately referred to the occupational therapists.

***OT3:** I may get a referral for pain management and reduced mobility. The client may need walking aids by certain healthcare professionals but... it truly is ... education (that) is required there and the client is better seen by the physiotherapist. But because we (occupational therapists and physiotherapists) both look at ambulation, it can **be confusing for some healthcare professionals** they may not know how to distinguish(ing) the differences...I would get more referrals that were not specially OT. I thought this (referral) seems a little bit more PT and why have I got this referral? So it then impacts... my time...*

The health professionals' confusions about the role difference between occupational therapists and physiotherapists could sometimes lead them to refer clients to both services to ensure the clients receive all services they need. One of the non-occupational therapy participants, who was an experienced case manager, stated her experience of referring the clients to both services.

***NOT2:** You're not sure who you're supposed to refer to so you refer to both (occupational therapy and physiotherapy). So if you could have referred just to one and get it right, that would be better...*

To address inappropriate referrals, occupational therapists could spend more time communicating with other health professionals to clarify their scope of practice and

assist other health professionals with generating appropriate referrals. One of the occupational therapy participants mentioned the amount of time spent in communicating with the physiotherapists to decide who the most appropriate professional was to see the client.

OT1: How does it affect OT practice? Well there's lots of dialogue between OT and physio and everybody has to talk to them to verify if ... a referral is appropriate. So... the OTs and physios are always tugging back and forth... not tugging they're supporting one another, it's not a negative thing at all but they're always communicating about what's appropriate...

Another occupational therapy participant reported an impact in the time used by an occupational therapist in addressing a referral that could be better addressed by a physiotherapist.

OT 3: I would get more referrals that were not specially OT. I thought this (referral) seems a little bit more PT and why have I got this referral? So it then impacts... my time...

The role overlap between the occupational therapists and physiotherapists in home health may draw them to work closely with each other; however, it also causes confusion for other health professionals that prevent them from making appropriate occupational therapy referrals. As a result of this, role overlap can cause inefficiencies in the system and decrease the quality of service provided to clients.

4.5.4 Nursing Hierarchy in Home Health and Limited Understanding of Occupational Therapy Hinder the Implementation of Occupational Therapy Recommendations, Resources Allocation to Occupational Therapy and Occupational Therapists' Role Expansion

Although occupational therapists were perceived to be experts in assessment, participants expressed that their recommendations were not always seen as important. Participants stated that occupational therapists' recommendations are not followed through in home health where there is a perceived hierarchy with which occupational

therapists are seen to have less power within the team. One of the non-occupational therapy participants perceived occupational therapist's recommendation as an appendix to support her clinical recommendations.

NOT2: *I've appreciated their (the occupational therapy) reports...so it helps to support what you were thinking but now you have some documentation that helps to support whatever it is you're wanting to do for that client...*

When there is a conflict between the recommendations of occupational therapists and that from other health professionals, the non-occupational therapy participant stated that occupational therapy recommendations are usually overridden. She provided an example when there was a difference of opinion between an occupational therapist and a case manager on the amount of home support a client required, the occupational therapist's opinion was discounted and the case manager made final decision about the client's needs.

NOT2: *“Usually, the case manager will rule over that particular situation sometimes because at the end of the day that case manager is doing (authorizing) the hours... who wants to have a fight.. I think if the case manager is inexperienced or not a collaborative type player in the game, they may fail to take the advice of the OT and use best practice deal with the issue.*

An occupational therapy participant also shared her opinions of how her recommendations about the clients' needs were not followed through by other health professionals. She felt this may put clients and caregivers at risk.

Interviewer: *do you feel that your (the occupational therapists') recommendations always get respected and followed through?*

OT2: *When I talk to them (other health professionals), yes I feel like it gets respected but the follow-through... no, not always.*

Interviewer: *So how do you feel about that?*

OT2: *It's a little bit frustrating sometimes... because you're trying to do what you can and then when the other discipline doesn't or can't then... it does put people at risk in the end.*

According to the non-occupational therapy participants, many leaders and decision makers have a nursing background, and have a limited understanding of occupational therapy practice. Therefore, some policies might have been put in place without acknowledging the occupational therapists' expertise. A non-occupational therapy participant raised a current home support extra hours approval policy as an example.

***NOT2:** if you have a... bariatric client who maybe bedridden or needs a track lift, sometimes you're needing to have two home support works in order to provide care. So, they're (the managers are) always trying to look at...how can you mitigate that so my opinion is... **if the OT or the PT says we need two home support workers we need two home support workers** cause in my opinion they're the professionals when it comes to that...I only authorize hours.*

In the current policy, the participant stated that occupational therapists are required to ask for the managers' permissions for home support exceptions even though the occupational therapists themselves are experts to determine the exact amount of home support that the clients need.

***NOT2:** I know that that's an issue that they (occupational therapists) have already gone out and spent all that time then they have to do an SBAR (a communication tool when asking for permission for home support exceptions) because even though it's (assessing transfers is) (with)in their scope of practice and that's what they say but because they've added something **out of the normal policy**, they have to SBAR. So that's more paper work that has to be transmitted up the chain to be looked at...**That's (their recommendation is) their professional judgment.** Why would they be hired to do their job? That is their job and I think if you say I need two (2-person assistance), I need two (2-person assistance)*

The occupational therapy participants expressed views that home health occupational therapists tend to receive fewer resources for staffing and equipment due to the limited understanding of occupational therapy practice in home health from the leadership team and decision makers. One of the occupational therapy participants

perceived that home health occupational therapists do not receive as many staffing resources as the home care nurses do.

OT2:** ...based on understanding of what we do and if people don't (understand what the occupational therapists do), we **may not get the funding for more staffing...** the policies might affect us negatively....they start like a pilot project of a palliative program **and we're not involved at all. We have a role in palliative care but they put more funding towards... home care nursing...** we have asked for more staffing before and it was said that there's... no more budget... to increase staffing for...rehab but then... actually a question that's never been answered. We've asked **how come there's always dollars... for home care nursing?** So they **tend to be able to hire staff for nursing but for rehab,** they actually had to take away a physio (physiotherapist's) position for a rehab assistant... **I do question how much does the manager understand our role** because we constantly say we're so backed up, we need more staff or even to hire someone casually to come in to help us out for a bit but there is no money for that so that part is very frustrating and it **feels like you're not understood, your role is not understood, like what you do maybe doesn't even matter...

Another occupational therapy participant shared her experience for not receiving adequate support from her manager and team leader for attending educational events for professional development.

***OT3:** We've been told before one paid education day per year and that is **up to the decision of management** based on workload level. In terms of our OT clinical skills... my professional opinion is that one day a year is not sufficient. We do have a number of skills and it's important to keep them up to date... because we're busy with work these are things that I... would be done in my own time...**Education day is dependent upon what the team leader's opinion is and caseload...**I don't even think we have it in home health and **they may not clear on what core courses are recommended** to keep our baseline skills up to date and supported.*

As mentioned in Section 4.5.1, occupational therapists were seen as effective care coordinators, however, both groups of participants reported that in a nursing dominated practice context, home health occupational therapists are offered very limited opportunities to do generic health care roles such as care coordinators and health care leaders. One of the non-occupational therapy participants provided an example, which

showed how the home health case manager positions are only open to nurses, but not other health professionals.

*NOT1: Just taking it as an example... Most case manager (roles) were filled by social workers and then they (were) switched to BCNU (BC Nursing Union) (which)... has (a) right in their policies that home care case management is a nursing job, not a social work job so they've gradually been taking over more and more of that and... now... which they're saying that **can only be done by a nurse... most of the managers are also nurses** so...they may be... **supporting their own (profession)**... they may not even have been doing it consciously but... their colleagues are working with them and they only... may have a narrower vision of that...*

The non-occupational therapy participant continued to emphasize that nurses may not have received specific training on case management; however, they are provided with opportunities to do the job since the leaders are mostly nurses who possess more power in the health care system.

NOT1:** The only people you have for case managers doing practicum are social worker students... and yet... **some of the offices will only hire nurses for that that job** unless they're desperate...The leadership team doesn't include other disciplines, they're all nurses. **The nurses have a lot more power than... the other disciplines and they're paid more money... those with power sometimes define what others do...

An occupational therapy participant also agreed that the leaders tend to advocate for the professional groups which they have their professional background in.

***OT1:** well in our office we have an OT as a team leader now and that's an asset because they can speak up for the OTs. For managers, we have a new manager. I think it would be wonderful if she did a home visit with an OT. **I think her background is nursing... She may not understand our practice"** (p.16)*

The occupational therapy participant stated that the home health leadership team is made up of mostly nurses. They stated that they would like to see more occupational therapists becoming leaders.

Interviewer: Other than the group of other health professionals, how about leadership team, do you think they have a good understanding of what the OTs do?

*OT1: “No I think...the challenge in leadership (is that) it’s primarily **made up of nurses** and I would like to see more OTs in leadership positions.”*

4.6 Summary of Findings

In this qualitative study, three non-occupational therapists and three occupational therapists, who practiced in interprofessional home health teams, were interviewed to help us to understand their perceptions of home health occupational therapists. Home health occupational therapists were perceived to be experts in identifying clients’ needs due to their effective assessment skills. Although non-occupational therapy participants appreciated the holistic way occupational therapists practiced, they were not aware of the complexity of an occupational therapy assessment, which considers the interrelationships amongst all performance components, occupation and environment. Home health occupational therapists were seen to be only focusing on clients’ self care and physical needs. All participants recognized occupational therapists for their expertise in cognitive assessments and would like to see them to do more of them.

The participants acknowledged that occupational therapists are great collaborators who can partner well with clients and other team members for providing health service. Despite the perception of being experts in rehabilitation, occupational therapists in home health were perceived to be often limited to doing primarily equipment interventions. The non-occupational therapists acknowledged difficulties with understanding the roles of occupational therapists due to their lack of insight into how their perceptions of occupational therapists differed from occupational therapists’ perceptions, role overlap between occupational therapists and physiotherapists, nursing

hierarchy in the context of home health and the difficulties and limited opportunities in advocating for occupational therapy service.

In home health, the way that the roles of occupational therapists were perceived made a significant impact in occupational therapy practice. Based on the occupational therapists' perceived skills in assessment and collaboration, participants recommended that occupational therapists would be good care coordinators. The strong association between equipment and roles of occupational therapists perceived by the non-occupational therapists could lead to inappropriate occupational therapy referrals. The perceived overlap between the roles of physiotherapists and occupational therapists could cause inappropriate and inefficient use of occupational therapy service.

Participants reported that there is a nursing hierarchy in home health. This hierarchy combined with the decreased understanding of occupational therapy could limit the implementation of occupational therapy recommendations, resource allocations to fund occupational therapy services and an expansion of occupational therapists' roles in home health.

CHAPTER 5 DISCUSSION

The literature showed that health professionals' role perceptions of occupational therapists have an impact on occupational therapy practice in contexts such as mental and rehabilitation health care settings (Fortune & Fitzgerald, 2009; Norman & Peck, 1999; Simpson et al., 2005; Smith & Mackenzie, 2011). This study confirmed that role perceptions also influence home health occupational therapy practice. In home health, occupational therapists appear to have the potential to widen their scope of practice; however, currently their scope of practice is limited. Our findings showed that some of the factors that might limit role perceptions and the occupational therapists' scope of practice in home health are: health professionals' lack of understanding of occupational therapy service, the predominantly nursing context of home health, and the challenges occupational therapists have in articulating the complexity of occupational therapy service.

In this section, three major points from the findings will be presented. After each point the clinical implications of that finding will be discussed.

1. Role perceptions as they affect home health occupational therapy practice
2. Proposed expanded roles for occupational therapists in home health
3. Potential barriers to occupational therapists' role expansion.

5.1 Role Perceptions as they Affect Home Health Occupational Therapy Practice

The education that occupational therapists receive and the practice context that they immerse themselves in, influence occupational therapy practice. The standards of practice guided by the provincial occupational therapy regulatory body create a basis for

what occupational therapists do and how they perform their roles in practice. The socio-economic and institutional practice environments also determine the roles of occupational therapists. The findings from this research confirmed that non-occupational therapists' role perceptions of occupational therapists can have a significant impact on occupational therapy practice in interprofessional home health teams. Role perceptions can cause limitations in the ability of occupational therapists to implement occupational goals; and inappropriate and inefficient use of occupational therapy service in home health. These limitations can significantly affect clients' care.

5.1.1 Focusing on Self Care could Limit Practice and lead to Poor Client Outcomes

All participants perceived that home health occupational therapists mainly addressed clients' self care, this perception might hinder the implementation of occupational goals that are not self care-related. Occupational therapy goals and interventions that assist clients with activities related to productivity and leisure were not reported in this study. This role perception could result in clients' occupational goals not thoroughly being addressed because clients might not be given opportunities with the home health occupational therapists to identify and pursue any needs related to productivity and leisure.

In occupational therapy, the word occupation refers to "groups of activities and tasks of everyday life, named, organized, and given value and meaning by individuals and a culture. According to Canadian Association of Occupational Therapy (1997, P.34), occupational therapists work with clients to enable meaningful occupations "including looking after themselves (self care), enjoying life (leisure), and contributing

to the social and economic fabric of their communities (productivity)”. One of the major reasons home health occupational therapists concentrate primarily on clients’ needs in self care could be the culture, mandate and philosophy of home health, which focuses on clients’ abilities to manage activities of daily living. Clients who have difficulties managing their self care usually have higher health care costs than those who do not. Since both human and financial resources are scarce in home health, and self care is considered to be the most basic and necessary type of occupation, clients’ ability to take care of themselves is usually the main focus for occupational therapists working in home health (Flowers et al., 2011; Toto, 2006). Client-centred care is at the core of occupational therapy practice and it has been proven to be an effective way to achieve better health outcomes (Black, 2005; Sumsion, 2005). The overemphasis on clients’ ability to take care of themselves in the health care system could create a challenge for occupational therapists who strive to deliver client-centred care, if clients’ stated goals do not match with the team’s values and beliefs. The study findings are similar to those of Egan et al. (2010) and Fortune & Fitzgerald (2009) who found occupational therapists had difficulties implementing client-centred occupational goals when the medical model guided the approach to care within a service. For example, in home health, if clients’ goals are related to productivity and leisure, it is unlikely that these goals will be supported by the interprofessional teams. It is questionable whether home health decision makers, management and other health professionals are aware that occupational goals can be a way to optimize clients’ function and an outcome that indicate improved occupational performance. Limiting occupational goals to only self care could prevent

clients from achieving their optimal health status and their capacity to maximize their functional abilities.

Clinical Implications

Occupational therapists need to educate home health decision makers, management and interprofessional teams about the broad definition of occupation and how occupation can be used to improve client outcomes. It is important for interprofessional team members to understand that occupation includes self care, productivity and leisure, and all of these occupations can be used to maximize clients' function and occupational performance. Home health decision makers and teams need to understand that productivity and leisure are not "luxuries" in the health care system, but are valuable contributions to improving clients' health outcomes. Home health occupational therapists are encouraged to consider clients from a holistic perspective and look beyond their self care needs.

5.1.2 Role Confusion can lead to Inefficient Practice and Inappropriate Client Services

Confusion about the roles of occupational therapists expressed by non-occupational therapy in home health could create inefficient and ineffective occupational therapy practice, which negatively affect clients' care. One example of this is role overlap. The findings indicated participants perceived that there is a role overlap between occupational therapists and other health professionals in home health, and in particular physiotherapists. This is similar to Smith & Roberts (2005) who reported that rehabilitation managers, occupational therapists and physiotherapists in a mental health setting identified role overlap between occupational therapists and physiotherapists. In

addition, Boutin-Lester & Gibson (2002) and Smith & Roberts (2005) found that clients are confused about the roles of occupational therapists mostly due to the role overlap with physiotherapists. Our findings aligned with their findings and showed that the similarities between the roles of occupational therapists and physiotherapists confused members in interprofessional home health teams. Both occupational therapists and physiotherapists address clients' physical needs and they usually use equipment as interventions. The similarity leads to the perceptions that the two professions are interchangeable. This may negatively affect clients' service as the non-occupational therapists may refer clients to one profession for certain needs that may actually be better served by another profession. For instance, physiotherapists specialize in gait analysis and training and might be better to help a client who has difficulty with ambulation after a stroke. If a client's difficulty with ambulation is due to the cognitive challenges, occupational therapists may be the more appropriate professionals for addressing this need as they are experts in assessing cognition. In some complex situations where the challenges of ambulation are related to multiple factors, the client may be best served by both occupational therapists and physiotherapists. The lack of role clarity can lead to clients not receiving appropriate health service that they need and deserve. Some health professionals try to refer clients to both physiotherapy and occupational therapy when they are unclear about the difference between the two professions which can cause inefficiencies in the system.

Clinical Implications

Home health professionals require a clarification on the difference between the roles of occupational therapists and physiotherapist in home health. Guidelines need to be developed and implemented immediately to assist other health professionals with generating appropriate referrals to occupational therapy and physiotherapy. Due to the similarity between the two professions and the complexity of clients' needs, home health decision makers, management and teams are recommended to understand the importance of including both physiotherapists and occupational therapists in team discussions and support the collaboration. Home health interprofessional team members are encouraged to set aside time to consult with occupational therapists and physiotherapist before proposed referral are made to those professions. Through the team discussions, clients' needs can be best addressed by the most appropriate profession.

5.1.3. Strong Associations between Equipment and Occupational Therapists might lead to Practice Inefficiencies and Client Dependence on Health Care

The findings showed that there was a strong perceived association between the occupational therapists' roles and equipment. This perception could lead to underutilized occupational therapy services and inefficient occupational therapy practice. It could also undermine clients' potentials and make them more dependent on the system. All participants mentioned that equipment interventions were the most frequently used occupational therapy intervention in home health. The non-occupational therapy participants frequently mentioned equipment, even though they were not always sure how the equipment related to the role of the occupational therapists. The non-

occupational therapists' perception of occupational therapists "taking care of everything related to equipment" led them to make referrals that might be inappropriate to the occupational therapy service. These referrals consumed the occupational therapists' time, which could lead to delayed or reduced services to other clients.

Non-occupational therapy participants perceived association between occupational therapists and equipment was so significant that equipment appeared to be the only intervention provided by the occupational therapists. According to Altman (1991) and Furååker & Nilsson (2011), the reason that occupational therapists often limit their interventions to equipment is because of time constraints. Thus an increase in therapeutic time could lead to more diverse and client-tailored occupational therapy interventions. The perception of occupational therapists "just dealing with equipment" could potentially take away clients' opportunities for receiving other more appropriate occupational therapy interventions. This finding was similar to DePalma (2006) and Smith & Mackenzie (2011) who found that other health professionals, clients and families were not exactly sure about the roles of occupational therapists and the services that they offered. Clients who might benefit from occupational therapy might not be able to get necessary services due to the narrow view of occupational therapists only dealing with equipment. The intent of occupational therapy is to enable clients' independence and to maximize their skills of everyday life (Townsend & Polatajko, 2007).

Occupational therapists partner with their clients to consider using remedial approach that restores clients' function before using a compensatory approach, such as equipment, to overcome challenges (Randomski, 2008). Ryburn, Wells, & Foreman (2009) showed in their study that when remedial approach was used with frail older adults in home

health, the older adults showed an improved quality of life, functional status and had lower needs of ongoing home care services and hence a lower cost to the system.

Premature introduction of equipment without providing rehabilitation services to clients who have the potential to remediate their function may make them more dependent on the equipment and the system. In addition, there are times when clients' needs can be better met by strategies other than equipment. For instance, a client with cognitive challenge may find verbal reminders more helpful than equipment because of the limited learning ability to use the equipment properly in a consistent manner. Utilizing mostly equipment to address clients' needs may result in decreased quality of life and clients' satisfaction. In the long run, it can possibly cost the health care system more to provide equipment to clients who have the capacity to be independent if they were given rehabilitation services instead.

Clinical Implications

Other health professionals will benefit from learning about why and when occupational therapists recommend equipment for clients. Not all clients who need equipment have occupational issues. Referring clients for occupational therapy services should not be dependent on their perceived need for equipment, but rather on their need to resolve their occupational issues. Non-occupational therapists are encouraged to learn that equipment is only one of many diverse intervention strategies used by the occupational therapists. For clients who have potential to be more independent, occupational therapists should be able to provide rehabilitation services that can maximize clients' function to reduce their dependence on equipment and health care services (Barnes & Frock, 2003). For

clients who may benefit from interventions other than equipment, occupational therapists should be given adequate time to work with clients to identify different strategies that will maximize their independence and ensure their needs are satisfied. When clients become more independent and satisfied, they would place fewer burdens on the health care system. In order for occupational therapists to employ diverse intervention strategies to maximize clients' independence, home health decision makers and management will need to provide them with more therapeutic time and resources to practice to their full scope.

5.2 Proposed Expanded Roles for Occupational Therapists in Home Health

Even though the non-occupational therapists could not accurately and thoroughly state the roles of occupational therapists, they were able to provide constructive ideas about possible roles for occupational therapists in home health. They recommended engaging occupational therapists in coordinating client care, providing more rehabilitation services and spending more time in addressing clients' cognitive needs, which are very relevant to occupational therapy practice in home health.

5.2.1 Care Coordination

In the study, home health occupational therapists were perceived to be the most appropriate professionals to conduct hospital pre-discharge assessments and coordinate care for clients transitioning from hospital to home. Currently in home health, formal care coordinating roles may include home health case managers, hospital liaisons and care coordinators that are not usually occupied by occupational therapists. In addition, occupational therapists do not consistently conduct hospital pre-discharge assessments.

Due to their already high caseloads, hospital pre-discharge assessments may not always be seen as a high priority by the home health programs and their occupational therapists. The hospital discharge planning is often left to the hospital teams and care coordinators who have primarily nursing backgrounds. Some of the research has questioned the effectiveness of hospital pre-discharge assessments completed by hospital staff (Atwal, McIntyre, Craik, & Hunt, 2008; Mountain & Pighills, 2003; Patterson, Viner, Saville, & Mulley, 2001). Home health practice has a different philosophy and culture from hospital practice that home health occupational therapists may be more able to engage clients and monitor their needs after hospital discharge; therefore, the effectiveness of pre-discharge assessment performed by home health occupational therapists is worth further exploration.

The study findings also indicate that home health occupational therapists have a unique expertise that could make them skilled in care coordination. This result agrees with the findings of Toto (2006) that described possible occupational therapists' contributions to the interprofessional team. Toto (2006) stated that occupational therapists are experts in determining the cause of an occupational issue and can provide specific recommendation to resolve the issue. Based on their education and philosophy of practice, occupational therapists see clients from a holistic perspective. Despite the problems with role overlap mentioned previously, role overlap can still bring benefits to the interprofessional teams. Occupational therapists' role overlap with other professions can increase their ability to collaborate and link them with other team members to improve clients' functional outcomes. Their ability to train and educate other team members to empower clients to be more independent can ensure clients only get the

support that they actually need. All these skills and qualities make occupational therapists good care coordinators. This position is supported by the findings of Grant et al. (2007) who described occupational therapists as being good at care coordination especially for clients who transition from hospital to home. During this transition, most clients require assistance to sort out their equipment and rehabilitation needs that can be well supported by home health occupational therapists.

Clinical Implications

Since facilitating hospital decongestion is a key topic these days and limited resources are available, the effectiveness of pre-discharge assessments completed by home health occupational therapists needs further investigation. Home health occupational therapists have the skills to coordinate care for clients; therefore, their roles could be expanded to include the roles of care coordinator especially for clients who are transitioning from hospital to home.

5.2.2 Rehabilitation

The occupational therapists and non-occupational therapists who were interviewed recognized the importance of expanding the roles of occupational therapists to include providing home-based rehabilitation; however, more resources and time are required to support the implementation and the cultural shift to accommodate this change. This is in agreement with Toto's (2006) findings that home health occupational therapists should expand their roles in rehabilitation. As indicated by Egan et al. (2010), the shorter stays in acute care and the growing aging population increase the demand for rehabilitation services in the community to support clients' ability to remain independent. Occupational therapists have the expertise to empower clients, and their

caregivers, to optimize the clients' ability to perform activities of daily living and to increase their quality of life. Providing rehabilitation at home, rather than in traditional settings such as hospitals and rehabilitation institutions, is much more economical for the health care system and more rewarding for both clients and their family (Barnes & Frock, 2003). When rehabilitation is provided in the clients' home, the skills they learn from occupational therapists can be practiced in the setting where the clients carry out their daily activities. Occupational therapists can take the home environment into consideration when developing a personalized intervention plan with the client. Thus, skill transfer should be less of an issue (Steultjens et al., 2004). This should increase clients' success in rehabilitation. When clients become more independent at home, hospital readmissions can be prevented and residential care admissions can be delayed. In summary, rehabilitation at home can reduce the cost of care and increase the efficiency of the system, because clients can be more independent and place fewer burdens on the health care system (Barnes & Frock, 2003).

Although research evidence showed the importance of providing rehabilitation at home, occupational therapists seem to struggle with accessing resources and adjusting to the shift in practice culture. Historically in home health, nurses addressed and documented clients' ability to take care of themselves. If clients were unable to perform their own care, nurses provided home support services while occupational therapists provided equipment and resources as a quick intervention. While the rehabilitation approach can achieve better and more sustainable health outcomes for clients (Barnes & Frock, 2003), implementing the change is likely to be a long process that requires additional research evidence to inform how the change can happen. We may also need

more resources and time for health professionals to absorb this major cultural shift before it can be successfully implemented.

Clinical Implications

It is recommended that home health occupational therapists expand their roles so that they can provide rehabilitation in clients' home. Health care decision makers and management are encouraged to further understand the potential benefits of providing rehabilitation in clients' home environment, which can be a cost effective way to optimize clients' health. The increased awareness will hopefully support home health decision makers and management to advocate for occupational therapists to expand their roles in rehabilitation. Occupational therapists in the study stated that the major barrier for providing rehabilitation at home was the lack of therapeutic time and resources, like rehabilitation assistants. We need to further investigate what resources are required to provide home-based rehabilitation services and to support the adjustment needed for this cultural shift.

5.2.3 Cognitive Assessment

Participants perceived that occupational therapists were good at addressing clients' cognitive needs yet in home health they were currently not spending adequate time in this area. Participants stated that it was important to further understand how clients' cognition affected their occupational performance in order to recommend the most appropriate living options that would enhance clients' safety and independence. In home health, when clients or families notice any unsafe incidence in clients' home such as leaving the burner on, forgetting to take their medications etc, they tend to take this as

a sign of their inability to cope with living at home and subsequently request admission to residential care facilities. Occupational therapy has been proven to be effective in supporting clients with cognitive impairment to continue living at home (Cheney, 2011; di Gioacchino et al., 2004; Draper, 2008; Tsai, Yang, Lan, & Chen, 2008). When occupational therapists clearly identify what the cognitive issues are, they may recommend some simple compensatory strategies such as posting written reminders in the kitchen to cue clients to turn the burner off or ordering blister packs for medications to support the clients' ability to continue living at home. A more supportive housing option like residential care may not always be the best choice for the clients. As the population ages, more clients may present with cognitive challenges that require more services from occupational therapists to maintain the clients to live at home.

We know that it is important to address clients' cognitive challenges; nevertheless in current home health practice, occupational therapists can only conduct a preliminary cognitive screen and spend very limited time in cognitive interventions. According to Peoples, Satink, & Steultjens (2011) and Winfield (2003), physical needs are usually more visible hence they receive more attention from the health professionals than other invisible needs such as cognitive and emotional needs. The decreased time and resources available for assessments may force home health professionals to unintentionally focus more on the clients' physical needs and provide a quick intervention to meet the physical needs (Winfield, 2003). Also, the presence of other community health services such as community mental health and specialized senior services may give an impression that the non-physical needs can be addressed by other health services. Mitchell & Unsworth (2004) found that inadequate staffing and a large

and diverse caseload are barriers for occupational therapists to deepen their knowledge of specific clinical conditions. In this study, occupational therapy participants did not verify whether they focused more on the clients' physical needs than their cognitive and emotional needs, although they acknowledged the use of equipment as a quick fix and their desire to spend more time addressing clients' cognitive challenges.

Clinical Implications

Further research is needed to find out whether occupational therapists truly focus more on clients' physical needs in home health as this can affect the holistic occupational therapy practice and hence the quality of clients' care. As the population ages, clients' needs for cognitive assessments and interventions will increase. More resources such as therapeutic time are recommended to enhance home health occupational therapists' ability to conduct cognitive assessments and provide interventions to maintain clients living at home.

5.3 Potential Barriers to Occupational Therapists' Role Expansion

The role perceptions of occupational therapists by different health professionals affect occupational therapists' practice in home health. Even though there are many possible perceived opportunities for occupational therapists to expand their roles, the predominant medical culture in home health and the difficulties occupational therapists have in articulating their services can make it challenging to expand their roles.

5.3.1 Nursing Hierarchy

Though the medical model of curing a condition may work well for clients with acute care needs, it may not be as applicable to the clients with chronic health issues.

This may be a good time to restructure our staffing in home health to enhance the implementation of chronic disease management. If a client has a specific acute need such as needing a hip replacement, he or she might only need a quick intervention to address the need. However, if a client has chronic health concerns such as Parkinson's disease, he or she may benefit more from a client-centred chronic disease management approach. Chronic disease self management refers to the "individual's ability to manage their symptoms, treatment, physical and psychosocial consequences, and lifestyle changes inherent in living with a chronic condition" (Barlow, Wright, Sheasby, Turner, & Hainsworth, 2002, P.178 as cited in Vance & Siebert, 2009). Ideally, the health care system needs to be developed in a way that will allow the practitioners to embrace the chronic disease management approach when appropriate. The existing home health services are often dominated by the medical model approach; the chronic disease management approach has just recently been introduced to practice. The concepts and key elements involved in self management support resonate with occupational therapy values and approaches. This study found that both the non-occupational therapy and occupational therapy participants agreed that occupational therapists are good at engaging clients in identifying their care needs, coordinating the care plans as well as empowering them to be more independent. If we would like to promote successful implementation of chronic disease management practice, we will need to have appropriate health professionals like occupational therapists to drive the change.

In home health, most health care decision makers and management have a nursing background and nurses usually makeup the majority of the interprofessional teams. Participants perceived that home health decision makers and management who

have nursing background may have a lack of understanding of occupational therapy. Simpson et al. (2005) & Smith & Mackenzie (2011) showed that nurses have challenges in understanding the roles of occupational therapists. These challenges might be related to the different philosophies of occupational therapy and medicine (Caldwell & Atwal, 2003; Wilding & Whiteford, 2009). Using the medical model and a lack of understanding of occupational therapy from home health decision makers and interprofessional teams could restrict occupational therapy practice in home health.

Currently the practice context of home health is not set up to fully utilize the skills of occupational therapists. For instance, even though occupational therapists are perceived to be good at care coordination and the concept of case management aligns with that of occupational therapy across all settings (Toto, 2006), very few occupational therapists may have been given opportunities to practice in formal care coordinating roles such as case managers and hospital liaisons in current home health structure. Historically home care nurses did “everything” to take care of the clients at home (Zakrajsek, 1999). This history may have supported the current thought that nurses should be care coordinators, because some home care nursing services previously went beyond direct nursing care to include personal care, rehabilitation, social work, dietary consultation and case management. This study confirmed that occupational therapists within home health teams have the skills to be care coordinators. Involving occupational therapists in care coordination may effectively support clients with chronic health issues and allow nurses to focus more on direct nursing care to address clients’ acute medical needs. Therefore, there is an opportunity for restructuring our current home health teams to better meet the needs of our clients.

Participants pointed out that some of the current policies may have been developed without recognizing the skills of occupational therapists. The process of policy development may have had no or very limited consultation with occupational therapists or the policy may have been set up for another reason with no intention to undermine occupational therapy practice. It is not clear whether the development of current policies is associated with the home health decision makers' and managers' understanding of occupational therapy practice; yet occupational therapists may see their skills not being recognized during the process of policy development.

From a clinical perspective, participants stated that home health occupational therapists' recommendations are not always respected, or followed through with, due to the power struggle with other home health professionals. These findings align with the studies conducted by Caldwell & Atwal (2003) and Wilding & Whiteford (2009) that showed occupational therapists are considered to be secondary in the medically-oriented health care context. This bias does not recognize the expertise occupational therapists have in maximizing clients' occupations. Ignoring occupational therapy recommendations could result in a significant decline in clients' function and an inefficient health care system. Ideas for improving interprofessional collaborative practice such as co-locating interprofessionals in the same area within an office, joint educational events, shadowing each others' practice and creating opportunities for formal and informal consultations should be further explored.

Clinical Implications

Considering the urgency of implementing a chronic disease management model to meet the population needs and deal with the issues of current nursing shortage,

now is the time for the home health decision makers to reorganize the human resources and offer more formal case manager roles to occupational therapists in home health. We also need to further explore whether home health decision makers and managers truly understand occupational therapy practice. In order to embrace a collaborative interprofessional practice context, home health policy makers are encouraged to collaborate with occupational therapists for policy and process development for practice. On a clinical level, more opportunities need to be created for formal and informal interprofessional collaboration so that occupational therapy can be better understood by other members in the interprofessional teams.

5.3.2 Difficulty with Articulating Occupational Therapy

Occupational therapists need to equip themselves so they can articulate and communicate the value of their service to home health decision makers, management and interprofessional teams. The findings showed that home health occupational therapists were perceived to be not doing enough marketing for their service. During the interviews, some occupational therapy participants' comments revealed that they struggled with explaining to others about their roles as occupational therapists within the home health teams. This finding aligns with the research conducted by Edwards & Dirette (2010), Egan et al. (2010), Smith & Mackenzie (2011), and Wilding & Whiteford (2007) that occupational therapists seldom promote their service to others within the interprofessional teams. When trying to explain about their roles, occupational therapists have challenges in articulating and explaining what their roles are and what kind of services they provide.

Clinical Implications

Home health occupational therapists require more support from their profession to advocate for their profession and communicate with others about the values of their service. More literature review and research will be required to identify effective ways of marketing occupational therapy service to health care decision makers, and health professionals within the interprofessional teams.

CHAPTER 6 LIMITATIONS

The research presented here is based on a small sample in one home health program in one specific geographical area; therefore, the results cannot be generalized beyond the study itself. The information gathered only reflects the perspective of the participants as interpreted by the researcher. In fact, this reflects the intent of qualitative research. If these findings are to be generalized to a larger population, future quantitative research needs to be conducted in this area.

Being a novice researcher, the principal investigator's interviewing techniques may not have allowed her to capture the full experience of the participants, particularly during the earlier interviews. To compensate for this, the principal investigator developed an interview guide to facilitate the interview and reminders to ensure important details are not missed in the interviews. She also did a mock interview to practice her interviewing skills. Debriefing with her supervisor after each interview also helped with the skill improvement.

Due to the difficulty with recruitment, one of the participants recruited was a case manager with a combined physiotherapy and occupational therapy degree. Even though her experience of practicing as an occupational therapist and a case manager in home health provided a valuable perspective for us to understand the research question, it was challenging to classify her responses as the viewpoints from either the occupational therapy participant group or the non-occupational therapy participant group. Classifying her as an occupational therapy participant is reasonable as her viewpoint closely aligned with other occupational therapy participants' perspective.

Some of her viewpoints were unique due to her current practice as a case manager. The principal investigator emphasized this participant's background in the participants' profile at the beginning of Chapter 4 – Findings, in order to minimize the confusion for the readers.

The principal investigator previously worked as an occupational therapist in one of the home health offices. Although no participant was recruited from the home health office where she worked, three participants previously knew the principal investigator. The principal investigator may have been perceived as an “insider”, this perception may affect the amount and the quality of information provided by the participants. During the interviews, there were several times two occupational therapy participants struggled with the amount of information and details to provide about occupational therapy practice. They stated “you know what I mean...”, “you know what it is like...” and “would you like me to carry on to explain this?” The participants might have assumed that the principal investigator should know about occupational therapy practice as an occupational therapist herself that they did not provide as much detail as they would have in front of a person whom they do not know. The principal investigator was able to further facilitate the conversations and redirect participants to elaborate on their answers during the interviews. The principal investigator also reminded participants that there is no right or wrong answers to the interview questions and they were encouraged to freely reflect on the current team situations and express their opinions.

The culture and mandate of home health is to maintain clients living at home. The perceptions of what occupational therapists do in home health may have been significantly affected by home health culture. Clients' occupational goals that are not

related to maintaining clients at home may not be seen as relevant in the current home health practice. The culture may have affected how the participants reported what the occupational therapists do.

CHAPTER 7 CONCLUSION

Interprofessional practice is a widely used term and it is globally promoted in today's health care. Many health teams claim that their team members practice collaboratively to achieve clients' identified goals for improving clients' health outcomes. However, evidence shows that in many practice settings, occupational therapists experience challenges practicing within an interprofessional health team. One of the factors that can contribute to these challenges is related to how the role of occupational therapists is perceived by different health professionals. Research evidence on the role perceptions of occupational therapists in home health and the influence it has on occupational therapy practice is very limited.

Even though this qualitative study is small, it provides a better understanding of how occupational therapists' roles are perceived by other health professionals within the interprofessional teams. The study provides insights into how these perceptions can affect home health occupational therapy practice. More importantly, no Canadian research could be found on this topic. This study gives a first glance of how role perceptions of occupational therapists affect home health occupational therapy practice in Canada.

In order to enhance clients' outcomes and maximize the use of health care resources, more work needs to be done to improve occupational therapy practice in home health interprofessional teams. Each profession has its responsibilities to achieve this goal. Occupational therapists need to sharpen their skills in promoting their profession to health care decision makers, management and interprofessional team

members in home health. Interprofessional team members should also take the initiative to learn more about the roles of occupational therapists to enhance their collaborations with them. Health care decision makers and management need to engage occupational therapists in developing health policies, provide them with resources to practice to the full scope and create opportunities for role expansions and interprofessional practice. Finally, researchers are encouraged to further investigate home health decision makers' and managers' perspectives on the roles of occupational therapists in home health. With all health professions and researchers working collaboratively, a more efficient system can be created in home health to achieve better health outcome for our clients.

REFERENCES

- Altman, G. (1991). Home care occupational therapy in Vancouver, Canada. *WFOT Bulletin*, 23, 26-28.
- Atwal, A., McIntyre, A., Craik, C., & Hunt, J. (2008). Older adults and carers' perceptions of pre-discharge occupational therapy home visits in acute care. *Age & Ageing*, 37(1), 72-76.
- Ayalon, L., & Baum, N. (2010). Social workers in home care: The Israeli case. *Educational Gerontology*, 36(10-11), 858-871.
- Barlow, J., Wright, C., Sheasby, J., Turner, A., Hainsworth, J. (2002). Self management approaches for people with chronic conditions: a review. *Patient Education and Counseling*, 48, 177-187.
- Barnes, P. A., & Frock, A. H. (2003). The expanded role for rehabilitation in home care. *Home Health Care Management & Practice*, 15(4), 305-313.
- Baxter, S. K., & Brumfitt, S. M. (2008). Professional differences in interprofessional working. *Journal of Interprofessional Care*, 22(3), 239-251.
- Black, R.M. (2005). Intersections of care: An analysis of culturally competent care, client centered care, and the feminist ethic of care. *Work*, 24(4), 409-422.
- Borell, L. (2008). Occupational therapy for older adults: Investments for progress. *British Journal of Occupational Therapy*, 71(11), 482-486.
- Boutin-Lester, P., & Gibson, R. W. (2002). Patients' perceptions of home health occupational therapy. *Australian Occupational Therapy Journal*, 49(3), 146-154.
- Bulpitt, H., & Martin, P. J. (2010). Who am I and what am I doing? becoming a qualitative research interviewer. *Nurse Researcher*, 17(3), 7-16.
- Business Dictionary. (2012). Online Version. Retrieve From <http://www.businessdictionary.com>
- Caelli, K., Ray, L., & Mill, J. (2003). 'Clear as mud': Toward greater clarity in generic qualitative research. *International Journal of Qualitative Methods*, 2(2), 1.
- Caldwell, K., & Atwal, A. (2003). Professional issues. the problems of interprofessional healthcare practice in hospitals. *British Journal of Nursing (BJN)*, 12(20), 1212-1218.

- Canadian Association of Occupational Therapists. (1997). *Enabling occupation: An occupational therapy perspective*. Ottawa ON: CAOT Publications ACE.
- Cesta, T. (2011). Reducing readmissions: Case management's critical role. *Case Management Advisor*, 22, 8-11.
- Cheney, P. (2011). The dementia dilemma: Strategies for home care treatment. *Home & Community Health Special Interest Section Quarterly*, 18(3), 1-4.
- Coar, L., & Sim, J. (2006). Interviewing one's peers: Methodological issues in a study of health professionals. *Scandinavian Journal of Primary Health Care*, 24(4), 251-256.
- College of Occupational Therapists of British Columbia. (2013). Retrieved from www.cotbc.org
- College of Physiotherapists of British Columbia. (2013). Retrieved from www.cptbc.org.
- College of Registered Nurses of British Columbia. (2013). Retrieved from www.crnbc.org.
- Conneeley, A. L. (2002). Methodological issues in qualitative research for the researcher/practitioner. *British Journal of Occupational Therapy*, 65(4), 185-190.
- Curtin, M., & Fossey, E. (2007). Appraising the trustworthiness of qualitative studies: Guidelines for occupational therapists. *Australian Occupational Therapy Journal*, 54(2), 88-94.
- Deitrick, L., M., Rockwell, E., H., Gratz, N., Davidson, C., Lukas, L., Stevens, D., . . . Sikora, B. (2011). Delivering specialized palliative care in the community: A new role for nurse practitioners. *Advances in Nursing Science*, 34(4), E23-36.
- DePalma, J. A. (2006). Research corner. rehabilitation therapy services in home care: Evidence. *Home Health Care Management & Practice*, 19(1), 61-62.
- di Gioacchino, C., Ronzoni, S., Mariano, A., di Massimo, M., Porcino, R., Calvetti, D., . . . Zuccaro, S. M. (2004). Home care prevents cognitive and functional decline in frail elderly. *Archives of Gerontology & Geriatrics*, , 121-125.
- DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education*, 40(4), 314-321.
- Draper, B. (2008). Occupational therapy is cost-effective for older people with dementia and their caregivers. *Evidence Based Mental Health*, 11(3), 83-83.

- Easton, K. L., McComish, J. F., & Greenberg, R. (2000). Avoiding common pitfalls in qualitative data collection and transcription. *Qualitative Health Research, 10*(5), 703-707.
- Edwards, H., & Dirette, D. (2010). The relationship between professional identity and burnout among occupational therapists. *Occupational Therapy in Health Care, 24*(2), 119-129.
- Egan, M. Y., Kubina, L., Lidstone, R. I., Macdougall, G. H., & Raudoy, A. E. (2010). A critical reflection on occupational therapy within one assertive community treatment team. *Canadian Journal of Occupational Therapy, 77*(2), 70-79.
- Ehrlich, P. L. (2006). Caring for the frail elderly in the home: A multidisciplinary approach. *Home Health Care Management & Practice, 19*(1), 38-44.
- Employee and Family Assistance Program (2012). Retrieved from www.efap.ca.
- Farlex (2013). The Free Medical Dictionary. Online Version. Retrieved from <http://medical-dictionary.thefreedictionary.com>
- Finlayson, M. (2000). Position statement on home care. *Canadian Journal of Occupational Therapy, 67*(5), 351-352.
- Fisher, A. (2001). Enabling occupation: A role within a multidisciplinary context. *British Journal of Therapy & Rehabilitation, 8*(8), 302-305.
- Flowers, D., Siebert, C., & Zahoransky, M. (2011). The role of the occupational therapy practice framework in home health care. *OT Practice, 16*(13), CE-1-ce-7.
- Forbat, L., & Henderson, J. (2005). Theoretical and practical reflections on sharing transcripts with participants. *Qualitative Health Research, 15*(8), 1114-1128.
- Fortune, T., & Fitzgerald, M. H. (2009). The challenge of interdisciplinary collaboration in acute psychiatry: Impacts on the occupational milieu. *Australian Occupational Therapy Journal, 56*(2), 81-88.
- Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian & New Zealand Journal of Psychiatry, 36*(6), 717-732.
- Furååker, C., & Nilsson, K. (2011). The consultative work of occupational therapists working in municipal healthcare. *Scandinavian Journal of Occupational Therapy, 18*(2), 101-108.

- Gantert, T. W., & McWilliam, C. L. (2004). Interdisciplinary team processes within an in-home service delivery organization. *Home Health Care Services Quarterly*, 23(3), 1-17.
- Gearing, R. E. (2004). Bracketing in research: A typology. *Qualitative Health Research*, 14(10), 1429-1452.
- Grant, M., Ward, G., Dring, P., Booth, J., Jacob-Lloyd, H., Steed, A., & Hibberd, J. M. (2007). Intermediate care: An occupational therapy perspective. *International Journal of Therapy & Rehabilitation*, 14(3), 130-134.
- Green, J., Willis, K., Hughes, E., Small, R., Welch, N., Gibbs, L., & Daly, J. (2007). Generating best evidence from qualitative research: The role of data analysis. *Australian & New Zealand Journal of Public Health*, 31(6), 545-550.
- Harr, C., Openshaw, L., & Moore, B. (2010). Interdisciplinary relationships between chaplains and social workers in health care settings. *Journal of Health Care Chaplaincy*, 16(1-2), 13-23.
- Higginbottom, G. (2004). Sampling issues in qualitative research. *Nurse Researcher*, 12(1), 7-19.
- Hoffmann, T., & Cantoni, N. (2008). Occupational therapy services for adult neurological clients in queensland and therapists' use of telehealth to provide services. *Australian Occupational Therapy Journal*, 55(4), 239-248.
- Hutchinson, S., & Wilson, H. S. (1992). Validity threats in scheduled semistructured research interviews. *Nursing Research*, 41(2), 117-119.
- Kearney, M. H. (2007). Going deeper versus wider in qualitative sampling. *JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing*, 36(4), 299-299.
- Kielhofner, G. (2006). *Research in occupational therapy methods of inquiry for enhancing practice*. Philadelphia: F.A. Davis Co.
- Kelly, M. (2010). The role of theory in qualitative health research. *Family Practice*, 27, 285-290.
- Kesselman, P. (2010). The physician's role in home health care. *Podiatry Management*, 29(6), 75-82.
- Krauss, S. E. (2005) Research Paradigms and Meaning Making: A Primer. *The Qualitative Report*, 10(4), 758-770.

- Larkin, C., & Callaghan, P. (2005). Professionals' perceptions of interprofessional working in community mental health teams. *Journal of Interprofessional Care*, 19(4), 338-346.
- Lawson, R. (2007). Home and hospital: Hospice and palliative care: How the environment impacts the social work role. *Journal of Social Work in End-of-Life & Palliative Care*, 3(2), 3-17.
- Liamputtong, P. (2009). Qualitative data analysis and practical considerations. *Health Promotion Journal of Australia*, 20(2), 133-139.
- MacDonald, M. B., Bally, J. M., Ferguson, L. M., Murray, B. L., Fowler-Kerry, S., & on, J. (2010). Knowledge of the professional role of others: A key interprofessional competency. *Nurse Education in Practice*, 10(4), 238-242.
- McCallin, A. (2001). Interdisciplinary practice -- a matter of teamwork: An integrated literature review. *Journal of Clinical Nursing*, 10(4), 419-428.
- McDougall, P. (2000). In-depth interviewing: The key issues of reliability and validity. *Community Practitioner*, 73(8), 722-724.
- McGarry, J. (2009). Defining roles, relationships, boundaries and participation between elderly people and nurses within the home: An ethnographic study. *Health & Social Care in the Community*, 17(1), 83-91.
- McKinnon, A. L., Townsend, E., & Maconachie, R. (1990). Position paper on occupational therapy in home care. *Canadian Journal of Occupational Therapy*, 57(1), 1-8.
- Meadows, K. A. (2003). So you want to do research? 3. An introduction to qualitative methods. *British Journal of Community Nursing*, 8(10), 464-469.
- Miller, C. (2008). Interprofessional practice. *Alberta RN*, 64(8), 14-15.
- Mitchell, G. J., & Cody, W. K. (1993). The role of theory in qualitative research. *Nursing Science Quarterly*, 6(4), 170-178.
- Mitchell, R., & Unsworth, C. A. (2004). Role perceptions and clinical reasoning of community health occupational therapists undertaking home visits. *Australian Occupational Therapy Journal*, 51(1), 13-24.
- Merriam Webster Dictionary. (2013). Online Version. Retrieved from <http://www.merriam-webster.com/dictionary>.

- Mortenson, W. B., & Dyck, I. (2006). Power and client-centred practice: An insider exploration of occupational therapists' experiences. *Canadian Journal of Occupational Therapy*, 73(5), 261-271.
- Moulton, C. (1997). Current trends in the practice of home health care of occupational therapists treating patients who have had a stroke. *Occupational Therapy International*, 4(1), 31-51.
- Mountain, G., & Pighills, A. (2003). Pre-discharge home visits with older people: Time to review practice. *Health & Social Care in the Community*, 11(2), 146-154.
- Norman, I. J., & Peck, E. (1999). Working together in adult community mental health services: An inter-professional dialogue. *Journal of Mental Health*, 8(3), 217-230.
- Nugus, P., Greenfield, D., Travaglia, J., Westbrook, J., & Braithwaite, J. (2010). How and where clinicians exercise power: Interprofessional relations in health care. *Social Science & Medicine*, 71(5), 898-909.
- O'Sullivan, A., & Siebert, C. (2004). Occupational therapy and home health: A perfect fit. *Caring*, 23(5), 10.
- Patterson, C. J., Viner, J., Saville, C., & Mulley, G. P. (2001). Too many pre-discharge home assessment visits for older patients? A postal questionnaire survey. *Clinical Rehabilitation*, 15(3), 291-295.
- Patton, M.Q. ed. (2002) *Qualitative Research and Evaluation Methods*. 3rd ed. Thousand Oaks. Sage.
- Pellatt, G. C. (2005). Perceptions of interprofessional roles within the spinal cord injury rehabilitation team... including commentary by Lingard L. *International Journal of Therapy & Rehabilitation*, 12(4), 143-150.
- Peoples, H., Satink, T., & Steultjens, E. (2011). Stroke survivors' experiences of rehabilitation: A systematic review of qualitative studies. *Scandinavian Journal of Occupational Therapy*, 18(3), 163-171.
- Pullon, S. (2008). Competence, respect and trust: Key features of successful interprofessional nurse-doctor relationships. *Journal of Interprofessional Care*, 22(2), 133-147.
- Quick, L., Harman, S., Morgan, S., & Stagnitti, K. (2010). Scope of practice of occupational therapists working in Victorian community health settings. *Australian Occupational Therapy Journal*, 57(2), 95-101.
- Ramsey, R. (2011). Voices of community-practicing occupational therapists: An exploratory study. *Occupational Therapy in Health Care*, 25(2), 140-149.

- Randall, G. (2007). The reform of home care services in Ontario: Opportunity lost or lesson learned? *Canadian Journal of Occupational Therapy*, 74 (3), 208-216.
- Rappolt, S., Williams, P., Polatajko, H., Cott, C., & Soever, L. (2003). Securing public funds for home care occupational therapy services: we need a national home care research strategy. *Occupational Therapy Now*, 5(5), 4-8.
- Radomski, M.V. (2008). Planning, guiding and documenting practice. In: M.V. Radomski and C.A. Trombly Latham (Eds.), *Occupation Therapy for Physical Dysfunction*, (6th ed., p. 50–64). Baltimore, MD: Lippincott Williams & Wilkins
- Robley, L. R. (1995). The ethics of qualitative nursing research. *Journal of Professional Nursing*, 11(1), 45-48.
- Rolfe, G. (2006). Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of Advanced Nursing*, 53(3), 304-310.
- Ryan-Nicholls, K., & Will, C. I. (2009). Rigour in qualitative research: Mechanisms for control. *Nurse Researcher*, 16(3), 70-85.
- Ryburn, B., Wells, Y., & Foreman, P. (2009). Enabling independence: restorative approaches to home care provision for frail older adults. *Home and Social Care in the Community*, 17(3), 225-234.
- Simpson, A., Bowers, L., Alexander, J., Ridley, C., & Warren, J. (2005). Occupational therapy and multidisciplinary working on acute psychiatric wards: The tomkins acute ward study. *British Journal of Occupational Therapy*, 68(12), 545-552.
- Smith, E., & Mackenzie, L. (2011). How occupational therapists are perceived within inpatient mental health settings: The perceptions of seven Australian nurses. *Australian Occupational Therapy Journal*, 58(4), 251-260.
- Smith, S., & Roberts, P. (2005). An investigation of occupational therapy and physiotherapy roles in a community setting... including commentary by Sparkes V and Nancarrow SA. *International Journal of Therapy & Rehabilitation*, 12(1), 21-29.
- Stalker, K., Jones, C., & Ritchie, P. (1996). All change? the role and tasks of community occupational therapists in Scotland. *British Journal of Occupational Therapy*, 59(3), 104-108.
- Steultjens, E.M., Dekker, J., Bouter, L.M., Jellema, S., Bakker, E.B., & Van den Ende, C.H. (2004). Occupational therapy for community dwelling elderly people: A systematic Review. *Age & Aging*, 33(5), 453-460.

- Strasser, D. C., Falconer, J. A., Herrin, J. S., Bowen, S. E., Stevens, A. B., & Uomoto, J. (2005). Team functioning and patient outcomes in stroke rehabilitation. *Archives of Physical Medicine & Rehabilitation*, 86(3), 403-409.
- Sumsion, T. (2005). Facilitating client-centred practice: insights from clients. *Canadian Journal of Occupational Therapy*, 72 (1), 13-21.
- Suter, E., Arndt, J., Arthur, N., Parboosingh, J., Taylor, E., & Deutschlander, S. (2009). Role understanding and effective communication as core competencies for collaborative practice. *Journal of Interprofessional Care*, 23(1), 41-51.
- The Ohio State University. (2013). *Rehabilitation*. Retrieved from http://medicalcenter.osu.edu/patientcare/healthcare_services/stroke/rehab/Pages/index.aspx.
- Thome, B., Dykes, A., & Hallberg, I. R. (2003). Home care with regard to definition, care recipients, content and outcome: Systematic literature review. *Journal of Clinical Nursing*, 12(6), 860-872.
- Toto, P. E. (2006). Success through teamwork in the home health setting: The role of occupational therapy. *Home Health Care Management & Practice*, 19(1), 31-37.
- Townsend, E. & Polatajko, H. (2007). *Enabling occupation II: Advancing occupational therapy vision for health, well-being and justice through occupation*. Ottawa, ON: CAOT Publications ACE.
- Traynor, K. (2011). Health system's readmission prevention plan relies on pharmacists. *American Journal of Health-System Pharmacy*, 68(23), 2208-2210.
- Tsai, A. Y., Yang, M., Lan, C., & Chen, C. (2008). Evaluation of effect of cognitive intervention programs for the community-dwelling elderly with subjective memory complaints. *International Journal of Geriatric Psychiatry*, 23(11), 1172-1174.
- Vance, K., & Siebert, C. (2009). Supporting self-management in home health and the community. *Home & Community Health Special Interest Section Quarterly*, 16(3), 1-4.
- Wellard, S., & McKenna, L. (2001). Turning tapes into text: Issues surrounding the transcription of interviews. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 11(2), 180-186.
- Whalley-Hammell, K. (2002). Informing client-centred practice through qualitative inquiry: evaluating the quality of qualitative research. *British Journal of Occupational Therapy*, 65(4), 175-184.

- Wilcock, A. (2006). *An occupational perspective of health* (2nd ed). Thorofare, NJ: Slack Inc.
- Wilding, C., & Whiteford, G. (2007). Occupation and occupational therapy: Knowledge paradigms and everyday practice. *Australian Occupational Therapy Journal*, 54(3), 185-193.
- Wilding, C., & Whiteford, G. (2009). From practice to praxis: Reconnecting moral vision with philosophical underpinnings. *British Journal of Occupational Therapy*, 72(10), 434-441.
- Winfield, J. (2003). Best adaptation redeeming people's homes: Enlightened occupational therapy. *British Journal of Occupational Therapy*, 66(8), 376-377.
- Wright, B., Lockyer, J., Fidler, H., & Hofmeister, M. (2007). Roles and responsibilities of family physicians on geriatric health care teams: Health care team members' perspectives. *Canadian Family Physician*, 53, 1954-1954.
- Xyrichis, A., & Lowton, K. (2008). What fosters or prevents interprofessional teamworking in primary and community care? A literature review. *International Journal of Nursing Studies*, 45(1), 140-153.
- Zakrajsek, D. B. (1999). The home health therapist as case manager. *Topics in Geriatric Rehabilitation*, 15(1), 1-14.
- Zarbock, S. F. (1996). Sharing in all dimensions. The role of pharmacists in home care. *Home Care Provider*, 1(3), 151-152.

APPENDIX I- Matrix for Recruitment

Participant	Professions	**Years of experience (3-10 years)	***Office (not from New Westminster)	****Size
1	Occupational therapist			
2	Occupational therapist			
3	Occupational therapist			
*4	Nurse/Case manager/ Physiotherapist/Social worker			
*5	Nurse/Case manager/ Physiotherapist/Social worker			
*6	Nurse/Case manager/ Physiotherapist/Social worker			

*Participant #4, 5 and 6 are non-occupational therapists. We will require one from at least 3 of the following professions: Nursing, case management, physiotherapy and social work.

**Only health professionals with a range of 3 to 10 years of experience will be eligible.

*** Participants need to be from different offices in home health other than New Westminster Home Health

**** Participants from different office sizes will be preferred.

APPENDIX II – Determination of Home Health Team Size

Data was collected through Fraser Health Organization Chart 2010.

(http://fhpulse/about_us/org_charts/VP%20Clinical%20Operations%20%20Korabek)

Office	CM (FTE)	HCN (FTE)	PT (FTE)	OT (FTE)	SW (FTE)	Dietitian (FTE)	Total FTEs	Size Comparison / % (FTE of the office / FTE of the largest office x 100%)	Definition of office size (*)
Abbotsford	10.5	13.0	2.8	3.0	1.0	0	30.3	49	Medium
Chilliwack	7.8	12.56	2.3	3.1	0.5	0	26.26	42	Medium
Newton	9.0	23.73	2.0	3.3	0	0	38.03	61	Medium
Langley	11.1	16.21	2.0	3.0	0.7	0	33.01	53	Medium
Burnaby	18.5	30.09	6.17	6.0	1.0	1.0	62.31	100	Large
Gateway	11.4	20.9	2.5	4.8	0.6	0	40.2	65	Large
New Westminster	8.5	14.51	2.0	3.0	1.0	0	29.01	47	Medium
Maple Ridge	6.3	21.43	2.6	3.1	1.0	0	34.43	55.3	Medium
Mission	3.3	4.96	0.7	0.8	0.5	0	10.26	16.5	Small
Delta	4.09	7.02	1.8	1.3	0	0	14.21	22.8	Small
White Rock	12.0	16.75	3.5	3.6	0	0	35.85	57.6	Medium
Tricities	14.0	24.66	4.2	4.5	2.0	0	49.36	79.2	Large

* An office with a size percentage under 33% is defined to be a size small office. An office with a size percentage of 34-65% is defined to be size medium office. An office with a size percentage above 66% is defined to be a size large office.

APPENDIX III – Email Invitation

You are invited to participate in this research study to explore interprofessional practice in home health.

Title: “How do health professionals’ perceptions of the roles of occupational therapists affect occupational therapy practice in interprofessional home health teams? “

Researcher: Irene Cheung, candidate of the Masters of Science (post-professional Occupational Therapy) Program in Dalhousie University, Halifax.

Your commitment:

If you agree to be in the study you will be asked to participate in a 15 minute telephone screen to screen for eligibility. Once you are eligible to participate in this study, you will be involved in a one-hour interview at your chosen time and location, and to read the summary of your interview at a later date to ensure it reflects what you have said.

Who can participate in this study?

If you are a frontline occupational therapist, home care nurse, case manager, physiotherapist or social worker, who has been working in home health for 3 – 10 years in any home health offices except New Westminister Home Health in Fraser Health Authority, we need your participation.

A \$20 visa gift card will be given to those who complete the study in recognition of the time spent in participating in the research.

If you are interested or have any questions about the study, please contact the researcher, Irene Cheung.

* The participants who work in home health teams other than New Westminster are eligible.	D. Maple Ridge E. Newton F. Gateway	K. White Rock L. Langley
What is your role in the home health team? * The participant who works in any one of these roles is eligible.	A. Home care nurse B. Social worker C. Physiotherapist D. Case manager E. Occupational therapist	
Researcher use only		
Is this individual eligible to participate in the study?	Yes or No (if yes, enter this data into the matrix)	
Would this individual participant fit the sample needs?	Yes or No (If yes, randomly assign a pseudonym to this participant. The assigned alphabet is: _____)	
<u>If the individual fulfills the sampling requirement, say:</u>		
<i>"It appears that you are eligible for the study. I will need the following information so that I can email you the consent form. If you have any questions once you receive the consent form, you can contact me by (note email or phone). I will go over the form with you when we meet for the interview, and you will have to sign the form before we do the interview.</i>		
What is your name?		
What is your preferred contact phone number?		
What is your preferred email address?		
When and where can we arrange an interview? (A day before the interview the researcher will call the participant to make sure he /she has received the consent form, still feels comfortable with participating in the study, and is still available at the scheduled time for the interview.)	Date: Place:	Time: * Ensure that the location is convenient for the participant and cannot be seen by their colleagues.
<u>If this individual DOES NOT fulfill the sampling requirement, say:</u>		
<i>Thank you very much for your time and interest in the study. It is unfortunate that you are not eligible for this study. All the data that you have provided in the screen will be destroyed and will not be used in this study. Once again, thank you very much your interest and participation.</i>		

APPENDIX V – Written Consent Form



Consent Form

Title of the study: Role perceptions of occupational therapists in home health

FHREB 2012-089

Principal Investigator:

Irene Cheung, BSc OT (Hon), BSc
Project Leader
Program Planning & Improvement, Home Health
School of Occupational Therapy
Dalhousie University

Research Supervisor:

Dr. Grace Warner, MS PhD
Assistant Professor, School of Occupational Therapy
Faculty of Health Professions
Dalhousie University
5869 University Avenue
Forrest Building
Halifax, Nova Scotia B3H 1W2

Introduction:

We invite you to take part in a research study being conducted by Irene Cheung who is a graduate student at Dalhousie University, as part of her Masters of Science (Post-professional) occupational therapy degree. Your participation in this study is voluntary and you may withdraw from the study at any time. Your performance evaluation at work will not be affected by your decision to participate in this project. The study is described below. Participating in the study might not benefit you, but we might learn things that will benefit others. You should discuss any questions you have about this study with Irene Cheung.

Purpose of the study:

The main purpose of the study is to explore how various health professionals perceive the roles of occupational therapists in home health and how these perceptions affect occupational therapy practice in interprofessional home health teams.

Study design:

A total of 6 health care professionals will be invited to participate in an individual one-hour interview. During the interview, you will be asked about your perception of the functions and roles of occupational therapists in home health, if there are any role overlaps and how you think the perceptions affect occupational therapists' practice in interprofessional home health teams. The interviews will be voice-recorded.

Who Can Participate in the Study:

You may participate in this study if you are a frontline occupational therapist, home care nurse, case manager, physiotherapist or social worker, who has been working in home health for 3 – 10 years in an office other than New Westminster Home Health in Fraser Health Authority.

Who will be Conducting the Research:

The Principal Investigator, Irene Cheung, will conduct the interview. With the support from Dr. Grace Warner, the Principal Investigator will analyze the data and report the findings.

What You Will Be Asked To Do:

You will be asked to commit a total of no more than 3 hours of your time to this research project:

1. You will be receiving a telephone screen from the researcher over the phone for about 15 minutes (time varies depending on the amount of questions that you may have about the study).
2. You will be asked to attend an interview for a maximum of 1 hour.
3. The interview site will be negotiated between you and the researcher. You may want to suggest a place closer to your office for your convenience. In order to maintain confidentiality, you may want to feel comfortable with the chosen location, where you will not be seen by your colleagues. The time required to travel to the interview location and back to your office should take no longer than an hour. The interview will be voice-recorded.
4. You will be asked to read the summary of themes from your own interview which should take less than half an hour and indicate if the summary reflects what you said in the interview.
5. You may be contacted to clarify your viewpoints after the interview (a maximum of 15 minutes).

You may contact the researcher if you wish to withdraw your data within 14 days after attending the interview.

Possible Risks and Discomfort:

1. It may be possible that you have some unpleasant emotions when discussing sensitive topics regarding interprofessional practice and role perceptions during the interview. You do not need to answer any questions that make you uncomfortable. You can also choose to terminate your participation at any time without providing a reason.
2. You may have fear about the comments that you make in this study may affect your current job or career advancement. I would like to reassure you that the information that you provide for this study is only going to be shared with the researcher and her research supervisor. The data that you provide will only be used for the research purposes. Your employer or managers will have no access to any of this information.
3. Since home health is a small community and the researcher is part of the home health team in Fraser Health, **it is possible that your identity could be disclosed.** To minimize the opportunity of disclosing your identity, you may choose to use a pseudonym to minimize identify disclosure. When reporting the findings, your personal information will be adjusted so that your identity will be masked as much as possible.
4. Fraser Health Home Health directors have agreed to pay for the travel expense and mileage for your participation in this study. Claiming for the travel expense and mileage as how you would do it for regular work related duties may expose your identity to the clerical support and manager. You can choose not to claim for your travel expense and mileage if you have any concerns.
5. Verbatim quote may be used for presenting research findings. This may increase the possibility of identity disclosure. Your direct quotes will not be used unless you provide permission on the consent form. You can choose not to consent to the use of quote and still participate in the study.

Possible Benefits:

No one knows whether or not you will benefit from this study. There may or may not be direct benefits to you from taking part in this study. We hope that the information learned from this study can be used in the future to benefit other people.

Compensation/Reimbursement

This research study is endorsed by the home health directors. They have approved staff using work time to participate in this research study. Expenses for parking and transportation can also be claimed as regular work-related travel expense. A \$20 visa gift card will be offered in recognition of your time spent in the research.

Confidentiality

All interviews will be conducted at a location away from your office. You are encouraged to select a location where you feel comfortable that you will not be seen by your colleagues.

After completion of the telephone screen, demographic data collected from you will be recorded on a document that can only be accessed only by the researcher and her research supervisor. Your confidentiality will be respected. However, research records and health or other source records identifying you may be inspected in the presence of the Investigator or his or her designate by representatives of the Fraser Health Research Ethics Board for the purpose of monitoring the research. No information or records that

disclose your identity will be published without your consent, nor will any information or records that disclose your identity be removed or released without your consent unless required by law. You will be assigned a unique study number as a subject in this study. Only this number will be used on any research-related information collected about you during the course of this study, so that your identity [i.e. your name or any other information that could identify you] as a subject in this study will be kept confidential. Information that contains your identity will remain only with the Principal Investigator and/or designate. The list that matches your name to the unique study number that is used on your research-related information will not be removed or released without your consent unless required by law.

Fraser Health Home Health directors have agreed to support the study by paying the mileage and travel expense caused by health professionals' participation in the study. Should you choose to claim for the mileage and travel expense, your clerical support and manager will know about your involvement in the study. If you have concerns about this, you can choose not to claim for your mileage and travel expense.

All information that you provide for this research study is confidential and will only be used for this research purpose. The data that you provide in this study will not be shared with your employer and will not affect your current job or career advancement. **If during the interview the information shared that may indicates possible professional misconduct or incompetency about yourself, the researcher has the professional obligation to further understand the situation.** The researcher will consult with the respective professional regulatory body to identify appropriate actions without disclosing your identity. Some examples of professional misconduct may include engagement in sexual misconduct, abuse, theft, inappropriate relationship with clients or former clients. Examples of incompetent practice may include failing to assess clients, incomplete or inaccurate documentations. **If it is determined that the researcher needs disclose your identity to the professional regulatory body for further investigation, you will be notified by the researcher.** You will then be asked to terminate your participation in the study. All data that has been collected from you will not be included in the study. All information regarding you will then be destroyed from the researcher's record.

With your permission, the information that you provide during the interview will be voice-recorded and transcribed. All written documents will be stored in a locked file cabinet in the researcher's office and the electronic files will be saved on a password protected computer drive. The information will be backed up and saved on a secured drive on the Dalhousie computer server. The written and audio records along with the transcripts will be kept by the research supervisor on the Dalhousie computer server for 5 years after publication. All other copies of the data and the original documents or files that include participants' information will be shredded. All computer files will be deleted and those that are saved on the USB will be erased using the Media Wiper. During the transcript reviewing process, you will only be reviewing your own summary of themes. The summary of themes will be put in a doubled envelop with a "private and confidential" stamp on the front envelop. The mailing will be handled by the researcher. By signing this form, you do not give up any of your legal rights.

Questions or concerns:

If you have any concerns or complaints about your rights as a research subject and/or your experiences while participating in this study, contact either Dr. Anton Grunfeld or Dr. Allan Belzberg, REB co-Chairs by calling 604-587-4681. You may discuss these rights with one of the co-chairmen of the Fraser Health REB.

If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Catherine Connors, Director, Research Ethics, Dalhousie University for assistance at (902) 494-1462 or ethics@dal.ca.
If you have any questions about the research study, please call the researcher, Irene Cheung.

This research has been reviewed and approved by the Research Ethics Committee at Dalhousie University and the Ethics Committee at Fraser Health Authority.

Sincerely,

Irene Cheung, BSc OT (Hon), BSc
Principal Investigator
Project Leader, Program Planning and Improvement, Home Health, Fraser Health
Authority
Candidate of MSc (Post-Professional OT) program in Dalhousie University

Role Perceptions of Occupational Therapists in Home Health Consent Form Signature Page

Formal Consent by Signature

I (your name) _____ have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study. However I realize that my participation is voluntary and that I am free to withdraw from the study at any time. .

I consent to the following (Please circle Yes or No)

- Voice recording: Yes or No
- Use of quotations: Yes or No

I also consent to the following:

- I have read and understood the subject information and consent form and am consenting to participate in the study, Role Perceptions of Occupational Therapists in Home Health.
- I have had sufficient time to consider the information provided and to ask for advice if necessary.
- I have had the opportunity to ask questions and have had satisfactory responses to my questions.
- I understand that all of the information collected will be kept confidential and that the result will only be used for scientific objectives.
- I understand that my participation in this study is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time.
- I understand that I am not waiving any of my legal rights as a result of signing this consent form.
- I have read this form and I freely consent to participate in this study.
- I have been told that I will receive a dated and signed copy of this form.

This consent form is signed by (Print your full name) _____

Participant's signature (your signature) _____ on
(date) _____

Researcher's signature _____ on
(date) _____

We will need to send you a copy of summary of themes from your interview for your review and a copy of the signed consent form for your record, please provide your mailing OR email address:

Email or Mailing address: _____

APPENDIX VI – Considerations for the Interviewing Process

Research title:

Role perceptions of occupational therapists in home health

Purpose of the interview:

To obtain rich and detailed information from the participants that reflects the reality of the role perceptions of occupational therapists and their impacts on interprofessional home health teams.

Format

A semi-structured individual in-depth interview: the interviewer will collect data that is relevant to the study, but there will be enough flexibility to facilitate the conversation during the interview. The interviewer may identify patterns and themes from the participant's response to ask further questions to gain deeper understanding of the situation.

The Responsibilities of the Interviewer

1. Be familiar with the interview guide
2. Explain the process of the interview, the participant's responsibility, the benefits and risks involved in the interview
3. Obtain the participant's verbal consent prior to the start of the interview
4. Test the voice-recorder in advance and ensure that it is set up properly for the interview but not too threatening for the participant. Microphone can be placed on the table.
5. Use the guide as a reference to facilitate the interviews
6. Use interprofessional skills to develop rapport with the participants
7. Listen carefully and ask related probing questions to identify relevant and deep information regarding the research topic
8. The interviewer records the participants' non-verbal communications including gesture, facial expression, tone of voice and pace of speech throughout the interview. If needed, the interviewer can reflect her observation of non-verbal communication to the participants and ask for clarification. For instance, the interviewer may say, "It appears that you are grimacing. What are you reacting to?"

APPENDIX VII – Interview Guide

Introduction

This is a guide for the interviewer who conducts interviews for the research study focusing on how the role perceptions of occupational therapists affect occupational therapy practice in interprofessional home health teams.

START HERE

1. When the participant enters through the door, the interviewer **greet the participant** and says,
“Good morning/afternoon, welcome to the interview. Please have a seat to make yourself comfortable... I would like to thank you in advance for your participation in this research study.”
2. The interviewer explains the **purpose of the research study and the focus of the interview**.
“This research is to study the role perceptions of occupational therapists in home health and their impact on the occupational therapy practice in interprofessional teams. The focus of the interview is to allow you to freely express your opinions, feelings and experiences to reflect the current situation in your home health team. In this interview, I will ask some questions about your perceptions of home health occupational therapists and your experience of working with them in the home health interprofessional team. There is no right or wrong answer. Feel free to share any detailed examples and/or stories to illustrate your points”.
3. The interviewer reviews the **consent form** with the participant and requests them to sign the consent form.
“I am reviewing the signed consent form here with you... Do you have any questions about the consent form before you sign it?”
The interviewer provides them with a copy of the signed consent form
4. The interviewer reminds the participant the **reasons of voice-recording**.
“The whole process of this interview will be voice-recorded. The reason for this is to ensure all important information given will be captured in the research.”
5. The interviewer **explains the report**.

“Sometimes, quotes will be used to illustrate the participants’ point in a report. If your quotes are selected to be included in the research report, you will not be personally identified. Would you be interested in having a copy of any report or publication?...”

(if the participant answers yes) Alright, I will make sure I will mail a copy to you.

(if the participant answers no) That’s okay. We won’t forward you a copy then. ”

6. The interviewer reminds the participant of the **approximate duration of the interview**.

“I anticipate that this interview will take about an hour”

7. The interviewer asks if the participant has **any questions**.

“Do you have any questions before we start?... (Wait for 5 seconds for the participant to respond)

Is it okay that we proceed to the interview now?..”

Now is time to turn on the voice-recorder.

Interview questions for occupational therapist:

Section 1: Function of occupational therapists in home health

1. *What do you think the occupational therapists do in home health?*
2. *From your experience working as an occupational therapist, give me some concrete examples of what you have been doing in your role as an occupational therapist in home health?*
3. *In your opinions, are there any things that occupational therapists should be doing **more**? What are those things? What are the barriers for you performing those tasks?*
4. *Are there any things that you think occupational therapists in home health should be doing **less**? What are those things? Why do you think you have to do these?*
5. *How do you think the current home health occupational therapy services make a difference in clients’ lives? Family and caregiver support? Health care system?*

Section 2: Role overlap

1. Please describe any overlaps between the roles of occupational therapists and any other health professionals in Home Health that you have heard about or personally experienced.

2. How do role overlaps impact occupational therapy practice in home health? How do they affect other health professionals' practice? How do they affect your practice?

Section 3: Impact of role perception on occupational therapy practice in home health

1. All health professions have core beliefs or underlying principles guiding their practice. What do you think the core beliefs or underlying principles of occupational therapy are? How are these core values applied in the current home health practice environment?

2. Do you think other health professionals in your team perceive the home health occupational therapists' roles the same way as you do? If there is a discrepancy, how do you think the discrepancy affects the following areas:

- Clients' lives*
- Communicating with other members in your team*
- Your level of job satisfaction*
- Clients' access to home health occupational therapy service*
- Your daily practice (number of referrals and the appropriateness of referrals)*
- The health care system*

3. If you are asked to provide a piece of advice or words of wisdom to encourage home health occupational therapists for their practice, what would that be?

Interview questions for health care professionals who are not occupational therapists:

1. *What do you think the occupational therapists do in home health?*
2. *From your experience working with occupational therapists, give me some concrete examples what you have seen occupational therapists doing in home health?*
3. *In your opinions, are there any things that home health occupational therapists can be doing **more**? What are those things? What do you think are the barriers for them performing those tasks?*
4. *Are there any things that you think occupational therapists in home health should be doing **less**? What are those things? Why do you think they have to do these things?*
5. *How do you think the current home health occupational therapy services make a difference in clients' lives? Family and caregiver support? Health care system?*

Section 2: Role overlap

1. *Please describe any overlaps between the roles of occupational therapists and any other health professionals in Home Health that you have heard about or personally experienced.*
2. *How do role overlaps impact occupational therapy practice in home health? How do they affect other health professionals' practice? How do they affect your practice?*

Section 3: Impact of role perception on occupational therapy practice in home health

1. *All health professions have core beliefs or underlying principles guiding their practice. What are the core beliefs or underlying principles of your profession? What do you think the core beliefs or underlying principles of occupational therapy are? How are these core values applied in the current home health occupational therapy practice environment?*

2. Do you think home health occupational therapists perceive their roles the way you do? Why do you say so? Any concrete examples? If there is a discrepancy, what is contributing to this discrepancy?

3. If you are asked to provide a piece of advice or words of wisdom to encourage home health occupational therapists for their practice, what would that be?

APPENDIX VIII – Basic Questions Used for Coding Strategies

(Liamputtong, 2009)

Questions	What to look for from the transcript?
What?	What is the concern here? Which course of events is mentioned?
Who?	Who are the persons involved? What roles do they have? How do they interact?
How?	Which aspects of the event are mentioned (or omitted)?
When? How long? Where?	Referring to time, course and location: when does it happen? How long does it take? Where did the incident occur?
Why?	Which reasons are provided or can be constructed?
What for?	What is the intention here? What is the purpose?
By which?	Referring to means, tactics, and strategies for achieving the aim: What is the main tactic here? How are things accomplished?

APPENDIX IX – Transcriber Confidentiality Agreement

Transcriber Confidentiality Agreement

Title of Project: Role Perceptions of Occupational Therapists in Home Health

Principal Investigator

Irene Cheung
Masters of Science (Post-professional) degree candidate
School of Occupational Therapy
Dalhousie University
Halifax, NS
Phone: (604) 587 4433
FAX: (604) 587 4644
Email: irene.cheung@fraserhealthl.ca

I agree to keep confidential any information about this study. I especially will keep confidential the names and any other information about the informants or subjects of this study.

I also agree to keep audio files, typed transcripts and electronic information in a secure location, and to protect the audio files, typed transcripts, and electronic information from any person other than Irene Cheung.

Transcriber's Name (Please Print)

Transcriber's Signature

Date

APPENDIX X – Strategies to Improve Trustworthiness

The principal investigator recognized the importance of capturing and communicating experiences, meanings and social situations around the topic of role perceptions of home health occupational therapists; therefore, the following strategies has been employed to increase the trustworthiness of the study.

Excluding Colleagues from the Same Office as the Researcher's

The colleagues, who work in the same office as the principal investigator's, was excluded from this study to prevent participants' bias and conflict of interest. The principal investigator might have pre-established relationships with the colleagues within the same office that might leave presumptions about professionals' viewpoints, feelings and experiences. These might create inaccurate reflection and interpretation of participants' opinions that might lower the trustworthiness of the data. Since interprofessional relationship could be viewed as a sensitive topic, especially when the principal investigator was from the same office, colleagues might be hesitant to provide truthful data that might decrease the quality of the data.

Minimizing Participants' Bias

It was inevitable that participants from other home health teams might also have known the principal investigator from regional educational opportunities or meetings and might view her as an "insider"; this might prevent participants from providing truthful opinions. Although the topic of role perceptions was frequently discussed in home health, there might be a slight opportunity that some participants might hesitate in providing negative opinions towards the principal investigator's profession. Moreover, researchers are traditionally seen as someone who possesses more power in a researcher-

participant relationship. Participants might selectively provide answers which they believed the principal investigator would like to hear (Bulpitt & Martin, 2010; Coar & Sim, 2006; Conneeley, 2002). To minimize participants' bias, the principal investigator was aware of her role as a researcher and made that role clear to all participants.. The principal investgitor had a plan to carefully redirect participants focus back to the topic when the participants digressed the conversation during the interviews (see Appendix VI - Considerations for the Interviewing Process). To prevent confusion about the role of the principal investigator, the focus of the study was emphasized at the beginning of interviews so that participants could focus on expressing their viewpoints, feelings and experiences. The principal investigator also reminded the participants that there is no right or wrong answers to the interview questions and participants were encouraged to freely reflect on the current team situations and express their opinions. The principal investigator reminded participants that all information provided for the research was confidential. The instructions was repeated again during the interview to help to relax the participants and assist them in providing truthful information.

Use of Reflexive Research Diary

Since the principal investigator's perception, background, experience and interest could easily create bias in the research process, it was important to be insightful and identify all factors that might influence the study (Ryan-Nicholls & Will, 2009). Bracketing was initiated at the beginning of the study to identify the principal investigator's standpoint about role perceptions of occupational therapists and interprofessional relationship in home health, which could be achieved through journaling and reporting to the supervisor (Gearing, 2004). Any personal feelings and

knowledge towards individual participants was noted. An ongoing self-appraisal of moral, social and political stance was completed (Rolfe, 2006). A reflexive research diary was kept, in which emotions, personal biases, assumptions and values during the course of data collection and analysis was recorded (McDougall, 2000; Whalley-Hammell, 2002). The reflexive diary could be referenced when making decisions relevant to the study and drawing a conclusion from the study. It served as evidence of the principal investigator's learning and the evolution of her thought process throughout the study (Curtin & Fossey, 2007).

Debriefing after Each Interview

After each individual interview, the principal investigator debriefed with the research supervisor to identify her emotions and bias so that these perceptions would not affect the quality of the study (Conneeley, 2002; Hutchinson & Wilson, 1992).

Use of Interviews for Data Collection

Face-to-face interviews were chosen to collect data for this topic to provide a private and one-on-one opportunity for participants to provide information. Unlike surveys, the participants were able to clarify questions during the interviews so the interviewer could ensure that the information collected was relevant and trustworthy (Kielfhofner, 2006).

Experts' Review of Interviewing Questions

Since the relevancy and presentation of the interview questions could have a significant influence on the study outcome, the interview questions were forwarded to 3 identified key individuals for review prior to conducting the interviews (Hutchinson & Wilson, 1992; McDougall, 2000). The 3 individuals included a home health clinical

practice resource occupational therapist, a home health case manager clinical practice leader and a home health clinical resource nurse. These individuals had extensive experience and knowledge in home health practice, yet they were able to stay neutral as they were not involved in the study. They analyzed the wordings of each question and considered if they reflected what the principal investigator was intending to ask. These individuals confirmed that the questions did not impose the principal investigator's ideas onto the participants.

Research interviewing skills training

Proper interviewing was the soul of a qualitative research. Only with good interviewings skills do we obtain good interview data; only with good interview data are we able to do a credible interpretation. (Hutchinson & Wilson, 1992). Since there were major differences between research interviews and therapeutic interviews, being a novice researcher, the principal investigator did a mock interview and collected feedback from a colleague (Bulpitt & Martin, 2010). Based on the feedback and self reflection, the principal investigator improved her interviewing skills. During the interview process, interpersonal skills such as rapport building and active listening were emphasized. Furthermore, the researcher was prepared to deal with different participants' behaviours such as silence, emotional outburst, joking and hostility, while maintaining trustworthiness of the study (Fontanella, Campos & Turato, 2006).

Importance of the Interviewing Context

The interviewing context can have a significant impact on the quality of data collected during an interview. The researcher ensured a quiet interviewing venue with minimal distractions. All interviewing venues were occurred in a quiet place away from

the participants' office to prevent interruptions. A MP3 player was tested for sound quality at the venue. Poor sound quality for transcription that leads to inaccurate data transformation was avoided (Easton et al., 2000).

The principal investigator was responsible for the time control during the interviews to allow adequate time for participants to express their opinions comfortably. The principal investigator emphasized the whole interview would take about an hour so that participants could designate time for answering questions in the interviews (McDougall, 2000; Wellard & McKenna, 2001). All interviews were finished on time to allow participants to focus during the interviews so that they could provide accurate data, rather than worrying not being able to leave on time.

Member Checking

A summary of themes identified from the transcript of each individual's interview was shared with each participant to ensure data analysis was congruent with the participants' experiences (Fossey et al., 2002; McDougall, 2000). The significance of "member checking" as part of the research process was emphasized to the participants to encourage them to seriously read the summary of themes and actively provide written feedback. After collecting the feedback, the researcher could clarify with participants regarding their perspectives over the phone if needed.

Researcher Triangulation

Researcher triangulation was another strategy used to increase the trustworthiness of the study. It was easy to have researcher's bias if the data was analyzed in isolation, especially when the researcher was an "insider". Involving a non-clinician in the data interpretation could compensate for the bias (Coar & Sim, 2006;

Curtin & Fossey, 2007; Ryan-Nicholls & Will, 2009). Both the principal investigator and her research supervisor worked as a team to analyze some of the data by using coding and constant comparative analysis. The research supervisor assisted the principal investigator in identifying any prior-understandings and perceptions of the research process. An open and regular communication process was maintained so that both the principal investigator and her research supervisor were aware of the research process and implement it according to the plan.

APPENDIX XI – Ethics Considerations

The research design has taken serious consideration of ethics in the following areas.

Voluntary Participation

The principal investigator respected the participants as autonomous beings who deserved the right to make a voluntary decision about their participation. After receiving the email invitation, any interested professionals could initiate contact with the principal investigator via phone or email. This approach was to allow space and time for the health professionals to decide on their participations without any coercion or undue influence (Dalhousie University policy on the ethical conduct of research involving humans, 2008). The email invitation was sent out directly from the principal investigator, not through the managers or directors, to prevent coercion or undue influence (Dalhousie University policy on the ethical conduct of research involving humans, 2008). No participant was recruited from the home health team where the principal investigator used to have her clinical practice. The colleagues would not have felt pressured to participate in the research based on the pre-existing relationship with the principal investigator. At any point of time should the participants decided to discontinue their involvement in the study, they could do so without providing a reason.

Privacy and Confidentiality

The participants were reminded that all information they provided for the study was confidential and was only used for this research purpose. The interviews were conducted away from participants' office to ensure confidentiality. All data collected

was handled in a safe and secured manner. The data in paper format was stored in a secured file cabinet in the principal investigator's office. Computer files including word files and video clips were stored in a confidential Dalhousie University's computer server (Kielhofner, 2006). After completing each questionnaire over the phone, the data collected from each individual potential participant was recorded on a separate word document. The participants' demographic data was only accessed and analyzed by the principal investigator. Pseudonyms were randomly assigned to each participant to prevent disclosure of participants' identity. The pseudonyms were used for the participants' identity on any documents and labels during the study. After the interviews were recorded, each individual video was labeled with pseudonym for research analysis and report. In addition, transcriber was asked to sign an agreement to maintain confidential information collected during interviews (refer to Appendix IX – Transcriber Confidentiality Agreement). As for the member checking process, participants received their individual summary of themes, not summaries of all participants' opinions. The transcript was put in a doubled envelope with a "private and confidential" stamp on the front envelope (Forbat & Henderson, 2005). The mailing was handled by the principal investigator to ensure confidentiality.

Minimizing the Risks

The principal investigator was committed to minimize the participants' risks to the greatest extent as possible (DiCicco-Bloom & Crabtree, 2006). The risks may involve psychosocial stress and anxiety from different sources. The different sources of risks and the strategies to mitigate the risks included:

Content of interview and role of researcher

The discussion of sensitive topics including interprofessional relationships such as power dynamics and respect might be viewed as a threat for some participants to their professional dignity, confidence or psychosocial well-being. Since role perceptions of occupational therapists had been frequently discussed among health professionals in home health; hence, the amount of risk for discussing such topic should be relatively minimal. The highly personal interactions and trust built between the principal investigator and participants through interviews might create vulnerability to the participants (Robley, 1995). With the principal investigator being an occupational therapist working in home health, the participants might perceive her professional identity as a threat that might have increased the participants' psychological burden. To manage the risk, the research proposal was sent to the ethical review board in Dalhousie University and Fraser Health Authority ethics board for their approval before initiation of the research study. The principal investigator highlighted her identity in the email invitation and allowed participants to decide if they would like to participate in the study. The principal investigator also introduced herself as an occupational therapist at the first encounter of the participant and clarified her role as a principal investigator in the study. During the interview, the principal investigator did not wear a name tag nor provide any personal viewpoints to remind participants of her professional identity that might have helped to relieve their stress and anxiety during the interviews (Bulpitt & Martin, 2010). Participants were reminded that all data collected was confidential and was not to be shared with the employer, colleagues, other research participants or anyone other than the research team (Conneeley, 2002). If possible professional

misconduct or incompetency was disclosed about the participant during the interview, the principal investigator would consult with the respective professional regulatory body to identify appropriate actions without identifying the person. Some examples of professional misconduct might include engagement in sexual misconduct, abuse, theft, inappropriate relationship with clients or former clients. Examples of incompetent practice might include failing to assess clients or inaccurate documentation (www.cotbc.org; www.crnbc.ca; www.cptbc.org) . If it was determined that the principal investigator needs to identify the person to the professional regulatory body for further investigation, the person would be notified by the researcher. The consent form clearly outlined the limitation to confidentiality due to the principal investigator's professional obligations to report (see Appendix V – Written Consent Form).

Voice Recording and Member Checking

Voice recording during the interviews and member checking might cause stress and anxiety for some participants. Therefore, the purpose of voice-recording and member checking was fully explained and the participants were reassured of confidentiality and anonymity (Hutchinson & Wilson, 1992). Although one of the reasons of returning the summary of themes reported by participants was to empower them, the document reviewing process could possibly make some people feel embarrassed and burdened (Forbat & Henderson, 2005). Some participants might worry about what content would be published. In response to that, the quotes used by the principal investigator did not include personal information and would not identify the person. Participants could decide if they would like their quotes to be used or not on the consent forms. They were offered a choice of receiving a copy of the final research

report and/or the publications. A brochure of the Employee and Family Assistance Program (EFAP) was provided to remind participants of the availability of counseling service (www.efap.ca).

Identify Disclosure

Another risk for participants was identity disclosure from the detailed report. Since the size of the sampling and home health community was small, the participants had a risk to be recognized by others through the detailed report and their unique points of view. To minimize the opportunity of disclosing participants' identity, the participants' identity were represented by a pseudonym. Their personal information was readjusted to mask participants' identity as much as possible. The process of claiming for mileage and parking expenses had been approved but could potentially expose the participants' identity to the clerical staff and manager. Therefore, participants could choose not to claim for their travel expense if they had any concerns.

Other ways of protecting participants' identity included reminding participants to select interviewing venues, where they felt comfortable that they could not be seen by their colleagues.

Team Spirit and Work Conflicts

The risk for the home health teams and the health authority was minimized. If home health managers of the participant reported evidence of the team spirit being affected after participating in the study, their teams could access human resources consulting service through Professional Practice Integration office in the health authority. Another risk for the employer was the potential conflict of commitment as the principal investigator was doing her regular clinical work and the research concurrently.

The principal investigator negotiated with the director and manager in an open manner and she was allowed to flex her time to manage both clinical work and the research.

Informed Consent

The principal investigator ensured that an informed consent was in place from all the participants in advance of their participation in the study (DiCicco-Bloom & Crabtree, 2006; Meadows, 2003). The principal investigator provided a brief overview of the research to each potential participant over the phone. Verbal consent was obtained before conducting the screening. Once they were determined to be eligible participants, a consent form was emailed to the participants. Participants were encouraged to review the form and ask questions related to the study and the consent form prior to the interviewing day. On the day of the interview, the consent form was reviewed and participants were needed to sign the form before proceeding to the interview. At any moment of time should the participants wish to terminate their participation, they could leave without needing to provide any reasons.