

ORIGINAL ARTICLE

The Experience of Malaysian Occupational Therapists in Conducting Home Assessments and Home Visits with Older Clients

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ABSTRACT

Introduction: Home visits are complex processes for clients and occupational therapists. Despite the benefits of home visits, the numbers of home visits being conducted are decreasing in international settings due to service constraints or client reluctance. Published international studies may not be applicable to Malaysia due to cultural and geo-demographic differences relating to the home context. This study aimed to explore the experience of occupational therapists in Malaysia in conducting home visits. **Materials and Methods:** A focus group discussion was conducted with seven occupational therapists in one teaching hospital in Kuala Lumpur. The group session was audio-recorded, transcribed, summarised and analysed using thematic analysis. **Results:** Themes developed were: i) client factors inhibiting effective service provision, ii) uninformed policies and guidelines, and iii) professional identity and growth. **Conclusions:** Our study has revealed major challenges for Malaysian occupational therapists with regards to conducting home visits. Future studies should now evaluate factors underlying reluctance to participate in home visits and effective strategies to overcome these difficulties.

Key words: Occupational therapy, Home visit, Home modification, Perception, Qualitative study

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INTRODUCTION

Home visits are the key method used to undertake home assessments and plan and monitor home modification recommendations, while occupational therapists are the professionals most often called upon to conduct home visits (1-3). Managing home hazards through home assessments and home modifications are effective strategies to prevent falls among older people (1). Home visits by occupational therapists are therefore now considered an essential part of clinical practice.

Home visits are also valuable activities to collect relevant information for planning occupational therapy and other rehabilitation interventions. However, the number of home visits being conducted is decreasing over time (2, 4). Time, manpower constraints, adverse administration policies, limited evidence about the effectiveness of home visits, lack of inter-disciplinary

effort and the readiness of clients to accept home visits are among the factors contributing to the reduction of home visits by occupational therapists (2, 4, 5). These factors may also have a significant impact on the use of standardised home hazards instruments (3, 6) such as the Home Falls and Accidents Screening Tool (HOME FAST), as they rely on observation by the evaluator at the client's home (7).

When conducting home visits, occupational therapists should also consider the meaning of home for their clients. The meaning of home is a concept where a house is not only a place for accommodation but also provides a sense of belonging in the community, encompassing an individual's identity and personality, and supporting individual independence, interests and activities (8-11). How a house is perceived depends on the socio-cultural context of where the older person resides. In Malaysia, each house has a set of rules usually following the residents' ethnic-belief. For example, the Chinese-Buddhist's house would have furniture arranged according to Feng-shui or luck belief and position the Chinese altar at the front outside of the house. In an Indian-Hindu house the deity would be positioned

in the middle of the house. As well, ancestry houses especially in rural areas have strong sentimental value and as such are preserved by their occupants. Thus, any recommendations by the occupational therapist for the modification of homes may be rejected by clients, as the suggested modifications may alter the meaning attributed to the home by their older clients (8-11). This is an important aspect to consider as part of a home visit, assessment and modification recommendation, especially in ethnically diverse countries such as Malaysia.

Despite a growing understanding of the factors influencing home visits by occupational therapists internationally, few studies investigating home assessments and home visits have been conducted in Malaysia (3, 11, 12) to inform home assessment and home visit service provision. The available quantitative studies investigated the prevalence of home hazards in Malaysian houses meanwhile the two qualitative studies explored the perception on falls prevention and intervention from older clients' and healthcare practitioners' perspective. However, the two qualitative studies provided minimal exploration on home visit and hazards management service. Therefore, this study aimed to understand the challenges faced by Malaysian occupational therapists in conducting home visits and home assessments with their older clients.

MATERIALS AND METHODS

The study received ethical approval from the University of Sydney research ethics committee (Ref No: 2015/068). A focus group discussion with Malaysian occupational therapists was conducted by the first author and was guided by the framework outlined by Ivanoff and Hultberg (13). This framework asserts that the focus group is heuristic processes where the participants and the researcher learn from each other, re-evaluating own understanding on the discussed issue and how to manage the issue based on social constructivism epistemological stance (13). An open and non-judgemental environment was adopted to ensure participants felt at ease and empowered to communicate and interact with one another on the topic of undertaking home visits with older people. This was achieved by ensuring a level of commonality and shared experience within the group. A qualitative design was chosen because this allowed exploration of an issue where little is understood, where the issue can be complex and results can provide rich and deep foundation knowledge on a particular topic (13, 14).

Participants

The focus group consisted of seven clinical occupational therapists recruited from one teaching hospital in Kuala Lumpur. Occupational therapists were considered eligible for the study if they fulfilled the following

criteria: i) experienced in conducting at least one home visit and home assessment in the previous year ii) the home visit was conducted for the benefit of an older client and iii) willing to participate in the focus group discussion. Occupational therapists were recruited as they are experienced in home assessment and they are key informants to provide information on pertinent local issues that may not be experienced by other professions.

Procedure

The focus group was conducted in a meeting room at the teaching hospital isolated from other staff members to ensure the participants' anonymity, and the discussions remained confidential. Participants were provided with an information sheet and consent was obtained prior to the beginning of the session. Each participant was provided with a list of questions (Appendix I) in advance to guide the discussion but was instructed not to stick prescriptively to the line of questioning. These questions were developed from a review of the literature (2-5) and discussions between the first and the second authors. There were three umbrella questions with sub-questions (Appendix I). Refreshments were provided and the participants were allowed to discuss their views in any language convenient to them so long as they were understood by all participants. This approach further created a sense of ease and encouraged informal discussions. The researcher acted as the moderator for the focus group with one assistant. The assistant was an occupational therapist who was not a participant in the study and took notes from observations during the focus group. An open format was adopted whereby the researcher's role was to facilitate discussion and steer discussions towards addressing the topics highlighted by the questions. The session lasted for one hour and was audiotaped.

Data analysis

The data management and analysis of this qualitative study was guided by the Sutton and Austin (15) framework. Analysis of the interview data involved thematic content analysis. As the sample size is small and only involved a single data collection point, the analysis was conducted manually by the first author. The audio-recording was listened to several times and was transcribed verbatim. Listening to the audio-recording, reading the transcript and referring to the research notes was done simultaneously to obtain an overall impression for interpretation. The technique called "reading between the lines" (15) was implemented by hearing the participants' voice tone, emotional expression, connotation and non-verbal cues to get a feel for the participants' experience and to grasp the underlying message. Coding was conducted by making notes in the margin of the hard copy of the transcript. Themes were then generated by condensing and summarising several codes under a coherent and meaningful message in collaboration with the second author.

Several steps and measures were taken to ensure the trustworthiness and credibility of the findings. As the session contained pidgin language (a mixture of different languages in a conversation) the transcript was then translated into English by the first author to allow other researchers to be involved with the analysis (14, 15). The credibility of the findings was enhanced through discussion with the assistant occupational therapist who was the observer during the focus group session as part of the member-checking process (14). Trustworthiness of the findings was strengthened by allowing the third author to verify the synthesis of information conducted by the first author (14).

RESULTS

Participant characteristics are presented in Table 1. Three main themes and nine subthemes were identified after detailed evaluation of the transcripts. Below are the findings according to the themes and sub-themes generated from the focus group. Each participant was designated with a pseudonym to ensure the participants' confidentiality and anonymity.

Theme 1: Client factors inhibiting effective service provision.

Occupational therapists found conducting home visits, assessments and implementing modification recommendations challenging due to differences in clients' perceptions. Occupational therapists viewed home visits as important to ensure a good outcome for interventions such as for falls and injury prevention or support functional improvement, but the clients considered that the home visit process impacted them in ways that were unrelated to intervention, such as financial expenses and the aesthetic value of any changes on the house. Within this main theme, four sub-themes emerged as follows:

Financial

Financial issues for clients were the most frequent issues highlighted during the focus group discussion. Many clients who received occupational therapy services were from the lower and middle income brackets. Therapists were concerned that recommendations which may involve sophisticated and high-cost modifications would lead to low adherence from clients due to the likely costs incurred. Furthermore, clients were required to pay for each home visit, which means that follow-up visits are not commonly conducted. Thus, only simple modifications were usually recommended to clients from lower socioeconomic classes. Older people may also be asset rich and resource poor, and non-conductive house designs requiring numerous costly modifications. Sometimes, occupational therapists worked with social workers and doctors to apply for financial assistance from government welfare departments and other potential aid agencies. For clients with better financial status, adherence was better as they were able to hire contractors and architects, and involved therapists in the design of their modifications.

Culture

Culture is a complex issue involving the family, social and community relationships of the older person and the cultural values of society as a whole which directly influences the older person's perception of the importance of home visits, assessments and modifications. Participants indicate that the value placed by clients on independence in functional activity may clash with the occupational therapy philosophy that promotes active independence. The widespread availability of affordable, live-in full-time domestic helpers was highlighted as a cultural barrier for some older people to accept home modifications. For instance:

"Sometimes the family has a maid [full-time foreign domestic workers]. The maid will manage everything

Table 1: Characteristics of the participants (n=7)

Participant	Age	Gender	Years of experience	Highest education level	Area of practice	Frequency of home visit conducted*
A	42	Male	14	Bachelor	Spinal (previously neuro-surgical)	Occasionally
B	27	Male	5	Diploma	Geriatric	Frequent
C	38	Female	15	Bachelor	Geriatric	Occasionally
D	33	Female	4	Diploma	Spinal	Occasionally
E	27	Female	5	Bachelor	Paediatric (previously geriatric)	Rarely
F	28	Female	6	Diploma	Geriatric	Frequent
G	27	Female	4	Bachelor	Neurology	Frequent

* *Frequent* = conducted home visits every month; *Occasionally* = conducted home visits every three to six month; *Rarely* = conducted home visits every six month

required in the house. Thus, even when we've trained [the carer or older person to be independent], the maid will substitute [the independence requirement] to fulfil the older person's needs". (Participant E)

As older people may employ domestic workers to take over their daily tasks, participants believed there is a disincentive to invest in home modifications to maximise their own functional independence. Participants suggested that the collectivist social culture common among Asian clients brings about further difficulties in arranging home visits and recommending modifications. Older people often live with other family members such as their spouse or children, with family members often playing major roles in the decision making. Furthermore, older people often live in houses owned by their children, or would move between the houses of their adult children. For instance:

"When we want to discharge a person and we ask "which house?" [the older person would say]: "all five houses. Later, one [adult] child will ask their mother to live in their house. Then another one will ask the same". (Participant B)

In other cases, occupational therapists needed to deal with community leaders to help the client. Especially in public housing, the occupational therapist needs to meet with the community leader and the community leader acts as a 'negotiator' with the building developer or the government officials for the modification or financial assistance. Participant B told of his experience:

"Usually there will be the community committees, [or] the residents assist with the [aid] application [of the client] and bring it to the developers [or responsible parties]"

Client's perception and attitude

Older people were seen to have a belief that modifications will change their homes into a *hospital-like* environment, which was perceived as unfavourable by the client and family members. This was noted by Participant C:

"Older people have lots of perceptions actually. They don't want their house looks (sic) like a hospital... umm... for example we put tape here and there [modification for safety], so they [older people] complains "Oh... just came out from the hospital, then at home still feels like in the hospital"."

However, sometimes clients had made their own modifications to their home by consulting information freely available on the internet. For instance:

"Nowadays, we can easily access the internet, so they [the older client and family members] can search for everything from the internet. Then when we come for the

[first] home visit, the modification had been completed. We were surprised and asked: "Oh. How come...? Just last week I had provided the idea..." [the client replied]: "Yeah... we asked the contractor whether they can do it, and they did. So we proceed". Like that... Hmm..." (Participant D)

Although their own initiative is commendable for the client, there may be a risk of modifications not meeting the actual needs of the clients or being of a poor standard without the appropriate assessment and recommendation of an occupational therapist. Participant E gave an example:

"For dementia patients, we cannot modify the house recklessly. When we alter the environment, this will make the patient more confused. We need to do a careful evaluation and other assessment such as cognitive assessment beforehand. Then we will be able to properly plan the recommendation for the patient".

However, participants experienced a low rate of clients rejecting a home visit. Only follow-up home visits to check on progress had a high rejection rate due to financial issue and the belief that it is not necessary. For instance:

"Some clients refused to have a home visit... but usually due to personal matters". (Participant E)

Home ownership

Participants indicated that older clients in urban areas often did not own the house they lived in. Their house often belonged to their adult children. In the case of ancestral homes, these are often held in joint ownership with siblings or other family members. Other older people rented or lived in public housing. The home owner may not understand the need for home modifications or may reject the recommendations due to fear of devaluing their property. Alternatively, the older person may not wish to trouble their adult child by asking for a modification to their house. Public housing may require engagement in bureaucratic processes. Therefore, the older person's ability to access home modifications is still limited by lack of ownership of the private housing or inappropriate housing.

Theme 2: Uninformed policies and guidelines

Health and housing systems in Malaysia were perceived as a challenge by participants. These encompassed the formal systems in administration and the healthcare working sector, and informal systems such as relationships with other health professionals and relationships with the community at large. Below are the sub themes within theme 2.

Excessive bureaucracy

Restrictive administration policies were seen to limit the ability of the participants to perform home

visits. Occupational therapists are primarily based in hospitals, and perceived high cost meant that home visits were limited to a 25 km radius from the hospital which may be smaller than the catchment area of the hospital. Therefore, many clients were not eligible for a home visit service due to geographical factors. Furthermore, limited resources, such as transportation provided by the institution have restricted the number of home visits per week that can be undertaken. While it is sometimes possible for occupational therapists to refer clients to occupational therapists in other hospitals or rehabilitation centres nearer the client's home, many rural communities are not adequately served by occupational therapists.

Participant B told of his situation: *"The home visit service is actually limited by transportation and distance. Previously we covered up to 50km and it is now reduced to 25km. We [the hospital] are the major hospital so we not (sic) just having clients around neighbouring areas but as far as Seremban [neighbouring state]. So we need to have alternatives by contacting therapists in Seremban to do the home visit and reported back to us."* While participant F added: *"Sometimes the client came from Sabak Bernam [rural area] and we could not do the home visit. To request the therapists there, they also limited in term of manpower and if they are willing to do, still take some time [as they have their own responsibility and clients]."* Participant E mentioned some strategies to deal with this: *"Alternatively, we asked the client to take pictures [of the house and areas in the house] and pass it to us for evaluation, or we just interview the client asking about their house condition."*

Interdisciplinary working

Participants indicated that many other health disciplines did not understand the role of occupational therapists. Some other health practitioners assumed the occupational therapist's role was limited to psychiatric services or they were unable to differentiate the role of physiotherapists from occupational therapists, often assuming that occupational therapy also involved exercises. This was stated by several participants:

Participant A: *"What they [other health professions] know [about OT] is [dealing with] psychiatry".*

Participant E: *"They [other health professions] think physical [rehabilitation is done by] Physiotherapy, mental [rehabilitation is done by] OT, {laughing}"*

Participant F: *"(sometimes) they think OT and physiotherapy, [is doing] exercise"*

Thus, referrals to occupational therapists for home visits were limited. Other health practitioners did not perform home visits. The role of the occupational therapist was valued as the multidisciplinary team were only involved

in case discussions about clients after the home visit had been performed by the occupational therapist.

Limited knowledge

Only one participant had received formal training on assessing the home environment and recommending modifications for people with disabilities. Other participants gained their knowledge through experience and accessing online learning or reading books. Participants expressed concerns with regards to their inadequate training on home assessments, with no formal education on related theory, and the lack of standardised instruments for home hazards evaluation. Participant F mentioned her worries:

"For us, [the knowledge] is still insufficient, we need more... because mostly [of the learning] based on what we observe but the theory is still lacking".

Recently, the participants were introduced to one standardised instrument; the HOME FAST, and now use it in practice. The participants were pleased and hoped for to be able to implement more evidence-based practice, such as incorporating standardised instruments into practice in the future.

Participant B said: *"normally, our department has its own instrument (non-standardised)..."* and participant E added: *"Yes... and now we started to use it [HOME FAST] since the original author taught us..."*

Theme 3: Unique development for professional identity growth

Enjoyable professional task

Home visits were often seen as enjoyable and sometimes interesting by participants. They always found their older clients warm and welcoming when they conducted their home visit. Participant C described:

"Older people always give us a warm welcome. When people from hospital come to their [older people] house, they feel proud that we visited".

The clients usually trusted the occupational therapist's knowledge. The participants believed that their knowledge and experience were expanded by undertaking home visits, so that they could target their interventions and home visits made their recommendations more effectively.

Participant E mentioned: *"Every visit provides a different exposure"*. Participant D added: *"What we learned in theory is sometimes not applicable to reality within the client's house"*.

Expanding the role of occupational therapy

Home visits were viewed as a platform for occupational therapists to strengthen and promote their role to

other health professionals. Home visits also provided an opportunity for the participants to liaise with other health professionals when their expertise and opinion was needed.

This was mentioned by Participant E: *"... So when they (other health professionals) joined the MDT (multidisciplinary meeting), and when we (occupational therapists) present [the case study and the findings from the home visit], they will know that occupational therapy can do home visits. So when they [other health professionals] go anywhere, transferred to other hospitals, they can bring the knowledge and promote about occupational therapy role".*

Participants felt that home visits helped them to expand their thinking about their roles in terms of thinking more creatively about how to meet the needs of clients and to accommodate broader issues of client safety in their homes. In addition, home visits addressed not just the physical needs of a client by modifying the environment but also included making recommendations about how a client undertook their functional activities.

DISCUSSION

One of the challenges is the contradiction between what is needed for the client to prevent falls and what is wanted by the client to remain in their home. Occupational therapists have a duty to conduct a home visit and assessment to gather enough information and then provide modification recommendations to ensure a safer home environment. However, the service is limited by general financial and cultural issues, and the attitude of the clients.

The biggest issue in conducting a home visit and recommending home modifications are the financial concerns of clients. Our findings were in contrast to the findings of a previous study where almost all respondents are able to pay for complex modifications (16). Mostly older people in Malaysia do not have insurance and need to pay by themselves (17, 18), but many older people belong to the low or middle income bracket (18). Although healthcare in Malaysia (especially in government institutions) is subsidised (17, 19), payment for home visits and home modifications remain almost exclusively out-of-pocket, and the government does not meet such expenses. Charitable donations are an alternative for funding the modification but access to this funding is labour intensive, and lacks consistency.

Culture was also shown to play a major role in shaping the perceptions of older people and their family members about home visits and home modifications. Perception of the older clients and their family on home visit was different than the therapeutically benefit perceived by the therapists (20). Denial and refusal of

interventions among older people is usually related to the negative stigma associated with depending on aids and adaptations or considering falls as a part of the normal ageing process (3, 21). Culture is part of the client's identity which frames their health-seeking behaviour and their willingness to engage with health-related interventions. The violation of cultural rights or the implementation of modifications without due recognition of cultural influences may jeopardize the client-therapist relationship and may inhibit adherence to recommendations. Home modifications may alter the aesthetic meaning of the house, and can make the older person uncomfortable with any modifications. This finding complements those by Tanner et al. (10) who reported that the meaning of home is an important element to be preserved by the older person to ensure a sense of comfort in the home and to enable ageing-in-place. Thus, modifications should be tailored to individual needs taking into consideration the meaning of the home for that individual. For example, recommendations could be temporary to facilitate wheelchair use with provisions for continuous change considering the client's potential recovery.

The participants also identified the influence of the home visit process beyond the individual client. According to Aplin et al. (9) home modifications not only impact the client but also family members and society, either positively or negatively. Furthermore, choice of workmanship to maintain the aesthetic value of the house, proper consultation by the therapist, involvement of the client in decision-making, and consideration of perception on societal dimension of the home environment are crucial for the success of home visits and home modifications (9). Home visits are perceived either by the older person and family members as a complex process. From the perspective of the client, a home visit could be viewed as a process for the health professionals to find the client's mistakes (5). This perception leads to feelings of anxiety about the alteration of the older person's environment and function, and can indirectly affect carers (5, 11). However, older people are able to rapidly develop coping mechanisms and receptiveness to recommendations provided by therapists (5, 22) if proper measures are taken such as explaining the need for the home visit, assessment and modification. Scarce knowledge or pessimistic attitudes about the accessibility and inclusion of people with disabilities has limited compliance about disabled-friendly environments (23). Therapists should rationalised why home visits need to be tailored to the client's condition and why it is necessary to engage the client in decision making (4, 24). In addition, occupational therapists have greater influence on encouraging clients to adhere to the recommendations and clients are usually more receptive to discuss the benefit of the intervention (25, 26). Therefore it is important to educate the clients and family members to understand the importance of home visits, home assessments and modifications to promote

the uptake of the intervention and for older people to be able to explain the intervention to other community members.

Challenges beyond client-related issues were also identified by participants. Current policy, guidelines and frameworks are less supportive towards home visit practice, especially in Malaysia where there is no comprehensive ageing policy (27). The National Older Persons Policy (28) is a general policy for Malaysia and does not provide guidance on falls prevention and intervention. A more comprehensive guideline such as the Panel on Prevention of Falls in Older Persons American Geriatrics Society and British Geriatrics Society (29) need to be developed for Malaysia. A comprehensive guideline is an effective communication medium for health practitioners and a good reference point for the public.

Referrals to occupational therapists who are more familiar with home visits may be complicated by other health practitioners believing the role of occupational therapists is limited to psychiatric services or is similar to physiotherapy. A study by Jer-Hao et al. (30) indicates that health practitioners rarely understand the role of occupational therapists. However the limited capacity of occupational therapists in undertaking home visits is exacerbated by the need to fulfil other clinical responsibilities. Therefore, occupational therapists should actively educate and promote their profession to other health practitioners and clients.

Inter-professional practice is usually viewed as effective in improving client outcomes, and involves more than just conducting an interdisciplinary meeting (31, 32). In Malaysia, collaborative practice between health professionals is limited and there is poor knowledge about other disciplines across health professions. Inter-professional education should be mandated in the training curriculum of all healthcare professionals. Inter-professional education has been established in developed countries (33) but it is relatively new in Malaysia (34).

Formal learning for therapists is also crucial to prepare for best practice based on evidence. In a previous study, health practitioners were reluctant to do fall prevention and intervention due to a lack of confidence because of limited knowledge and training (3). In a study by Denton et al. (35), practitioners were taught a module related to geriatric care and home visits, and they were more prepared for the intervention, and experienced less anxiety. Effective and affordable conduits for continuing professional education should therefore be evaluated and instated.

Nevertheless, despite these issues, home visits were seen by participants to have a positive impact and were

able to contribute to the development of professional growth among health practitioners. Home visits enable practitioners to appreciate the cultural diversity of clients, and intervene with clients using a holistic approach according to the client's unique needs and provide invaluable experience for the therapists on toleration, openness and self-improvement (5, 22, 36). Therefore, home visits allow health professionals to be more empathetic and client-centred in their practice.

The study findings cannot be generalised to Malaysia because the findings were limited to participants from a one teaching hospital in single urban area and small sample size. For instance the funding of home modifications for clients may be quite different in other settings which would affect the perceptions of occupational therapists about their practice. Participants were also located in a teaching hospital, which assumes that occupational therapists have more opportunities for professional development. However, the findings still indicated a lack of education for these participants on home assessment practices. Future research on this topic should be conducted in different settings such as in rural and remote areas, in the government and private sectors, and in hospital and community clinics, to capture the holistic and diverse experience of therapists in conducting home visit services.

There were no opportunities to conduct member checking or further data collection with the focus group participants due to restrictions in their availability. Difficulty in the early process of research such as gaining ethics approval, funding, recruitment and granting access to occupational therapists delayed data collection which may have affected their willingness to participate. Therefore, only one focus group discussion was conducted. Language issues caused some difficulties during the translation of the recording of the group from pidgin language to English to allow other English speaking researchers to participate in the coding and interpretation of the data. This challenge is prominent in qualitative studies conducted cross-culturally and in developing countries (3, 37).

CONCLUSIONS

Our qualitative assessment of the perception of home visits and home modifications by occupational therapists in Malaysia is the first to explore this topic within the Asian context, and has revealed some unique perceptions specific to the Malaysian cultural, political and socioeconomic landscape. The findings of this study are invaluable in informing future policy and research to identify sustainable solutions to maintaining home visits, home assessment and home modification services.

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