Perceptions of the Role of Diversional Therapy within Nursing Homes by Directors of Nursing

BY

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Abstract

Provision of leisure and recreational services has the ability to significantly contribute to the quality of life of older adults living in residential settings including those residents living in nursing homes. Therefore diversional therapy services should be seen as a vital part of these facilities. Currently, there is a feeling within the diversional therapy profession that there is a lack of understanding of the true role of the diversional therapist within various health care facilities, including nursing homes.

The purpose of this study is to examine the perceptions of the role of the diversional therapist within nursing homes by directors of nursing. Qualitative research methods were used with the aim of gaining the true perceptions that directors of nursing have on various areas of diversional therapy practice. Thirteen in-depth interviews were conducted with directors of nursing at various nursing homes in the Sydney area. The interview data suggests that although the directors of nursing were generally supportive of diversional therapy, there is clearly a lack of understanding on behalf of the directors of nursing on various areas of diversional therapy practice, including roles, skills, training and education of a diversional therapist. Other issues were revealed in the interviews and are also of importance in relation to the diversional therapy profession such as suitability of the name diversional therapy, employment conditions and other professional issues affecting diversional therapy practice.

This study aims to increase diversional therapists knowledge in relation to the perceived roles that directors of nursing hold on the diversional therapy profession and therefore to give the diversional therapy profession some kind of base line on which to focus their educational programs on the diversional therapy profession. Also, to increase the documented research base on diversional therapy practice and associated issues.

Keywords : Diversional Therapy, Roles, Directors of Nursing, Professional Issues

Introduction

The diversional therapy profession can be described as an emerging profession, and as such it is progressing through many changes and dilemmas (Koop, 1993). Diversional therapists are primarily responsible for the provision of leisure and recreational opportunities to people who have a variety of needs, including residents living in nursing homes.(Brown, 1994). Recreational and leisure services are now the right of all nursing home residents as set out by the government via Outcome Standards for nursing homes. Even though in recent years, increasing attention has been paid to providing recreation opportunities and activities for residents of nursing homes, hostels, hospitals and others in residential care, little attention seems to have been paid to the requirements and needs of staff to conduct these recreational activities (Department of the Arts, Sport, the Environment, Tourism and Territories, 1990). Currently there is a feeling within the diversional therapy profession that there is a lack of understanding of the true role of the diversional therapist within various health care facilities, including nursing homes. The perception of such shortcomings for staff providing recreational and leisure activities has inadvertently turned into more negative attitudes to and perceptions of the types of services provided and of the diversional therapy profession as a whole. As Bauze observed, "in some areas of the health care system, there appears to be a negative attitude towards diversional therapy. These attitudes could result from a lack of knowledge and recognition of the services diversional therapists can provide for clients, and misconceptions of the role of diversional therapists as an integral and valuable member of the multi-disciplinary team" (1993, p.8).

This study explores the perceptions of the role of diversional therapy by directors of nursing in nursing homes. Since diversional therapists in nursing homes are generally employed by the directors of nursing, it is essential that directors of nursing have a

thorough knowledge of the roles and responsibilities of the diversional therapist within the nursing home. Cherry and Kneeshaw (1993) believe that the full support and encouragement of the director of nursing in particular is essential for the successful functioning of the diversional therapist and their program. Diversional therapists on the other hand are sceptical about the knowledge and understanding of some directors of nursing of the role of the diversional therapist in these nursing homes. If therapeutic recreation professionals are to function effectively, it is essential that they be aware of barriers that may create conflict between disciplines and interfere with accomplishment of client-related goals (Smith, Perry, Neumayer, Potter and Smeal,1992).

This study will further attempt to fill part of the gap that exists between assumptions and true life knowledge on what directors of nursing perceive to be the role of diversional therapy within nursing homes. By identifying barriers that may be occurring in this area the diversional therapy profession can develop appropriate educational means to remedy the situation. Resolution of these issues and understanding of the role of the diversional therapist will ensure that more effective services can be provided both within nursing homes and various health care facilities.

This is a qualitative study that was conducted through a series of face-to-face individual in-depth interviews with directors of nursing in a number of nursing homes in metropolitan Sydney. After a review of the relevant literature, the methodology of the study will be presented, findings on the perceptions held by directors of nursing will be examined and a discussion of the findings will be presented. Recommendations in relation to the outcomes of the study will be made in the final chapter.

Literature Review

Leisure has long been considered a basic human right (Brownlie, 1981). According to the World Leisure and Recreation Associations (1983) this implies the obligation of governments to recognise and protect this right and to ensure that no one shall be deprived of this right for any reason. Leisure is thus no longer a privilege or a reward; it is a condition of well-being. As such, leisure is relevant in any setting where people retain their right to live like human beings (Sylvester, 1992, p. 18-19). This need for enjoyable and stimulating activities is as essential for the aged as it is for the young (Hayes, 1974). As Brown explains "everyone has the right to a fulfilling life, right until death. This is a well documented human need. Older people who find themselves in special care, for whatever reason, are not exempt from this need for fulfilment, neither do they have any less right to it" (1994, p. 244). Leisure has the ability to significantly contribute to the quality of life of older adults in residential settings including those residents living in nursing homes (Department of the Arts, Sport, the Environment and Territories, 1992). For these reasons the provision of leisure and recreational activities within nursing homes should be seen as a necessity, therefore the employment of a diversional therapist within a nursing home is essential.

Even though leisure is a basic human right and the provision of such services could be justified on that premise, the many benefits derived from leisure and recreation are also of importance when studying this area. Living in a nursing home does not change the basic needs of people for creative use of leisure time. Opportunities must be provided to develop new experience for the elderly. Appropriate activity programs participated in and suited to the individual are often crucial factors in preventing and delaying mental and physical deterioration (Hayes, 1974). For the frail or dependent older person, recreational programs are particularly important in maintaining well-being and life satisfaction

(Minichiello, Alexander and Jones, 1992). Recreation can relieve the boredom and loneliness which sometimes culminate in illness. Within the limitations of the older person, they must prevent stagnation through leisure pursuits which will keep them physically active and mentally alert (Hayes, 1974). As the Healthy Older People's Report explains "social isolation and loneliness are contributing factors to a wide range of mental and physical health problems. Lack of personal networks, social interaction, physical activity and assistance with activities of daily living, seem to be associated with poorer self-assessment of personal health and well being" (Department of Health, 1989, p.56).

Planned recreation services can also make a significant contribution to individuals perceptions of enjoyment and well being (Teaque and Mac Neil, 1992). According to Teaque and MacNeil, "individualized leisure services may .... be used as an intervention strategy to not only maintain health but also to help restore an individual's ability to lead an independent, satisfying life" (1992, p. 225). They go on to say that leisure services, "continually offer (individuals) challenge, variety, and choice which bolster their perception of personal causation and control. As a result, adjustment to an institutional setting should be improved" (1992, p. 228). Grey and Pelegrino (1973) believes that the most prominent benefits of leisure participation include, feelings of mastery, achievement, exhilaration, acceptance, success, personal worth, pleasure and a positive self image.

"The benefits of activities are many. They will improve social skills, maintain and improve physical fitness, maintain intellectual skills, promote stimulation and interest in life and provide for pleasure and fun" (Brown, 1994, p.251). Appropriate leisure activities which are stimulating and meaningful enhance an individual's motivation as well as promoting a positive outlook, encouraging social interaction and stimulating pride in achievement (Pittman, 1990). According to the Department of the Arts, Sport, the Environment, Tourism and Territories (1990) recreation can bring direct benefits which may include,

building a sense of belonging and security, mental stimulation, happiness, increasing decision making, independence, relaxation, socialisation, escapism, an opportunity to express ideas and be creative, increased self esteem, decreased boredom and frustration and personal growth. Indirect benefits can also be gained, including maintaining fitness levels, improved sleep patterns which reduce the need for sedatives and other medications, reduction of digestive complaints and maintaining physical and mental health.

It can be seen recreation has many benefits. This increases the importance of the provision of such services not only in the community but particularly in nursing homes. "Nursing homes provide accommodation and long-term nursing care for chronically ill, disabled or demented patients" (Australian Institute of Health, 1994, p. 118). Currently, there are approximately 28, 516 people living in nursing homes (Australian Institute of Health, 1994). Because of this large number it is important that the needs of these people are addressed and taken into consideration when services are provided within nursing homes. These services include the provision of recreational and leisure programs and activities.

Over the last fifteen years or so, within the context of Australian Society, diversional therapists have emerged as the occupational group who have assumed responsibility for providing leisure and recreation for people experiencing the effects of ageing, disability or disadvantage (Brown, 1994). Diversional therapy, according to Cherry and Kneeshaw, is "thought to be a necessary component of nursing home life and essential for assisting residents in leading as fulfilling life as is possible, considering their frailties" (1993, p. 14). The opportunity for participation in safe, satisfying recreational activities makes an important contribution to the health, fitness and well-being of the community, according to Richardson (1990). This applies particularly to residents living in nursing homes.

When the benefits and importance of participation in leisure and recreational activities are explored, it is obvious why the provision of such services is essential within nursing homes, and why diversional therapists are the professionals best equipped to provide them. The benefits of leisure and recreation coincide with the aim of the diversional therapy profession which is to enhance self esteem and facilitate personal fulfilment by providing opportunities for the individual to participate in leisure and recreation activities of their personal choice. Brown (1994) believes that through participation in recreation and leisure activities that individuals develop skills, confidence and self awareness. Leisure and recreation experiences also encourage positive feelings mastery, pleasure and satisfaction. The positive attributes of leisure and recreation contribute to an enhanced self esteem which is essential if diversional therapy is to enhance the psychological, social and physical well being of individuals who experience barriers to participation in recreational pursuits (Brown, 1994). "Recreation should provide creative outlets, personal development, social inter-relationships, links to the world outside the institution, physical exercise, chances for individual pursuits of learning, aesthetic and cultural programs, and a chance to serve others" (Hayes, 1974, p.141).

Recreational programs that are designed to capitalize upon the personal interests and skills of residents naturally serve to combat the sense of helplessness associated with closed environments and a well managed program of organised recreation supervised by a qualified leisure professional can provide both the opportunity to utilize existing skills (and learn new ones) and the motivation to continue to use one's faculties (Teaque and MacNeil, 1992). The case for providing recreational and leisure programs for residents living in nursing homes is strengthened by the findings of a study by Clarke and Bowling (1990) who found that when residents were involved in recreation with health professionals and involved in music their moods were more positive and happiness was

more likely to be displayed. Comments that were passed between patients in the ward and residents in the home also indicated that some form of diversion was needed to prevent boredom and more positive moods were observed when patients were involved in recreation with staff and when they were able to listen to music. It is also possible to make a medical case for recreation. The greatest value of recreation is that it can be prescribed as a definitive therapeutic treatment. Because the activities included in recreation programs usually require some degree of skill and concentration, recreation allows the patient to lose himself in the activity at hand, giving his mind a rest from the mental and physical problems that beset him. It provides a controlled outlet for the release of tensions that otherwise might be directed inward or towards others. It offers a means whereby the patient can acquire and put into practice new knowledge about himself. Recreation helps morale by giving the individual a feeling of satisfaction and accomplishment at having mastered some small skill or compensated for a handicap (Felix, 1962, cited in Kraus, 1983). Therefore, "recreation experience can be considered therapeutic because it offers a wide variety of social, emotional, physical, or intellectual benefits (Teaque and MacNeil, 1992, p.226).

With the increasing awareness that leisure and recreation is an essential service in nursing homes, an increase has occurred in the numbers of people employed to fulfil this need. Diversional therapists are the professionals primarily responsible for providing these services, and practitioners providing these services may be employed under a variety of titles, including diversional therapist, recreational officer, activities officer and programme co-ordinator (Faculty of Health Sciences, University of Sydney, 1995). In many instances, nursing homes utilize the services of volunteers or employ an activities co-ordinator who has had no previous formal training or experience in planning and directing a resident recreation program. Similarly, they employ people who have worked as activity co-ordinators for several years but have had no formal training. The only trained persons

available to provide the recreation services are professionals, who by virtue of their education and training are able to demand a higher salary than many nursing homes think they can afford or are willing to pay. For the most part, the low salary scale and the general working conditions in skilled nursing homes precludes the employment of professionally trained personnel (Tague, 1974). This is slowly starting to change. With the introduction of tertiary training for diversional therapists many directors of nursing working in nursing homes are starting to realize the importance of having a tertiary trained person to co-ordinate, implement and evaluate the recreational programs for the residents. This is also reflected in the award wage for recreation workers that recognises the difference between a tertiary trained diversional therapist and a person with no formal training or experience. The award also clarifies the use of various names or titles for people running the recreation and leisure programs.

Since diversional therapy can be seen as an emerging profession and one of the newest members of the health care team (Bauze, 1993), diversional therapists need to be accepted as a member of the multi-disciplinary team now functioning within the nursing home. As Fried and Leatt explain "health care organisations are increasingly required to utilize multi-disciplinary approaches to patient care as well as in response to managerial and organisational problems" (1986, p. 1156). But optimal functioning of a multi-disciplinary health care team is not easily achieved or maintained. Sellick explains "the development of co-operative team-work has a lot to do with group dynamics, social relationships and the attitudes of team members.... each member comes to the team with certain expectations of how each team member should function, but unless these expectations are clearly defined and negotiated, confusion and hesitancy can occur. This may create role conflict, role overlap or role overload" (Sellick, 1985, p.35). Studies of team practice all indicate that attitudes of individual members towards work and to their colleagues are critical to effective team-work; they also have shown that the majority of teams function at levels

well below their potential (Sellick, 1985). It can also be argued that attitudes are determinant of team conflicts associated with status, authority, power and leadership issues.

There are a number of barriers that may result in conflict and interfere with the effectiveness and efficiency of multi-disciplinary teams (Smith et al, 1992). "The relationship between the recreation worker and the employer is important in enabling them to deliver effective recreation services" (Department of the Art, Sport, the Environment, Tourism and territories, 1990, p. 16). Managers must take into consideration the role expectations and self image of the various health care workers, as well as their perceptions and knowledge of other's responsibilities and skills (Fried and Leatt, 1986). "To assure effective co- ordination of services, health care managers are required not only to understand the roles of the various occupational groups represented in the organisation, but also to be aware of the extent to which role ambiguity and role conflict exist. An understanding of this dynamic is essential to better working relationships among health care team members" (Fried and Leatt, 1986, p. 1157). Managers also need to understand the professional aspirations of staff and how insensitivity to their professional needs may affect their morale (Fried and Leatt, 1986). But it would appear that many proprietors and administrators do not see the value of diversional therapy in nursing homes and therefore do not give it their full support, believing that the medical model is sufficient for the lifestyle of their residents (Brown, 1988).

This barrier between the diversional therapist and the health care manager also occurs with other staff. Diversional therapists generally have a number of roles including an organiser, instructor, entertainer, friend. While they are trying to be all things to all residents, they may not receive much support from other staff who may say things like "What a good job you have, playing games while I have to work!". These people (medical, administrative

and service staff) may not always be supportive or understand the role of the recreation worker. Other staff may in fact believe that the work of the recreation worker is all play rather than work. Lack of insight and awareness between professions tends to discount the complexity and personal commitment involved in such fields as recreation (Department of the Arts, Sport, the Environment, Tourism and Territories, 1990), and this lack of understanding of the role of the diversional therapist/recreation worker may have many detrimental effects; for instance "task duplication, gaps in service, or inter-professional rivalries and conflict" (Fried and Leatt, 1986, p. 1156). Also, the minimization of professional autonomy produces continuous levels of tension among the multi-disciplinary team (Ivey, Brown, Teske and Silverman, 1988). If however, only one of the professional groups perceives that there is a problem, resolution of the problem will be difficult (Smith, et al, 1992). This may be the case for the diversional therapy profession. Therefore it is essential that the members identify clearly and precisely where the barriers and misunderstandings are occurring, in relation to their role within the health care system.

Methodology

This study was conducted using qualitative research methods. Qualitative research methods were the preferred method of study because " in-depth interviewing is conversation with a specific purpose - a conversation between researcher and informant focussing on the perception of self, life and experience, and expressed in his or her words. It is the means by which the researcher can gain access to, and subsequently understand, the private interpretation of social reality that individuals hold" (Minichiello, 1990, p. 87). Semi-structured in-depth interviews were used rather than unstructured interviews because a broad topic was chosen and the interview needed to be guided to ensure the topic area was covered sufficiently. An ethics proposal was submitted to the School of Community Health, Faculty of Health Sciences, University of Sydney, Ethics Committee and approval was give prior to the study being conducted.

An interview guide was developed around a list of topics but the order of questions was not fixed, neither was the wording. The content of the interview was focussed on the issues that were central to the research question but the type of questioning and discussion allowed for flexibility within the interview context (Minichiello, 1990, p.92). Therefore informants were able to freely express their true feelings and perceptions as they saw the issue and this was the main aim of the study. The researcher asked only questions that related to the theme areas. Questioning was kept to a minimum for all interviews to minimise interviewer bias and the researcher was aware not to ask leading type questions.

Data was collected using semi-structured in-depth interviews. Thirteen interviews were completed with directors of nursing at thirteen different nursing homes. Individual respondents were selected according to the nursing home they were working in. It was the aim of the researcher to capture an array of responses from the directors of nursing on

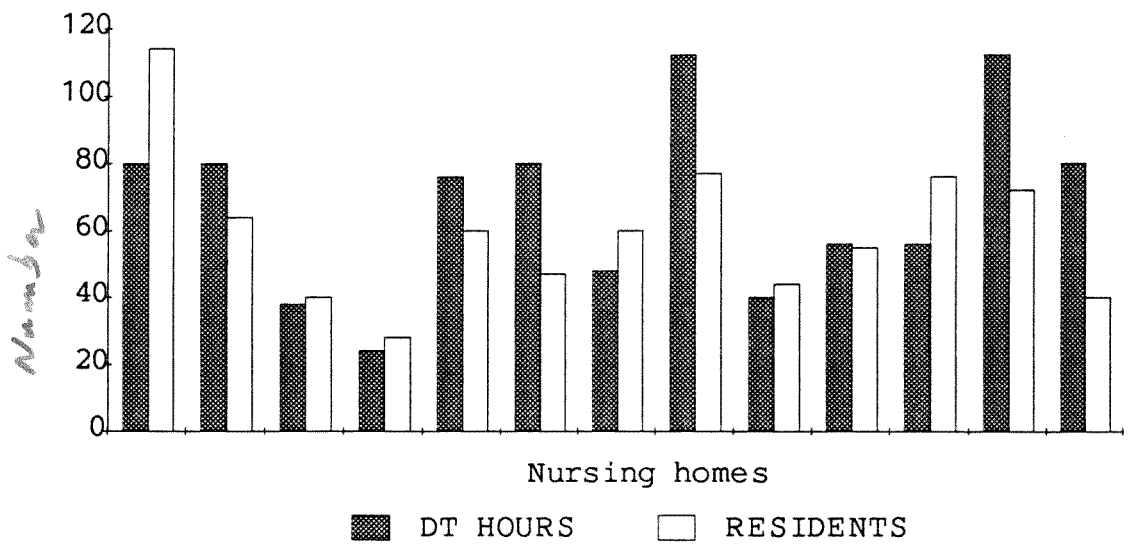
their perceptions of the role of diversional therapy within nursing homes. Nursing homes of various types and sizes were included in the study because of likely differences in the perceptions that the directors of nursing may have. While many nursing homes in Australia are privately owned, there are also voluntary institutions run by charitable or religious organisations, and government-managed homes (Howe, 1990). The sample covered the range of non-government nursing homes.

The aim was also to cover a variety of nursing homes in relation to the number of hours allocated to diversional therapy services, nursing homes that employed graduate and non-graduate diversional therapists, the number of residents living in the nursing home, large and small facilities and the geographical area the nursing home was situated in. Potential nursing homes for the study were chosen from a list of nursing homes in the Sydney area. Nursing homes were chosen randomly from the list of nursing homes. Every fifth nursing home was chosen as a potential participant but not all the nursing homes chosen initially were involved in the actual study. This occurred because the numbers required for this study were fulfilled and because some directors of nursing decided not participate in the study. Once the nursing home was chosen they were contacted by phone to ascertain if they had a diversional therapist employed there and how many residents were living in the nursing home. Of the thirteen nursing homes, two were religious organisations, one was an ethnic specific nursing home and ten were privately owned. Out of the ten privately owned nursing homes, three were owned by the same proprietor but had separate directors of nursing that managed them. The nursing homes chosen also varied in terms of the diversional therapy hours and the amount of residents living in the nursing home.

The nursing homes used in the study were located within the Sydney metropolitan area. The hours allocated to diversional therapy services ranged from twenty-four hours per week to one hundred and twelve hours per week , with the average being 68 hours per

week. Out of the thirteen nursing homes, two had diversional therapy graduates working in them, one had a graduate from the Recreation and Leisure course and the remaining nursing homes had diversional therapists with varying qualifications, ranging from registered nursing to no training or previous experience. Because only three of the thirteen nursing homes had tertiary trained diversional therapists working in them, the study may be slightly biased towards those nursing homes who employed non graduate diversional therapists. The number of residents living in the nursing homes varied from twenty eight residents to one hundred and fourteen residents with the average being 60 residents. (See graph 1 for a comparison of diversional therapy hours allocated and the numbers of residents living in the nursing home.)

Graph 1



This graph represents a comparison between the nursing homes used in the study in relation to allocated hours to diversional therapy and the amount of residents living in the nursing home.

Four of the nursing homes were part of larger facilities that also had a hostel section and self care units. The directors of nursing were all female and their educational backgrounds and the amount of years working as a director of nursing varied. The minimal educational qualifications were hospital based registered nursing training. Six of the thirteen informants had only this qualification and the other seven informants had undertaken further education. This education included such qualifications as Bachelors Degrees, Graduate Diplomas and a Masters Degree. The informants also varied in terms of the amount of time working as a director of nursing from about eight months to twenty five years. See table 1 for a summary of the characteristics of the directors of nursing, the diversional therapists and the nursing homes involved in the study.

Once the nursing homes were chosen, taking into account these variables, an Information Sheet (Appendix A) explaining the study and a Consent Form (Appendix B) were mailed to the directors of nursing at the nursing homes. The directors of nursing were then followed up with a phone call from the researcher to ascertain whether they were willing to participate in the study. In total eighteen letters were sent over a period of time and from the eighteen potential participants, thirteen directors of nursing agreed to be involved in the study. Of the five who were not involved in the study, three directors of nursing felt they did not have the time to be involved in the study, one director of nursing was on annual leave at the time the study was conducted and one director of nursing flatly refused to participate. The director of nursing who refused to participate had no hours allocated to diversional therapy within the nursing home therefore the study may be slightly biased towards directors of nursing who have employed and come into contact with a diversional therapist. The thirteen directors of nursing who agreed to participate were then involved in a semi-structured in-depth interview.

The semi-structure in-depth interviews consisted of open ended questions which centred around the themes of perceived roles, skills, training, duties and benefits of diversional therapy within the nursing home and the name diversional therapy. Similar questions were asked at each interview but the discussions that followed varied. The duration of the interviews ranged from thirty minutes to ninety minutes. The interviews were taped on a tape recorder after permission was gained from the informant. No notes were taken during the interview as the researcher preferred to fully concentrate on what was being said.

Immediately after each interview was conducted field notes were made on "the facial and physical expressions of the informant, the details of the setting and perceptual impressions" (Minichiello, 1990, p. 251). The field notes also included the "researcher's reflection on what was said (or not said) and observed" (Minichiello, 1990, p. 251). The taped information from each interview was then transcribed to form a transcript file. The transcript file included an exact transcription of the interview, reflections on the researchers conduct, ideas and methodological notes. A cover page was attached to the transcript file. The cover page included the informants code number, topic, date, place of the interview, length of the interview, relevant information and any special circumstances that related to the study. A diagram of the interview setting was also attached to facilitate recall of the interview process. The transcript files were organised so as to facilitate the process of coding data for analysis (Minichiello, 1990).

In addition to the transcript file a personal log and an analytical log were completed for each interview. The personal log, as suggested by Minichiello 1990, included a descriptive account of the informant and the setting, reflective notes on the field work experience and methodological issues. The analytical log, as suggested by Minichiello 1990, included a detailed examination of the research questions asked and ideas emerging as the study

progressed. Upon completion of the transcript file, the personal log and the analytical log the data was analysed in terms of emerging themes. The data was coded under the headings of perceived roles, skills, benefits, training, documentation, the name and other issues relating to the profession of diversional therapy. Once the data was coded it was extracted and collated under each theme heading for ease of further analysis. Further analysis of the data was completed to ascertain the true perceptions that directors of nursing have on the role of diversional therapy within nursing homes. The findings are reported on under each theme heading.

Nursing Home	Hours Allocated to Diversional Therapy	Number of Residents	Educational Level of Diversional Therapists	Educational Level of Directors of Nursing	Director of Nursing (Female/Male)
1	80	114	Nursing Training	Registered Nurse	female
2	80	64	No Formal Training	Registered Nurse, B.A.	female
3	38	40	No Formal Training	Registered Nurse	female
4	24	28	Red Cross Course	Registered Nurse	female
5	76	60	No Formal Training	Registered Nurse, B.A., Post Grad.	female
6	80	47	DT Graduate/No Formal Training	Registered Nurse, Grad. Dip.	female
7	48	60	Recreation/No Formal Training	Registered Nurse	female
8	112	77	Nursing Training	Registered Nurse, Cert	female
9	40	44	No Formal Training	Registered Nurse, B.A, B.A.	female
10	56	55	Psychology/No Formal Training	Registered Nurse	female
11	56	76	No Formal Training	Registered Nurse, Grad Dip.	female
12	112	72	T Graduate/RN/No Formal Training	B.A. Nursing, Dip. , Masters	female
13	80	40	No Formal Training	Registered Nurse	female

Table 1 : Characteristics of the directors of nursing, diversional therapists and the nursing homes used in the study.

Findings

Through the in-depth interviews with the directors of nursing some valuable information was gained on what the directors of nursing perceive to be the role, benefits, skills and training of a diversional therapist and on other issues such as documentation, the suitability of the name diversional therapy and other important issues that may affect diversional therapy as a profession. It is important to note here that the following findings are a reflection on what the thirteen informants felt and their thoughts on the issues discussed in the interviews. The findings are reported under each of the main theme headings.

a) Roles of the Diversional Therapist

In the discussion of the role of the diversional therapist fifty-nine separate issues were raised by the directors of nursing. Of these, thirty five issues were raised by two or more of the informants and fourteen by four or more (See Appendix C). The most common response from the informants when asked what the role of the diversional therapist in a nursing home was, that the diversional therapist provided activities for the residents to do which occupied the residents time during the day. Twelve directors of nursing saw this to be the diversional therapists major role. As **DON 4** explained :

> "The diversional therapists role is one of providing activities for the residents, for making sure that the social activities that they are use to doing are fulfilled."

DON 6 stated the diversional therapist :

> "Occupies the residents in a multitude of ways, whether it's doing something one to one, or whether it's .... setting up a group of them to have a game of cards."

This would be seen as one of the major roles or duties of the diversional therapist in not only a nursing home but in many health care facilities.

Next, ten directors of nursing saw assessing the residents and gaining a social history on the residents as part of the role of the diversional therapist. The assessment involves finding out what the residents likes, dislikes, their family connections, past life history and any other relevant details on the resident. **DON 10** felt :

> "Assessing each residents needs, is absolutely important."

and **DON 11** explained :

> "The diversional therapist or the activities officer should know more than any of us about their background, their likes and dislikes, how they like to spend their time, their family connections, their spiritual and religious beliefs, that sort of thing."

Again this would most likely be a standard role of the diversional therapist in any health care facility. A difference may be the diversional therapist working in a nursing home needs to do a more in-depth type of an assessment either with the resident or a family member than may be required in other facilities.

Next, two issue were seen by nine directors of nursing as part of the role of the diversional therapist. The first was that the diversional therapist was involved in feeding the residents at lunch time and supervising the dining room at meal times. Nine of the thirteen informants stated that the diversional therapist was involved in feeding of the residents mainly at lunch time and many of the diversional therapist were also given the role of supervising the dining room at meal times. As **DON 2** explained :

> "The diversional therapists feed at lunch time to give a hand. I often think that it's good for them so they can talk to some people they might not talk to at other times of the day when

they are busy."

and **DON 7** also explained :

"I have my recreation officer always in the dining room at lunchtime to keep the peace and to maintain a friendly atmosphere and for the introduction of new residents and at the same time will help feed any people who may just need a hand in the dining room at lunchtime."

Equally frequently, nine directors of nursing saw running day to day and one to one activities as part of the role of the diversional therapist. This was seen as a major duty. Many of the informants felt that a majority of the residents were unable to participate in large group activities because of their high dependency. As **DON 1** explained :

"A lot of the time is taken up with more one to one therapy"

and **DON 7** believed the diversional therapist :

"Has more time to spend with a person on a one to one basis"

Eight directors of nursing saw organising outings and bus trips as part of the role of the diversional therapist. Outings and bus trips were seen to be a way of keeping the residents involved in the wider community and to help keep the residents feeling they were not isolated in the nursing home. **DON 1** stated :

"They go out on bus trips, they are the ones that involve the community"

and **DON 4** explained that one part of the diversional therapists role was :

"To organise bus trips"

It is worth noting that a majority of the nursing homes would have some form of bus trip or outing regularly. This may explain the frequency with which this activity was mentioned. Of the three nursing homes that were owned by the same proprietor, the

diversional therapists organised combined outings between the nursing homes. The three nursing homes shared a bus and often organised outings together so the residents from the different homes could mix and socialise.

Next, seven directors of nursing saw organising group activities for the residents as part of the role of the diversional therapist. Group activities were seen to be a good way for residents to have the opportunity to socialise with others in a pleasant environment. Even though a lot of diversional therapists are leaning more towards individual activities, group activities are still seen as a major medium in which to provide activities to the residents. With out some form of group activity the residents may become very isolated and lonely. **DON 1** explained :

"They (the diversional therapists) run group activities everyday"

and **DON 10** stated :

"They have groups in the morning and groups in the afternoons."

Next, six directors of nursing saw supporting the residents, being a companion, a friend and organising the residents committee meetings as part of the role of the diversional therapist. As **DON 1** explained :

"Their role probably comes more into the mental and emotional,
as far as support for the residents"

and **DON 7** felt the diversional therapists :

"Form a very strong friendly relationship with the residents."

In relation to the residents committee, **DON 11** stated :

"A big part of her job is to sort of organise and co-ordinate
the residents group meetings, resident management meetings"

and **DON 12** felt :

"Well another job of the diversional therapist is to be involved

in the residents support groups."

It is however part of the nursing homes responsibility to organise a forum whereby residents living in the nursing home can have an opportunity to have a say in how the nursing home is run and raise issues of concern. Some of the informants explained that they were trying to get the residents to be more involved in the meetings rather than the diversional therapist being left to run the meetings.

In many of the nursing homes in this study the diversional therapists role was not only to be involved with the residents but also to be involved with the relatives of the residents. Many of the directors of nursing felt that the diversional therapist role should be involved in supporting the relatives as well. As **DON 3** stated :

"Another thing is she's got to deal with the relatives"

and **DON 12** explained :

"She gets involved with the relatives and sets up the meetings
and sets up the support group meetings and a bit of liaison with
the relatives."

The informants felt that the relatives needed a lot of support and many of the nursing homes organised support and educational meetings for the relatives to help them deal with issues that arise when a family member is placed in institutional care. The diversional therapists were involved in these meetings and were often seen to be the ones who organise and co-ordinate the meetings.

Next, six directors of nursing saw providing entertainment, organising major activities or celebrations and providing a friendly and social atmosphere as part of the role of the diversional therapist. **DON 5** felt the recreational therapist was :

"Somebody to organise the grand things"

and **DON 13** felt the diversional therapist should organise :

"All the cultural and special days."

When asked about the role of the diversional therapist some of the informants responded that the diversional therapist provides the residents with entertainment or that the diversional therapist entertains the residents. Also, some of the informants felt the diversional therapist provided the residents with a more friendly and social atmosphere.

The other responses which are detailed in the Appendix were expressed by three or fewer of the informants. Their conceptions of the role ranged from professional therapeutic activities, through fund raising and administration, to activities resembling those of a caring relative. Whether or not all of these roles are really the responsibility of the diversional therapist is a matter which will be further discussed.

b) Skills of the Diversional Therapist

The area of skills and attributes that a diversional therapist should possess was addressed in the interviews. The interviews revealed that the informants feel the diversional therapist needs a lot of skills to fulfil their role as a diversional therapist. Many of the skills described by the informants are such that they would be quite general to all health care workers. Only a few of the skills and attributes identified would be specific to a diversional therapist. Of the thirteen interviews, a total of forty five different skills were revealed to be important for a diversional therapist to possess. Twenty seven of the revealed skills and attributes were expressed by two or more of the informants and only eight of the responses were expressed by four or more of the informants (See Appendix C)

The most popular response from the directors of nursing to the skills of a diversional therapist was that a diversional therapist needs to be skilled in the area of communication. Seven directors of nursing identified this as the most important skill. As **DON 3** stated :

"Skills in communication which is a big part because if they can't communicate they can't do anything, you need that in any job."

Similarly, **DON 12** explained that :

"The types of skills would definitely have to be communication if you can not communicate with these people then you are totally ineffective so communication and looking at different types of communication, understanding the art of the actual skills of communication."

According to **DON 3** communication skills are general skills that a majority of health care workers would need to possess to do their work. For a diversional therapist however, communication skills are essential.

After communication skills there were three separate responses expressed by the six of the informants. Firstly, the directors of nursing saw organisational and time management skills to be important skills that the diversional therapist needs to possess. **DON 2** felt that the diversional therapist :

"Needs organisational skills of some sort"

and **DON 6** stated that the diversional therapist needs to :

"Have organisational skills, they have to be able to have time management skills."

Again, this is a general skill that many health care workers would need to possess to perform their duties effectively and efficiently. In these times when health resources are scarce all health care workers need to be organised to ensure they can fulfil the duties required of them. Also, many employers are requiring employees to prove that they are productive in their work therefore time management and organisational skills are essential.

Secondly, six of the directors of nursing saw being able to understand and relate to the residents as a skill the diversional therapist needs to possess. **DON 4** felt that :

"They (diversional therapists) must be able to understand
the clientele they're looking after."

and **DON 13** explained :

"They have to be able to understand the residents and
understand their needs."

A diversional therapist needs to be very attuned to the residents needs so they can develop and implement appropriate programs.

Finally, six directors of nursing felt that diversional therapists need to be well motivated themselves and be outgoing and positive in order to motivate the residents. **DON 8** stated that :

"They need to be very well motivated."

and **DON 12** felt that the diversional therapist should be :

"Very positive, self motivator, initiator and a coach."

Next, five directors of nursing saw skills in arts and crafts as a skill the diversional therapist needs to possess. **DON 3** stated :

"I think they need skills in handicraft"

and **DON 6** felt that the diversional therapist :

"Needs to be arty and crafty."

Traditionally, craft was one of the main activities diversional therapists provided to their clients.

Next, four directors of nursing saw understanding of medical conditions and human nature as a skill the diversional therapist needs to possess. As **DON 8** explained :

"They have to have a very good understanding in human nature"

and **DON 10** felt that diversional therapists :

"Need to have a good knowledge of the ageing process, so

that they do not over expect people, in like gentle exercises"

This skill or knowledge is again relevant to all health care workers working in age care system. With this type of knowledge a diversional therapist would be able to relate effectively with the residents and as a result would be able to plan appropriate activities suited to the residents skills and abilities.

Next, four directors of nursing saw that a good sense of humour is a skill the diversional therapist needs to possess. **DON 8** explains :

"First and foremost they need to have a sense of humour."

Similarly, **DON 10** felt that :

"A sense of humour is really important."

The informants felt that a healthy sense of humour was good for relating to the residents and that it was also an effective coping mechanism and stress relief for the diversional therapist. Humour has many benefits both for the residents and the staff. As Bellert (1989) explains health care professionals and clients are utilizing humour as a coping mechanism, as a communication tool and as a tool to promote the psychological and physiological healing process.

Next, four directors of nursing saw being friendly, caring and kind as a skill or attribute that the diversional therapist needs to possess. **DON 7** stated :

"I think they need to be friendly and a bit out going"

and **DON 11** felt that the diversional therapist needs to be :

"A pleasant person."

Some of the informants felt this would be an attribute they would look for when employing a diversional therapist.

Next, three directors of nursing saw flexibility, tolerance, empathy and to be able to motivate the residents as skills the diversional therapist needs to possess. **DON 8** felt the diversional therapist :

> "They've got to be very flexible because things and people change here from day to day "

and that :

> "They have to also learn skills that will bring the best out of the residents"

DON 8 also explained that the diversional therapist needs to have :

> " A high tolerance level"

As **DON 7** stated :

> "Well in this setting I think you need to have a great empathy to deal with many people and have a general interest in elderly people"

Similarly, **DON 9** stated :

> "I would look for people who have empathy with aged people."

The other responses which are detailed in the Appendix were expressed by two or fewer of the informants. The skills identified as necessary for the diversional therapist to possess for them to be able to fulfil their role ranged from people skills, through skills in caring, to skills of a house maid. The other areas discussed in the interviews related more to the types of attributes the informants felt diversional therapists need to do their work. These included to be well groomed, have good health, good personal hygiene, have a good

command of the English language, be a dedicated type of person, be calm and relaxed, have common sense, have good self esteem, be creative, independent and be able to speak a second language. As it can be seen the informants felt diversional therapists need to possess a lot of skills and personal attributes to be able to fulfil the role of a diversional therapist. Although, many of the skills identified are common skills a majority of health care workers would need to possess rather than being skills specifically related to diversional therapy. It is interesting to note that even though the informants feel the diversional therapist needs to possess all these various skills a majority of the nursing homes had employed people who had no formal education or qualifications in this area (See Appendix C).

c) Training and Education For Diversional Therapists

In total thirty six separate issues were raised in the thirteen interviews. These thirty six issues were not common to all informants but fourteen of the recorded responses were common to two or more of the informants but only five responses were expressed by four or more of the informants. Of the thirty nine recorded responses eleven of the issues raised related directly to the types of education diversional therapists should have and the other twenty five responses related to general issues of diversional therapy education and training (See Appendix C).

The types of education and training the informants felt that diversional therapists should have include education and training in : dementia, nursing, arts and crafts, working with the elderly, disabilities and diseases, relating to people (people skills), safety issues, disruptive behaviours, how to occupy the residents all day, aromatherapy and massage and in how to feed a resident.

The most common responses in relation to general issues of education and training for diversional therapists was that a base line would be some type of education for the profession of diversional therapy. Five of the directors of nursing felt this was important. As **DON 10** stated when asked about the type of training a diversional therapist would need to have to do their work :

"Well obviously formal qualifications are a really good base line"

and **DON 4** felt that :

"A diversional therapist should have some formal education"

Also, five of the informants felt that diversional therapists trained through the university would be different to non university trained diversional therapists. **DON 2** stated when asked about whether she felt there was a difference between a university trained diversional therapist and a non university trained diversional therapist (or recreation activities officer) :

"I think there is different qualities, different calibre."

and **DON 5** stated :

"I feel a tertiary trained diversional therapist would come out with
a real sense of professionalism."

and she also felt that you can not compare a trained person with a non trained person, whether it be in diversional therapy or in any other profession. **DON 12** also felt that :

"Having someone who is qualified is worth three or four that
are not qualified."

Next, three issues were revealed by four of the informants equally. The first includes the fact that some of the informants did not know what the training for diversional therapists involved and they showed a lack of understanding of the diversional therapy course at the university. **DON 1** stated :

"I'm not really familiar with what they actually do at

university."

And **DON 6** stated when asked about the training for diversional therapists :

"Well I must say I'm a little ignorant and naive there because
I don't really know what the training is, when they go through
their university course."

Next, the issue of TAFE course Working with Older People was also mentioned in a few of these interviews. Four the directors of nursing thought that this course was the diversional therapy course and others were not sure where this course fit in. **DON 3** explained that :

"I know she is doing this course in diversional therapy,
at tech."

Similarly, **DON 13** stated the diversional therapist working in the nursing home has :

"Done a TAFE course for diversional therapists."

And **DON 8** really was unsure about the course Working with Older People, for she stated that :

"I really don't know if TAFE has a course on activities for the aged.
I think there is one but it's not recognised but if someone came in
and they had that certificate, piece of paper. I'm sure it's from
somewhere, I'm not quite sure where. I think it might be through
the TAFE."

The Working with Older People course is a course done through the TAFE system but is not a diversional therapy course. The only diversional therapy courses available at this point in time are offered through the Faculty of Health Sciences, University of Sydney and Charles Sturt University in Albury. The courses being offered are of a Bachelors Degree level and formally an Associate Diploma level of tertiary education. A course is also offered through the University of Technology which is a Bachelors Degree in Leisure and

Recreation with some of the graduates specialising in aged care and working in the field of diversional therapy. Only one of the thirteen nursing homes had a person with these qualifications and the director of nursing did not class her being as trained as a diversional therapist with university training. That person was classed as a recreation activities officer.

The other issue raised by four of the directors of nursing in this study was that in society there is a perception that you do not need to be trained to work with the elderly. **DON 7** stated that :

> "Just because you've looked after your grandmother or have had your grandmother living with you, I don't think that qualifies you to know how to deal with elderly people in a nursing home."

Similarly, **DON 12** explained that :

> "I think it goes back to the attitudes towards older people in that you don't have to be trained to look after older people."

This may account for the fact that many nursing homes employed untrained staff or staff with very little training such as assistants in nursing and recreation activities officers. Funding to nursing homes may be another factor that influences that lack of trained staff.

Three directors of nursing felt it is important for the diversional therapist to keep up to date with knowledge. The informants were keen that the diversional therapist should continue to increase their knowledge and skills. As **DON 1** explained :

> "They (diversional therapists) do take advantage of the education that's offered to them so you know to increase their knowledge that's definitely a plus."

Other issues revealed in the interviews were expressed by two or fewer directors of nursing. **DON 2** and **DON 5** explained that they would prefer to have trained diversional therapists but they would not place two trained and inexperienced diversional therapists together in the work environment. **DON 5** felt that you can not compare a trained person with a non trained person because the trained person has far more skills and knowledge to be able to do their work. However, she did explain that although training accounts for a lot it does not necessarily mean that the person is cut out to work in a nursing home on a day to day basis. **DON 6** also felt this to be so and **DON 3** felt that diversional therapists need to have a theory base as well as hands on experience.

DON 4 stated that people can still be good diversional therapists even if they do not have the higher education and that a person's ability is important as well as their tertiary education. **DON 1** explained that it did not seem to have to be a university trained person to do the job of a diversional therapist. **DON 5** was of the opinion that the nurses could carry out the leisure and recreational activities with the residents, as she called them the "Quality of Life" activities. She believed the nurses do not need any training to perform these quality of life activities. Finally, **DON 10** felt the diversional therapy course should be more accessible but she was unaware of the external diversional therapy course that is being offered through Charles Sturt University. The introduction of the external course may provide the opportunity for currently untrained diversional therapists to gain formal tertiary qualifications.

d) Benefits of Diversional Therapy

Through the interviews with the directors of nursing many benefits to employing a diversional therapist at the nursing home were revealed. The benefits related directly to

what the informants felt the residents gained from being involved with the diversional therapist. In total, from the thirteen interviews, twenty three benefits were felt to come from diversional therapy intervention. These twenty three benefits were not common to all the informants but sixteen of the recorded responses were revealed by two or more informants and ten responses were expressed by four or more of the informants (See Appendix C).

Of the twenty nine perceived benefits, the most commonly reported benefit was that diversional therapy provides some sort of socialization and that diversional therapy intervention decreases isolation that the resident may otherwise feel. Nine directors of nursing felt this was the major benefit. As **DON 1** explained :

> "We have group activities that is part of socialising and people like to do things in a group."

DON 13 feels the diversional therapist :

> "Sits with the residents and speaks with them and to be with them so those people are not isolated."

Of the responses from the informants nine of the thirteen felt that diversional therapy fulfilled this benefit to the residents of the nursing homes.

Next, seven directors of nursing saw increasing the quality of life of the resident as a benefit derived from diversional therapy intervention. When **DON 5** was asked about the benefits she felt the residents gained from being involved in leisure and recreational activities she responded with:

> "Quality of Life, absolutely"

And when **DON 7** was asked a similar question she responded with :

> "The activities that they are providing do help to

enhance their (the residents) Quality of Life"

As Quirke states "increasing quality of life being the most important factor that diversional therapists strive to achieve" (1994, p. 15). Therefore the benefit of increasing the residents quality of life is seen as an important benefit that not only the informants feel is a major benefit but the diversional therapy profession itself would feel is a major benefit.

Next, seven directors of nursing saw the provision of mental and physical stimulation as a benefit derived from diversional therapy intervention. In one of the interviews **DON 4** explained that diversional therapy :

" Keeps them active, mentally active, physically active,
emotionally happy and socially active as well."

Similarly, when **DON 8** was asked about the benefits the residents gain from being involved in diversional therapy, she responded with :

"Mental and physical stimulation."

This is a benefit and aim that is expressed in the definition of diversional therapy. Therefore it is not only a benefit recognised by the diversional therapy profession but it was also recognised by some of the directors of nursing as a benefit.

Next, five directors of nursing saw providing the residents with something to do, to decrease boredom and to help the residents pass their time as a benefit derived from diversional therapy intervention. As **DON 2** expressed in the interview :

"The residents really look forward to it (the activities),
they love it, it keeps them happy I mean, it gives them
something to do, it is such a long day they get up at 6am
and they go to bed at 6pm or 7pm or 8pm at night and
it gives them something to do except for watching the television."

and **DON 11** feels that diversional therapy :

"Relieves the boredom."

Also, five directors of nursing saw the fact that the residents were still able to maintain their previous skills with the help from the diversional therapist or through the diversional therapy program as another benefit. As **DON 3** explains :

"You can involve them in things they like to do and used to do, like the cooking or the gardening."

Also, **DON 4** feels that the diversional therapist :

"Makes the nursing home homelike, the diversional therapist's job is to make sure these people are still doing what they normally do in their daily lives."

These aspects were seen to be of great benefit to the resident.

Next, came five responses that were revealed equally by four directors of nursing. The first benefit centred around the fact that diversional therapy contributes to keeping the residents oriented to reality. **DON 1** states that diversional therapy helps the resident :

"Be aware that it is another day and what the weather is like, what day it is, what things are happening and that they are aware of what is going on and that diversional therapy plays a big part of keeping people aware of what is happening."

The second benefit revealed by four directors of nursing was that diversional therapy intervention provides some kind of interaction, develops rapport and gives the residents some extra communication. **DON 1** feels that diversional therapy provides :

"Some extra communication which is just one to one that does not relate to personal care you know your not only

getting this interaction because some one has to shower

you or because they have got to feed you"

and **DON 2** sees that diversional therapy :

"Gets a little bit of interaction going and a bit of rapport

developing."

The third benefit revealed by four directors of nursing was that the residents have something to look forward to. **DON 8** feels that diversional therapy activities :

"Gives them (the residents) something to look forward to,

they love it."

The fourth benefit revealed by four directors of nursing was that the residents gained enjoyment as a benefit derived from diversional therapy intervention. As **DON 10** stated when asked :

"What sort of benefits do you feel the residents get from

being involved in diversional therapy ?"

"I think more pleasure and that is what their lifestyles are

all about."

Similarly, **DON 12** feels that diversional therapy provides :

"More enjoyment programs" for the residents.

The fifth benefit revealed by four directors of nursing was that diversional therapy intervention helps the resident to feel important, it gives the resident recognition and acknowledgement that they are still valuable members of society. As **DON 6** explains the resident is :

"Getting recognition, acknowledgement and that some

one cares for them."

Next, three directors of nursing saw the provision of friendship as a benefit derived from diversional therapy intervention. **DON 7** explains that :

> "The friendship, the feeling of still being important because someone is spending the time on a one to one basis with them and enjoying me the person."

Also, three directors of nursing saw a different kind of contact other than with nursing staff was a benefit derived from diversional therapy intervention. As **DON 6** explains the diversional therapist is :

> "a different contact, ...like you might be incontinent and heavy and all you feel is that I'll just bother the nurses because I want to go to the toilet but I'm scared cause they're going to have to use the lifter and all this. Where as when they see the therapist come in they can relate differently because they are not a carer."

Similarly, **DON 11** feels that :

> "Often the residents like to talk to someone who is not a nurse, not a nursing or medical person."

Another benefit expressed by three directors of nursing was an increased self esteem of the resident. When **DON 10** was asked about the benefits the residents gain from being involved in diversional therapy activities, she responded :

> "Self esteem, interests, pleasure .... benefits, well more useful."

And to the same question **DON 11** responded that the diversional therapist :

> "Can often improve people's morale and self esteem."

The remaining benefits revealed were expressed by individual informants. **DON 1** felt that diversional therapy is able to tap into areas that the residents are interested in and that they provide contact with people outside the nursing home. She feels that the diversional therapist links the residents with the community. As **DON 1** stated :

> "They provide a great link with the community so that
> they don't feel so isolated in the nursing home."

DON 2 saw diversional therapy intervention as developing the residents co-ordination and she feels that diversional therapy helps with dementia management. She feels that residents who would not normally sit still do so when they are in activities. **DON 13** felt the same benefit was derived from diversional therapy intervention. She feels that if residents are not active or if they are bored they become aggressive, abusive and they wander more.

DON 7 felt an important benefit was the aspect of competition. She explains :

> "It is that competition thing which I think we have, many
> of us through our lives, we like to do well to succeed or
> to win and diversional therapy is maintaining that need."

DON 8 feels that the diversional therapists are :

> "Quite often responsible for helping to maintain a level
> of independence that the residents would not be able to
> obtain if the diversional therapists were not there."

and **DON 11** felt that diversional therapy :

> "Broadens the residents outlook and keeps them up to
> date with current affairs"

She also feels the diversional therapist is the best person to give encouragement to the residents. And finally **DON 12** feels that diversional therapy is :

> "Someone who comes in with street clothes, that says
> okay let us go and visit someone, there is a normality

there, it helps to bring the pendulum back to normality."

Overall, diversional therapy was seen to be of great benefit to the residents living in the nursing home. The informants saw diversional therapy as promoting the well being of the resident in a variety of ways.

e) Suitability of the Name Diversional Therapy

The issue of the suitability of the name diversional therapy was addressed in each of the interviews, the objective was to gain an overall feeling of whether the directors of nursing felt that the name diversional therapy suits or is appropriate to what the diversional therapist role is within the nursing home.

From the thirteen interviews, thirty one issues were revealed as relating to the name diversional therapy. But only seven of the thirty eight recorded responses were common to two or more of the informants and only four of those responses were common to four or more of the informants (See Appendix C). Therefore, the informants responses do not lead themselves to a consensus on one side or another. From the thirteen interviews seven informants expressed that the name diversional therapy was a suitable title. Many of the informants were undecided especially when there are no set alternatives.

The most common issue discussed was the fact that the name diversional therapy indicates diverting. The informants felt that the word diversional indicates that the diversional therapist will be taking the residents mind off their problems and off the situation they are currently in. Six directors of nursing felt the name indicate this. **DON 3** explained that the name diversional therapy indicates :

"Taking them away from that just sitting in a chair and your diverting them into doing other types of activities" and "Diverting the mind off just being I'm old and I'm in a nursing home and I don't have to do anything."

Similarly, **DON 7** felt that diversional therapy :

"Does divert the person away from where they're at and their own medical problems."

Of the informants that felt the name diversional therapy was a suitable name they all felt that the word diversional does indicate that the person employed under that title is going to divert the residents in some way.

Next, four directors of nursing felt that diversional therapy is a 'therapy'. **DON 3** described the diversional therapy activities as being :

" All therapeutic"

And **DON 7** described when asked about the name diversional therapy and the suitability of the word therapy :

"It is therapy that they provide"

Also, **DON 12** felt that name must contain the word therapy. She states in the interview :

"It has to be therapy"

Also, four directors of nursing felt that diversional therapy is a more professional name and the more preferred name than any of the other titles such as recreational activities officer, activities officer or recreation officer. As **DON 10** explained :

"I tend to use diversional therapy because it is a professional name"

And **DON 9** felt that diversional therapy is :

"Recognised you know professionally"

and that she feels that the diversional therapists :

"Prefer to be called diversional therapists because it has
a greater status than recreation activities officer"

DON 9 also feels that the general community perceives the name diversional therapy in a better light than the other names. Also, in relation to the preferred name **DON 2** stated :

"I like diversional therapy better than I like activities
officer"

and **DON 1** explained that recreation activities officer and the like is not as suitable as diversional therapy because :

"Just doing activities that is not what they are doing I
think maybe if you think about it diversional therapy is
what is happening."

Through the interviews it became quite apparent that many of the directors of nursing felt that the diversional therapist/recreation activities officer preferred to be called a diversional therapist over any other title. As **DON 9** explained :

"I do find that the two diversional therapists want to be
called diversional therapists, they don't want to be called
recreational officers."

Employment of people under a particular award justified their role hence their title. Skills and previous training had no bearing on their duties. Only a few of the directors of nursing insisted on calling the non graduate diversional therapists a recreation activities officer. When **DON 11** was asked why she called them recreation activities officers rather than diversional therapists she responded by saying :

"Well I guess it is really because you can't call them
diversional therapist because they are not."

When the issue of the suitability of the name diversional therapy was raised in the interviews each informant had different ideas. These ideas took on both positive and negative forms of feedback on the name. The more positive forms of feedback have been discussed above. There were also comments made that take on more of a negative aspect. The following ideas were expressed by individual informants only.

DON 5 did not feel that the name diversional therapy was suitable. She felt that the word diversional has negative connotation and that the word therapy indicates that the resident needs some type of treatment or that the residents have something wrong with them. As **DON 5** stated :

> "It is as though they have got something missing, they need treatment and so in that sense it would be good to get away from the word therapy"

She also felt that the older community resent the use of the word therapy and it would be good to move away from using that word in the title. **DON 5** feels that a more positive term should be chosen. **DON 10** feels that the name may indicate instead of well-being there is actually a dependency and she stated that :

> "I think to the lay person it can be 'gosh what are they doing, like therapy.' I think therapy could be more frightening to someone, ... there is nothing wrong with me."

And **DON 13** explained that she did not know what the title diversional therapy meant and she prefers the title recreational officer or activities officer as that is more appropriate for the duties performed. She also explained that diversional therapy is more than just diversional.

Other issues were revealed from the interviews that are important concerns to the diversional therapy profession and need to be taken into account. Some of the informants

preferred the name diversional therapy over the other alternatives that are presently being used. **DON 8** explained that the name is not the main issue, what the diversional therapist does is more important. She feels that everyone needs a category and that is what a name is for nothing more than that. **DON 4** feels that everyone should be called a diversional therapist if that is what they do, she does not feel there should be a distinction between university trained diversional therapists and non trained people. **DON 12** on the other hand has a problem with people calling themselves diversional therapists when they have not completed the university training. **DON 12** also stated that :

> "As soon as you say diversional therapy you think of craft, music, sedentary life, so the old person is sitting there. I like things like active walking, movement exercises, you know something that is an active program where they would be psychologically active or physically active."

Finally, **DON 10** also felt that you do not want a name that is opposite to well being and that the diversional therapy profession needs to do some research into the suitability of the name.

f) Documentation for Diversional Therapists

From the thirteen interviews a total of twenty five issues concerning documentation for diversional therapists were expressed by the informants. Of the twenty five issues discussed eleven were common to two or more of the informants and six of the issues discussed were common to four or more of the informants (See Appendix C). There were three issues revealed equally by six directors of nursing concerning.

Firstly, six directors of nursing revealed the issue of the diversional therapist having separate documentation to the other staff. Six of the informants explained that the diversional therapists working in the nursing home had their own separate documentation. When asked **DON 7** replied :

> "She (the diversional therapist) has her own documentation that she writes up on a weekly basis of what each resident has done that week and they do a monthly summary in their own records on each resident."

During the interview **DON 3** was asked whether other staff were able to access the diversional therapists documentation, **DON 3** replied :

> "Well they don't really .... it's kept up in the diversional therapy room. We have our own notes down here."

Next, six directors of nursing felt that the diversional therapist is responsible for recording the residents social history. **DON 2** explains :

> "They do a whole social history from the relatives or from the residents themselves."

Similarly, **DON 4** stated that :

> "For each resident there is a social profile which is attended to by the diversional therapist."

It is probable that a majority of diversional therapists are responsible for recording a social history of the resident but only six informants discussed this as a main issue when asked about diversional therapy documentation.

Also, six directors of nursing explained that the diversional therapist documents their intervention with the residents in some form or another. **DON 6** explains that the diversional therapists documentation includes :

"I like them to write on a routine basis that something has occurred. Like if it was their birthday, and make a note of that or if they've done exceptionally well then a note of that should be made or if they've found something works particularly well."

Next, five directors of nursing revealed that the diversional therapist documents their intervention in the care plan for the resident. When **DON 1** was asked she explained that :

"They document on the care plans to what sort of diversional therapy things that person, whether it is perhaps someone who doesn't join in group activities but they like them to pop in and have a chat one to one. They document that sort of thing what seems most appropriate for that resident and what the resident enjoys the most."

DON 9 also, when asked a similar question, stated that :

"They write on the care plan, plan of care for the resident. They write directly on to those and they write how those programs might work for them and that ranges from people who are alert to people who have specific problems like dementia, confusion or the very frail aged."

Next, four directors of nursing that besides having separate documentation, the most common place was that the diversional therapist documents their intervention in the progress notes of the residents file. As **DON 5** explains :

"They write in the progress notes, they say how they find the resident is responding to the activities that they offer."

Similarly, **DON 4** stated that :

> "We have progress notes for the diversional therapist where she will report at least once a week if people have joined into activities, how the program is going and if they've been on bus trips and what they'd like to do and so on."

The residents file would seem to be a more appropriate place for the diversional therapist to document their intervention than in separate files. Information concerning an individual resident should be accessible to all staff. Another interesting comment in relation to diversional therapy documentation in the progress notes came from **DON 11**. She explained that :

> "If .....as a therapist, if she has a comment to make on the overall plan she writes in the progress notes. For instance, in the dining room if somebody stops eating and starts throwing food around she's the one that's going to report that in her progress notes."

The researcher would query whether this is an appropriate aspect of care the diversional therapist should be documenting in the progress notes.

Also, four directors of nursing explained that diversional therapy documentation and documentation in general was seen to be a necessary and an important aspect of the residents care. **DON 8** feels that it :

> "Is an important part"

and **DON 10** stated that :

> "I think it is absolutely necessary."

DON 6 felt that diversional therapy documentation and documentation in general was an important area that diversional therapists should be skilled at doing. She also felt that :

"Documentation is our front line basis so if we can gain
dollars, well that's advantageous for everyone concerned."

Next, three directors of nursing felt that diversional therapy documentation is a large job that the diversional therapist has to do. **DON 10** explained :

"Well I think it's a nightmare for diversional therapists."

Similarly, **DON 11** stated that :

"It is quite a job actually."

A few of the informants felt the diversional therapist spent too much time on documentation. Some diversional therapists were reported to be spending up to fifteen hours per week completing the documentation they had set up to do, others were spending a whole day per week doing their documentation. Other informants reported that the diversional therapist working in the nursing home did little documentation or the director of nursing knew the diversional therapist did some sort of documentation but they were unsure of what the documentation involved as they had not seen it before.

Two directors of nursing explained that there is no point in having documentation that is not shared with other staff. As **DON 12** stated in the interview :

"They (diversional therapists) keep social histories and
I find that disconcerting that it is their knowledge and
I think it should be shared."

She also felt that the diversional therapists :

"Should not be the keepers of the social histories as far
as I am concerned and neither should we be the keepers
of the nursing care plans, it should all be together and
integrated."

The researcher would tend to agree with this point of view.

There were some other issues that came from the interviews and discussed by individual informants on the topic of diversional therapy documentation that may be of interest. Firstly, **DON 2** felt that it is important to teach all staff to be able to document in an effective manner so the nursing home can gain the maximum funding. She felt that it was also important for the diversional therapist to be able to document appropriately and that it is of no use for the director of nursing to write in the files on diversional therapy issues because she would not be able to accurately document what has occurred. **DON 4** felt that documentation was useful when trying to prove that the nursing home is meeting the Outcome Standards. For diversional therapists that would be Objective Six - Variety of Experience (Commonwealth/State Working Party, 1987). **DON 6** expressed her feeling on the lack of knowledge and skills that the diversional therapists have in relation to documentation. She felt that the diversional therapists do not realise the legalities involved with documentation. **DON 10** thought it was a good idea to have integrated notes because then the resident is looked at in a more holistic way by the staff and she felt documentation is a good way for the diversional therapists to communicate with each other as they work on separate days. The director of nursing explained that the documentation has to be pertinent and realistic and that computer skills would assists in the areas of documentation. She also felt that tick sheets are a graphic way to evaluate the diversional therapy program in terms of which residents were attending and which residents are less involved but that tick sheets are really not suitable for professionals to use.

From the findings on the issues of diversional therapy documentation it can be seen that the informants had a variety of views and ideas and that there are obviously no set standards in relation to documentation within the diversional therapy profession. This may

account for the vast array of differences in diversional therapy documentation in the nursing homes and the differences in expectations from the directors of nursing.

g) Other Issues Relating to the Diversional Therapy Profession

The interviews revealed many issues in relation to various areas of diversional therapy practice with in nursing homes. There were also other issues discussed by the informants during the interviews that do not relate to the theme areas identified but that warrant further discussion. These issues may be of interest and some may be of concern to the diversional therapy profession. Because there were many issues that fell into this area of professionalism, they have been separated into sub areas. These include team, employment, duty, activity and professional issues. For a summary see Appendix C.

The sub area team issues includes only a few points. Firstly, five of the informants expressed that the diversional therapist is part of the whole team and that everyone in the nursing home works together. **DON 1** stated :

> "I think that they're part of the whole team so their role and everybody's role is for the benefit of the resident to provide the best care"

and **DON 12** felt the diversional therapist :

> "Is an intricate part of the team, we have very much a team approach here."

Secondly, three of the informants revealed that the diversional therapist was involved in team meetings where the residents are discussed. **DON 2** stated :

> "We have team meetings and we all talk about what we can do for each of the residents and the nurses give their suggestions and the diversional therapists give suggestions on both sides so

that we all go in the same direction."

It was surprising more of the informants did not express this as an area that the diversional therapist was involved in within the nursing home.

The next sub area included issues related to the employment of the diversional therapist. Firstly, eleven of the informants expressed that the diversional therapist was an essential and important part of the nursing home. As **DON 8** explained :

"They are extremely necessary people to the overall well being of the patient"

Similarly, **DON 9** felt :

"They're a very valuable part of the team, people who take care of diversional activities, they provide a focal point in the nursing home."

Also, **DON 13** stated :

"They are a must in the nursing home and I think everyone knows it."

Next, six of the informants stated that they would employ a diversional therapist with any types of skills and they would consider other training besides the diversional therapy qualifications from the university. **DON 8** explained :

"We've had some very good nurses that have become very interested in that side of it and they've gone over and they have been taught by a senior therapist."

DON 11 also explained :

"Older people seem to be better at it than some of the younger ones I mean I have had a trained diversional therapist here for a time who did virtually the same and she wasn't nearly as calm with the people as this one is. So to my way it's no

discrimination."

This issue is disconcerting when there is a university course running to train people specifically in diversional therapy but there are directors of nursing are willing to employ people with no specific training or experience in the areas of diversional therapy. The next issue is also quite disconcerting. Four of the informants felt that when employing a diversional therapist they would consider personality over qualifications and experience. **DON 3** stated :

> "It does depend on their personality. I have not had a diversional therapist bar that one (graduate diversional therapist) that sort of did not get in and do things with the residents."

Also, **DON 9** explained that :

> "I like to look at the type of personality they have."

On the other hand four of the informants felt a university graduate diversional therapist would know what is required of them and they would prefer to employ a person with formal qualifications. **DON 7** stated :

> "Somebody who has diversional therapy qualifications because I feel that person would come here and should know what is really required"

DON 12 also stated :

> "Trained people compared to the others, they are quite different. They take a much more of a professional approach."

Other issues were raised by individual informants. **DON 5** felt the use of a recreational therapist in the nursing home was fairly limited and she would prefer the nurses to carry out that role. She also stated that eventually she will not have recreational therapists who do only recreation and she felt she would rather spend the money on employing more nurses than recreation therapists. A few of the informants expressed that the nurses and

other staff felt the diversional therapists had an easy job because it was not physical and the informants felt the other staff did not value the work of the diversional therapist. **DON 12** felt diversional therapy completed the circle of holistic care. She also explained during the interview that she had advertised for a diversional therapist and had many people apply that were not trained or had no experience. She felt it is better to have two trained diversional therapists and many of volunteers than a number of untrained diversional therapists. **DON 11** stated she would like to have twenty four hour cover of diversional therapy and both **DON 11** and **12** felt that nursing homes find it hard to get trained diversional therapists and that a trained diversional therapist could not use all their acquired skills in a nursing home. **DON 7** stated that she employed a recreation activities officer because it was cheaper but she will eventually employ a trained diversional therapist. **DON 13** explained that she employed her diversional therapist because she could speak a second language which is essential for an ethnic specific nursing home. Finally, **DON 1** and **10** felt that diversional therapy is a stressful, challenging and emotionally draining job.

The next sub area included issues that related to the duties of diversional therapist. Firstly, five of the informants stated that no nurse go on the residents outings or bus trips. **DON 3** stated when asked by the researcher :

> "Does a nurse usually go out on the outings or just the diversional therapist."
>
> "Just the diversional therapist unless more than seven are going. So if it is more than seven two recreational officers go"

and **DON 6** stated :

> "Both diversional therapists go because I can't bear a nurse to go unfortunately."

Only four of the informants said they send a nurse on the outing with the residents and the diversional therapist. Next, the issue of the diversional therapist being involved in nursing duties was discussed. Four of the informants clearly expressed the diversional therapist was not to be involved in any type of nursing duties. Three of the informants stated that generally the diversional therapist was not involved in nursing duties but they did help out when they were short of nursing staff and three of the informants explained that the diversional therapist was involved in nursing duties as well as diversional therapy duties. As **DON 3** explained :

> "Well when I said toileting um if the nurses were busy you know the diversional therapist wouldn't just sit there and say you'll have to wait for the nurses you know she would automatically say we'll take you to the toilet."

Similarly, **DON 6** stated :

> "Well I said to them if someone wants to go to the toilet and your quite capable of putting them on the toilet then I believe that your role is to put them on the toilet not to go and push the buzzer and say hey nurse come and put Mrs Jones on the toilet."

Next, three directors of nursing revealed that the nurses perform the diversional therapy activities when the diversional therapist is away and also that in some of the nursing homes the nurses have in their job descriptions to be involved in diversional therapy activities.

Other issues revealed by individual informants were also discussed. **DON 3** explained that the diversional therapist uses her own car to run errands for the residents and the staff. Both **DON 3** and **4** stated that the diversional therapist must raise money to fund their diversional therapy program and **DON 3** felt the diversional therapist could do the nurses role but the nurses could not do the role of the diversional therapist because they are not

trained. **DON 11** felt that working in a nursing home is very repetitive and she explained that the diversional therapist had a settling influence over the nursing home. She also felt the diversional therapist should do the residents menu orders in the mornings because it is a good way for her to say hello to all the residents. **DON 12** stated that it would be good for the diversional therapist to assess and organise activities and for volunteers to carry out those activities. Finally, **DON 13** felt the diversional therapist is the one who spends most of the time with the residents.

The next sub issue centred around the diversional therapy programme and resident involvement. Three of the informants stated the diversional therapist needs to do activities that suit the residents not what suit the staff. As **DON 2** explained :

> "We're not here for us, what suits us, we're here for what suits them, the residents"

and **DON 3** described the diversional therapist as :

> "They've got to be people who put the resident first before they put themselves."

DON 3 and **11** felt the diversional therapists do not just do activities, their role consists of more than that. **DON 7** and **10** stated the diversional therapists must respect the residents right not to be involved in activities and **DON 2, 5** and **8** felt a lot of the residents can not meaningfully participate in group activities and that the group activities only suit a small minority. **DON 1** sees diversional therapy as a variety of activities which make up a program and that it is more than just crafts. Finally, **DON 5** also feels the recreation therapists set a schedule and everyone has to fit in with that schedule and she feels that the residents should not have to fit into the nursing home schedule, the nursing home should fit into what the residents want to do.

The last sub section includes general issues raised by the informants during the interviews. Three directors of nursing felt it was important for the diversional therapist to attend diversional therapy meeting organised through the Diversional Therapy Association. They felt these meetings provided valuable education and networking for diversional therapists. **DON 4** and **12** see diversional therapy as going forward and **DON 10** feels diversional therapy is really only known in aged care but it is blossoming into other areas. **DON 4** stated that diversional therapy is involved in nursing homes because people see the need and they can see the value. **DON 6** feels the skills in diversional therapy are not as in force as they are in nursing and that a title does not make a professional person because professionalism is the way you conduct yourself. **DON 10** explained that some of the best diversional therapists are self taught with life skills and she felt it is not fair that a diversional therapy graduate gets paid less than someone who is not trained for the first year of working. **DON 10** also strongly expressed that their should be more resources specially for diversional therapists. Finally, **DON 12** explained that she had a person apply for a diversional therapy position who had no qualifications or experience. When she asked the person to start off with some volunteer work, the person soon rang back to say she had a job as a diversional therapist at another nursing home. The informant found this to be quite concerning and she wonders whether untrained diversional therapists are capable of providing a meaningful program or whether they are just a companion to the residents.

This section highlights the fact that the perception directors of nursing hold are very complex and there are many areas of interest when looking at the perceptions of the role of the diversional therapist. This section also highlights that there are many areas that will need to be covered if the diversional therapy profession is to develop an educational package on the role of the diversional therapist and its associated areas.

Overall, the interviews with the directors of nursing revealed a wide range of issues in relation to the role, skills, benefits and training of a diversional therapist and on other issues such as documentation, suitability of the name diversional therapy and general issues in relation to the diversional therapy profession. The issues and comments revealed by the directors of nursing highlights that generally the directors of nursing feel that diversional therapy is an essential part of the nursing home but the study also highlights that there is generally a lack of knowledge and understanding in relation to some areas of diversional therapy practice. The findings from this study provide the diversional therapy profession with some clearer guide-lines on where the lack of knowledge and understanding is occurring therefore comprehensively adding some ideas on where to target an educational program. The lack of knowledge and understanding on various areas of diversional therapy practice could be attributed to a variety of reasons, therefore they warrant further discussion.

Discussion

The interviews with the directors of nursing raised many issues. Many of the issues raised provide the profession with positive feedback, but other issues should be of concern to diversional therapists and warrant further discussion. The main areas that warrant further discussion include the perceived roles, skills, training and education of the diversional therapist, diversional therapy documentation within the nursing homes and suitability of the name diversional therapy.

The first area that warrants discussion is the roles and duties the directors of nursing felt the diversional therapist was responsible for performing. A thorough search of the literature revealed very little material about the profession and the roles a diversional therapist is meant to perform. The Diversional Therapy Association of New South Wales has a statement of duties that is aimed at guiding the diversional therapist when negotiating a job description (See Appendix D). Other than this statement of duties, there are really no other guide-lines on the duties a diversional therapist should be responsible for performing. Therefore this responsibility is left to the diversional therapist to negotiate, or it is left to the director of nursing or management to write. As a result this then is open to abuse.

The directors of nursing interviewed for this study felt the diversional therapist working in the nursing home fulfilled a large number of roles and duties within the nursing home. Generally, they had a fairly good idea of what the role of a diversional therapist entails, for example organising activities for the residents, and assessing the residents in terms of their leisure and recreation interests. However the interviews also revealed some roles and duties that were perceived to be part of the diversional therapists responsibility but which really should not fall into the realm of diversional therapy. The main role was that the

diversional therapist should be involved in feeding the residents at meal times. From the responses given by the directors of nursing one might conclude that each of the informants considered mealtime activities as a social activity and as such, part of the diversional therapist's responsibility. However, while feeding may be seen as a social activity, it would be interesting to investigate whether the diversional therapists involved in feeding were allowed to choose which residents they fed, and when, or whether in fact these therapists were simply given the hardest or slowest residents to feed. The Health Standard (Newsletter of the Health and Research Employees' Association, 1991), states clearly that it is not part of the diversional therapists job to feed clients. The employer should therefore not require the diversional therapist to do this. "In addition the employer has a duty of care with respect to residents/clients to ensure that appropriately trained (and where necessary, appropriately registered) employees undertake duties that could entail some risk to the residents/clients in the facilities run by them " (1991, p. 14). Therefore no diversional therapist should be required to perform the role of feeding residents at meal times in nursing homes or any other health care facility.

Other inappropriate activities perceived to be part of the diversional therapists responsibility include toileting, running errands for the residents, taking residents for appointments, and general nursing duties. The last is of particular concern. Over a third of the informants felt the diversional therapist should carry out both nursing duties and diversional therapy duties. Diversional therapists are employed to fulfil a specific role which should not involve any nursing duties at all. This is an area that needs to be clearly excluded from a diversional therapists role by the diversional therapy profession. The other issue involved the diversional therapists and residents outings/bus trips. The majority of the directors of nursing do not send any nursing staff on outings or bus trips with the diversional therapist. Many diversional therapists are expected to take many residents out on their own and therefore may be left with the responsibility of

administering medication or dealing with toileting while outside the nursing home. Like the matter of feeding this needs to be clarified within the diversional therapy profession. It is essential that the diversional therapist not be put in a position where the duty of care for the resident could be jeopardized. A registered nurse should accompany the diversional therapist on any outing in case a medical emergency arises, and to administer any medications and take care of the toileting duties.

Another role identified by some of the informants that warrants some further discussion was that the diversional therapist provided the residents with an opportunity to be involved in craft activities. This area is not a new role for diversional therapists. Traditionally craft has one of the main activities diversional therapists provided to their clients. Handicraft was the bases of the diversional therapy profession (Cribb, 1993). Although over the years there has been an increasing dependency of residents in nursing homes (Minichiello, Alexander and Jones, 1992), many of the residents would be unable to do any type of craft work or would be limited to the type of craft work they could do. The provision of craft activities would be a role and skill with limited use for a diversional therapist working in a nursing home.

On the issue of training and education for diversional therapists, the directors of nursing interviewed in this study generally displayed a lack of understanding and knowledge of the type of training diversional therapists should undertake. Only a few of the informants knew of the training available to diversional therapists. The training currently available being a Bachelors Degree course and formerly an Associate Diploma course. Many knew there was some sort of course, but thought it was a course offered through TAFE, and a few of the informants did not even know there was a diversional therapy course at all. Since many of these informants had non graduate diversional therapists working in the nursing home one could possibly conclude that the directors of nursing had employed

some one without the diversional therapy training because they were uninformed about the training and education available.

Not surprisingly, lack of knowledge about the content of the diversional therapy tertiary education course was also obvious. Many of the informants asked the researcher for clarification on what the training involves. The directors of nursing who had a good understanding of the education and training available to diversional therapists, were those who had graduate diversional therapists working in the nursing home, or who were hoping to employ a graduate diversional therapist in the future.

Other issues of concern were raised during the interviews that relate to the training and educational requirement of the diversional therapist. Some of the directors of nursing stated that they would employ someone with a variety of skills and that they would take a person's personality over their qualifications. Only four out of the thirteen informants stated that they would prefer a qualified diversional therapist to a non qualified diversional therapist. This is of great concern, because if directors of nursing are willing to employ a person without training or experience as a diversional therapist or a recreation activities officer, then it relays a message that no qualifications are needed and therefore the job requires little skill. Some of the directors of nursing actually felt the other staff thought diversional therapy was an easy job. This is another area of concern and this issue highlights the fact that other health care workers may not have a clear understanding of the diversional therapy profession. If the profession is to continue to grow and develop then this is not the sort of message that needs to be relayed to other health care workers and the general community. Also, the issue of quality of the diversional therapy programme presented to the residents must be questioned, if it is being co-ordinated and organised by an untrained person with limited skills and knowledge of diversional therapy practice.

This lack of knowledge and understanding of the education and training of a diversional therapist should be a major concern for the diversional therapy profession. If the directors of nursing are ignorant of the training available for diversional therapists, then they will continue to employ people with no training or experience in diversional therapy. If the profession is to grow professionally, this issue must be addressed and action taken to prevent the employment of untrained and inexperienced diversional therapists. Also, the lack of knowledge and understanding of the training and educational requirements for a diversional therapist highlights the importance of an education program being implemented to educate the directors of nursing on what the training involves and other issues in relation to the diversional therapy profession.

These findings may explain the directors of nursing's perceptions of the skills the diversional therapist would need to possess to perform their duties. The directors of nursing identified many skills the diversional therapist would need to possess to be able to do their work. However, the majority of skills identified were general skills that all health care workers would need to possess to fulfil their role effectively, such as communication skills, organisational and time management skills. The directors of nursing involved in this study identified very few skills specific to diversional therapy practice. This may be because the informants do not recognise that diversional therapists have any specific skills, and it may explain why many of the directors of nursing in this study have employed diversional therapists with no specific training in the field of diversional therapy.

This is of great concern. Since there are currently tertiary education courses specifically for diversional therapists, it could be assumed that the diversional therapists who complete there courses would graduate with a lot of skills specific to the diversional therapy profession. These skills may include the ability to evaluate activities, to adapt activities to

suit the client group to analyse a task and break it into teachable parts. However, the directors of nursing may not have identified many skills as specific to diversional therapy because the untrained people employed as a diversional therapist may not possess these skills, and therefore the informants would not be in a position to observe the use of these skills in the nursing home. This is an area where diversional therapists as a professional group need to educate not only directors of nursing but other health care workers, so as to ensure that they clearly understand the skills needed to do the work and that the work of a diversional therapist requires many skills unavailable to untrained workers.

The responses regarding documentation for diversional therapists in this study revealed some interesting issues. The study has established that diversional therapists complete a vast array of documentation within nursing homes. The diversional therapy profession has no set standards for the type of documentation diversional therapists should be completing. Although the Diversional Therapy Association has produced a set of forms recommended for use by diversional therapists, these forms are in no way compulsory. It was interesting to note that some of the diversional therapists did not contribute to the residents' central file. Since, the residents medical file or progress notes is the most appropriate place for any information about the resident to be recorded, the resident's medical record would be the most appropriate place for the diversional therapist to record their intervention. One of the aims of documentation is as a communication tool therefore documentation should be recorded in a central file. If diversional therapists are to work and be seen as part of the multi-disciplinary team within the nursing home, then they should be involved in recording their intervention in the residents file along with the other staff.

A majority of diversional therapists would of course also need their own documentation of their programme, the evaluation of the activities and so on. But again any information on

the actual resident should be stored in their medical record. A couple of the informants made the practical suggestion that the diversional therapist records their resident information on a form which is eventually added to the residents central file. However some of the directors of nursing expressed concern at the diversional therapist keeping resident information locked away in their offices. These informants felt, quite reasonably, that documentation is only useful if it is accessible.

It is likely that the directors of nursing had influence over whether the diversional therapists contributed to the residents central file and what types of documentation the diversional therapists were involved in. It is also likely that the directors of nursing did not understand or know of the documentation completed by the diversional therapist and the reasons for it. Also, some of the directors of nursing felt the diversional therapists were spending far to much time doing their documentation. Some diversional therapists, according to the informants, were spending up to fifteen hours each per week on their documentation. This is far too much and the documentation process needs to be clearly reviewed.

The responses of the directors of nursing revealed that diversional therapists completed a wide range of documentation in the nursing homes, which clearly suggests a more standardized type of documentation is needed. The area of documentation is clearly an area of diversional therapy practice that diversional therapists working in nursing homes need to standardise and improve on.

The suitability of the name diversional therapy was discussed during the interviews. A variety of interesting viewpoints were expressed by the directors of nursing and these comments warrant further discussion. Although the name diversional therapy has been used for many years, there was no clear consensus on whether the name is suitable or not.

Many of the directors of nursing felt the name diversional therapy adequately described the role of the diversional therapist. Many of the directors of nursing like the name, and preferred it over other names (such as recreation activities officer) because they saw it as a more professional title. Although, some of the directors of nursing did not realize the name was used to identify a graduate diversional therapist as specified under the award. In other cases this was the reason why the diversional therapist was called a recreation activities officer, rather than a diversional therapist. The use of the word therapy was also felt to be an appropriate term and many of the directors of nursing felt the diversional therapist's intervention was a therapy.

Although many of the directors of nursing expressed a positive view on the use of the name diversional therapy, the profession needs to re-evaluate what the name is intended to convey to other health care professionals and to the general community. The diversional therapy profession needs to work out whether they want to be seen as diverting their clients because this is obviously what diversional therapy means to a majority of the informants interviewed in this study. It was also concerning that some of the informants felt the name diversional therapy conveys negative connotations and is opposite to well being to both health care professional and the general community. This is an area that diversional therapists as a professional group must address to ensure the name continues to convey the kind of messages intended by the profession.

The only area that did not really reveal any issues of concern was the area of benefits for the residents involved in the diversional therapy programme. This area provided some positive feed back on the perceived benefits of diversional therapy intervention. The directors of nursing identified many benefits that the residents gain, and many of the benefits revealed relate to the benefits identified in the literature review. It may be concluded from this that the directors of nursing in this study believe the residents gain a

great deal from diversional therapy intervention, and this is the reason why the directors of nursing saw diversional therapy as a vital part of the nursing home and the diversional therapist as an essential member of the health care team.

From the interviews with the directors of nursing, it can be concluded that the general lack of knowledge and understanding on the training and educational requirements for diversional therapists influences the type of person employed to fulfil this role, which is generally an untrained person with no experience, therefore the directors of nursing can not accurately identify the skills involved in the work of a diversional therapist which in turn leads to a misunderstanding and lack of knowledge on the true role of a diversional therapist. These factors would also influence the areas of documentation and on the perceptions of the suitability of the name diversional therapy.

Overall, the interviews revealed some very important information about the perceptions of the role of diversional therapy within nursing. Some of the issues raised and ideas expressed by the directors of nursing during the interviews provide the diversional therapy profession with a clearer idea of what directors of nursing perceive the role of the diversional therapist to be. Generally, the directors of nursing have a fair understanding of the role of the diversional therapist within the nursing home especially in relation to the benefits of diversional therapy intervention for the residents. While some of the directors of nursing had a clear understanding of the issues related to diversional therapy practice, others did not understand the role of the diversional therapist. Although the findings from this study may not accurately reflect the perceptions of all directors of nursing, what emerges is that as a profession, diversional therapy needs to develop and implement an educational program that includes some of these misunderstood areas. The findings of this study give the diversional therapy profession clearer guide-lines on the areas that need to be targeted in an educational program.

Conclusion

This study has revealed many issues in relation to the perceptions that the directors of nursing involved in this study hold on the role of diversional therapy within nursing homes. Although it can not be expected that directors of nursing would know everything about the role of the diversional therapist, one could expect that as an employer each director of nursing would have a fairly thorough knowledge about that role. This study has established that although the directors of nursing saw diversional therapy as a vital part of the nursing home, they generally lacked knowledge and understanding of the role of the diversional therapist and of the duties, skills and training required.

The study has also revealed areas where a lack of knowledge and understanding may have an impact on the diversional therapy profession, such as the name diversional therapy, documentation issues and certain areas of diversional therapy practice. It was found that the area of the role of the diversional therapist is simply not an area that can be looked at in isolation. The role of the diversional therapist is closely linked to the skills a diversional therapist needs to possess to fulfil that role, the benefits derived from diversional therapy intervention and the training and educational requirements needed to fulfil the role of the diversional therapist. Knowledge and understanding, or lack of knowledge and understanding of any particular area addressed tended to flow through to each of the areas. For example, what each director of nursing perceived to be the skills of the diversional therapist was very much influenced by what training and education they felt the diversional therapist needed to fulfil their role. Therefore, any study of the area of the role of the diversional therapist can not be simply a matter of looking at the roles a diversional therapist is expected to fulfil. It involves a complex web of issues that greatly influence the knowledge and understanding of diversional therapy as a profession.

To remedy this lack of knowledge and understanding, diversional therapy, as a profession, needs to develop and implement an educational program that includes the areas identified in this study. An educational program for directors of nursing and other health care workers is particularly important in establishing the viewpoint that recreation and leisure services are major contributors to the quality of care in a nursing home, rather than simply a means of "keeping residents busy" (Teaque and MacNeil, 1992). Directors of nursing and other health care workers need to have a clear understanding and an appreciation of the diversional therapist working within the nursing home, since effective interdisciplinary interaction depends on the members of each profession understanding and appreciating the contributions made by members of other professions (Pearson, 1983).

This study also has further implications for the diversional therapy profession. While this study only targeted one small group of health care workers that diversional therapists come into contact with, there are many other groups that could be targeted for a similar study as the feeling of lack of recognition and understanding of the role of the diversional therapist is not only restricted to nursing homes but occurs in other health care facilities as well. Until diversional therapy as a profession increases its documented research base, its growth as a profession will be slowed and the problems it is currently facing will continue to haunt diversional therapy practitioners of the future.

Recommendations

Recommendations from this study for the diversional therapy profession and for further research include :

1) There is clearly a need to implement an educational program for directors of nursing and other health care workers on the areas identified in the study as lacking in knowledge and understanding of the diversional therapy profession and practice.

2) As a profession, diversional therapy needs to identify the specific roles and duties that a diversional therapist should be undertaking as part of their employment as a diversional therapist. This should include a job description that would cover the various duties and roles that should be undertaken when employed as a diversional therapist.

3) Diversional therapists, as a professional group, need to regulate the use of the name diversional therapy to those people who have the tertiary training through the university courses and as stipulated in the wage award for diversional therapists.

4) As a profession diversional therapy needs to have a minimum educational requirement for a person to fulfil the role of a diversional therapist. The minimum educational requirement should be the tertiary qualifications that are only gained through the university system.

5) This study could be conducted on a larger scale to incorporate many more directors of nursing on what their perceptions of the role of the diversional therapist within nursing homes is. A larger study would be able to more conclusively prove whether there is a general lack of knowledge and understanding on the role of the diversional therapist as found in this study.

6) A similar study could be conducted to include not only directors of nursing working in nursing homes but also any discipline with whom a diversional therapist works and which may have an impact on the diversional therapy services. This could include registered nurses, enrolled nurses, occupational therapist and other health care professionals.

Glossary

For the purpose of this paper the following terms need to be defined :

1) Diversional therapy

"Diversional therapy practitioners provide, facilitate and co-ordinate leisure and recreational activities which are designed to support, challenge and enhance the psychological, spiritual, social, emotional and physical well being of individuals who experience barriers to participation in leisure and recreational pursuits affecting their quality of life" (Diversional Therapy Association of New South Wales, 1995).

2) Diversional Therapist :

"Diversional therapist means a person who is responsible for the diversional activities of residents and who has completed the Associate Diploma course in Diversional Therapy conducted by the Cumberland College of Health Sciences" (Diversional Therapy Association of Australia, 1994, p.2).

3) Recreation Activities Officer :

"Recreation activities officer means an employee, other than a diversional therapist, who is responsible for diversional activities of residents" (Diversional Therapy Association of Australia, 1994, p.2).

4) Role Conflict :

"When expectations are incompatible" (Sellick, 1985, p. 35)

5) Role Overlap :

"Where the blurring or confusion of specific tasks occurs among health care team members in areas of practice" (Bauze, 1993, Appendix A).

6) Role Overload :

"If a team member is unable to meet multiple expectations" (Sellick, 1985, p. 35).

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The University of Sydney
Faculty of Health Sciences

INFORMATION SHEET

"PERCEPTIONS OF THE ROLE OF DIVERSIONAL THERAPY WITHIN NURSING HOMES BY DIRECTORS OF NURSING : A QUALITATIVE STUDY"

Dear participant,

You are invited to participate in a study which will be exploring the perceptions and attitudes of directors of nursing to the role of diversional therapy within nursing homes. This project is part of the requirement of a Post Graduate Course in Community Health in the Faculty of Health Sciences, The University of Sydney, being undertaken by researcher Jacqueline Quirke whose supervisor is Dr Freidoon Khavarpour (PH: 604 8503).

If you agree to participate in the project you will be involved in an indepth interview which will last for about 30 - 45 minutes in duration at a time and location that is convenient to you. Participation in this project is entirely voluntary and you may withdraw at any time during the interview or the study process.

The questions asked will relate to your perceptions and attitudes towards diversional therapy as a profession within your facility and within the healthcare system as a whole. This project has been approved by the University of Sydney and meets the guidelines for ethical research which requires full disclosure to participants of the purpose of the research, and guaranteed confidentiality to all participants.

The information you give in the interview will be confidential and your identity will not be disclosed to any other person. The interview will be recorded on a tape recorder but your name, personal details and name of the facility will not be used in the final report. During the interview you will have the opportunity to raise any questions you may have. You may contact Jacqueline Quirke on (W) 830 8000 pager 048 or (H) 489 7622 if you wish to participate in this study or if you wish to discuss any aspect of the interview or other matters related to this research.

Your contribution to this project would be greatly appreciated.

Yours sincerely,

Judith Mair.
Head of the School of Community Health.

The University of Sydney
Faculty of Health Sciences

School of Community Health

INFORMED CONSENT

I, _____ hereby voluntarily consent to participate in the research entitled:

PERCEPTIONS OF THE ROLE OF DIVERSIONAL THERAPY WITHIN NURSING HOMES BY DIRECTORS OF NURSING: A QUALITATIVE STUDY.

conducted by: JACQUELINE QUIRKE

I understand that the information obtained from this research may be used in future research, and may be published. However, my right to privacy will be retained, ie: personal details will not be revealed.

The procedure as set out in the attached information sheet has been explained to me and I understand what is expected of me and the benefits and risks involved. My participation in the project is voluntary.

I acknowledge I have the right to question any part of the procedure and can withdraw at any time without this being held against me.

I have been familiarized with the procedure.

Signed by Subject: _____

Date: _____

Witness: _____ (Name)

_____ (Signature)

_____ (Date)

Appendix C

This section gives a summary of the issues revealed in the interviews with the thirteen directors of nursing. The issues and comments are presented under each of the theme headings. The first column represents how many of the informants expressed that particular issue or comment, the second column represents which of the informants expressed that particular issue and the third column represents the comment or issue raised during the interview.

a) ROLES

12	1,2,3,4,5,6,7,8,9,11,12,13	To provide activities, to give the residents something to do, to occupy them
10	2,3,4,6,7,8,9,10,11,12	To assess the residents, to do case histories, find out the residents likes, dislikes, etc
9	2,3,4,6,7,9,10,11,12	To feed the residents and supervise the dining room
9	1,2,3,4,6,7,9,10,13	One to one therapy, individual activities
8	1,2,3,4,6,7,9,11	To organise bus trips
7	1,2,4,6,7,9,10	Group activities - varying sizes
6	2,6,7,9,11,12	To run the residents meetings
6	1,2,7,8,10,11	Support the resident - (mental & emotional), be a friend, build rapport
6	2,3,7,10,11,12	Support the relatives, run relative support groups
6	2,3,7,8,11,13	Entertain
6	2,3,4,6,7,12	To organise a program
5	3,4,5,6,13	To organise major activities
5	1,7,8,9,11	To facilitate a friendly atmosphere, settle new people in, for socialisation
4	2,3,5,6	To do nursing duties - toileting, etc

3	1,2,12	To meet the residents needs
3	1,4,6	Incorporate residents interests
3	2,6,9	To increase Quality of life for the residents
3	2,9,12	To facilitate socialisation
3	2,3,4	To be involved in fund raising
3	3,8,12	To divert the residents
3	8,9,11	To organise religious affairs
3	4,11,12	To look after the social side of the residents life
3	3,6,13	To talk and listen to the residents
2	3,12	Do shopping for residents
2	1,3	Link residents with the community, involve community
2	1,4	Reality orientation - keep residents aware of what is happening
2	2,12	To be involved in team meetings
2	2,4	To be involved when the standards monitoring team comes
2	8,10	To stimulate interest
2	3,12	To check the residents draws and ensure they have appropriate personal items
2	3,4	To do posters, invitations, get well cards
2	4,6	To publish a news letter
2	4,6	To provide variety of experience
2	9,10	To evaluate activities
2	6,11	To be a mediator
1	1	Tap into people's interests
1	1	Co ordinate volunteers
1	1	Decrease isolation
1	1	Adapt activities to suit clients

1	1	Interaction with residents that is not done through necessity - such as self care
1	1	Promote well being of the resident
1	2	Teaching the residents things
1	2	To make the nursing home homely
1	2	Run down the street for staff
1	4	Co ordinate students
1	5	To add to our sum of knowledge
1	6	To gain the trust of the residents
1	6	To liaise with appropriate staff
1	7	To provide the fun things, pleasurable things
1	9	Liaise with the hairdresser
1	9	To organise holidays
1	9	To meet the residents motivational & recreational needs in excess of the nurses can do
1	10	To help the residents improve the few things they can do
1	11	To do the menus orders
1	11	To be involved in the electoral role activities
1	11	To read the residents files
1	12	To look after financial matters if people don't have relatives
1	12	Dt takes over some of the responsibility of the family if they don't have family or relatives
1	13	To keep the residents active

b) SKILLS

7	2,3,4,6,10,12,13	Good communication
6	2,4,6,8,10,12	Organisational skills, time management

6	3,4,6,7,10,13	To be able to understand each resident - relate to them
6	7,8,9,11,12,13	Well motivated
5	1,2,3,6,9	Craft and art skills
4	4,8,10,12	Sense of humour
4	3,7,10,11	Friendly, kind, caring
4	1,7,8,10	Knowledge of medical conditions and human nature, dementia, etc
3	1,8,12	Be able to assist and encourage people to be involved - motivating
3	2,8,12	Need to be flexible
3	3,10,12	Listening skills
3	2,9,12	To be able to formally run a program, plan, evaluate and arrange activities
3	6,10,13	To be able to organise activities the residents want
3	6,7,8	Need to be tolerant
3	7,8,9	Empathy
3	2,10,11	Experience with older people, good with elderly
2	3,10	Basic cooking skills
2	9,12	Good at documentation
2	10,12	To be able to respect the resident
2	1,6	People skills
2	2,11	Well groomed, good health, personal hygiene
2	3,11	Patience
2	3,12	Lifting skills
2	4,10	Good command of the English language
2	4,8	To be able to assess the residents needs
2	8,13	Good understanding of dementia behaviour
2	3,12	To be able to handle different people - aggressive residents
1	3	Nursing skills

1	4	To be able to fund raise
1	5	Broad knowledge base
1	6	Dedicated sort of person
1	6	Be calm and relaxed
1	6	Need to have perseverance
1	7	General interest in the elderly
1	8	Common sense
1	9	Skills in social areas
1	9	Work well in a team
1	10	To be able to feed
1	10	Life skills
1	10	Good self esteem
1	10	Creative
1	10	Be able to let off steam
1	10	General Knowledge - current affairs
1	10	Computer skills
1	10	Appreciation of music

c) TRAINING AND EDUCATION

5	3,4,5,7,10	Base line would be some type of education, for the profession
5	2,4,5,6,12	DT graduates have a different calibre compared to non graduates, the knack, the Uni course sorts out who is going to be good, have more skills
4	3,8,9,13	Doing study in DT at tafe, does not know where Working with older people course fits in
4	1,5,6,7	DON does not know what the training involves, lack of understanding of DT course

4	2,5,7,12	Just because you have looked after your grand mother does not mean you are qualified to work with the elderly
3	1,4,9	Important for DT to keep up to date with knowledge
2	5,6	Feels that skills and training accounts for a lot but it does not necessarily mean that the person is cut out to work in a NH on a day to day basis
2	2,5	Would prefer it if both DT's were trained
2	4,12	DON is a firm believer of skills and education, education is of benefit, education is great
2	1,5	Dementia
2	1,6	Need to learn crafts
2	2,3	In working with older people
2	1,3	Nursing background with education from DTAA
2	7,11	In disabilities and diseases
1	1	Does not seem to have to be a university trained person
1	1	DTAA can give education in DT specifically
1	1	People skills
1	2	Would not put two graduates with no experience together
1	2	Likes to have at least one DT that is trained or has some sort of qualifications
1	3	In safety procedures
1	3	In disruptive behaviours
1	3	In how to occupy the residents all day
1	3	Need theory as well as hands on
1	3	Becomes a DT with a certificate
1	4	People can still be good DT's even if they do not have the higher education

1	4	Person's ability is important not only their tertiary education
1	4	Does not feel having a Bachelors Degree is the answer for DT
1	5	Can not compare a trained person and a non trained person
1	5	Feels the nurses do not need any training to do the "Quality of Life" activities
1	7	Has a DT that is trained through Ku-ring-gai - specialised in age care
1	9	DT are actively involved in improving there role
1	9	In aromatherapy and reflexology
1	10	DT course should be more accessible
1	11	DT visited a couple of other nursing homes to learn, some courses and had an orientation
1	11	Need training in feeding
1	12	Qualified person is worth 3 or 4 non qualified people

d) BENEFITS

9	1,2,4,7,8,9,11,12,13	Socialisation, decrease isolation
7	1,2,3,5,7,9,11	Increased quality of life
7	12,3,4,7,8,9	Stimulation - mental and physical
5	2,6,8,11,13	Something to do - decrease boredom, helps pass the time
5	2,3,7,9,12	Maintains previous interests, social skills
4	1,2,8,11	Provides some kind of interaction, rapport, extra communication
4	2,3,8,10	Residents have something to look forward to
4	2,4,10,12	Enjoyment, emotionally happy
4	1,2,10,11	Keep residents aware that it is another day, what day it is, what's happening in the world, weather, etc - reality orientation

4	3,6,7,10	Feel important, recognition, acknowledgement, achievement, success
3	6,11,12	Different contact
3	7,10,11	Increased self esteem
3	1,7,8	Of benefit to the client
3	7,8,12	Friendship
2	2,3	Diverts
2	3,4	The nursing home is more homely
1	1	Encourages involvement
1	1	Provide contact with outside people - link with community
1	2	Helps with dementia management
1	2	Develops co- ordination
1	7	Competition
1	8	Maintains a level of independence
1	11	Broadens the residents outlook

e) NAME

6	1,2,3,7,10,13	Diversion - taking their minds off things
6	2,3,4,7,8,11	Likes the name DT
4	2,3,7,12	Feels DT is therapy, therapeutic
4	3,4,9,10	DT is a professional name
2	1,2	DT is more appropriate than recreation activities officer
2	5,10	The word therapy indicates that they need treatment or they have something wrong
2	2,10	Don't like activities officer
1	1	Either name is not suitable because of what it implies
1	2	Has an alcoholic association

1	2	Might like another name better
1	3	Calls them recreation activities officers because of the award
1	4	Everyone should be called a DT if that is what they do
1	5	Feels that older people resent the word therapy
1	5	Therapy is distasteful
1	5	Diversional has negative connotations
1	5	Feels we should have a positive term
1	8	Feels the name is not the main issue - what they do is more important
1	8	Every one has a category and that is what the name is for
1	9	Feels the community perceives DT in a better light
1	9	Finds DT's would rather be called DT's than RAO's
1	9	Feels both names define what they are doing
1	10	The name may indicate instead of well being there is actually a dependency
1	10	May be confusing to a lay person - may wonder what they are doing
1	10	Need to do some research into the name
1	10	Don't want a name that is opposite to well being
1	11	Don't call them DT's because they are not
1	12	Has a problem with people calling themselves DT's when they are not trained
1	12	When you hear DT you think of craft, music, sedentary life
1	13	Did not understand the word DT at first
1	13	Prefers recreational officer or activities officer - more appropriate
1	13	DT is more than just diversional

f) DOCUMENTATION

6	1,3,4,6,10,11	Involved in documenting DT intervention
6	2,3,7,8,11,13	DT's have separate documentation
6	2,3,4,7,11,12	Does a social history
5	1,5,7,9,12	DT writes on care plans
4	6,8,10,12	Documentation is for accountability, necessary
4	4,5,6,11	DT's write in the progress notes
3	1,5,6	Need to document intervention same as other staff and in a central place
3	4,10,11	Documentation is a nightmare for DT's, large job
2	6,8	DT's are doing far too much documentation - cutting down to a more realistic amount
2	8,12	Good form of communication
2	6,12	Feels there is no point in having documentation that sits in an office, should be shared
1	2	Try to teach the staff to document better so they can get maximum funding
1	2	No use for DON to write in file on DT activities because she would not know - better for DT to do it
1	4	Documentation to prove they are meeting the Outcome Standards
1	6	DT's don't realise the legalities with documentation
1	8	Feels DT's documentation is an important part of the clinical record
1	10	Need to have documentation that is for your own benefit
1	10	Professionals can not really have tick sheets but they are graphic
1	10	Computer skills could help in documentation
1	10	Documentation has to be pertinent and realistic

1	10	With documentation you can see who is not involved
1	10	For communication between DT's
1	10	DT's have separate sheets that can be added to the residents main file
1	11	DT writes if the residents eating habits change
1	12	DT's should not be the keepers of the social history

g) PROFESSIONAL ISSUES

(Team issues)

5	1,2,9,11,12	Everyone works together - team, part of a whole team
3	2,11,12	Involved in team meetings - talk about what they do for the resident
1	2	Personality rather than training has to do with working as a team
1	4	DT must be able to work in a team
1	9	Staff communicate both formally (written) and verbally

(Employment issues)

11	1,2,3,4,6,7,8,9,11,12,13	Dt is essential, couldn't survive with out them, important, valuable
6	2,3,8,9,11,13	Willing to have a DT with any types of skills, other training would be considered
4	2,3,9,11	When employing a DT goes on gut feelings, personality
4	7,10,11,12	Feels a trained DT would know what is required, prefers trained
3	1,6,12	The nurses and other staff think it is an easy job - not physical, etc
2	6,8	Prefers to have an older DT - younger ones not mature enough
2	3,6	Takes a special type of person to be a DT
2	11,12	NH's find it hard to get a trained DT
2	11,12	Trained DT's can not use all their skills in a NH, not interested
2	1,10	Stressful job, challenging, hard

1	5	Feels the use of a DT is fairly limited - DT to co-ordinate activities
1	5	Would prefer to have the nurses doing the "Quality of Life" activities rather than the DT - nurses should give the holistic care
1	5	Eventually, the DON will not have recreational therapists who do only recreation
1	5	Would rather spend the money on nursing than on DT
1	6	Trained person with experience makes a difference
1	6	Trained people need to get experience
1	6	A good DT breathes and sleeps DT
1	7	Should be seeking the people who are qualified to fill the role
1	7	Employed a RAO because it is a little cheaper
1	8	Have had some nurses who have made good DT's
1	9	On roster called RAO because they are not trained
1	10	Dt is extremely emotionally draining
1	12	Advertised for a DT got people who were not trained or no experience
1	12	Dt completes the circle of holistic care
1	12	Untrained tends to want to be friends
1	12	Better to have 2 trained DT's and lots of volunteers
1	13	Employed a NESB DT because of the residents

(Duty issues)

8	2,3,4,6,7,9,10,11	Sees feeding as a DT role - supervising the dining room
8	3,6,7,8,10,11,12,13	Nurses get involved on major days or when they have time
5	2,3,4,6,11	No nurses go on the outings
4	7,9,10,12	Nurses always go on outings
4	2,4,8,11	DT's should NOT do nursing duties
3	2,8,13	Nurses can go on outings it depends on what residents go

3	3,5,6	DT's should DO nursing duties ie take the resident to the toilet
3	4,7,13	Fairly defined roles but can help when very short staffed
3	3,9,10	Nurses do activities when DT is away
2	5,9	Nurses have it in their job description to look after the social & emotional needs as well - to be involved in DT activities
2	3,4	Raises money for DT program
1	3	DT uses own car for work related activities
1	3	DT could do nurses role but nurses could not do DT role as they are not trained
1	5	The RAO tends to focus on games and entertainment
1	5	Feels that when the DT hands over to the nurse the quality of the relationship is cut off
1	5	Feels that their is clear lines of demarcation and that interferes with a good therapeutic relationship
1	7	DT's help with toileting on outings
1	9	DT's deal with the non clinical side
1	9	DT's get a different perception to add to a holistic approach
1	10	DT's need preparation time
1	11	Working in a NH is very repetitive
1	11	DT doing menu issues is a good way to say hello to the residents
1	11	DT's have a settling influence over the NH
1	11	Would like the DT to read the reports more and be involved in reports
1	12	DT has to discuss programs with DON
1	12	DT can assess and organise and volunteers can carry through
(Activity issues)		
3	2,3,7	Need to do activities that suit the residents not what suits the staff

3	2,5,8	A lot of residents do not like group activities, or can not meaningfully participate in group activities
3	3,7,8	Residents are social beings, human beings
2	7,8	DT is very important for the residents, quality time
2	7,10	Have to respect the residents right not to be involved
2	3,11	DT do not just do activities
2	4,6	The residents confide in the DT, relate differently to the DT
1	1	Sees DT as many activities which make up a program
1	1	DT is not just crafts, has moved away from just being that
1	5	Feels the RAO does not do the activities the residents want
1	5	Feels the nurses knows better what the residents needs are
1	5	The nurses get to know the residents interests, past life, their capabilities,
1	5	Sees that the emphasis is on individual activities
1	5	Feels that the DT's have had their own little sphere of activities
1	5	Feels that not a lot of thought was given to the residents who could not join in with group activities
1	5	The DT is ready at a certain time so everyone else has to work around the schedule they set out
1	5	Base the Quality of Life activities on what the residents used to do
1	5	Should not expect the residents to fit into the nursing home activities
1	6	DON likes to see small groups rather than large groups
1	7	DT has great advantages for the residents and staff
1	7	Forms a close relationship with the relatives
1	7	Some residents can only be seen on a one to one basis

1	8	Here to make the residents happy and contented even if it is in a confused state
1	9	Can learn to live with a physical disabilities but you can not live with social isolation and poor motivation
1	11	Nobody is able to do arts and crafts any more
1	11	DT need to know what is going on with each of the residents
(Professional Issues)		
3	3,10,11	Attends DT meetings
3	4,9,10	Important to belong to the association - networking
2	2,3	Sees DT as a profession because they have support meetings and an association
2	4,12	Can only see DT as going forward not backwards
1	3	Learns a lot from DT meetings
1	3	Done any training you are a professional
1	4	DT is involved because people see the need and can see the value
1	5	DT would add to the sum of knowledge
1	5	Feels that DT's impose a schedule on the residents and the care giver. And this schedule can not be realistically met so it causes tension
1	6	Title does not make a professional person it is the way you conduct yourself
1	6	Feels the skills in DT are not really as in force as with nurses
1	10	DT is representing the facility
1	10	Feels that DT is really only known in aged care but it is blossoming
1	10	Some of the best DT's are self taught with life skills
1	10	It is not fair that DT grad's get paid less than someone who is untrained

1	10	Need to have more resources specially for DT's
1	11	Does not see any conflict in the role of the DT and the nurse
1	11	Nurses resent taking instructions from a non nursing person
1	12	Untrained DT applied for a job - easily got another job at another NH
1	12	Untrained DT - need to look at the evaluation of the untrained DT's program. Are they capable of providing a program or are they just a companion
1	12	DON would like to see in the future DT to be more active less diversional
1	12	Feels trained DT has a more professional approach
1	12	To give respect to the resident - comes from a professional background

Appendix D

Statement of Duties

1) Maintain the Code of Ethics of the D.T.A.A.
2) Have a knowledge of the policy of the organisation.
3) Be accountable to the diversional therapy supervisor and / co-ordinator or accept responsibility for supervision and / or co-ordination of diversional therapy staff, where applicable.
4) Assess the client's needs, preferences and capability, compiling an individual activity profile.
5) Provide opportunities for the individual to choose to participate in a range of age appropriate activities and recreational pursuits, planned and organized in consultation with the client.
6) Offer activity programs to all clients, incorporating both individual and group activities.
7) Explore and develop the use of community facilities and resources.
8) Plan and display weekly/monthly program to inform residents, staff and others of proposed activities.
9) Implement and conduct programs in a manner which will facilitate client participation and achievement.
10) Maintain a written assessment of client needs, abilities and progress with ongoing evaluation.
11) Evaluate the programs in terms of their objectives and modify where necessary.
12) Liaise with appropriate staff regarding client care and progress and report any signs of change or unusual behaviour. Participate in inter-disciplinary client review.

13) Prepare budgets, inventories and maintain financial and statistical records as required.

14) Purchase or order equipment and stores and maintain work area and equipment.

15) Work with and give guidance and basic training to students, aides, voluntary workers, relatives and staff, as required.

16) Be capable of implementing the fire safety procedures of the facility.

Reference : Diversional Therapy Association of Australia.(1995). *Statement of Duties.* Sydney : Diversional Therapy Association of Australia.