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How Does Intraprofessional and Interprofessional Collaboration Impact the Use of Occupation-Based Practice in Skilled Nursing Facilities

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How Does Intraprofessional and Interprofessional Collaboration Impact the Use of Occupation-Based Practice in Skilled Nursing Facilities

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DEPARTMENT OF OCCUPATIONAL SCIENCE AND OCCUPATIONAL THERAPY

This project, written by Stedmon Deon Hopkins under direction of Dr. Leah Simpkins, Faculty Mentor, and approved by members of the project committee, has been presented and accepted in partial fulfillment of requirements for the degree of

DOCTOR OF OCCUPATIONAL THERAPY

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Certification

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Executive Summary

Background: Research shows that there are many barriers to the implementation of occupation-based practice amongst occupational therapy practitioners. One barrier that requires a more in-depth review is the process of interprofessional and intraprofessional collaboration amongst staff in skilled nursing facilities.
Purpose: The purpose of this research project was to examine how interprofessional and intraprofessional collaboration influence occupational therapists and occupational therapy assistant's ability to provide occupation-based practice in skilled nursing facilities.
Theoretical Framework. The frameworks utilized throughout this study included the National Interprofessional Competency Framework and the Occupational Therapy Intervention Process Model (OTIPM).
Methods. This study utilized a qualitative case study design to understand how staff within skilled nursing facilities viewed the impact of intra- and interprofessional collaboration has on occupation-based practice. Participants were recruited utilizing purposeful sampling to gain a full diverse picture of the phenomenon being studied. Participants were interviewed for between 15 - 30 minutes individually and interviews were transcribed verbatim. The transcripts were coded which led to the development of three themes.
Results. After the seven participants were interviewed three themes emerged from the data. The three themes were: absence of shifting mindsets, respecting roles to benefit clients, and missed opportunities.
Conclusions: The themes and subthemes of this study bring to light the challenges to effective collaboration and how it impacts occupation-based practice, while also discussing what effective collaboration looks like and how it can benefit the clients that receive services. By having the different professions represented in this study, there is a diverse overview of the experiences had within the facility giving a better understanding and view of the nature of intra- and interprofessional collaboration helping to better perceive how occupation-based practice may be impacted.

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CERTIFICATION OF AUTHORSHIP

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Certification of Authorship: I hereby certify that I am the author of this document and that any assistance I received in its preparation is fully acknowledged and disclosed in the document. I have also cited all sources from which I obtained data, ideas, or words that are copied directly or paraphrased in the document. Sources are properly credited according to accepted standards for professional publications. I also certify that this paper was prepared by me for this purpose.

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Section 1: Nature of Project and Problem Identification

Introduction of Problem

When asked what occupational therapists do, there may be a wide array of answers. According to American Occupational Therapy Association:

> Occupational therapy is the only profession that helps people across the lifespan to do the things they want and need to do through the therapeutic use of daily activities (occupations). Occupational therapy practitioners enable people of all ages to live life to its fullest by helping them promote health, and prevent – or live better with – injury, illness, or disability. (2020)

With this definition, it can be said that the profession uses occupations to assist people in promoting increased health and overcoming barriers due to disability or injury. It has been noted that therapists have a responsibility to create unique and individualized treatment methods to better assist clients. The process of being client-centered in practice means that as practitioners we collaborate with our clients to enable them to identify and achieve goals. It is the duty of occupational therapists to ensure that the clients are involved in the process of making decisions about the evaluation and the intervention services that are provided (Hinojosa et al., 2017). It is the obligation of occupational therapists to use occupations in practice and to do so in a manner that is client centered. According to the Occupational Therapy Practice Framework, Boop et al. (2020) describe being occupation-based has a “characteristic of the best practice method used in occupational therapy, in which the practitioner uses an evaluation process and types of interventions that actively engage the client in occupation” (2020, p. 79).

Occupation-based treatment, according to Hinojosa et al. (2017, p. 241), “pertains to the occupational therapist using evaluation tools and intervention strategies that involve the client being actively engaged in occupational performance.” This can generally come in two forms: occupation as a means and occupation as an end. Occupation as a means, as defined by Gray (1998, p. 358), “refers to the use of therapeutic occupation as the treatment modality to advance someone toward an occupational outcome.” This describes the use of occupation as a process used throughout the intervention process to assist the client in achieving their goals. As stated by Gray (1998), “occupation as an end refers to not only limited to a goal or desired outcome, but rather can be the overarching goal of all occupational therapy intervention” (p. 357). Therefore, occupation as an end can also be used to describe the process of using preparatory methods and activities with the end goal of the client’s occupations in mind. It is important to be able to understand how occupations can be utilized throughout the goal setting and intervention process to promote client outcomes. As Lamb (2017) stated, the interventions that are utilized must be focused on occupation, on facilitating participation and engagement in the meaningful, necessary, and familiar activities of everyday life . As long as these interventions promote and help to increase the clients end goal related to occupation then they are meaningful interventions. Being able to maintain a focus on interventions allows the therapist to remain true to the purpose of the profession of occupational therapy.

With the profession being rooted in the use of occupations, why do many occupational therapists encounter barriers to the utilization of occupation-based treatment and client-centered practice methods within skilled nursing facilities? There have been

multiple studies done that discuss the perceptions, effectiveness, barriers, and utilization of occupation-based and client-centered treatment methods (Daud et al., 2016a; Daud et al., 2016b; Mattingly, 2012; Sumison & Smyth, 2000). In a study by Sumison & Smyth (2000), barriers to client-centered care were addressed along with resolutions through a non-experimental, survey design. Overall, 16 barriers were noted with the top four reasons being: the therapist and the client having different goals, the therapist's values and beliefs prevent them from accepting the client's goals, the therapist being uncomfortable letting the client choose their own goals, and the intervention being dominated by the medical Model. The initial barriers listed in this study showed there is a disconnect in what the healthcare practitioners see as important and what the client views as important. Pierce (2003) stated that "it is important to acknowledge that placing power in the hands of the client is a recent shift from the more traditional "expert" approach, which places most goal setting power in the hands of the therapists and other medical professionals" (p. 277).

It has also been found that therapists are experiencing issues when applying occupation-based intervention into practice. In a study conducted by Daud et al. (2016b), they aimed to discover what challenges were being faced when therapists attempt to implement occupation-based interventions into practice. The results were classified into the areas of client factors, occupational therapy factors, no use of a client-centered approach, logistical factors, and contextual factors. The results of this study showed that many of the barriers experienced involved a range of factors related to the client's attitude and motivation toward treatment, the therapist's knowledge and skill in occupation-based practice, environmental factors, and how occupation was not viewed as

an effective therapy strategy by other professionals. Daud et al. (2016b) stated there is a lack of awareness about the role of occupational therapists by other professionals and that has an impact on referrals received for occupation-based practice. This shows there may be individuals that are not receiving occupation-based treatments due to staff not being aware of how occupational therapy can play a role in these individuals' lives. This can also be seen when a student stated that “it would help if everyone else had an idea of what we did, like the medical team, for instance, in my setting. If they knew what we did, maybe we could be a bit more occupation-focused where you get referrals in a timely manner” (Di Tommaso et al., 2016, p. 210). This study went into detail as to how each of these factors play a role in a therapist's inability to complete occupation-based practice. Utilizing this study gave more understanding of what therapists’ experience in relation to the type of interventions being utilized.

Another study by Di Tommaso et al. (2016) looked at how occupational therapists perceived the use of occupations in practice. This study particularly looked at new graduate occupational therapists and examined their views of the use of occupation. This study was used to determine what types of things they noticed within practice and how occupation was being utilized and if it was not, then why. The study uncovered multiple themes, some of which included rhetoric versus reality, which examined the difference in what they were taught in school versus what they actually experienced. Under this theme it was also noted that many of them felt they would like to use occupation, but could not, due to utilizing impairment-based interventions. This goes along with facilities and their staff not fully understanding the use of occupation as the primary focus of occupational therapists’ treatment. Many staff in these facilities believed it was the occupational

therapist's job to strengthen the clients through exercises and to work on goals set by third party payors. Two more themes that played a role in the barriers these students faced included they felt they needed permission from other therapists to utilize a more occupation focused approach and also the type of education received.

These aforementioned studies all highlight how therapists are facing barriers to being able to fully utilize occupation-based and client-centered practice strategies in practice. Literature discusses the use of occupation-based practice in a variety of settings, with varying populations, and between different therapists. Some of the literature even suggests ways to solve and overcome these barriers. Even still, there are many therapists in practice that do not utilize these crucial practice styles in their treatment plans. One area that the literature does not fully explore as a barrier that is prevalent in skilled nursing homes involves the staff and their collaboration. Occupational therapists working in skilled nursing facilities need to be able to have open communication and collaboration with the certified nursing assistants, social workers, nurses, minimum data set (MDS) coordinators, administrators, and many more. This collaboration and cohesiveness between disciplines and the entire healthcare team is what is going to advance the healthcare workforce and enhance patient care (Foronda et al., 2016; Lumague et al., 2006).

Interprofessional collaboration is a concept that was briefly mentioned in the previous studies as having an impact on the practitioner's ability to participate in occupation-based practice. Interprofessional collaboration "occurs when multiple health workers from different professional backgrounds work together with patients, families, and communities to deliver the highest quality of care" (Johnson, 2017, p. 1).

Intraprofessional collaboration refers to collaboration that is done between a specific discipline. For purposes of this research project, that will be collaboration between occupational therapy and occupational therapy assistants. Interprofessional and intraprofessional collaboration are crucial for clients in skilled nursing facilities to be able to succeed and fully benefit from interventions. Skilled nursing facility staff, including the occupational therapists, need to be aware of how to support each other. Occupational therapists have goals of increasing independence and quality of life through occupations, and those goals can help support the nursing staff with their day-to-day activities and responsibilities. According to Fortune and Fitzgerald:

> The development of occupationally engaging environments requires a strong commitment to organizational change, the availability of sufficient resources, respectful relationships, and perceived professional support. Only then can interdisciplinary cooperation between ward staff be enabled. Without this cooperation and a shared vision of what is important and how it will be achieved, it is unlikely that an occupational milieu can be established or maintained. (2009, p. 86)

Interprofessional and intraprofessional collaboration are key to making sure that all staff are on the same page and have similar goals in mind for the patients to promote success.

Needs Assessment

During Summer 2020, a needs assessment was completed by the author in preparation for the capstone study. Semi-structured interviews with one occupational therapist and one occupational therapy assistant were conducted. The interview questions were all based around perceived barriers or supports related to occupation-based practice

and the therapist's views or thoughts regarding occupation-based practice. One common theme of both interviews was that both therapists felt there was a need for further staff training within the skilled nursing facilities. Both therapists mentioned staff training and support being a barrier. One participant discussed multiple occasions where the certified nursing assistants (CNA's) were doing daily tasks for the patient instead of letting them do it for themselves. This made it hard for the skills learned in therapy to translate over to their everyday life, whether they were returning home or living there long-term. There was a clear belief that the staff played a role in the barriers experienced to providing occupation-based practice.

Problem Statement

The needs assessment revealed the role that skilled nursing facility staff may have in therapists' utilization of occupation-based practice. There is research discussing barriers to occupation-based practice in skilled nursing facilities involving resources, time, and knowledge. One area that is not discussed as much is the role other staff may have on this method of practice. There is also little known about the role of intraprofessional collaboration on the use of occupation-based practice within skilled nursing facilities.

Purpose of the Project

The purpose of this research project was to examine how interprofessional and intraprofessional collaboration influences occupational therapists and occupational therapy assistant's ability to provide occupation-based practice in skilled nursing facilities. This was a qualitative case study. A case study is used to conduct research that

involves the study of a case within a real-life context or setting while a qualitative study is utilized because there is a problem or issue that needs to be explored (Creswell, 2013, p. 97, 47). With this research study, a clear problem was explored through the studying of professionals who work within skilled nursing facilities.

Research Questions

The research questions addressed in this study were:

1. How does interprofessional and intraprofessional collaboration impact occupation-based practices in a skilled nursing facility?
2. What role, if any, do occupational therapists and occupational therapy assistants see other professionals and themselves as having regarding occupation-based practice in skilled nursing facilities?
3. What are the experiences of occupational therapists, occupational therapy assistants, and skilled nursing facility staff with interprofessional collaboration and how does it impact occupation-based practice in a skilled nursing facility?

Theoretical Framework

The National Interprofessional Competency Framework (Orchard et al., 2010) was used to guide how interprofessional collaborative relationships are viewed and assessed. It is based around competencies of varying healthcare professionals and education. “Rather than focusing on demonstrated behaviors to determine competence, the framework relies on the ability to integrate knowledge, skills, attitudes, and values in arriving at judgements” (Orchard et al., 2010, p. 8). This framework helped guide the interview process of this research project by focusing on the competency domains of:

interprofessional communication, patient/client/family/community-centered care, role clarification, team functioning, collaborative leadership, and interprofessional conflict resolution.

Due to the purpose of this research project and the need to have an understanding of how interprofessional collaboration impacts occupation-based practice, the framework domains play a major role. Communication between healthcare professionals was essential in order for the teams to work together to provide the best outcome for their clients and is the initial factor that should be viewed when exploring this phenomenon. Patient, client, and family roles also played a major role during the interviews when discussing barriers or problems that may arise. As noted in the literature, there are many situations where the client factors play a role in barriers to occupation-based practice, and there is a link between those factors and the collaboration between the professionals as well. Role clarification and team functioning are both concepts that relate to each other by ensuring that each party involved is aware of their roles and the role they can play to help each other in achieving their professional goals and ultimately helping their clients achieve their goals. The concepts of collaborative leadership involve there being a leader who offers support through facilitation of team processes, decision making, encouraging collaboration, and more. Interprofessional conflict resolution was another factor that played an important role when discussing interprofessional collaboration. "Learners/practitioners actively engage themselves and others, including the client/patient/family, in positively and constructively addressing interprofessional conflict as it arises" (Bainbridge et al., 2010, p.9). Due to the nature of this study, there were

discussions related to conflict between professionals that related to role clarification, functioning, or other unanticipated factors.

When discussing occupation-based practice and client-centered care, the theoretical framework that applies to this study is the Occupational Therapy Intervention Process Model (OTIPM). This Model encourages therapists to use a top-down, client-centered, occupation-based approach with clients during the assessment and intervention process (Hinojosa et al., 2017). With this research, the basis is on utilization of client-centered and occupation-based practice and what barriers and facilitators are being experienced by occupational therapists and occupational therapy assistants. The OTIPM is based on the principles that:

> Each person is unique and has the will to engage in activities that yield a sense of meaning and purpose for the person, people's engagement in occupation is the central focus of our profession, our primary method for promoting abilities of person's to engage in occupation is to use their engagement in occupation as our primary intervention strategy, and the primary intended outcome of occupational therapy services is to enable our clients to achieve and maintain their ability to engage in occupations needed to fulfill life roles and to attain the fullest possible level of participation in society. (Hinojosa et al., 2017, p. 240)

With this Model, the importance of client-centeredness, occupation-based, and occupation-focused interventions are stressed to be crucial within the profession and to enhance the quality of lives of clients that receive services. This Model also stresses the importance of using a top-down approach to treatment which is done by first understanding the narrative of the client and what they value most followed by treating

the patient in a holistic manner focusing on their occupational deficits. Using this Model helped give a clear definition of terms related to the process of occupation-based practice and helped guide factors that were addressed throughout the interview process.

Significance of the Study

Due to the barriers in providing occupation-based care to residents in skilled nursing facilities related to intra- and interprofessional collaboration, this study aimed to uncover these barriers, and potentially improve patient care through improving or increasing OBP, interprofessional collaboration, and intraprofessional collaboration. By focusing on these three areas, optimal client care can be achieved or improved upon within skilled nursing facilities.

By utilizing and increasing the use of OBP, client outcomes and satisfactions can be improved due to the increased chance of meeting their goals. OBP, the primary treatment strategy of occupational therapists, has been proven to be highly effective in helping clients meet their goals and increase independence within skilled nursing facilities. By exploring the aspects of intra- and interprofessional collaboration within this facility, the barriers to OBP in relation to peers can be understood and examined to better improve client outcomes.

Interprofessional collaboration also has the potential to improve client outcomes, especially when viewing the client holistically. It is unlikely that any one profession is capable of meeting all the needs of a client. By properly implementing the concepts of interprofessional collaboration, including teamwork, proper communication, and role acknowledgement, the care team is better equipped to treat the client with any barriers

they may be facing. This study identified barriers to interprofessional collaboration that need to be further addressed to improve the way teams work together.

Lastly, intraprofessional collaboration is another area that has the potential to improve client care when implemented appropriately. Intraprofessional collaboration is important because it shapes the way the OTA and the OT work together. By improving the barriers that are present to intraprofessional collaboration, the way the OT and OTA collaborate can also improve, therefore positively influencing how the client is treated and the interventions that are administered. This allows the OT to gain more insight into a client through the OTA that is possibly spending more time with the client, while giving the OTA the opportunity to receive suggestions from the OT on how to treat the client. By looking at the three above areas, there is potential to improve client care and improve meaningful outcomes.

Section 2: Review of the Literature

Occupation-Based Practice

Perceptions/Efficacy of Occupation-Based Practice

Occupation-based practice is perceived differently by professionals within the field whether they are experienced or entry level occupational therapists. In a study by Di Tommaso et al. (2019), new graduates' perceptions of the utilization of occupation in practice was assessed using two focus groups that consisted of eight therapists. This study was conducted because they recognized the need for practitioners to utilize occupation in practice again. Through this phenomenological study which included 18 (1-2 hours long) interviews, the barriers being faced by these new graduates were assessed. The results showed multiple themes, that included: Enacting occupation-based practice, occupation is a luxury, and experience: it is more of a confidence thing. The first theme many of the participants mentioned was that they understood why it was important but could not describe how they utilized occupation in their treatments. It was also mentioned that they had other roles and focuses within their settings and that utilizing occupation would take more time. Participants believed that clients could not participate in occupation until they had overcome their limitations and that occupation was something to use when they had spare time or if they were utilizing it, they were not prioritizing their time. Lastly, many of the participants felt they needed more experience. This study helps to set the stage for understanding how some therapists, particularly new graduates, view occupation-based practice. It shows that there are barriers related to client factors and perceptions that make occupation-based practice difficult to implement.

Jewell et al. (2016) conducted a study that explored occupation-centered practice in skilled nursing facilities by identifying current occupational therapy interventions and if occupation-centered practice occurred in short term rehabilitation clients. The study also aimed to determine if clients were engaging in an occupation-centered approach (Jewell et al., 2016). The study found that there was a correlation between the environment and the types of interventions that occurred. Occupation-based interventions equaled 5% of the total time the therapist spent on interventions. Occupation-focused and occupation-based interventions made up 37% of the interventions completed. Exercise and rote practice accounted for 50% of the total time of interventions provided. Passive interventions accounted for 8% of the total time recorded. The study concluded that the majority of interventions did not involve the use or focus on occupation. This further shows there is a disconnect between what should be happening in practice and what is happening in skilled nursing facilities.

In a study by Wong et al. (2018), occupational therapist's perspectives on occupation-based interventions were gathered based on clients that experienced hip fractures. The purpose of the study was to explore the perspectives occupational therapists held regarding the delivery of occupation-based interventions in post-acute care for clients with hip fracture (Wong et al., 2018). The background of why this study was created was based upon the notion that individuals with hip fractures are at an increased risk for injuries, comorbidities, rehospitalization, mortality and lower quality of life. They also may not be able to participate in their activities of daily living (ADLs) and have decreased independence. The occupational therapist needs to be able to work with the entire team to ensure that the individual's needs are met, and they have increased quality

of life and better outcomes. The study was done through focus groups that were facilitated by a researcher with training in qualitative methods. The study yielded three themes: conducting an occupational profile, integrating occupation-based intervention in the facility, and identifying goals for engagement after discharge. The three themes that emerged show the value of occupational therapy for clients to achieve outcomes and the importance of utilized occupation throughout the intervention process. The themes also show how occupational therapy can contribute to client outcomes and shows our value as a part of the interdisciplinary team.

Regarding the efficacy of utilizing occupation, a study by Colaianni and Provident explored the benefits and challenges of utilizing occupation in hand therapy (2010). The purpose of this study was to examine the perceptions of occupational therapists working in hand therapy in the U.S. regarding occupation-based hand therapy. The perceptions could be barriers and benefits (Colaianni & Provident, 2010). The study found that many therapists preferred to use exercise and manual techniques. The article does a good job breaking down the percentages of how often these techniques are used with ADLs being about 21-30% of the time while active range of motion and progressive resistive exercises are about 61-90% of the time. The study also identified multiple themes regarding the benefits and the challenges to occupation-based treatment. Benefits included: facilitating meaningful therapeutic experiences, facilitating functional activity, and facilitating holism. Some of the barriers included logistic issues, reimbursement issues, credibility of occupation-based treatments, and limitations imposed by the client's medical condition or the treatment protocol.

Facilitators

It is important to address and to be aware of what factors act as facilitators to practitioners being able to apply occupation-based practice. A study by Mahani et al. (2015) explored the facilitators of implanting occupation-based practice among Iranian occupational therapists. There were two themes developed from this study. The themes were factors attributed to context and factors attributed to the therapist. There were also six sub themes that were developed from this study. The subthemes were: Educational programs of occupational therapy departments, public information on occupation-based practice, and the clinical setting compatible with occupation-based practice. These three sub themes were all related to context. The sub themes related to the therapist were positive attitude regarding effectiveness of occupation-based practice, emphasis on client-centered and family-centered practice and convincing the clients on the importance of occupation-based practice. This study also discussed how it may be important to have education on occupation-based practice to increase its use. This is directly related to necessary education for staff in skilled nursing facilities to increase the use of occupation-based practice.

Barriers

When looking at the barriers that occupational therapists experience in regard to occupation-based practice, Daud et al. (2016a) completed a study looking at what issues arose in clinical practice. The purpose of the study was to identify the challenges of implementing Occupation-based Intervention (OBI) in practice in Malaysia. This study was conducted to identify the challenges for many therapists who want to utilize OBI

within their practice context (Daud et al., 2016a). This study was a Delphi study with three rounds utilizing a mixed methods approach and open-ended questionnaires that were sent to the participants, followed by closed-ended questions. The study identified the challenges to applying OBI involving client factors, occupational therapy factors, no use of a client-centered approach, and contextual factors. This study also outlines implications for practice and states that research can be used to solve the issues with lack of OBI in practice along with reflection from the occupational therapists on how to improve their treatments. Education could also be a helpful method to solve some of the issues addressed. Related to interprofessional collaboration three of the limiting factors included: "Lack of awareness about the role of the occupational therapist by other professionals limits referral for occupation-based intervention, multidisciplinary members always perceive that movements and strength are essential requirements for function, multidisciplinary members do not understand the purpose of occupation-based intervention, and practicing occupation-based intervention makes occupational therapy services less significant than other multidisciplinary professionals" (Daud et al., 2016, p. 277).

Client-Centered Care

How it Relates to Occupation-Based Practice

In an article by Mroz et al. (2015), the relationship between client-centered care and occupational therapy was explored in its relation to health reform. As stated previously, occupation-based practice is a key component of occupational therapy and necessary to practice ethically. In the third principle of the AOTA Code of Ethics, it is stated that occupational therapists should, "respect and honor the expressed wishes of

recipients of service and establish a collaborative relationship with recipients of service and relevant stakeholders, to promote shared decision making" (Howard et al., 2015). According to Hinojosa (2017, p. 342), "When client-centered services are ensured, interventions are likely to be occupation-based."

According to Mroz et al. (2015, p. 690), "occupational therapy has long considered client centeredness a key component of practice." The use of client-centered care in occupational therapy is going to include the patient and the therapist being in a collaborative relationship to ensure that the client's goals are being met by including them in the decision-making process. This relationship to ensure client-centeredness and enhancing the decision-making process can not only include the client and their family/caregivers, but it can also include the other professionals that may be working with and caring for the client. As mentioned above when client centered care is used it generally includes occupation. "Collaborative approaches aimed at enabling occupation with clients who may be individuals, groups, agencies, governments, corporations or others" that requires "occupational therapists demonstrate respect for clients, involve clients in decision-making, advocate with and for clients in meeting their needs, and otherwise recognize clients' experience and knowledge" (Canadian Association of Occupational Therapists, 1997, p. 49 and Canadian Association of Occupational Therapists, 2002, p. 180 as cited by Mroz, 2015, p. 690).

Facilitators/Barriers

When studying client-centered care and how it's utilized in clinical settings, it is also important to understand the barriers that are experienced by practitioners. In a study implemented by Sumison and Smyth (2000), 36 occupational therapists were

interviewed, most of which had 11-15 years of experience. The purpose of this study was to determine how occupational therapists felt and described barriers to client-centered practice and then to share how they felt these barriers could be addressed. This study used a non-experimental quantitative approach. The results of the study showed that the three most prevalent barriers involved the client and the therapist having different goals for treatment, the therapist's values and beliefs prevented the therapist from accepting the client's goals, and the therapist was uncomfortable with allowing their client to choose their own goals. Barriers also listed include the therapist not having enough time to implement client-centered care practice and the treatment being dominated by the medical Model (Sumison & Smyth, 2000). These barriers show that there may be factors that are external to the therapist's practice that impact their practice and may involve other staff. Some of the solutions that were given to the researchers to resolve these barriers include: "Management and peer support for use of client-centered practice, involvement of all staff in client-centered practice, and staff education having time to learn how to practice in a client-centered fashion" (Sumison & Smyth, 2000, p. 19).

Another study that evaluated the perception of client centered practice and furthermore examined the barriers present involved 11 occupational therapists and 30 of their clients. The purpose of this study was "to examine the collaboration in the decision-making process between the client and the therapist and to see how that decision-making process changes between various settings" (Maitra & Erway, 2006, p. 300). This study concluded that clients had mixed feelings about client-centered care and what their role was, and some were not sure what client-centered practice was. The type of facility also played a role on how client-centered practice was utilized and having clients participate

in goal setting. Barriers to client-centered practice also included clients with decreased cognition, clients that do not have a desire to participate, decreased facility productivity, clients that were not able to express their concerns, clients with no motivation to be independent, and environmental barriers.

Interprofessional/Intraprofessional Collaboration

How Interprofessional Collaboration Looks When it is Implemented

Interprofessional collaboration as noted in previous literature is an important concept within the healthcare field. According to the literature, there are certain criteria that can be noted when interprofessional collaboration is utilized in the correct capacity. Poor collaboration among professionals can be the cause of decreased outcomes for clients in hospital settings (Vestergaard & Nørgaard, 2018). The study included five different departments and eight professions. Data was collected through focus group interviews with participants. The professions represented in the study included physicians, nurses, nurse assistants, occupational therapists, physiotherapists, laboratory scientists, radiographers, and medical secretaries. There were many findings from this study discussing interprofessional collaboration. Some of the major points of the study included how interprofessional collaboration gives better understanding of other's methods for working and how they coordinate for the betterment of the patient. The authors noted that interprofessional collaboration provides "a common language, and it is only possible when you have mutual respect" (Vestergaard & Nørgaard, 2018, p. 188). This shows there is a certain level of education that everyone can benefit from in work settings to understand how each individual works to provide better outcomes for clients.

Another concept related to the successful implementation of interprofessional collaboration involves collaborative learning. Stakeholders felt that success depended on having extra time and space for collaborative learning as noted in the following quote, "we may need to focus more on seeing the patient together with other professions in order to learn from each other's methods" (Vestergaard & Nørgaard, 2018, p. 190). In order for interprofessional collaboration to work, the professionals need to be able to work within a similar or close physical location to be able to work together.

One of the last concepts that will be mentioned here is how successful implementation of interprofessional collaboration includes having support from all leaders, and that those leaders "clearly and constantly signals that IPC [interprofessional collaboration] is what we want" (Vestergaard & Nørgaard, 2018, p. 191). In order to implement interprofessional collaboration, occupational therapists must ensure that everyone is on board, educated on the concepts of interprofessional collaboration, and are willing to work with each other, and that includes upper management.

Another aspect to learning about interprofessional collaboration is to understand what makes it work. In an article written by Johnson (2017), interprofessional collaboration is outlined in terms of the importance, barriers, and competencies needed to promote interprofessional collaboration. The competencies required for interprofessional collaboration to work well include equal voice which includes promoting effective communication between professionals and their clients. "Clients need to hear that they have an equal voice in their care. It can be amazing to discover what clients do and do not understand just by asking" (Johnson, 2017, p. 5). By including clients into the process of planning treatment, the treatment will be more client-centered and increase the outcomes

of that client. Another part of interprofessional collaboration is communication and teamwork. The key to team competency is fostering psychological safety, which is the belief that one will not be punished for speaking up, admitting to mistakes, or giving ideas (Eppich, 2016). This passage highlighted that it is important for everyone to be included in the decision-making process and that it is crucial to understand and gain the perspective of all perspectives. One last concept mentioned in this article was to promote understanding of other professionals' roles and responsibilities. One way to do this in the beginning would be to ask how well co-workers, clients, and caregivers understand everyone's role and responsibilities in the process (Johnson, 2017). This ensures everyone is aware of what the other can bring to the table and better understand how what they can offer can be used in relation to everyone else's roles to come up with the best client outcomes.

Chatalasingh and Reeves (2014) completed a study about what makes interprofessional teams work well. The study utilized an ethnographic design over a nine-month period involving 30 health professionals including physicians, nurses, social workers, pharmacists, dietitians, and other healthcare professionals including students and trainees. The findings from the study included characteristics of team leaders, leading by directing learning about tasks, leading as coaches of team learning relationships and tasks, leading by supporting team learning relationships, and leading by delegating task and relationship learning activities (Chatalasingh & Reeves, 2014). The findings of this study showed that effective leadership involved the leader's ability to adapt to changes and thus showed what leadership looks like in the interprofessional environment utilizing a situational leadership approach (Chatalasingh & Reeves, 2014).

Interprofessional Collaboration as a Barrier

In a study by Delaney et al. (2017), research was completed with the aim of "evaluating perceptions of the ethical impact of interprofessional and patient communication as it occurs in everyday practice in a large paediatric Australian hospital using a social work perspective" (p. 505). The study identified five communication challenges including troublesome knowledge challenge, diplomacy challenge, conciliation challenge, everyman and his dog, and brick wall challenge. The first four challenges listed all involved challenges with the interprofessional team and interprofessional ethics. The challenges listed discuss how there may need to be adjustments to communication between professionals in order to better meet the needs of the client. By identifying the challenges in communication between healthcare staff and families and between the interprofessional team can help to build strategies to remediate these communication issues.

Johnson (2017) addressed barriers to interprofessional collaboration including an unprofessional mindset, organizational challenges, and lack of training in teamwork. Having an unprofessional mindset means that professionals provide services parallel to each other. Doing this means that "the average hospital client sees individual providers all day long, each providing interventions and education from their own perspective with little thought about how their interventions might integrate with other providers' interventions and education" (Johnson, 2017, p. 2). Organizational barriers included the pay for service payment model which contributed to the above barrier of services being offered parallel to each other. This causes schedules to be focused on giving practitioners one-to-one time with clients further propelling the idea of professionals working

independently instead of as a group. The last theme identified was teamwork, or the lack of. “Until recently, many healthcare professionals were not taught interprofessional teamwork skills when they were in school. In addition, traditional health care education and practice have been based on hierarchies that limit communication” (Johnson, 2017, p. 3). Within the healthcare setting there are many different professionals with varying ideas, roles, styles of work, and personalities. While it may be difficult for everyone to effectively work together, training could enhance their ability to come together to provide the best care for their clients.

Intraprofessional collaboration

Nardella et al. (2018) described the outcomes of education on intraprofessional collaboration and how to implement intraprofessional collaboration and sustain it. This article identified the competencies required for intraprofessional collaboration. Some of these included: engaging in a consensus decision-making approach to client-care, knowing when to see out information and support from the occupational therapist or occupational therapy assistant partner, acting on the basis of one’s own scope of practice, communicating with each professional to clarify their roles, demonstrating active listening skills, and many more (Nardella et al., 2018). This is a very comprehensive list showcasing what needs to be done in order to promote intraprofessional collaboration between occupational therapists and occupational therapy assistants. Another section of this article discussed how to design, implement, and sustain collaborative intraprofessional education. It is important for school curriculums to stress the importance of intraprofessional collaboration. Going over things such as communication skills, roles, teamwork, supervision, and other factors will help with the professional

relationship when practicing. “When students learn about and experience effective OT–OTA collaborations in the educational environment, best practices” (Nardella et al., 2018, p. 7). As for sustaining intraprofessional collaboration:

> One of the most productive means of ensuring the sustainability of intraprofessional education is to build a goal and action steps into the OT or OTA program’s strategic plan. Strategic planning initiatives guide faculty professional development and enhance the effectiveness of everyone involved in the teaching and learning process for collaborative intraprofessional OT–OTA education and practice. (Nardella et al., 2018, p. 12)

Once intraprofessional collaboration is instilled into programs for occupational therapists and occupational therapy assistant programs, students will be more prepared to practice in a more collaborative effort in their respective settings.

According to Looman et al. (2020), participants showed they believed intraprofessional collaboration was beneficial. This study focused on approximately 70 participants aging from 24 to 64. Participants included primary care residents, ER residents, geriatric residents, and surgery residents. The researchers conducted approximately 45 hours of observations and 42 interviews. The themes that developed from the observations and interviews included: competing professionals, incidental and purposeful learning, and the work environment. Each of these themes were used to explain in further detail the aspects of intraprofessional collaboration that arose. It is imperative to benefit from intraprofessional collaboration and learn how to implement it, and understanding of roles, and power dynamics is crucial.

By researching occupation-based practice, client-centered care, interprofessional collaboration, and intraprofessional collaboration, it can be understood that each of these concepts plays a vital role in providing the best care for residents. Occupation-based practice and client-centered are both approaches that allow occupational therapists to provide quality and meaningful care to residents. In skilled nursing facilities though, quality care is not only provided through what the rehabilitation staff provide, but what all staff implement during the residents stay. This is why it is crucial to fully understand how the aspects of collaboration are perceived and to fully understand how they play a role in what all staff provide, which is what this study aims to explore.

Section 3: Methodology

Project Design

For this study, the researcher used a qualitative instrumental case study design. According to Creswell (2013), an instrumental case study is one that looks to understand a specific issue or problem and uses one or more cases to understand the problem. This type of design worked best for this study, given there was a clear issue identified during the needs assessment and following a review of the current literature; therefore, the researcher chose this method to better understand interprofessional and intraprofessional collaboration with varying healthcare disciplines within the same skilled nursing facility setting. This study utilized a thematic analysis approach because this method helps to reveal the various elements of data that need to come together for a successful analysis and considers how they build on and connect to each other (Braun & Clarke, 2021). This study was approved by the University Institutional Review Board.

Data Collection

Setting

This study took place with staff working at the same skilled nursing facility in a southeast state. The facility employed multiple healthcare workers including occupational therapists, occupational therapist assistants, physical therapy staff, a social worker, and various nursing staff.

For this study the researcher focused on the healthcare professionals that provided direct patient care. It was expected there was interprofessional collaboration between the occupational therapists and the staff within the skilled nursing facility to provide the best

care for the residents, and that there were collaborative efforts between the occupational therapists and the occupational therapist assistant within the facility.

Recruitment

The participants were selected using purposive sampling to gain full insight into the phenomenon with a diverse group of participants from varying professions. Purposeful sampling can be utilized as a way to deliberately select information rich cases (Braun & Clarke, 2021) as seen by the diverse group of participants recruited in this study. The inclusion criteria for participants included individuals aged 18 or older at their skilled nursing facility and have worked in their prospective roles for one year or more delivering patient care. Participants must have been at this particular facility for one consecutive year's duration in their current role. Exclusion criteria included any of these professionals that have been in their roles for less than one consecutive year or do not provide care to residents. This encouraged the individual to have knowledge of the therapy process and to have had some interaction with the therapists. Participants who did not understand or speak English were excluded.

Recruitment of participants took place through various means of communication including email, telephone communication, and social media contact. To maintain confidentiality, the participants were not made aware of whether or not other potential participants took part in the study.

Procedures

The researcher first explained the study to the individuals. If interested, the participants were given a consent form (see Appendix A) and an interview time was scheduled. Participants were informed there were no rewards or financial gain from

participation, and that they could drop out or stop the interviews at any time. The interviews were held at a location that was preferred to the volunteer.

The participants were interviewed using a semi-structured open-ended interview (see Appendix B for interview questions). The interviews took between 15 minutes and 30 minutes. The participants were asked if they were willing to partake in multiple interviews and each participant stated that they would. This gave the researcher the opportunity to follow up with the interviewees in order to ensure that a full picture of the phenomenon being studied was captured. The interviews were conducted at the preferred setting for the individual. Due to COVID-19 some interviews were done in a virtual setting utilizing a provided password protected Zoom link and meeting room. All interviews were recorded and will be stored by the primary researcher for five years duration and then destroyed. The interviews that occurred in person were recorded using the primary researcher's personal recording devices. After the completed research project, all data was downloaded and provided via USB drive to the faculty advisor via tracked USPS mail and stored on campus in a locked filing cabinet in the office of the Department of Occupational Science and Occupational Therapy with Dr. Leah Simpkins.

Data Analysis

Familiarity of Data

The researcher transcribed the interviews verbatim and then listened to the interviews while reading the transcripts to ensure accuracy. This also gave the researcher more time to reflect on what was said in the interviews. The researcher became more familiar with the data while coding as well. The researcher also took field notes to better

understand the data both contextually, behaviorally, and regarding the setting throughout. These notes were reviewed again during the transcription process.

Coding

The next step included coding the data. Reflexive thematic analysis using an inductive approach was used to analyze the data. According to Braun and Clarke, "the researcher always brings philosophical metatheoretical assumptions and themselves to the analysis, meaning an inductive orientation is better understood as 'grounded' in data" (2021, p. 6). The researcher went line by line through the seven interviews, coding key words and phrases of importance within the data. A total of 162 codes emerged from the data that were either direct quotes from the data, or phrases that represented perceptions or ideas from the participants. Using an inductive approach means that coding was done through gaining familiarity with the data and allowing for time and reflection to understand what has been gathered through the interviews to develop themes. The codes were then organized in a way that allowed the researcher to begin grouping similar codes into categories to begin theme development.

Themes

In order to begin the process of creating themes, the researcher wrote each code on a note card for ease of categorization. Themes were developed as an output from that data from patterns and shared ideas that arose from the interviews (Braun & Clarke, 2021). The themes have been defined for clarification of meaning that will be described in the results section. The three themes were absence of shifting mindsets, respecting roles to benefit clients, and missed opportunities. Within the three themes that came from the data, there were multiple sub themes.

Ethical Considerations

All participants were given a consent form prior to engaging in the study to give them an explanation of the study and their role, and to understand that their participation in the study was voluntary. This also served the purpose of informing them of the level of risk associated with the study, to understand the study's full purpose, to ask questions of the primary researcher, and that there would be no consequences to choosing to not to participate or stopping during the study.

In order to maintain confidentiality, the names of the participants were matched with their titles and the names were not released to anyone. A list of the names and their matching titles were kept in a locked file cabinet in the researcher's office which is also locked. The researcher is the only person with a key to the file cabinet. Throughout the report, the participants will only be referred to by their titles. Throughout the interview and the research, it will be important that the facility is not identified, and the researcher will ensure that the staff in the facility are not aware of who partakes in the study. Once the participants identified an interest in the study, the researcher and the participant set up a time and place that is quiet and away from the work setting to conduct the interview. Of the seven interviews, two were held virtually at a secure comfortable location of the participants choosing.

The recorded interviews were placed in a secure, password protected encrypted folder on the primary researcher's computer, that only the primary researcher has access to. During the recordings, the Zoom meeting room was locked and required a secure

connection and password provided by the primary researcher for the interviewee to open and participate.

Trustworthiness

In order to ensure trustworthiness within the study, the researcher utilized multiple methods. The first method utilized is peer debriefing with two other peers. By having peers review the data and analysis methods, the researcher was better able to identify any concepts that may have otherwise been overlooked and also ensured that the data analysis was thorough and accurate. This team has also helped in reducing the amount of grammatical errors and wording. Another strategy utilized in this study was the use of bracketing. By bracketing, the researcher ensured they were aware of any biases they may have had prior to beginning the study, so those notions did not skew or influence the analysis. Secondly, the researcher had an outside party review the research questions to look for possible bias and ask the questions back to the researcher. Lastly, member checking was done throughout the interviews to ensure the information gained from the interviews were valid and accurate. These were done during certain interview questions to ensure the researcher understood the answers being given and that they accurately represented what was being said.

Timeline of Project Procedures

Timeframe	**Capstone procedure**
Summer 2020	Established and implemented Needs Assessment

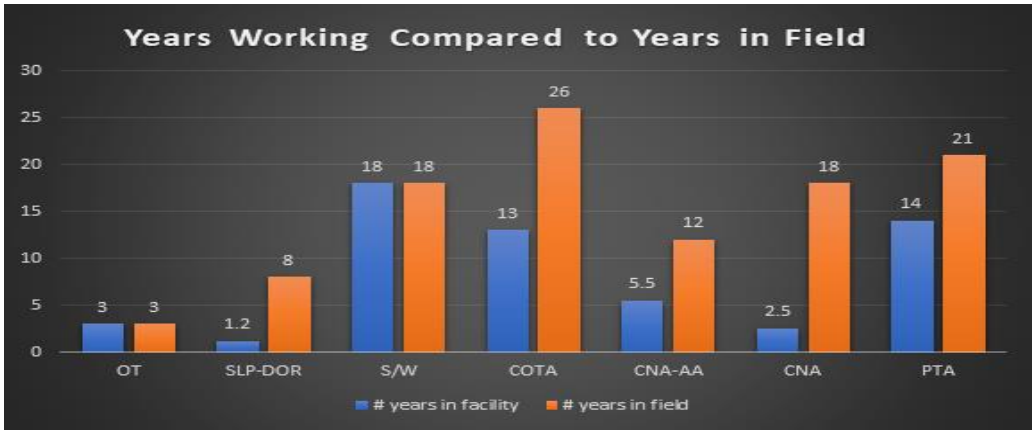
Fall 2020	Developed IRB proposal 8 weeks
Summer 2021	Implemented Applied Leadership Experience and write up of literature that is found
Fall 2021	-Recruitment of participants – 3 weeks (Data collection will begin while recruiting participants to ensure that all necessary professionals and staff that will be interviewed are) -Begin and complete data collection – 5- 7 weeks -Analyze data – 4 weeks -Present Capstone report and findings

Section 4: Results and Discussion

Participants

There were seven people from the same skilled nursing facility that participated in this study. The professionals included in this study were an occupational therapist (OT), a speech language pathologist that was also the Director of Rehabilitation (SLP-DOR), a social worker (SW), a certified occupational therapist assistant (COTA), a certified nursing assistant (CNA) that also worked as the activities assistant (CNA-AA), a CNA, and a physical therapy assistant (PTA). A breakdown of the participants showed there were 57% (n = 4) females and 43% (n = 3) males, as they have chosen to identify themselves, aged 27 - 54. The participants had a variety of years of experience in their field and at the facility, as seen in Figure 1 from 1.2 to 18 years.

Figure 1: Years Working Compared to Years in the Field



Note. A table showing a comparison of the years each participant worked in their field and the years at that facility.

Themes

Through analysis of the data using an inductive approach, the researchers' understanding and perspectives of the data, and experiences of the participants, three themes emerged from the data. These themes included Absence of Shifting Mindsets, Respecting Roles to Benefit Clients, and Missed Opportunities. Following the themes, a story from each of the individuals is presented that describes a situation that was perceived by the participant to be a successful implementation of intra- or interprofessional collaboration. The meaning and of the themes are explored as follows, using direct quotes from the participants as support.

Absence of Shifting Mindsets

The theme of Absence of Shifting Mindsets reflects the many challenges experienced when working with other staff members and challenges related to providing the best care for their residents. Some of these challenges not only come from lack of awareness and not learning about the roles of others regarding occupations, but also lack knowledge of staff roles, despite their longevity within their own prospective roles. The Absence of Shifting Mindsets also applies to staff and barriers to collaborative care due to lack of education given to or received by staff. When discussing the challenges there were multiple sub themes that arose from the gathered data. Exploring this theme, the three sub themes that emerged were lack of awareness, set in their ways, environmental barriers.

Lack of Awareness. This sub theme focused on how there were many staff with limited awareness of what occupations and occupation-based practice are, and what occupational therapists do. Without this base knowledge, it was difficult for staff to truly understand the role that occupational therapists play in client's outcomes and how collaboration can be beneficial to them. As one participant stated, they have "never thought about what occupations are" (CNA-AA), so there was a lack of understanding of what occupations are amongst some of the staff. Although some of the staff mentioned being in their roles for 10+ years, they still lacked knowledge related to what occupational therapy does as seen in the following statements.

"Occupations are what you do for a living." (SLP - DOR)

"Occupations are a job." (CNA)

Described occupations as the "occupants" at the facility. (CNA-AA)

Responses like this show there is education that is needed to be done to enhance knowledge of occupations within the facility.

Similarly, when asking about what occupation-based practice is, there were varying answers given from the participants. One of the participants described occupation-based practice using strategies such as utilizing the upper extremity bike, doing sit to stands, using adaptive equipment, and upper body strengthening. (COTA) The two CNAs perspectives about occupation-based practice conveyed only surface knowledge of occupation-based practice:

> "Occupation practice. Yea it is like helping them get back to where they need to be, like being able to walk on their own, being able to cook, bathe, themselves, Just take care of themselves when they go home." (CNA-AA)

> "It's on the individual. What they're needing done." (CNA)

And when asked to go into a little more detail, the participant responded by stating "they need help learning how to brush teeth or help and go to the bathroom or helping them get up, sit on the side of the bed. Daily activities." (CNA)

Participants also lacked awareness about the scope of occupational therapy practice, with several describing occupational therapy based on body part. For instance: "Traditionally, I typically think of upper body, fine motor, also activities of daily living but I also know it can be a lot more than that too." (SLP-DOR) In this example by the speech therapist, the participant uses only examples of upper body and fine motor skills when describing occupational therapy, despite recognizing there is more that occupational therapists can do. This participant mentions later on in the interview the creativity that OTs have and how she appreciates that.

The next example comes from the CNA-AA who stated, "they help them learn to walk again, have them get mobile and be able to move their arm, and to move their legs and be able to get up and move again." This is another example of the staff member narrowing the profession to mobility without truly understanding the full scope of practice.

When discussing this sub theme, it is also important to understand the impact that clients have on their own care. Regarding clients, there were many aspects addressed that

showed the client's attitudes and perceptions also impact their treatment and how their lack of awareness of how OT can help them understand what OT is. The CNA-AA and the OT both gave their views on how client motivation plays a big role in their utilization of occupation-based practice. The CNA-AA appeared to give many examples of clients just giving up and not having the motivation to get better. For example, at one point the CNA-AA mentioned, "I've seen people declining with feeding themself or just declining not eating and it's just not worked out. Like, people just don't want help and they want not occupational therapy. They just give up. They don't want to." This is one example that shows how a client's motivation can impact their ability to participate. One reason for this can be attributed to client's wanting someone to do things for them. The OT gives an example of an experience they ran into regarding a client wanting the staff to do things for them.

> "The other day I was assisting someone with a shower so that we could work, they had a specific goal for a shower transfer. But then obviously you get in the shower, you typically take a shower. So I was assisting them with the shower and I encouraged them after handing me the washcloth, saying wash my legs. I encouraged them to wash their legs, and they said well, you haven't done anything yet. I told them that the goal was for them to be able to do it. If there's not a reason that they cannot wash their legs, such as at home when they were independent with bathing, and they said they wash their legs. But then I later found out when the CNA told me the patient did not want me to their showers anymore because I made them do things. And the CNA, they told the CNA well you typically do it for me. So with and again, same thing, sometimes they get in a

> hurry or whatever, that it might be just doing everything and then the patient, some of them, not all of them, very general patients expecting the OT's do it for them because that's what other people have done." (OT)

This is another example of how clients can have a lack of awareness of OT which impacts their participation in therapy and the care they receive.

Set in Their Ways. Participants noted that at times the staff were set in the ways they cared for clients. As mentioned by the SLP-DOR, "old school therapists that are set in their ways focusing on exercises…if it doesn't look like traditional therapy, as far as like exercise, or you know a certain number of reps, they're not as open to [working together]." This is similar to the OT that stated that sometimes assistants "focus more on specific activities….like the peg boards and things like that and less on actual occupations." These are two clear examples of two therapists recognizing there are times that other staff will focus more on what they are used to doing and not really updating treatments. It is possible that experience plays a role in this as well. The COTA that was interviewed in this study had 26 years of experience which is well over that of the majority of participants interviewed. Due to the OT's lack of experience or time at the facility (3 years), she stated that "I feel like it is hard to encourage more occupation-based without necessarily stepping on any toes and without coming off in the wrong way, because different people do things differently." The OT mentioned in the following response the possibility of what the reasoning can be to not focus on occupations. "I don't know if it is for a time filler or due to old habits and things like that, or just not wanting to focus necessarily on the occupation all the time, but rather what is convenient and there to do." (OT) This goes along with therapists being stuck in their ways and focusing

on less meaningful activities. The OT also mentioned that CNAs also can cause a barrier to her completing OBP.

> "The biggest thing is focusing on each person specifically, not just enough. Sometimes they [CNA's] get in a hurry and kind of treat everybody very similarly and they don't focus on each individual person and their needs or abilities. So I think focusing on that for each person and focusing on what each person can do or what each person needs help with and things like that, that they can make it more occupation based for everybody." (OT)

The SLP-DOR stated "some people get territorial about that, even swallowing too. I guess, because I think traditionally it used to be OT that did it," meanwhile the CNA also stated that "sometimes we make comments or stuff that needs to be done and they [therapy] don't think that that's the way it should be, that it should be another way." This displays lack of communication and how staff have factors related to how co-workers not changing their mindset can impact their care and cause staff to "butt heads" as the CNA stated when asked what it looks like when collaborating with staff.

Environmental Barriers. According to Boop et al. (2020), environmental factors include "aspects of the physical, social, and attitudinal surroundings in which people live and conduct their lives" (p.76). For purposes of this sub theme, environmental factors will include communication with staff, time factors, and issues getting supplied when needed. Each of these factors are impacted by the fact that the way facilities function are not always able to promote or provide optimal situations for staff to be able to complete their job duties to the best of their ability. All of these factors play a role on the issue with improving outcomes for residents, due to their inability to perform OBP or

limiting the collaboration with staff. Communication barriers can be seen through an example given by the CNA. She stated that “evening staff has minimal opportunities to report to therapy” and that “some stuff may not be reported as it should be depending on who’s there at that time of day.” (CNA)

Equipment and time also played a role in client outcomes as well. As mentioned by the CNA-AA, “we tell them what we need and they just like we can’t get it because it’s not in the budget. We don’t have the budget for it, you know.” Along with equipment, time was mentioned by several staff as a barrier. First the PTA stated multiple barriers related to time including, “you’re trying to reach a goal in a time that doesn’t really reflect what you need” following that he stated that “it's kind of that would be negative about it just because of time restraints, I should say you're on.” Along with this, the COTA says:

> “Sometimes if you have two people going home in two days, right and they both have say a cooking activity and somebody kind of monopolizing the kitchen. They’re using it, you know, you’ve either got to put that treatment off for another day or another time, or maybe you could combine it some way so that they’re sharing the task or doing a couple things together, but yet, you're still able to have them do things that checks their safety but if it’s something like there’s several things to be chopped up.” (COTA)

These examples showcase how time in various ways can be impactful for treatment. Time related to time you have with residents, and time related to when you are seeing residents along with other staff needs with their residents.

Success Story. Despite the challenges that many staff had when providing meaningful care, there were situations where the staff that have identified issues in collaboration still viewed it as beneficial for their residents. For example, with the CNA, although she mentioned "butting heads" and wishing therapists listened and trusted her opinions, she still was able to give a meaningful example of a time when working with the therapist was beneficial in the following passage.

> "Yeah, with the resident that I had, I was telling them her whole left side was paralyzed, completely gone, she was left-handed, she was not ever right and did never do anything with her and was struggling really, really bad. And they ended up helping her get some type of braces thing that they put on her. And she ended up doing real well with it because her right side was weak where she never used it. And they ended up helping her be able to use that hand, and it helped us out a lot with her feeding and everything." (CNA)

As seen, despite the barriers that this individual faced there were situations where collaboration was recognized, appreciated, and beneficial for all parties involved.

Respecting Roles to Benefit Clients

This theme focused on the aspects of interprofessional and intraprofessional care and the importance of understanding the roles of others. By understanding the roles of other professionals, collaboration is more efficient, thus leading to better care for clients. It is beneficial to understand what makes collaboration work well at both levels as well.

Respecting Roles Interprofessionally. When discussing successful interprofessional collaboration, it is important to discuss the knowledge that other professionals have regarding the roles of the occupational therapy staff and assess their knowledge of occupations and OBP.

The social worker, PTA, OT, and SLP-DOR had multiple examples of what made collaboration work along with stories related to successful moments. This may show a correlation in how knowledge of the profession may impact perceptions.

One example of what successful interprofessional collaboration looked like involved the use of co-treatment and consultations. The COTA, PTA, SLP-DOR, OT, and CNA-AA all mentioned specific ways they consulted or worked with another individual within their profession. The PTA and the OT both mentioned how working with other professions allowed them to discuss strategies and bounce ideas off of each other. The OT mentioned "just talking with PT about different types of transfers work better with different people for reason X, Y, or Z" and the PTA said "it's most beneficial if it is the very first time you see them together, see the resident together, because that way, you can, focus on the idea, different ideas coming from different therapist," highlighting the idea of viewing a resident from different professions and respecting what the other profession has to offer.

The COTA also had multiple examples of how he worked with the other professionals within the facility. These included working with the PT, Speech therapists, and social services. At one point when asked about professionals that he works with, he stated "both physical therapy and speech and then outside of the department, especially

with changes that are going on throughout their care and their discharge planning social services." (COTA) There were multiple opportunities for him to work with these other professionals. With the PT it was mentioned that they generally worked on strengthening tasks, balance, and ADL mobility tasks together, and with the social services, they usually worked on getting equipment, coverage issues, and planning for discharge.

Although communication was previously listed as a challenge in some aspects, it can also be beneficial when done appropriately, which shows that communication is an important factor when considering what makes collaboration work within skilled nursing facilities. Throughout the interviews the majority of the participants all mentioned communication that stood out to them or in some way played an important role in effective collaboration. Examples of this included the social worker stating that it was easy to communicate with therapy and what that communication looks like.

> "I communicate with them on a daily basis, pretty much so what typically, if we get a new admission, we like to have a physical therapist or occupational therapist or both input to talk about what that person's home is immediately like, what are the obstacles at home that they're going to face so that we can figure out what are the goals we got to be able to do to get home and as long as they are here and do therapy, we may talk about how they're reaching their goals or how they're not reaching their goals." (SW)

She continued to give further examples of how the therapist and her communicated as well. The social worker also said how it was important that OT's and PT's are involved

in meetings early on to better be able to understand what is going on and share their input. This goes along with what the OT says when she mentioned that,

> "the first thing that comes to mind is going to care plan meetings and things like that and just, especially during COVID when they were on the phone, so you were actually able to in person talk to people, and you would just call the people on the speakerphone and everybody there from dietary, to activities, to just social services. And I guess just basically kind of the same thing, everybody is sharing different things that they have. And everybody doing their part for the patient and essentially working together for that patient and just being able to talk about it not only with each other, but also with the caregiver or family member, whoever is involved that you're talking to." (OT)

These two examples showcase the importance of team meetings and the opportunity to share information from the different lenses of professions that will ultimately benefit the client.

The OT also mentioned in terms of communication, that she finds interprofessional collaboration easier than intraprofessional collaboration. When asked why it is easier, she stated it was "because I am the OT and other disciplines respect me as the OT. So they ask me like, oh, what do you think about this person and this equipment or this person and this approach or with the CNA's and things like that, asking how do you think that we should work with this person." (OT) This relates back to earlier when the OT mentioned that it can be hard communicating with the COTA's that she works with due to not wanting to step on their toes because they do similar jobs.

Respecting Roles Intraprofessionally. Successful intraprofessional collaboration in this sub theme, examines the positive relationship that the OT had with the COTA's that she had worked with and the COTA's relationship with the OT. When mentioning the difference in intraprofessional and interprofessional collaboration, the OT did mention that sometimes it depended on the person and the assistant because there were times they worked well together. When specifically asked about intraprofessional collaboration she said, "I have the same assistant at times, be very receptive, ask me my input on things or ask me what I think about this, or if I would try this." (OT)

The COTA, similarly, mentioned a positive example of working with the OT within their facility stating that, "with the OTR, especially, you know when I come and say hey, I've done ABCD, or this and that, it's helped to this point, but you know, I'm coming out of the wall and we can bounce some ideas." (COTA) He went on to discuss how it can be beneficial to have someone to discuss treatments with and get suggestions from those in the same mindset. For intraprofessional collaboration both the OT and the COTA felt that being able to have open communication can be beneficial to the relationship as well as regarding treatment ideas for their client.

Success Story. Along with sharing their perceptions about what promoted successful collaboration, multiple participants also shared success stories related to interprofessional collaboration. The example discussed here comes from the social worker.

> "Yeah, OK, so. I'm just thinking of one particular time we had a patient who came to us from an independent living, so he had some supervision there if needed, but

> ultimately he lived independently in an apartment. And the goal was to be able to go back to independent living and could not return if he could not do it, if he was not independent, could not return there. And so he came to us. He has little dementia. So there was some concern there, but otherwise was doing pretty well physically. And his son was ready to throw in the towel and say, we're just going to keep him here for long term care. The patient, on the other hand, had other ideas. And so there was this kind of tension between the two. And so what we did was ask the occupational therapist if they would meet with me and the family had the son come in and have the patient come in and actually observe the therapy session for that day and go through some of those daily activities of daily living that he would have to do at home. So we actually had him come in and watched him stand up from the chair, walk to the bathroom. Actually, we didn't actually use the bathroom. We simulated, you know, how you would how you had been down and pull up his pants or pull them down. And he could see that he was able to do those things. So we actually had him put on his jacket. So different things like that, so he could see that he was actually able to do it all. And what it did was it showed him how I was. So dad might be a little confused, but he's on he still able to take care of himself at this point. So the patient actually got to go back to living it. It was a success." (SW)

This story is an example of what collaboration can look like when done appropriately with the clients needs being at the forefront of treatment. This also gives an idea of what can be viewed as being beneficial when it comes to working with others.

Missed Opportunities

The theme of opportunities for improvement in OBP showed what the participants viewed as areas that could be improved when it comes to practice or opportunities that they would have liked to have been available to them when working with other staff. They ranged from discussing the missed opportunities they noticed, to opportunities they thought that OTs could provide to assist in their daily tasks. As with the previous themes, this one will end with an example of how even with these opportunities there are times where the OTs do help and assist the staff with their jobs.

Opportunities for Improvement. Within this sub theme, the OT and the SW both expressed situations where they felt there were missed opportunities for collaboration that could have benefitted the residents. While the SW mentioned opportunities directly related to working more closely with the OT, the OT gave a broader list of examples that encompassed many staff. The SW began by mentioning that she felt that OT takes a backseat to PT and that OT should be in the picture sooner.

> "I think the OT takes a backseat to the PT. I don't know if that makes sense, but we may have a PT at a meeting and really the OT might need to be there more than the PT because while the walking is important you and I both know if you can walk 50 feet but you can't get up out of your chair or you can go to the bathroom, but you can't pull up your pants and you live by yourself, that's an issue. So I think sometimes that if we could bring them into the meetings early on and have their input from the beginning, I think that would help." (SW)

In relation to this passage the SW also gave the example of wishing that OT and SW could collaborate more on home evaluations as having insight from both professions regarding d/c location and abilities would be beneficial.

In a similar fashion, the OT discussed various ways she felt that the collaboration could be improved between the profession and other faculty within the facility. She began early in the interview expressing that most staff could focus on OBP, which was the direction that the majority of the examples she gave. CNA's, OTA's and the activities department were all mentioned. The first two comments made were regarding the CNA's. She stated "they can encourage someone to do as much as they can within a certain amount, that it is their job to help people and essentially do it, but if they can continue to encourage the person completing or the person to complete the occupation as they are able, I guess typically on the ADL side of things." (OT) She also mentioned that increasing the individual care for each client would be beneficial when stating,

> "I just think the biggest thing is focusing on each person specifically, not just enough. Sometimes they get in a hurry and kind of treat just about everybody very similarly and they don't focus on each individual person and their needs or abilities. So I think focusing on that for each person and focusing on what each person can do or what each person needs help with and things like that, that they can make it more occupation-based for everybody." (OT)

In a similar way she also brought up that the OTA's should be more functional in how they treat their residents. These comments show a direct stance of how the OT feels that

it is important for staff to be more functional in treatments and treat each resident as an individual.

The OT also had similar thoughts about the activities department and their role with OBP care.

> "I think just kind of the same thing sometimes the activities are sort of thrown together. Today we're going to turn on the news and have a cup of coffee, or today we're going to watch a movie and eat popcorn. I know those things are important, but for residents that are not approved for therapy or private pay, don't get therapy whatever the reason might be, I feel like there are times when they can focus on more focused and occupation-based activities that can be done. Just kind of to involve either of those people that need a little bit more than they just get from an hour of PT and OT or whatever." (OT)

Understanding the missed opportunities that staff were experiencing and expressing, can give further insight into ways that care can be improved from the point of view of the staff that work directly with each other and the residents.

Relationship Between Communication and Care. Communication was another aspect that was brought up multiple times as an area that needed to be improved. The CNA, the COTA, and the SLP-DOR all gave examples related to communication being improved related to each other along with the residents' needs. For starters the SLP-DOR felt there were many missed opportunities to collaborate more and said that "there are always opportunities to collaborate more sometimes with really complex cases. I think maybe it's difficult because it's like OT kinda and PT gravitate together you know, but there can definitely be more OT and ST (speech therapy)." The CNA mentioned communication more in terms of helping to understand roles and how that impacts care.

> "Like sometimes we don't know who these therapists are that are there starting to show up, run the hallways and we don't know which ones they are, who they belong to. I think if we had more communication on who the staff actually was, what their jobs were, I do think it would help this CNA to realize, like, hey, this one might need this done or this one might need a weighted utensil. Maybe therapy could help teach them how to use it and stuff like that. I think it would help tremendously." (CNA)

Lastly, the COTA gave a different perspective to communication and how it was important to communicate with their residents. It was important to ensure awareness of what the patient prefers and needs in order to make sure they are not only at the center of care but also letting them know they are being listened to. The COTA stated,

> "I think being sensitive to what patients' needs are and what they, you know, what they express, you're going to have that patient and it's, I think it's important to

> listen, try to do that. Because you've got those patients that want to be seen at 9am and you'd have some that don't even talk to me till after one o'clock. You know, or you got a patient that probably should have already had a shower and been shaved, but it hadn't happened. So you were going to incorporate this summary into therapy.

Although not directly related to staff collaboration, it is crucial and beneficial to ensure sensitivity to clients needs as well as the care they are receiving. In both examples, being able to communicate with either the staff or the clients, will afford a better chance of providing meaningful care for the clients as well as ensuring they are receiving the services they require.

Education to Improve Collaboration and Role Acknowledgment. When asking the participants outside of the OT profession if there were any types of education they would appreciate from the OT that would benefit them or make their job easier, there were a variety of types of answers that the staff felt would be beneficial. Their responses have been categorized into the following chart (Figure 2).

Figure 2: Table of Education Opportunities Staff would like to see Implemented

Discipline	Education Suggestions
SLP-DOR	• Something like just education and general awareness. I mean, I feel like you don't always, I don't know, what OT is exactly, you know, even after I've been out of school and I don't know • I want to collaborate with OT more, but like do I know off the top of my head what I would want to do?
SW	• It would be helpful to have some education on dementia patients, you know, to me I think it's hard to see how do you teach somebody something that they can't always remember to do? How do you make sure they're safe? But how can we make a discharge safer for someone who has that memory deficit, who may not remember to use that safety equipment…. • If there are any resources out there that I can use to find that stuff [adaptive equipment] for them, that would be helpful because that's something I've come across lately.
CNA	• I do think a lot of people don't realize the difference in speech, physical therapy, and occupational therapy. I don't think that they realize the difference between them, especially the new ones that are coming on. They have no clue who anybody is. I mean, they can't tell you what occupational therapy does. They couldn't tell you what a physical therapist does and they couldn't tell you what speech does. They have no clue.
PTA	• I think more of an initial family training when the patient first comes in, just explaining to them what the differences between PT OT, what our goals are working on the PT OT, and none of the therapists do that.

Note. A table showcasing the responses that various staff perceive as possibly being beneficial to their job duties.

Of the five participants not within the OT profession, only four were included in the above chart. This is because the CNA-AA expressed that he truly could not think of any education opportunities that would benefit him as he felt that the relationship between the staff and the OT staff were great and they were always shown anything they needed. The rest of the response for the most part involved a level of general education on occupational therapy and what OTs do to benefit the facility and themselves. Only the

SW mentioned specific types of training that would help benefit her in her specific profession.

Success Story. With these suggestions for education opportunities not all the staff felt that there were opportunities for education. As mentioned, the CNA-AA felt that training and education was always offered and gave the following example.

> "They are good, I mean, they show us how to transfer people and they show us a lot of stuff. I think they're absolutely awesome. To transfer and to have somebody in and out of the bathtub, I mean. just how to help them walk, how to put up splints, how to put on back braces. Even one time, they showed us how to put on the neck collar. We had a resident there that had a messed-up neck and they would show us how to put on the collar, come all the way down to the chest. They showed us how to do all that." (CNA-AA)

Although this is one example from this participant, it is important to note that education and training was being done in terms of providing care, but this participant did not mention the need for general awareness training as the other participants had, which means there may still be a need for that across the board.

Discussion

Data gained from this research helps to better understand the experiences of staff related to intra- and interprofessional collaboration and occupation-based practice. While the data explored concepts such as challenges and facilitators of intra- and interprofessional collaboration and ways they can be improved, this section explores the possible reasons behind the ways interprofessional and intraprofessional collaboration are

understood and experienced while relating back to the original research questions and three themes that have emerged from the data. By going back to the original three research questions explored, we can better understand the significance of the data gained from the themes.

Based on the data and previous research, it is known that collaboration impacts occupation-based practice, but how that was experienced varied greatly. By not collaborating, communicating, and being team oriented, there were multiple negative experiences the majority of the participants expressed in their daily tasks. This study confirmed that lack of communication between staff can hinder the progress of clients and can translate into clients not receiving services as needed. As mentioned by participants in this study, understanding the roles of other professions, particularly regarding occupational therapy, was an essential part of being able to truly collaborate and provide meaningful care. Without the communication and knowledge of peers' roles it is difficult to benefit from the collaborative aspects of healthcare. Referrals, education, training, and even understanding your own role in increasing patient outcomes can be compromised. This aligns with Braithwaite et al. (2016) as referenced by Johnson (2017), that stated:

> Workplace culture, not individual personalities or group characteristics was the biggest contributing factor to difficulties with teamwork. Clearly, IPC [interprofessional care] involves more than communicating with one other. IPC requires acknowledging the uniprofessional education most health care providers received and how that education influences their language and attitudes. (p. 3)

Johnson (2017) stated that you have to first understand the uniprofessional education that most have received. Participants within this study had a good overview of their own professional roles at a surface level, but rarely discussed how their role fully impacted the roles of others and at times did not understand the roles of the occupational therapist and assistant within their facility.

While there were experiences noted that showed that not collaborating could negatively impact care, participants also stated that successes in collaboration played a role in occupation-based practice. Multiple participants expressed examples of success in working with the occupational therapists in situations where it was beneficial to have the therapist involved in training and taking the lead in client care. By having the occupational therapist involved from the beginning, there is an opportunity for more client-centered and occupation-based care to take place. According to Fortune and Fitzgerald (2009), "occupational therapists have a major role to play in identifying opportunities within usual care routines that allow patients to take a more active role" (p. 87). When the occupational therapist had the opportunity to be involved with other staff and even take the lead, occupation-based practice was better and more often utilized.

The data also showed how lack of awareness and a lack of understanding one's own roles impacted occupation-based practice and intra- and interprofessional collaboration. The examples from the data illustrate how even though these individuals work with OTs frequently within their facilities, they may have never been told what OT is or given the education necessary to enhance the team dynamics within the facility. Supper et al. (2017) found that "conceptual barriers are derived mainly from a lack of definition, awareness and recognition of the role of each professional. In particular, the

extent of the roles in a team is imprecise and dependent on the level of trust and integration of the professionals into this team" (p. 724). This lack of awareness and lack of education impacted how staff saw the roles of each other and also impacted how the OT staff best completed their roles.

The lack of awareness regarding scope of OT practice can be seen when staff focus more on mobility, endurance, and other physical aspects, for them to be able to complete their occupations versus utilizing occupation-based practice. This can be caused by staff members preferring to do what is more convenient and easier for them to do within their allotted time. Convenience and time were both hinted at and identified as a barrier to occupation-based practice when it was stated that "time and workload were reported as challenges to implementing the intervention" and "practicing OBI [Occupation-based intervention] consumed more time, but they do not have time for that because of the high volume of caseloads per day" (Daud et al., 2016a, p. 279). Another reason could be longevity within their field of practice. When viewing participant data, the two CNA's, the PTA, and the OTA had all been in their role for a total of 12-26 years. This indicated a reason they may be set in their ways, due to their comfort levels with their techniques and care for their clients. Based on the data these participants could benefit from education about roles within the facility.

Although there was a lack of awareness from some staff about the scope of OT practice and knowledge of what OTs did, there were examples that showed staff had an understanding of the profession. Even with the examples given, there should still be a higher level of understanding to improve the ways OTs and staff within the skilled nursing facility collaborate. According to the National Interprofessional Competency

Framework, Orchard et al. (2010) stated that “learners and practitioners understand their own role and the roles of those in other professions and use this knowledge appropriately to establish and achieve patient/client/ family and community goals” (p. 12) in order to best implement interprofessional collaboration. It is important not to underestimate the importance of education and knowledge of each other's roles.

Examining the impact of intraprofessional collaboration is similar in regard to its role in occupation-based practice. It comes with its facilitators and challenges as well within the facility being studied and have led to comments regarding respect. Respecting peers' roles is an important part in the relationship between the OT and OTA when working in the same environment. Sometimes that lack of respect can lead to barriers in collaboration and occupation-based practice. How the OT feels about intraprofessional collaboration is strongly influenced by their lack of not being occupation-based and lack of willingness to listen when given suggestions. It is possible the reasoning for not being occupation-based comes from the assistant subscribing to a more medical model in care. As stated by Di Tommaso et al. (2016):

> Participants expressed that their choices for practice were driven by workplace efficiency or the outcomes expected by their colleagues. Some participants unknowingly conformed to workplace expectations. However, some participants intentionally conformed to their colleagues’ expectations and dismissed the key tenets of occupational therapy in the process. (p. 211)

The environment and attitudes play a role by dictating how care is given to clients and what strategies are being used. Due to many staff not fully understanding the scope of

practice of occupational therapy and focusing mostly on the medical model, there is encouragement for therapists at times to focus more on exercises, mobility, and what they consider to be more functional. Many times, “occupational therapists conformed to the dominant biomedical culture and this adversely affected the therapists’ ability to think and talk about occupational therapy-specific values” (Di Tommaso et al., 2016, p. 211) which impacted their ability to really focus on the occupations that are important for the client. When intraprofessional collaboration is effective and implemented properly, it allows for the OT and OTA to work together and give each other ideas on how to better help a client achieve their goals. Although the OT is doing the evaluation and writing goals, including the OTA and using their clinical expertise noticeably improves client care.

Overall, collaboration is crucial when trying to provide the best care for clients in skilled nursing facilities and it has been shown that many staff value the need for OT to be an integral part of that collaboration. When OT is involved earlier in the process, there is an opportunity to implement education and training earlier on and ensure that the client is receiving meaningful care from the beginning. Everyone understanding their own roles and each other's roles is also crucial in being able to give the client the best, most holistic care they can receive. Without a knowledge or willing to learn, about roles of all staff, there will be missing components to a client’s care and impact their well-being

Limitations

Although the study successfully explored the role that interprofessional and intraprofessional collaboration has in relation to occupation-based practice in skilled nursing facilities, the study is not without its limitations. The study is first limited

because the researcher selected the participants that were in the study. Although this can and was beneficial to gaining an overall perspective of the facility, the participants knew the researcher as a former employee, which may have impacted responses that were given. Being a former full-time employee of the facility, the researcher also had bias regarding the use of OBP in this particular facility. The interview questions were peer reviewed in order to remove bias in the wording. Gender bias was another limitation of this study due to the primary researcher being male and interpreting the data and research from a male's point of view. Order selection bias was also present, as the primary researcher is an occupational therapist and selected the order in which participants would be interviewed beginning with the occupational therapist interview. The order of selection may have caused bias in selecting subsequent participants for the study. For a future study it is also recommended that there is a larger sample size over multiple facilities in order for the results to be better generalized. The small sample size only captures a portion of what the experience being studied shows.

Implications for Occupational Therapy Practice

There are many implications this study has for the field of occupational therapy and the residents that reside within skilled nursing facilities. Occupation-based practice has been proven to be best practice in occupational therapy as research has shown that by being occupation-based client outcomes are generally better. Although being a practice modality used primarily by occupational therapists, by assisting other staff and members of the care team to use occupations and make it a focus, the residents can receive a higher quality of care and possibly progress toward goals quicker. This can include education on the benefits of using occupations during treatment, how to incorporate or encourage

residents to be more independent or helping them better understand what their residents are capable of doing. In doing so CNA's and nursing staff will be able to better work with residents while also having more time to complete tasks that need to be done because residents will be better equipped to complete ADLs such as dressing, grooming, and hygiene tasks. Occupational therapists will have more time to work on client goals instead of spending time doing basic ADLs with the client.

This study also showed the importance of and challenges to intra- and interprofessional collaboration. In understanding what types of challenges are present, practitioners will be better equipped to address challenges and incorporate a more team based approach with the interdisciplinary team and the care team to improve outcomes for clients. Also through collaboration and education on the scope of occupational therapy, referral rates for residents may increase as well to ensure that clients are receiving the appropriate services. By understanding the mindset that individuals may be in, how they view peers, and the types of education opportunities needed, it is possible to target specific areas that can be viewed as barriers to best practice.

Future Research

One topic that remains to be explored is the impact of workplace culture and healthcare structures on intra- and interprofessional collaboration and its relation to occupation-based practice. By exploring this topic, more in depth and meaningful conclusions can be drawn from an overall understanding of the experience staff have in skilled nursing facilities. Also, for future research, the researcher would provide education to the facility and focus on the major concepts mentioned including roles, scope of practice, OBP, allowing OT to be present more earlier on in care, and other

areas of this study. Following the education, another study could be done to explore if the same barriers arise, are resolved, or if different barriers present themselves.

Conclusion

Without understanding how intra- and interprofessional collaboration impact occupation-based practice, the profession of occupational therapy cannot fully understand all the barriers experienced to providing optimal services. The themes and subthemes of this study bring to light the challenges to effective collaboration and how it impacts occupation-based practice, while also discussing what effective collaboration looks like and how it can benefit the clients that receive services. By having the different professions represented in this study, there is a diverse overview of the experiences had within the facility, giving a better understanding and view of the nature of intra- and interprofessional collaboration helping to better perceive how occupation-based practice may be impacted. By being aware of the challenges and opportunities for collaboration, practitioners and healthcare workers can be better equipped to deliver optimal service for their residents.

References

American Occupational Therapy Association. (2021). What is occupational therapy? Retrieved November 14, 2021 from https://www.aota.org/Conference-Events/OTMonth/what-is-OT.aspx

Bainbridge, L., Nasmsith, L., Orchard, C., & Wood, V. (2010). Competencies for interprofessional collaboration. *Journal of Physical Therapy Education 24* (1).

Boop, C., Cahill, S. M., Davis, C., Dorsey, J., Gibbs, V., Herr, B., Kearney, K., Lannigan, E. G., Metzger, L., Miller, J., Owens, A., Rives, K., Synovec, C., Winistorfer, W. L., & Lieberman, D. (2020). Occupational therapy practice framework: Domain and process (4th ed.). *American Journal of Occupational Therapy, 74*(Suppl. 2), 7412410010. https://doi:org/10.5014/ajot.2020.74S2001

Braun, V., & Clarke, V. (2021). Conceptual and design thinking for thematic analysis. *Qualitative Psychology.* Advance online publication. http//dx.doi.org/10.1037/qup0000196

Canadian Association of Occupational Therapists. (1997). Enabling occupation: An occupational therapy perspective. Ottawa: CAOT Publications ACE.

Canadian Association of Occupational Therapists. (2002). Enabling occupation: An occupational therapy perspective (rev. ed.). Ottawa: CAOT Publications ACE

Chatalalsingh, C., & Reeves, S. (2014). Leading team learning: What makes interprofessional teams learn to work well. *Journal of Interprofessional Care*, *28*(6), 513–518. https://doi.org/10.3109/13561820.2014.900001

Colaianni, D., & Provident, I. (2010). The benefits of and challenges to the use of occupation in hand therapy. *Occupational Therapy in Health Care, 24(2),* 130-146. https://doi:10.3109/07380570903349378

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches*. Sage Publications.

Daud, A. Z. C., Judd, J., Yau, M., & Barnett, F. (2016a). Issue in applying occupation-based intervention in clinical practice: A delphi study. *Procedia - Social and Behavioral Sciences, 222,* 272-282. https://doi:10.1016/j.sbspro.2016.05.158

Daud, A. Z. C., Yau, M. K., Barnett, F., Judd, J., Jones, R. E., & Muhammad Nawawi, R. F. (2016b). Integration of occupation-based intervention in hand injury rehabilitation: A randomized controlled trial. *Journal of Hand Therapy*, *29*(1), 30–40. https://doi.org/10.1016/j.jht.2015.09.004

Delany, C., Richards, A., Stewart, H., & Kosta, L. (2017). Five challenges to ethical communication for interprofessional paediatric practice: A social work perspective. *Journal of Interprofessional Care*, *31*(4), 505–511. https://doi.org/10.1080/13561820.2017.1296419

Di Tommaso, A., Isbel, S., Scarvell, J., & Wicks, A. (2016). Occupational therapists' perceptions of occupation in practice: An exploratory study. *Australian Occupational Therapy Journal*. https://doi.org/10.1111/1440-1630.12289

Di Tommaso, A., Wicks, A., Scarvell, J., & Isbel, S. (2019). Experiences of occupation-based practice: An Australian phenomenological study of recently graduated

occupational therapists. *British Journal of Occupational Therapy, 82*(7), 412–421. https://doi.org/10.1177/0308022618823656

Eppich, W. (2016). Interprofessional communication: Challenges and opportunities. Retrieved from http://intensivecarenetwork.com/interprofessional-communication-challenges-opportunities-walter-eppich-2/

Foronda, C., MacWilliams, B., & McArthur, E. (2016). Interprofessional communication in healthcare: An integrative review. *Nurse Education in Practice*, *19*, 36h–40. https://doi.org/10.1016/j.nepr.2016.04.005

Fortune, T. & Fitzgerald, M. H. (2009). The challenge of interdisciplinary collaboration in acute psychiatry: Impacts on the occupational milieu. *Australian Occupational Therapy Journal. 56*: 81-88.

Gray, J. M. L. (1998). Putting occupation into practice: Occupation as ends, occupation as means. *American Journal of Occupational Therapy, 52*(5), 354–364. https://doi.org/10.5014/ajot.52.5.354

Hinojosa, J., Kramer, P., & Royeen, C. B. (2017). *Perspectives on human occupation: Theories underlying practice*. F.A. Davis Company.

Howard, B. S., Bennet, L., Kennell, B., Erler, K. S., Elleman, B., Keith, J., Hensley, M., Ewy, D., Ritvo, R. A., Franco, M., & Argabrite Grove, R. E. (2015). Occupational therapy code of ethics. *American Journal of Occupational Therapy, 69*(Suppl. 3), 6913410030. http://dx.doi.org/10.5014/ajot.2015.696S03

Jewell, V. D., Pickens, N. D., Hersch, G., & Jensen, G. (2016). An exploration into occupation-centered practice in skilled nursing facilities. *Physical &*

Occupational Therapy in Geriatrics, *34*(1), 43-56. https://doi:10.3109/02703181.2015.1114062

Johnson, C. E. (2017). Understanding interprofessional collaboration: An essential skill for all practitioners. *OT Practice*, *22*(11), CE-1-CE-8.

Lamb, A. J. (2017). Presidential Address, 2017 – Understanding the potential of everyday opportunities. *American Journal of Occupational Therapy, 71*, 7106140010. https://doi.org/10.5014/ajot.2017.716001

Looman, N., Fluit, C., Wijngaarden, M. van, Groot, E. de, Dielissen, P., Asselt, D. van, Graaf, J. de, & Haan, N. S. de. (2020). Chances for learning intraprofessional collaboration between residents in hospitals. Wiley Online Library.

Lumague, M., Morgan, A., Mak, D., Hanna, M., Kwong, J., Cameron, C., Zener, D., & Sinclair, L. (2006). Interprofessional education: The student perspective. *Journal of Interprofessional Care*, 20(3), 246–253. https://doi.org/10.1080/13561820600717891

Mahani, M. K., Mehraban, A. H., Kamali, M., & Parvizy, S. (2015). Facilitators of implementing occupation-based practice among Iranian occupational therapists: A qualitative study. *Medical Journal of the Islamic Republic of Iran, 29*(307), 1-9.

Maitra, K. K. & Erway, F. (2006). Perception of client-centered practice in occupational therapists and their clients. *American Journal of Occupational Therapy, 60,* 298-310.

Mattingly, S. M. (2012). The experiences of an occupational therapist delivering occupation-based practice at a skilled nursing facility. *Online Theses and Dissertations. 70*. https://encompass.eku.edu/etd/70.

Mroz, T. M., Pitonyak, J. S., Fogelberg, D., & Leland, N. E. (2015). Health policy perspectives—client centeredness and health reform: Key issues for occupational therapy. *American Journal of Occupational Therapy, 69*, 6905090010. http://dx.doi.org/10.5014/ajot.2015.695001

Nardella, M. S., Carson, N. E., Colucci, C. N., Corsilles-Sy, C., Hissong, A. N., & Simmons, D. (2018). Importance of collaborative occupational therapist–occupational therapy assistant intraprofessional education in occupational therapy curricula. *American Journal of Occupational Therapy, 72*(Suppl. 2), 7212410030. https://doi.org/10.5014/ajot.2018.72S207

Orchard, C., Bainbridge, L., Bassendowski, S., Casimiro, L., Stevenson, K., Wagner, S., Winberg, L., Curran, V., Loreto, L., & Swatzky-Griling, B. (2010). A national interprofessional competency framework. *Canadian Interprofessional Health Collaborative.* https://health.ubc.ca/sites/health.ubc.ca/files/documents/CIHC_IPCompetencies_Feb12101.pdf

Pierce, D. E. (2003). *Occupation by design: Building therapeutic power*. F.A. Davis.

Sumsion, T., & Smyth, G. (2000). Barriers to client-centeredness and their resolution. *Canadian Journal of Occupational Therapy, 67*(1), 15-21. https://doi:10.1177/000841740006700104

Supper, I., Catala, O., Lustman, M., Chemla, C., Bourgueil, Y., & Letrilliart, L. (2015). Interprofessional collaboration in primary health care: A review of facilitators and barriers perceived by involved actors. *Journal of Public Health (United Kingdom), 37*(4), 716–727. https://doi.org/10.1093/pubmed/fdu102

Vestergaard, E., & Nørgaard, B. (2018). Interprofessional collaboration: An exploration of possible prerequisites for successful implementation. *Journal of Interprofessional Care*, *32*(2), 185–195. https://doi.org/10.1080/13561820.2017.1363725

Wong, C., Fagan, B., & Leland, N. E. (2018). Occupational therapy practitioners' perspectives on occupation-based interventions for clients with hip fractures. *American Journal of Occupational Therapy, 72,* 7204205050. https://doi.org/10.5014/ajot.2018.026492

Appendix A: Consent Form

Consent to Participate in a Research Study

How Interprofessional and Intraprofessional Collaboration and Practice Influence Occupational Therapists and Occupational Therapy Assistants Ability to Provide Occupation-based Practice in Skilled Nursing Facilities

EKU

Institutional Review Board Protocol Number
3961

Approval Valid
7/7/11-12/31/22

Key Information

You are being invited to participate in a research study. This document includes important information you should know about the study. Before providing your consent to participate, please read this entire document and ask any questions you have.

Do I have to participate?
If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering. If you decide to participate, you will be one of about 10 people in the study.

What is the purpose of the study?
The purpose of the study is to examine how inter and intraprofessional collaboration and practice influence occupational therapists and occupational therapy assistant's ability to provide occupation-based practice in skilled nursing facilities. Exclusion criteria will be any of these professionals that have been in their roles for less than one consecutive year. Participants who do not understand or speak English will be omitted from this study. It will also not include any staff that does not directly provide care to residents.

Where is the study going to take place and how long will it last?
The research procedures will be conducted at the skilled nursing facility or virtually utilizing video conferencing software. You will need to come to the skilled nursing facility one or more times during the study. These visits can take any will take about 30 – 90 minutes. The total amount of time you will be asked to volunteer for this study is 120 minutes over the next month].

What will I be asked to do?
In this study you will be asked to answer questions related to your profession and interaction with co-workers. Interviews conducted will be recorded and stored to understand the impact that collaboration has within your place of employment. You may be asked for follow-up interviews in order to give the researcher more clarification or to confirm/deny, assumptions made by the researcher.

Are there reasons why I should not take part in this study?
You should not take part in this study if you are under the age of 18, have not been in your role or at this facility for less than 1 year, or do not directly provide care to residents.

What are the possible risks and discomforts?
To the best of our knowledge, the things you will be doing have no more risk of harm or discomfort than you would experience in everyday life.

You may, however, experience a previously unknown risk or side effect.

What are the benefits of taking part in this study?
You are not likely to get any personal benefit from taking part in this study. Your participation is expected to provide benefits to others by helping healthcare practitioners and professionals understand the impact that collaboration has on client outcomes. This will hopefully in the future help there to be a more collaborative atmosphere in skilled nursing facilities to provide the best care for clients.

If I don't take part in this study, are there other choices?
If you do not want to be in the study, there are no other choices except to not take part in the study.

Now that you have some key information about the study, please continue reading if you are interested in participating. Other important details about the study are provided below.

Other Important Details

Who is doing the study?
The person in charge of this study is Stedmon Deon Hopkins at Eastern Kentucky University. He is being guided in this research by Dr. Leah Simpkins. There may be other people on the research team assisting at different times during the study.

What will it cost me to participate?
There are no costs associated with taking part in this study.

Will I receive any payment or rewards for taking part in the study?
You will not receive any payment or reward for taking part in this study.

Who will see the information I give?
Your information will be combined with information from other people taking part in the study. When we write up the study to share it with other researchers, we will write about this combined information. You will not be identified in these written materials.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. For example, your name will be kept separate from the information you give, and these two things will be stored in different places under lock and key.

However, there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court. Also, we may be required to show information that identifies you for audit purposes.

Can my taking part in the study end early?
If you decide to take part in the study, you still have the right to decide at any time that you no longer want to participate. You will not be treated differently if you decide to stop taking part in the study.

The individuals conducting the study may need to end your participation in the study. They may do this if you are not able to follow the directions they give you, if they find that your being in the study is more risk than benefit to you, or if the University or agency funding the study decides to stop the study early for a variety of reasons.

What happens if I get hurt or sick during the study?
If you believe you are hurt or get sick because of something that is done during the study, you should call Stedmon Deon Hopkins at 502-741-5554 immediately. It is important for you to understand that Eastern Kentucky University will not pay for the cost of any care or treatment that might be necessary because you get hurt or sick while taking part in this study. Also, Eastern Kentucky University will not pay for any wages you may lose if you are harmed by this study. These costs will be your responsibility.

Usually, medical costs that result from research-related harm cannot be included as regular medical costs. Therefore, the costs related to your care and treatment because of something that is done during the study will be your responsibility. You should ask your insurer if you have any questions about your insurer's willingness to pay under these circumstances.

What else do I need to know?
You will be told if any new information is learned which may affect your condition or influence your willingness to continue taking part in this study.

We will give you a copy of this consent form to take with you.

Consent

Before you decide whether to accept this invitation to take part in the study, please ask any questions that come to mind now. Later, if you have questions about the study, you can contact the investigator, Stedmon Deon Hopkins at 502-741-5554, or email at Stedmon_Hopkins14@eku.edu. If you have any questions about your rights as a research volunteer, you can contact the staff in the Division of Sponsored Programs at Eastern Kentucky University at 859-622-3636.

If you would like to participate, please read the statement below, sign, and print your name.

I am at least 18 years of age, have thoroughly read this document, understand its contents, have been given an opportunity to have my questions answered, and voluntarily agree to participate in this research study.

_____ _____
Signature of person agreeing to take part in the study Date

_____
Printed name of person taking part in the study

_____
Name of person providing information to subject

Appendix B: Sample Interview Questions

Interview Questions for Occupational Therapist and Occupational Therapy Assistant

1. How would you describe occupation-based practice?
2. When you think of occupation-based practice, what comes to mind?
3. What is your role with occupation-based treatment?
    a. If you utilize occupation-based treatment in your facility can you describe how that process looks?
    b. If it is not utilized, how would you describe the reason it is not?
4. Do you see occupation-based care utilized frequently by the occupational therapist/occupational therapist assistant?
    a. If so, how?
    b. If not, what limitations do you perceive as being a factor?
5. How would you describe interprofessional and intraprofessional collaboration?
6. Do you work closely with other healthcare professionals or team members?
    a. How would you describe their roles and in what capacity do you work with them?
    b. If not, what reasons would you give for not working closely with other professionals?
7. When you think of working with other healthcare professionals or team members, what stands out?
8. Do you feel that other staff influence your ability to utilize occupation-based treatment?

a. If yes, how so?

b. If not, then can you describe how they support you

9. What is your perception of other staff's ability to influence the use of OBP?
10. Is there anything else that comes to mind when you think about OBP or collaboration?

Interview Questions for Alternative Staff

1. What is your profession at this facility and what are your roles?
2. How would you describe occupations?
3. What do you think occupation-based practice is?
4. Do you feel your roles impact the occupations of your clients/residents?
    a. Why or why not?
5. Can you describe to me what the occupational therapist or the occupational therapy assistant does?
6. Do you work with the occupational therapist or occupational therapist assistant?
    a. If so, how closely and how?
    b. If not, how do you imagine your residents care and outcomes could be improved if you did?
7. How would you describe the process of working with the OT/OTA?
8. Can you describe to me a time where you worked well with the OT or OTA?
9. Do you feel there are missed opportunities to collaborate with the occupational therapists and occupational therapist assistants that could benefit the clients?
    a. What types of opportunities?

10. Are there any ways you feel that the collaboration between you and the OT or OTA's could be different?
    a. How?
11. What type of education, if any, can the occupational therapist provide to make your job better or easier?