

# A grounded theory investigation of how patients in skilled nursing facility rehabilitation make their therapeutic goals

Jennifer L. Oehler  
*Medical College of Ohio*

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### Graduate School

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For the Degree of  
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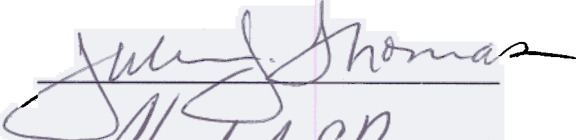


**Submitted by**

Jennifer Oehler

(Name)

In partial fulfillment of the requirements for the degree  
Master of Occupational Therapy

**APPROVED**

Name	Signature	Date
<u>David L. Nelson, Ph.D., OTR/L, FAOTA</u> Major Advisor		<u>12/16/04</u>
<u>Julie J. Thomas, Ph.D., OTR/L, FAOTA</u> Department Chair		<u>12/16/04</u>
<u>Christopher E. Bork, Ph.D.</u> Dean, School of Allied Health		<u>12/16/04</u>
<u>Keith K. Schlender, Ph.D.</u> Dean, Graduate School		<u>12-20-04</u>

A Grounded Theory Investigation of How Patients in Skilled Nursing Facility  
Rehabilitation Make Their Therapeutic Goals

Jennifer L. Oehler

Department of Occupational Therapy

Medical College of Ohio at Toledo

### **Abstract**

The purposes of this study were to investigate the reasons why some patients change their therapeutic goals, and why others remain committed to their original goals. This study was a beginning step towards development of a theory as to how patients make and modify their goals. Participants (8 females, 3 males) with mean age of 85.5 years ( $SD = 6.5$ ) were patients at a skilled nursing facility. An occupational therapist administered the Self-Identified Goal Assessment (SIGA). The investigator then conducted a semi-structured interview within 48-72 hours after administration of the SIGA. The interview transcripts were analyzed according to grounded theory procedures. The results indicated that none of the participants wished to change their therapeutic goals. Axial coding suggested a series of structured relationships among participants' developmental structures, occupational forms, meanings, and purposes. Selective coding led to the conclusion that the participants' overall purpose was to return home or to go to a new home. The goals that the participants identified on the SIGA, in collaboration with the occupational therapist, were the means by which to achieve their overall purpose.

A Grounded Theory Investigation of How Patients in Skilled Nursing Facility  
Rehabilitation Make Their Therapeutic Goals

The Occupational Therapy Code of Ethics (2000) states, “Occupational therapy practitioners shall collaborate with service recipients or their surrogate(s) in setting goals and priorities throughout the intervention process” (American Occupational Therapy Association, 2000). A goal is defined as the attainment of an optimal degree of the individual’s social well-being and ability to be active and fulfill vital aims with respect to family life, work, and leisure (Wressle, Öberg, & Henriksson, 1999, p. 81). The formation of therapeutic goals involves an interactive process between the client and the therapist.

Mew and Fossey (1996) wrote that client-centered occupational therapy necessitates a collaborative, interdependent partnership between the therapist and the client. The client-centered approach is important in occupational therapy because it facilitates the development of rapport with the client, enhances the therapist’s understanding of the client’s perspective, and facilitates meaningful therapy (Mew & Fossey, 1996).

Theoretically, it can be argued that client outcomes are better when the client and the provider collaborate on goal setting, treatment planning, and treatment implementation than when just the provider sets the goals and plans treatment alone. Neinstadt (1995) speculated that, in occupational therapy programs where only the therapist sets the treatment goals, typically the clients reach a plateau. Neinstadt (1995) theorized that clients put into an occupational therapy program in which they collaborate

with the therapist on their treatment goals, will make gains in their previously plateaued abilities.

Neistadt (1995) surveyed methods of assessing client's priorities and found that occupational therapists primarily used informal interviews to identify the client's priorities. While informal interviews are important to establish rapport with the client, they do not derive specific information about occupations that are important to the client. Informal interviews extrapolate general goals like "I want to walk" or "I want to return home". They do address where the clients want to go when they walk or what they are going to do when they return home which are the specific types of treatment goals that the occupational therapist can be concerned with.

Therapists need to gather background information about the client to find out which occupations are meaningful. This information is typically gathered through the administration of formal and informal assessments and evaluations. Clients are able to identify personally meaningful goals through the use of evaluations and assessments, which involve them in the goal setting process.

Formal assessment procedures precisely identify client's priorities in treatment. Recently there has been development of several formal assessments that measure client-identified goals and satisfaction with occupational performance. The Self-Assessment of Occupational Functioning (SAOF) is grounded in the Model of Human Occupation (Henry, Baron, Mouradian, & Curtin, 1999). The clients are involved in measuring their strengths and weaknesses on a 23-item checklist. After completion of the checklist, the client identifies priorities for change in his or her life resulting in a starting point for the client and therapist to collaborate on goal setting. Another method reported is the Goal

Attainment Scaling (GAS) that involves an interview process that can be used along with the open-ended identification of self-identified goals (Ottenbacher & Cusick, 1993). The GAS involves a seven step process through which the goals are identified.

The Canadian Occupational Performance Model (COPM) is a third formal assessment of client-identified goals. It is client-centered and considers the importance of occupations to the client using a semi-structured interview approach (Law, Baptiste, McColl, Opzoomer, Polatajko, & Pollock, 1990). The COPM encompasses the areas of self-care, productivity, and leisure as the primary outcomes being measured (Law et al., 1990). The COPM involves a five-step process to identify and measure problem areas in the client's daily functions: problem definition, problem weighting, scoring, re-assessment, and follow-up. It is designed to help occupational therapists establish occupational performance goals based on the client's perception of needs and to measure change objectively in the defined problem areas (Law et al., 1990).

Nelson and Payton (1997) explored the planning process in occupational therapy. In a survey administered to discharged occupational therapy clients about their participation in planning their care, 92% of the respondents strongly agreed or agreed that they had helped to determine their goals (Nelson & Payton, 1997). Yet, when these participants were asked to select a scenario that best describes their occupational therapy situation, a different picture emerged. Fifty-seven percent of the participants chose the scenario that described the therapist setting the goals, whereas only thirteen percent chose the one in which they played a major role in setting their goals (Nelson & Payton, 1997).

The goal setting process involves many other factors on how clients define their therapy goals. In a qualitative study conducted by Kielhofner and Barrett (1998), they

found that there are two important conceptual issues that need to be addressed in the goal setting process (a) the social process underlying the therapeutic use of occupation and (b) the experience of meaning in occupational forms (Kielhofner & Barrett, 1998). In another attempt to explore the factors involved in client goal setting, Barclay's (2002, p. 10) Model of Rehabilitation indicated that there are four client factors that influence the goal setting process: past experience, concept of independence, understanding of goals, and shared language (Barclay, 2002, p. 10). Other sources in the literature identified more factors that may be involved in the client's goal setting process: environment (Barclay, 2002; Wressle et al., 1999), patient motivation (Barclay, 2002; Wressle et al., 1999), and patient-therapist relationship (Haas, 1995).

In a quasi-experimental pilot study, Gagné and Hoppes (2003) explored the effects of collaborative goal-focused occupational therapy on self-care skills. They found that participants who received collaborative, goal-focused therapy had better performances in self-care skills compared to those in the control group. This study suggests that in treatment of self-care skills, it would be to the advantage of both the occupational therapist and client for there to be collaboration and goal focus in therapy.

McAndrew, McDermott, Vitzakovitch, Warunek, and Holm (1999) investigated therapist and client perceptions of the occupational therapy goal setting process. They found that clients were positive about therapists seeking their input into goals and establishing goals including meaningful occupations. This research did find that while the therapists may believe that they have an obligation to collaborate by asking the client for goals during the initial evaluation, the clients appear to want more substantive and



ongoing discussions of issues that have meaning to them through the duration of their therapy sessions.

The Self-Identified Goals Assessment (SIGA) is a new occupational therapy assessment designed for use in subacute rehabilitation and nursing homes (Melville, Baltic, Bettcher, & Nelson, 2002). Its purpose is to help clients identify meaningful goals for therapy and to make judgments about progress towards those goals. This assessment is done through an interview used to elicit one to four goals that are important to the client. The client is then asked to identify on a scale of 0-10 his or her current performance in these areas. A practical reason for the SIGA development was the amount of time that it saved the therapist in the initial evaluation compared to the 30 to 40 minutes the COPM took to administer (Cassidy, 2000).

Client involvement in the therapeutic goal setting process is important so that meaningful and purposeful goals are established. Yet, even with the client's participation in the goal setting process, it has been found that one-third of the 30 participants wanted to change their goals within 48 hours of making them (Melville et al., 2002). This finding suggests the importance of a qualitative study to investigate the reasons why some patients change their goals, and why others remain committed to their original goals. Needed is an overall theory as to how patients make and modify their goals. This study is a beginning step toward establishing this kind of theory.

To better understand the client's goal setting process, a qualitative approach using grounded theory is suitable. Grounded theory is "inductively derived from the study of the phenomenon that it represents" (Strauss & Corbin, 1990, p. 23). The grounded theory approach allows for the exploration into the phenomenon of why clients change or do not

change their therapeutic goals. Participants will be involved in semi-structured interviews that will enable them to state their reasons in their own words. This systematic and sequential process of data collection enables the researcher to capture the potentially relevant aspects of the topic as soon as they are perceived. This allows for a broader understanding behind this phenomenon (Strauss & Corbin, 1990). The grounded theory approach allows for the refinement and exploration of a theoretical formulation as fitting the collected data.

A parallel study was conducted by a different peer investigator at a different skilled nursing facility during the same time period. The advantages of having a parallel study were: triangulation across sites, across participants, across investigators, and across occupational therapists performing the SIGA.

## **Methods**

### ***Participants***

Participants were recruited after admission to the skilled nursing facility (SNF) unit at the Lutheran Memorial Home in Sandusky, Ohio. A licensed occupational therapist (the only one in the facility) approached eligible participants. Inclusion criteria included: (a) 50 years or older, (b) new admission to the SNF unit, (c) prescription from the referring physician to receive occupational therapy services, (d) planned stay in the SNF unit equal to or longer than five days, and (e) ability to complete the SIGA. If participants were willing, the investigator administered informed consent. Twelve persons gave informed consent, but data was available for only eleven participants because of a mechanical problem with the tape recorder. The eleven participants' primary and secondary diagnoses are listed in Table 1. The participants' prior and

discharge environments are described in Table 1. The mean age of the participants (8 females, 3 males) was 85.45 years ( $SD = 6.5$ ).

### ***Instrument***

The Self-Identified Goal Assessment (SIGA) was designed to identify one to four goals of the participant. The protocol of the SIGA is available on the World Wide Web (Melville & Nelson, 2001). However, the participants identified only two goals each (please see Table 2). The therapist began the process by asking each participant about prior functioning, home situation, and interests. The therapist then asked the participant to identify tasks “you would like to work on or improve on in therapy before you go back home.” The self-identified goals were then gathered through an interview conducted by the therapist. If the participant had difficulty identifying specific goals, the therapist inquired about past routines and “things that seem difficult to you now.” The therapist then asked the participant a general question: “How well they can do all of the things that they want to on a scale from 0 to 10, with 0 being that you can’t do them at all and 10 being that you can do them your very best” (Melville et al., 2002). The self-identified goals were then each rated by the participant on a scale of 0-10 based on how well he or she perceived his or her ability to perform them at that moment.

Melville et al. (2002) found the SIGA effective in helping participants in subacute rehabilitation to identify personally meaningful goals (p. 656). More than 90% of the 30 participants confirmed that the listed goals were their own goals and not just goals that other people wanted (Melville et al., 2002, p. 655). When participants were asked about their feelings when identifying their goals for therapy, some stated that the goal setting process enhanced their motivation for participation in therapy (Melville et al., 2002).

Hodge (1999) used focus group interviews with occupational therapy clinicians who were using the SIGA to study the content validity of the SIGA. The results supported the content validity of the SIGA. Hodge also made suggestions for modifications to the SIGA. Cassidy (2000) used focus group interviews to study the clinical utility of the modified SIGA. The therapist felt that this assessment helped clients gain some control in their therapy and increased their participation and motivation (Cassidy, 2000). Overall, the therapists found the SIGA to be clinically useful.

### ***Procedures***

At the beginning of the initial assessment, the occupational therapist explained the purpose of the study and asked the patient if he or she might be willing to participate. The initial evaluation took place within 48 hours of the potential participant's admission to the SNF unit. The therapist administered the SIGA. The therapist wrote and scored the potential participant's goals exactly as stated during the assessment. The therapist then called the investigator to schedule an appointment with the potential participant for an interview within 48-72 hours after the administration of the SIGA. Prior to the interview, the investigator re-explained the purpose of the study, answered any questions the potential participant had, and carried out the informed consent procedures required by the Institutional Review Board.

The investigator conducted a semi-structured interview with the participant that was recorded on audiotape and transcribed later. The initial interviews were conducted using pre-formulated questions (see Table 3) and follow-up probes. The questions for later interviews were modified according to analysis of the initial data. The ability to modify questions mid-study was important in order to address themes that emerged from

the data (Strauss & Corbin, 1990). The new questions were based on themes that appeared during the coding process. For example, during the study the investigator found that participants had not changed their goals. Based on that information, the investigator added the question, “Would you like to add to your goals?”

Triangulation of sources used data collected from a similar study that led to additional interview questions. The parallel study was conducted at the Lutheran Village of Wolf Creek, a skilled nursing facility in Toledo, Ohio. The information gathered from the participants’ interviews were reviewed by the investigator, the research advisor, and the peer investigator at the second skilled nursing facility to see if similar trends arised from the questions asked. The new questions were based on the themes that emerged at the two sites. The new questions were: “What is your ultimate goal?” and “Do you think that these (the goals) are ways to return home?”

Also, the investigators collaborated together in identifying themes that emerged through individual review of the transcripts and pooling of the themes. The occupational therapists that helped to recruit for this study also provided input into the emerging themes through discussion of how the participants formulated their goals and how the therapists recorded them.

The goal for the data analysis was theoretical sensitivity, with theoretical sensitivity defined as, “awareness on the part of the researcher, of the subtleties of the meaning of the data” (Strauss & Corbin, 1990, p.41). In the current study, theoretical sensitivity was achieved through review of literature sources, professional and personal experiences of the investigator, advisor input, and peer investigator.

The transcripts of the participants' interviews were first analyzed through "open coding". During open coding, the interview was broken down into discrete happenings, events, or ideas, and then given conceptual labels (Strauss & Corbin, 1990). The "concepts" were then examined, compared, conceptualized, and categorized (Strauss & Corbin, 1990, p. 61). If the concepts appeared to pertain to a similar phenomenon when compared, they were grouped together under a higher order, more abstract concept called a "category" (Strauss & Corbin, 1990, p. 61). The category was then given a more abstract name.

The investigator and peer investigator reviewed all of the transcripts and formulated a list of tentative categories based on open coding. Supplementing this list of categories were subcategories. The list was then presented to the research advisor, who then provided his input as to the grounding of categories in the actual data. The investigator, research advisor, and peer investigator then reorganized the categories and subcategories into a final list. This list was then compared to that of the peer reviewer's categories that was formulated from her data through the same process.

"Axial coding" was the next step performed in the analysis of the data. This is a set of procedures whereby data are put back together in new ways after open coding, by making connections between categories (Strauss & Corbin, 1990, p. 96). The traditional focus in axial coding is on specifying a category, or phenomenon, in terms of the condition that gave rise to it; the "context" in which it is embedded; the "action strategies" by which it is handled, managed, or carried out; and the "consequences" of these strategies (p. 97).

For this study, instead of using traditional terms for axial coding, the terms used in the axial analysis were drawn from the Conceptual Framework of Therapeutic Occupation (CFTO) (Nelson, 1994). The traditional axial coding terms of causal conditions, phenomenon, context, intervening, conditions, and action strategies were translated into the CFTO terms of developmental structure, occupational form, meaning, and purpose, while consequences were translated into occupational performance, impact, and adaptation.

According to CFTO, Nelson (1994, p. 10) has defined occupation as “the relationship between occupational form and an occupational performance”. The occupational form is defined as “the objective set of circumstances, external to the person, that elicits, guides, or structures the person’s occupational performance” while the occupational performance is “the voluntary doing of the person in the context of the occupational form” (Nelson, 1994, p. 11). A person has a developmental structure, which are the person’s sensorimotor, cognitive, psychosocial abilities and characteristics (Nelson, 1994). As stated earlier, meaning is an essential part of a client’s self-identifying goals. Meaning is defined by Nelson (1994, p. 21) as “the entire interpretive process in which an individual engages when encountering an occupational form”. Therefore, meaning encompasses the client’s interpretation of the physical and sociocultural features of the occupational form. While purpose is defined as “the experience of wanting an outcome to result from occupational performance; purpose is the link between meaning, developmental structure, and occupational performance” (Nelson, 1994, p. 23).

Finally, “selective coding” was performed. This is the process of selecting the core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development (Strauss & Corbin, 1990, p. 116). It is through selective coding that the categories are integrated and a grounded theory is formed. The final analysis was reviewed by a peer investigator, conducting a similar study in another skilled nursing facility, and by the research advisor to confirm the formed theory.

### **Results**

An unanticipated result of this study was that none of the participants wished to change their therapeutic goals that they identified on the SIGA. The phenomenon as to why the participants did not change their goals was then explored.

The results from the open coding process are described in an outline of categories and subcategories (see Table 4). These results were then re-formulated and organized in terms of CFTO during the axial coding process. The causal relationships among occupational form, developmental structure, meaning, and purpose are described in Figure 1. It is important to recognize that all of the participants had one of two ultimate purposes, to return home or to go to a new home. How the participants arrived at their ultimate purpose was personal to them and involved a combination of the categories that lie within each concept. The goals that the participants identified on the SIGA were means by which to achieve the overall purpose.

#### ***Developmental Structure***

A majority of the participants were admitted to the SNF due to primary conditions were orthopedic disorders that primarily limited to lower extremity movement (see Table



1). Often the participant did not understand the chronic illness and how it affected his or her life. One participant stated, “I don’t know what’s going to happen. Do you know what I mean? I was doing all of that and then I went to the doctor and I don’t know what that means, oh my legs could give out and then they sent me to the hospital. But, uh, I was doing all right with walking and dressing myself and I don’t know what happened.” Some of the participants had secondary diagnoses that influenced their ability to make appropriate goals for themselves. One participant describes how a chronic condition, that she has lived with, affected her goals: “It’s like this, some think that I could be able to learn to walk again, but I have lived with this CMT [Charot Marie Tooth] all my life and I know how it reacts because we have several family members with it and I am not sure they’ll ever be able to get me to walk.”

Memory impairment also played a role. A participant needed to be able to describe his or her prior life, living situation, and experiences of prior deficits. Memory also came into play when participants tried to achieve their goals. One participant stated, “I don’t remember even talking to her the first time. That was my goal before, wasn’t it?”

Levels of deconditioning varied among the participants. The physical aspects of deconditioning influenced the goal that the participants made. For example, one participant stated, “I decided this definitely because I told her I wasn’t able to stand long enough (I need to shave).” However, not only the physical aspects of deconditioning influenced the goal(s), but the participant’s perception of his or her physical status did too. For example, a participant stated, “I did the best I could. I done more that I thought I could do.”

As participants have aged, they have taken notice of their age related declines and how their lives have been influenced by the process. Participants noticed certain tasks were not as simple as they once had been or were impossible because they have become too frail and unable to perform them at all. One participant commented, “I don’t have the equilibrium like I used to have. I mean, my balance is gone and that’s why I can’t walk, really walk by myself.”

### ***Occupational Form***

The most influential external influence was the occupational therapist because she was seen as the expert. If the therapist was the expert, then she knew what it was going to take to achieve the participant’s overall purpose. According to one participant, “[the therapist] knows more than I do” in reference to goal setting. One participant described the occupational therapist as “the boss”. During the goal setting process, the participants collaborated with the therapist to develop goals that addressed their needs. As one participant described the relationship, “We wanted to strengthen this shoulder if we can because that’s one of the reasons I went to the doctor. This was starting to wear my shoulder out the way I was living because I was lifting so much weight with it all of the time. So Amy [the therapist in this study] said we’d figure out which way to go with that.”

The participant’s family also influenced him or her during the goal setting process through being a supporter or a decision maker. The family’s influence and method by which they influenced the participant had direct impacts on the therapeutic goals that the participant established. One participant described how her family supported and encouraged her through this process, “I have three children, and they said, ‘Mom, you are

of sound mind yet, very alert and able to do a lot of things and we think you should decide what you want to do. We're not going to tell you what we think you should do.' So they kind of left it up to me, um, to decide and then when I did decide what I wanted to do they, was in agreement. They said, 'Mom, I think you are right.'"

A family member could also encourage the participant to be passive in the goal setting process when the family member had the role of being the decision maker. One participant described this relationship, "I wouldn't do anything without her [daughter] because I keep her on hand in case there's a decision that she can make for me. She's pretty much like me in her thinking, yea."

The facility, including the occupational therapist and other patients, had a role in goal setting process. The facility that was used for recruitment for this study had only one occupational therapist so the participant could not choose whom he or she wanted to work with. Also, the therapist had her own personal methods for evaluation and goal setting, with patient input. The other patients present at the facility influenced the participants through visual and verbal input. One participant described how other therapy patients had influenced her: "Oh, no. See, I go down for therapy all of the time and I will. That has helped me, not her [the therapist] personally. But you know what goes on down there [therapy room]. Well you hear what other people [in therapy] say and then you think about it and oh, maybe that is right. And it helps you to make your own. I've got a lot of interference here. But I still hear other people, hearing them talk about it [therapy]." Hence this participant was influenced by the facilities milieu, including fellow patients.

Adequate amount of time was needed by the participant to assess how occupational therapy could address his or her needs in order to make goals. This needed time was found prior to the SNF admission and during the initial evaluation. Two participants stated that they had time prior to their SNF admission to evaluate their current physical deficits. One participant stated, “Oh, I was thinking about, I had eight weeks in bed, I was thinking about a lot. I was thinking about what I could do to recover.” In regards to the initial evaluation, a majority of the participants stated that they had ample amount of time to assess their needs and develop therapeutic goals to address them.

Participants’ future living possibilities also had an influence on the goal setting process. These possibilities included: home, children’s home, caregivers, and home health care. Some of the participants already knew the set-up of their future living environment and what would be required of them in order to live there. One participant explained, “I am hoping to go back to my condo, which is all one floor, right over here at Pine Wood. We could almost walk over there. And it’s very convenient, um, no steps or anything. It nice for somebody that’s in my condition right now.” Another participant stated, “I’m going to have Home Health Care come in when I go home.”

Availability of assistive devices was another important aspect of the occupational form. During the acute phase of their rehabilitation, some participants had begun to learn compensatory strategies. Examples of these were: “I can walk with a walker”, and “shoes I wear that help some but not that much.”

### *Meaning*

The meanings of the participants have been inferred through the analysis of the interviews and the information described above in reference to developmental structure and occupational form. One of the inferred meanings was the fear of being a burden upon family, caregivers, and others. As one participant stated, “I just decided I have to make use of myself and as long as I can play out myself I don’t like to bother anybody.”

Another meaning that has been inferred was that the participants were depending on their family’s advice and feedback. They may have needed the comfort of knowing that their families supported their rehabilitation decisions. Some participants appeared to have believed that the family had a better understanding than themselves of the actuality of the situation. The family could have had more knowledge of the participant’s future living situation because it would be the family’s home that he or she would be moving to. Also, the family may have had a better understanding of the disease because they did not have the deficits, like memory impairment, that the participant had.

The level of knowledge of disease progression or dealing was an important factor in decision-making. Those with little insight had difficulty in setting goals. As one participant stated, “I don’t know what is going to happen” in reference to his abilities associated with COPD.

The participant’s level of knowledge about the profession of occupational therapy and rehabilitation also influenced the level of meaning that the goal had. If a participant was knowledgeable about occupational therapy and rehabilitation, then he or she developed relatively meaningful goals. A majority of participants demonstrated some

level of understanding about occupational therapy and rehabilitation because they established goals appropriate to occupational therapy (refer to Table 2).

If a participant was able to think about future situations and possible obstacles, then relatively meaningful goals were the result. For example, the participant who had a one-floor condominium described how her kitchen had already been laid out to meet her anticipated needs. If he or she was not able to think that way, then he or she was going to set a goal that was general or that applied to past situations without relevance to his or her future situation.

A final meaning was a dislike of being a patient in a transitional facility. A major factor was the unfamiliarity of the setting. Another factor was the stress erected by being around people who were quite ill. Most participants felt out of sorts in the transitional facility.

### ***Overall Purposes***

The ultimate reasons for setting SIGA goals were a) to return home, and b) to go to a new home. Most participants were intent on returning to their homes whether they had lived there for many years, or whether the homes were relatively new to them. But, “home” could have been a place besides their former home. It could have been a son’s home that where she was going to reside permanently: “No, my son’s home. Well it is going to be my home now. They got rid of my home.” The participant might have been going to an intermittent housing situation. A participant stated, “First I’ll go to Terry’s [son] house for a couple of weeks and then I plan to go home.” For participants going to an extended care facility, (ECF). The ECF was viewed as having some of the

characteristics of a home. For example, one woman expected much family involvement there. The stability of an ECF was a contrast to the temporary nature of the SNF.

### *Instrumental Purposes*

The participants' SIGA goals were the stepping-stones to achieving the overall picture. The participants wanted to have speedier and/or faster recovery times so that they would not have to be in the SNF any longer than they had to. They set their goals, with the therapist's help so that early discharge would be possible for them to achieve. The same mentality was shown when they said that they would work on whatever the therapist wanted to give them. The participants knew that they had to achieve the goals through hard work in order to return home.

The participants wanted to please the therapist because they felt that she was the key for them to get out of the SNF. It was her approval that they needed to get in order to be cleared to go home. The SIGA goals also provided a way to measure their progress towards getting home. And last of all, the participants wanted to live up to their families' expectations. They wanted to prove that they were able to return home independently as opposed to entering a nursing home.

### **Discussion**

This study was initiated to find out why people change their therapeutic goals; however, it became a study of why people maintain their goals. In selective coding, the researcher must identify the central category that organizes all the other categories, as grounded by all the data. The central category of the current study is that the participants wanted to go home (to return or to go to a new home).

A person's developmental structure and occupational form interact together in the development of meanings for a person. The meanings then provide a purpose for a person. If a person has a purpose, then occupational performance results. Goal setting needs to be thought of in terms of the person's actual abilities and circumstances, but also in terms of the person's unique meanings. As Nelson (1994) stated, "the goal orientation of the person (the purpose) follows out of what is most meaningful" (p. 23). To find the goal orientation of the person (the purpose), the occupational therapist has to analyze the client's developmental structure and occupational form to predict meaning.

To summarize, the participants' developmental structures involved: mainly orthopedic disorders with primary limitations of the lower extremity movement; secondary diagnoses, some of which were severe and or chronic; varying levels of memory impairment; varying levels of deconditioning; and advanced age and frailty. The participants' occupational forms that were identified in this study were: the therapist; family members; aspects of the SNF including other patients; time to process wants/needs; and future living possibilities. The inferred meanings of the participants identified in this study were: fear of being a burden; seeing therapist as an expert; depending on family's advice and feedback; varying levels of understanding of disease progression; varying levels of knowledge of occupational therapy and rehabilitation; forward thinking and imagination; and dislike of certain aspects of being a patient. The goal or overall purpose for all of the participants was to return home or go to a new home.

This study reinforces the Occupational Therapy Code of Ethics (2000) in its statement that therapeutic goal formation is an interactive process. The occupational



therapist is a source of information about abilities and disabilities in general and of how occupation is influenced, but the client has knowledge about self and what he or she wants to achieve. Together the two can develop achievable therapeutic goals.

This study was also reinforcing the finding of Mew and Fossey (1996), in that collaboration between the therapist and client is needed to develop goals. Through building rapport with the client, the therapist gains a better understanding of the client's perspective and can facilitate meaningful therapy (Mew & Fossey, 1996). That was the case in this study because the therapist was able to work with the client in developing meaningful therapeutic goals that aligned with the client's overall purpose: to go home.

The SIGA collected necessary information regarding the client's developmental structure and occupational form in regards to the stated overall purpose, returning home. So the client and therapist were then able to collaborate to evaluate what was most meaningful. A participant stated, "I want to be able to get myself dressed, be able to walk to the bathroom, and do my housework." Her SIGA goals reflected this statement. The client's initial goals were therefore meaningful and purposeful.

The therapist must spend an ample amount of time with the client during the initial evaluation to begin developing rapport. This is important so that the client does not feel as if the therapist is setting the goals alone. Time is needed for the client to examine the self to identify deficits and to collaborate with the therapist in setting goals. The therapist needs to take time to develop a relationship with the client so that the therapist can develop an understanding of what the client wants and needs from occupational therapy. The goals that were stated in the SIGA were those that the client and therapist collaborated on, but the client stated them in his or her own words.

Melville et al. (2002) found that one-third of the 30 participants wanted to change their SIGA goals within 48 hours of making them. Why did none of the participants in the current study want to change their goals established using the same assessment tool? The Melville et al. (2002) study took place in a hospital-based transitional care unit, and the participants had a wider variety of diagnoses than the current study. The participants of the Melville et al. (2002) study were interviewed and assessed with the SIGA within 24 hours after admission by one of several occupational therapists, and the follow-up interview was 48 hours later. The follow-up interview was structured to inquire about the usefulness of the SIGA as opposed to a discussion about the goal setting process that was involved. The main difference may have been that the single therapist in the current study spent more time with the client in developing the goals in the first place.

An idea for future research is to investigate the role of the family in goals setting, with the following in mind. How an older adult views his or her position in the family unit might have an influence on the goals setting process. If he or she feels like a core member of the unit, then there might be enhanced motivation to achieve goals. If he or she feels less valuable in the unit, then the motivation might decrease. All of this might directly relate to family expectations concerning therapeutic outcomes.

Although the results of this study and that of the parallel study, conducted by a fellow graduate student at a different SNF, were similar, there were differences between the two. The parallel study's participants had a variety of neurological and orthopedic diagnoses, compared to the current study where the diagnoses were primarily orthopedic. The education and experience level of the occupational therapists were different. The therapist of this study held a Master of Occupational Therapy degree, whereas the parallel

therapist held a Bachelor of Occupational Therapy degree. Both therapists were trained in the use of the SIGA, but the therapist of this study wrote goals that were more diverse, more client-centered, and more occupational. The parallel therapist wrote goals for the participants that appeared to be based somewhat on pre-fabricated goals. Another difference was that the other study took place at a SNF connected to a larger facility providing various levels of care. Therefore, the transition from the SNF to the post-discharge site might have been less stressful in the other study. Finally, the interviewing styles of the two investigators varied. The investigator of this study may have built more rapport with the participants because she was the one who administered the informed consent. Therefore, the study may have been explained more clearly.

### ***Limitations***

There were limitations to this study that could have influence the findings. The sample size should have been larger to give a more representative sample. The occupational therapist may have needed more instruction and practice administering the SIGA. The time period for collecting data should have been longer; ideally, data should have been collected until there no new themes could be seen in the data (Strauss & Corbin, 1990). The investigator did not have much experience interviewing older adults prior to this study. According to grounded theory, the more experience the investigator has, the more valid the results (Strauss & Corbin, 1990). According to the principles of grounded theory, prolonged engagement with the participants increases the richness of data collected. Due to time constraints, the investigator was not able to spend time with the participants outside of the interview. Future study should follow patients from admission to discharge and then to the post-discharge situation.

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**Table 1. Characteristics of participants.**

<b>Gender</b>	<b>Age</b>	<b>Diagnoses</b>	<b>Prior Housing</b>	<b>Planned Discharge Housing</b>
F	70	Left Ankle Pain Charot Marie Tooth	Apartment (Alone)	Long Term Care
M	85	Right Total Hip Arthroplasty	House (Alone)	House
F	95	Left Acetabulum Fracture	House (Alone)	Extended Care Facility
F	90	Right Hip Fracture Degenerative Joint Disease	Extended Care Facility	Extended Care Facility
F	90	Infiltrate Right Lung Base Osteoporosis	House (Alone)	House
F	85	Right Total Knee Arthroplasty Degenerative Arthritis	House (Alone)	Son's House
M	91	COPD MI, CAD, HTN	House (Lived with son)	Long Term Care
F	82	Parkinson's CVA, COPD	House (Lived with spouse)	Long Term Care
F	84	Left Hip Fracture Osteoporosis, Parkinson's	House (Alone)	House
F	83	History of Falls	House (Lived with son)	House
M	85	PVD Renal Failure	House (Lived with spouse)	House

**Table 2. Questions asked by the primary investigator.**

Do you remember making these goals? (Goals are presented to the participant)

Did your therapist help you identify your goals?

-If yes, how did your therapist help you?

Did you have enough time to decide what goals you wanted to work on?

Are these your own goals, as opposed to what other people want for you?

Did you change your goals?

**If yes:**

Why did you change your mind about your goals?

How do you feel about your goals?

When did you change your mind about your goals?

Did you talk about it with anyone? Who? When?

What have you been doing here? Have things been easier or harder than you thought they'd be? Why? Please tell me about the details.

Have you thought of any other reasons why you changed your goals?

**If no:**

Why didn't you change your mind about your goals?

How do you feel about your goals?

Did you talk about it with anyone? Who? When?

What have you been doing here? Have things been easier or harder than you thought they'd be? Why? Please tell me about the details.

Do you think that you will change your goals in the future?

**Table 3. Participant's self-identified goals and ratings.**

<b>Goal</b>	<b>SIGA Rating</b>
1. Get self in and out bed.	3
2. Standing longer for grooming task.	3
1. Dress himself.	5
2. Walk to workshop.	3
1. Dress self.	3
2. Ambulate into kitchen and bathroom.	3
1. Dress self.	4
2. Transfer to toilet.	0
1. Independent with dressing.	8
2. Independent getting to bathroom.	8
1. Be able to dress herself.	5
2. Be able to walk to the bathroom independently.	1
1. Independent with dressing.	2
2. Independent getting to the bathroom.	2
1. Independent with getting to bathroom.	5
2. Stand for longer period of time with ADL tasks.	3
1. Independent with dressing.	5
2. Independent with home management.	6
1. Independent dressing self.	4
2. Independent walking to bathroom.	1
1. Walk to bathroom independently.	0
2. Get in and out of bed independently.	0



**Table 4. Categories generated through open coding.**

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1. Influences on goal setting process	a. Therapist influence	I. Provide suggestions ii. "Expert" iii. Collaboration
	b. Family influence	i. Support ii. Decision maker
	c. Knowledge of occupational therapy	
	d. Other patients	
2. Prior life	a. Prior roles	
	b. Living situation	
3. Forward thinking	a. Living situation	i. Home ii. Children
	b. Caregivers	
	c. Limitations	
4. Want to go home		
5. Levels of knowledge about current situation	a. Limitations	i. Compensations ii. Modifications
	b. Disease progression	
6. Some have goals, but expect others (medical team) to do work	a. Passivity	
7. Confusion	a. What is a goal versus a method?	
8. Influence of memory impairment	a. Validity of answers	
9. Time to process personal needs/wants	a. Prior to SNF admit	
	b. During initial occupational therapy evaluation	

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**Figure 1. A structural model using the conceptual framework of therapeutic occupation in axial coding.**

