The process of identifying goals among patients in skilled nursing facilities: a grounded theory investigation

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Submitted by: Jessica Cray

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

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Attachment: Abstract

Final Approval of SP MOT
The Process of Identifying Goals Among Patients in Skilled Nursing Facilities:

A Grounded Theory Investigation

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Abstract

Patient involvement in the goal setting process is important in occupational therapy in order to identify goals that are meaningful and purposeful to each patient. Occupational therapists also have an ethical responsibility to involve patients in the goal setting process. There are several assessments available, such as the Canadian Occupational Performance Measure and the Self-Identified Goals Assessment (SIGA), to help patients address goals that are important to them. The purpose of the study was to investigate why some patients change their goals, and why others remain committed to their original goals. The study used the grounded theory qualitative approach. Data were collected on ten patients with neurological and orthopedic impairments in a Northwest Ohio skilled nursing facility. An occupational therapist administered the SIGA to newly admitted patients. The investigator then administered a semi-structured interview within 48-72 hours of SIGA completion. Data analysis included open coding to develop categories, axial coding to define causal conditions using the Conceptual Framework for Therapeutic Occupation, and selective coding for theoretical formation. No participants wished to change their self-identified goals. Influences on goal setting included family, the facility, future living possibilities, and especially the occupational therapist. SIGA goals were perceived as instrumental toward the ultimate purpose of returning home.
The Process of Identifying Goals Among Patients in Skilled Nursing Facilities:

A Grounded Theory Investigation

Patient involvement in the goal-setting process is important in occupational therapy in order to identify goals that are meaningful and purposeful to each patient. According to the *Occupational Therapy Code of Ethics* (2000), “Occupational therapy practitioners shall collaborate with service recipients or their surrogate(s) in setting goals and priorities throughout the intervention process” (p. 614). In addition to the ethical rationale, there is a regulatory rationale. The Joint Commission on Accreditation of Healthcare Organizations requires active patient participation in goal setting and rehabilitation planning (1997).

Gagne and Hoppes (2003) addressed the issue of patient involvement in occupational therapy goal setting. They used a quasi-experimental design to examine the effects of goal-focused therapy on patient performance in occupations of daily living. Patients ($N=31$) from a rehabilitation hospital were assigned to either the experimental or control group. Each patient was measured on the Functional Independence Measure (FIM) at admission and at a two-week follow up appointment. The experimental group had possibly greater mean gains on all self-care occupations; however, only upper-body dressing demonstrated statistical significance (Gagne & Hoppes, 2003).

Although little research has addressed whether patient involvement in occupational therapy goal setting enhances outcomes, Pollock (1992) theorized that active client involvement in goal setting increases motivation to participate in the therapeutic process, thereby increasing the likelihood the client will be able to overcome difficult challenges in therapy. Nelson (1997) argued that patient involvement in goal setting is important and advocated research to attain a better understanding of this phenomenon.
McAndrew, McDermott, Vitzakovitch, Warunek, and Holm (1999) used a 5-point Likert scale to study patient and occupational therapist perceptions of the collaborative goal setting process. They found that therapists tend to have positive feelings towards collaborative goal setting, while patients tend toward neutrality on this issue; however, these authors also found that patients experience positive feelings when therapists affirmed goals that were important to them (McAndrew et al., 1999).

Patient involvement in goal setting has also been discussed in other health care professions. In nursing, a quasi-experimental study compared two methods of goal setting: mutual goal setting and nurse-determined goal setting. This study generated pilot data indicating that patients involved in mutual goal setting have better outcomes than patients involved in non-mutual goal setting (Czar, 1987).

Several factors have been identified that might influence the goal setting process. The first is the quality of the therapeutic relationship (Lyons, 1994). Lyons emphasized the importance of establishing “a context for interaction that facilitates rather than inhibits clients’ full participation in any decision making” (p. 28). One way to do this is by establishing rapport with the patient without overwhelming the person with a series of personal questions. A second factor is patient motivation (Treishmann, 1990). Treishmann suggested that a passivity-reinforcing environment might cause a lack of patient motivation; therefore, modifying the environment to encourage patient self-determination may be a solution to this problem. The third factor is learned helplessness (Raps, Peterson, Jones, & Seligman, 1982). Learned helplessness may be one reason why some patients view therapists as all-knowing experts in goal setting and themselves as incapable of setting their own goals.
The patient goal setting process was the focus of a single case qualitative research study. Barclay (2001) used in-depth interviews and patient observations to study the goal setting process between an occupational therapist and a patient with a spinal cord injury. This study determined that the patient goal setting process is influenced by the patient’s past experiences, his concept of independence, his understanding of goals, and use with a shared, understood language (Barclay, 2001).

Northern, Rust, Nelson, and Watts (1995) used audiotapes of patient evaluations, occupational therapy interviews, and a patient participation evaluation form to examine whether or not occupational therapists involved clients and their families in the goal setting process. The study found that clients and their families are involved in the goal setting process; however, they are not certain of their precise roles in the process.

Neistadt (1995) surveyed occupational therapists in an adult physical disability setting to determine the methods that they used when assessing their clients’ goals for therapy. The results indicated that although the therapists consistently note client’s priorities, they do so mainly through informal interviews. Although informal interviews are important for establishing rapport, Neistadt argued that formal procedures for assessing clients’ goals should be used to ensure that clients’ address goals that are truly important to them. The Canadian Occupational Performance Measure (Law et al., 1990) and the Self-Identified Goals Assessment (Melville, Baltic, Bettcher, & Nelson, 2002) are two standardized goal assessments used in occupational therapy.

The Canadian Occupational Performance Measure (COPM) is an “individualized measure that is client-centered, generic (that is, not diagnosis specific), and crosses developmental stages” (Law, 1990, p. 34). It is a standardized assessment that consists of a five-step process based on a semi-structured interview. It allows patients to identify performance areas that are important to
them and rate them on their importance, performance, and satisfaction. The COPM is designed to be used by most occupational therapists, except those who work in very specialized areas.

The COPM has been tested for reliability and validity. Law and Stewart (1996) found that the COPM had good test-retest reliability for Performance and Satisfaction. Construct validity and criterion validity were evaluated using a multivariate analysis with the Satisfaction with Performance Scaled Questionnaire, the Reintegration to Normal Living Index, the Life Satisfaction Scale, and the Perceived Problem Check List. The results showed that the COPM is significantly related to these four measures (McColl, Paterson, Davies, Doubt, & Law, 2000).

The Self Identified Goals Assessment (SIGA) was developed because United States subacute care settings require briefer assessments than the COPM. The SIGA is designed to be used by occupational therapists working in subacute rehabilitation and skilled nursing facilities. The SIGA is meant to “help the patient identify personally meaningful occupational goals to be addressed in therapy and to evaluate changing levels of patient-defined success in desired occupations” (Melville, Baltic, Bettcher, & Nelson, 2002, p. 650). The therapist interviews the patient to help the patient identify meaningful and purposeful areas that need improvement.

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. Therapists found the SIGA to be clear and useful. 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 therapists 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.
A study by Melville, Baltic, Bettcher, and Nelson (2002) investigated 30 patients’ perspectives of the SIGA using a four-step process. The process included structured interviews about the usefulness of post-admission and pre-discharge administration of the SIGA. The post-admission interview was given within 48 hours of an occupational therapist administering the SIGA. The results confirmed that 29 of the 30 subjects said that they recognized their own goals.

Interestingly, Melville et al. found that ten of the subjects wanted to change their goals within 48 hours. These results suggest a need to determine why patients who set their own goals want to change them. Qualitative research methods may be used to investigate why some patients change with 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.

The current study uses a grounded theory approach. This approach was chosen because it allows the researcher to “begin with an area of study and allows the theory to emerge from the data” (Strauss & Corbin, 1998, p. 12). The area of study is the process by which patients make and perhaps alter their goals for therapy. Needed is a grounded theory to explain this phenomenon.

**Method**

**Participants**

The subjects were recruited by an occupational therapist in the skilled nursing facility of the Lutheran Village at Wolf Creek in Toledo, Ohio. The inclusion criteria were (a) age of 50 years old or older, (b) new admission to the skilled nursing facility, (c) stay in the skilled nursing facility equal to or longer than 5 days, (d) referral to occupational therapy services by a physician, (e) participant ability to complete the SIGA, (f) participant ability to sign informed consent, and (g) availability for a semi-structured interview within 48 to 72 hours after completing the SIGA.
Four males and seven females gave informed consent, but one subject was unable to complete the interview because of memory impairments that interfered with the subject’s ability to answer the questions. Therefore, the final sample size was 10. The subjects’ ages ranged from 76 to 90, with the mean age being 83.4 ($SD = 4.6$). Subject demographics are described in Table 1.

The data for this study were collected at The Lutheran Village at Wolf Creek, a skilled nursing facility in Northwest Ohio. A parallel study conducted by another student investigator was conducted at The Lutheran Memorial Home, another skilled nursing facility in Northwest Ohio. The advantages to having a parallel study include triangulation across investigation sites, across subjects, across investigators, and across occupational therapists administering the SIGA. According to the principles of grounded theory, triangulation increases the validity of the study.

**Instruments**

The protocol for the SIGA is available on the World Wide Web (Melville & Nelson, 2001). The therapist and the patient engage in a semi-structured interview about home environment, prior functioning, and interests. Then the therapist asks the patient to identify occupations that “you would like to work on or improve in therapy before you go back home” (Melville, Baltic, Bettcher, & Nelson, 2002, p. 653). The patient attempts to identify up to four goals, which the therapist records. If the patient has trouble identifying goals, the therapist asks whether the patient feels prior routines will be difficult now.

Once the patient has identified goals, the therapist asks the patient a general question: “How well can you do all of the things you want to do 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, p. 653). The therapist shows the patient a visual analog scale that has 0 to 10 in large print associated with smiling and unsmiling faces to help the patient interpret the meaning of the scale.
Prior to beginning the study, the occupational therapist involved in the study received training on administering the SIGA. The therapist explained the research study to and requested informed consent from the potential subjects. The SIGA was administered by the therapist within 48 hours of the patient’s admission to the skilled nursing facility. The therapist then provided the investigator with the subject’s name, room number, and available times for the interview. The interview was conducted within 48 to 72 hours after administration of the SIGA. The investigator conducted the semi-structured interview in the patient’s room or another quiet area of the skilled nursing facility. The interview was audiotaped and transcribed.

The initial interviews used prefabricated questions with the option for the investigator to add additional questions as needed. Table 2 lists the planned questions that were used. The questions were designed to bring out similarities and differences among the subjects. The subjects’ answers to the questions gave the researcher new insights into the problem and allowed the researcher to modify the questions mid-study as deemed appropriate. For example, during the study, the investigator found that the initial subjects did not want to change their goals. Based on this information, the investigator then added the question mid-study, “Would you like to add to your goals?” to address the theme that emerged during the initial interviews. The ability to modify questions mid-study is important in order to address themes that emerge from the data.

The transcripts were analyzed according to grounded theory procedure. First, the information was broken down into separate ideas or thoughts, referred to as concepts. A name was then given to each concept. This process is called open coding (Strauss & Corbin, 1998). Once the concepts were identified, they were developed more by an active search through the data for
positive and negative examples of the concept. For example, if a concept was named “hope,” a search was made for indicators of hope as well as indicators of despair.

Theoretical sensitivity was incorporated into the interview and data analysis in order to “see” what was in the data. According to Strauss and Corbin (1990, p. 41), theoretical sensitivity is “awareness on the part of the researcher, of the subtleties of the meaning of the data.” The investigator needs to be able to give meaning to the data and separate what is relevant from what is not. In the current study, theoretical sensitivity was achieved through review of literature sources, professional and personal experiences of the researcher, and peer review. Once the data were transcribed, the principal investigator, peer investigator, and advisor were given copies of the transcription. The peer investigator independently open coded the transcripts. From this, a tentative list of categories and subcategories was developed. Coding was re-assessed in meetings with the research advisor. During the meetings, the investigators and research advisor collaboratively reorganized the categories and subcategories into a final list.

The next step in analyzing the data was axial coding. According to grounded theory principles, this involves putting the data back together in new ways by making connections between categories (Strauss and Corbin, p. 96). Axial coding focuses on identifying 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).

During the axial coding process, the traditional terms used in axial coding were translated into terms used in the Conceptual Framework of Therapeutic Occupation (CFTO) (Nelson, 1994). Occupation is the heart of the profession of occupational therapy. In the CFTO, Nelson (1994, p. 10) has defined occupation as “the relationship between an occupational form and an occupational
The Process of Identifying Goals

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). According to the CFTO, a person has a developmental structure, which consists of sensorimotor, cognitive, and psychosocial abilities and characteristics (Nelson, 1994). Meaning has already been mentioned as an essential part of self-identified goals. Nelson (1994, p. 21) defines meaning as “the entire interpretive process in which an individual engages when encountering an occupational form.” Meaning also includes the client’s interpretation of the physical and the sociocultural features of the occupational form. Purpose is another important term in self-identified goal setting. 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 (p. 23). Grounded theory terms causal condition, phenomenon, context, intervening conditions, and action strategies were translated into the CFTO terms occupational form, meaning, developmental structure, and purpose. Consequences were translated into occupational performance, impact, and adaptation.

After open coding and axial coding were done, selective coding systematically integrated the categories to form a grounded theory (Strauss & Corbin, 1998). Selective coding is a 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). The formed theory was confirmed by the data collected by the peer investigator, who conducted a similar study in another skilled nursing facility.
Results

None of the subjects wished to change their self-identified goals that they identified on the SIGA 48-72 hours after making them. Therefore, the analysis explored how the subjects identified their goals and why the subjects did not want to change their goals. Their self-identified goals and SIGA ratings are presented in Table 3.

The categories and subcategories that were identified during open coding are presented in Table 4. The results of axial coding, which explain the causal relationships between occupational form, developmental structure, meaning, and purpose, are presented in Figure 1.

Concept 1: Occupational Form

This concept includes everything in the subject’s environment that affected the subject’s ability to set goals. In this study, it was found that the people who had the most influence on the subject’s ability to set goals are the occupational therapist and the subject’s family members.

The facility that was used for recruitment of subjects had several occupational therapists; however, only one occupational therapist was involved in the study. The therapist involved in this study had her personal style for conducting initial evaluations and helping patients identify their therapy goals.

The subjects saw the occupational therapist as having the expertise and education to help them set attainable goals. One subject said that the occupational therapist “knows how to make people better…she does it all the time.” Several of the subjects felt that the occupational therapist collaborated with them during the goal setting process. For example, when asked whether the occupational therapist helped to identify goals, one subject stated, “Yeah, she helped me elaborate on them somewhat. I mentioned, for example, that I didn’t want to be a burden to somebody, my family. She asked whether I thought increasing my self-care would help.”
Family members were influential to the subject throughout the rehabilitation process. When a subject asked whether her family members would set similar goals, she stated, “I think she would want the same things as me. I want to get out of here really bad and my daughter understands that.”

On the other hand, family members may not be able to provide support to the patient. One reason may be that the family member is too ill to provide the necessary support. A subject stated that “my husband would never be able to set goals for me. He has never been the type to do things like that. I worry about him sometimes. He’s here too—a few doors down.” Another reason family may be unable to provide support is that they are busy with their commitments. When one subject was asked whether or not she had talked to anyone about her occupational therapy goals, she said, “No, I haven’t had very many visitors. My children are busy with work and their children.” Another subject said, “I just don’t have much family left. They live around here, yeah. They visited me earlier. Didn’t stay too long though—they’re busy.”

Having enough time to process what the subject wants to gain from occupational therapy is an important part of the occupational form. A majority of the subjects felt that the occupational therapist allowed enough time during the initial evaluation in order for the subjects to set their self-identified goals. When asked if there was enough time in the initial evaluation to identify goals, one subject stated, “Oh yeah, we had enough time. We came back here to talk. She didn’t hurry me or put a deadline on anything.” There were a few subjects who felt that there was not enough time allotted during the initial evaluation to set goals. During the initial evaluation of one subject, a storm interrupted the evaluation. This subject said “[The tornado] happened in the middle of this, and we all had to go into the hallways. The occupational therapist had to go move people, so I guess I was a little rushed.”
The time clients have to think about their therapy goals does not happen only during the initial evaluation. Clients who have been hospitalized for a period of time may have used that time to reflect on what they want to gain from their therapy. One subject stated that she had time during her hospitalization to think about her goals prior to her admission to the skilled nursing facility.

The available discharge environment also appears to influence the goals that the subject sets. If the planned discharge environment is to return home, the subject’s goals may differ from those of someone who plans to be discharged to an extended care facility. When one subject was asked why he set the goal of increasing his independence with self-care, he stated “I don’t want to be a burden to my wife when I go home.”

**Developmental Structure**

This concept includes anything that is within the subject that influences self-identified goals. The primary diagnoses that caused the subjects to be admitted to the skilled nursing facility were mostly acute conditions that varied from neurological to orthopedic disorders. Depending on the diagnosis, the disorders affected upper extremity movement, lower extremity movement, or endurance. The secondary diagnoses tended to be chronic disorders. The chronic disorders affected the subjects’ premorbid level of functioning, which influenced how independent they were prior to admission to the skilled nursing facility. For example, one subject with a secondary diagnosis of Parkinson’s disease said, “I feel that if I could stand to the point of not falling over and always grabbing something with my hands…but I know that there are times when I will lose my balance. I have Parkinson’s disease, which has created a problem with my mobility.” This subject understood that her falling due to her Parkinson’s disease was a premorbid condition that would still be a factor to deal with after her rehabilitation.
A subject’s prior life roles influence what he or she deems as important in life. For example, one subject led a very active lifestyle and had a strong desire to return to an active lifestyle. She stated, “I was very active. My balance makes things harder now. It’s hard to exercise when you can’t balance.” In an effort to return to her active lifestyle, this subject identified goals that dealt with her physical deficits.

A subject’s knowledge about his or her current abilities may put limits on what his or her self-identified goals are. For example, a subject stated, “I also have Parkinson’s disease, which creates a problem with mobility…I have two things to battle here.” Her insight into her disease allowed her to take its progression into consideration when identifying her goals.

Each subject’s personality affected how committed he or she was to the goals that were set. Some of the subject’s had assertive personalities that were communicated in the interview. A majority of the assertive subjects voiced strong opinions about goal-setting. For example, one subject stated that “Once you set your eye on what you call goals, plunge ahead with it—don’t look back.” On the other hand, several of the subjects had more passive personalities, which became evident during the interview process. A majority of these subjects took a more passive role in the therapeutic process and felt less strongly about their goals. As one subject stated, “I really don’t think about them [goals] a lot.”

A subject’s ability to hear the occupational therapist and the investigator impacted the responses that the subject gave. For example, if the subject did not hear a question, he or she may have simply replied with a yes or no answer because he or she did not want to ask the therapist to repeat herself.

A subject’s memory ability also influences the extent to which he or she is able to participate in the goal setting process. In order to set realistic goals, the client should be able to
recall prior roles; prior, current, and future living situations; and the potential support system. During the interview that was terminated due to the subject’s memory impairment, the subject was asked an orientation question of “Do you know where you are at right now?” The subject responded, “My granddaughter’s house.” How could this subject reliably recall accurate information in order to set relevant occupational therapy goals? The validity of the information gained from a subject with memory impairment is questionable. If a subject is unable to remember setting goals, how can he or she answer the questions about those goals accurately? For example, when one subject was asked if she remembered making her therapy goals, she responded, “Not really…only a little.” If she was having difficulty remembering the goals she made for therapy, the validity of her responses to the questions may be uncertain.

Meaning

The meanings that have been inferred are based on the analyses of the interviews and the information previously described in the sections on occupational form and developmental structure. Several of the subjects feared being a burden on their family or caregivers upon discharge from the skilled nursing facility. One subject explicitly stated, “I don’t want to be a burden to my wife.” On the other hand, other subjects did not explicitly state fears of being a burden; for example, one subject responded, “If I can accomplish these goals, then I think I will be okay to go home.”

The subjects saw the occupational therapist as an expert who had the knowledge and experience to know how to set good goals that would enable to the subject to achieve their overall purpose of returning home. One subject felt that the occupational therapist “knows how to make people better—she does it all the time.”

The subjects’ understanding of the role of occupational therapy also could influence the meaning behind the goals. If the subjects did not understand that occupational therapy values
incorporating meaningful occupations into treatment, then their goals may have had little meaning to them. However, the more the subject understood the purpose and values of occupational therapy, the more meaningful their set goals appeared to be.

Ultimate Purpose

Please refer to Figure 1, to see how purpose is the end result of meaning, which in turn is the combination of occupational form and developmental structure. The ultimate purpose of the subjects’ was to return home. One subject stated “All I want is to be back in my own apartment soon.” Their desire to return home was based on their ability to think about future life situations. For example, when one subject was asked whether or not she would like to change her goals in the future, she replied, “Oh, they probably will. I don’t know what they would change to. I know that when I leave here I’m going over to next door. To the apartments and I’ll be there.”

Instrumental Purpose

Each of the goals that the subject set could be seen as methods that needed to be achieved before obtaining the overall purpose of returning home. When one subject was asked why being able to walk was important to return home, she said, “I have a red Lazy Boy chair at home and I need to walk to it. It’s new—hardly used yet. Walking is very important.” The subject set goals in order to please the occupational therapist because the occupational therapist was seen as being responsible for allowing the subject to return home. When the subject achieved a goal, the therapist could concretely measure the gains that the subject was making in therapy. The subjects hoped that after achieving their goals, the occupational therapist would feel that they had made enough gains and would be able to return home. While one subject was talking about reasons for not changing her goals she said, “If she [occupational therapist] helped me, then that means they are probably good. If I can achieve them, then I will be able to go home.”
Setting goals also helped the subject avoid staying in the skilled nursing facility for longer than necessary. If the subject and the therapist had no end point to work toward, then it would be difficult to determine exactly when the subject was functioning well enough to return home.

**Discussion**

Figure 1 depicts how purpose is the end result, which comes out of meanings. Meanings, in turn, derive from a combination of occupational form and developmental structure. In this study, occupational forms could include helpers, such as nurses; experts, such as physicians; a strange environment; and family as visitors. This combination of occupational forms is a radical change from what the person was used to. The person wants simplicity, as summed up in the word "home," instead of staying in this facility, which is seen as a radical change. Although the subject does not know exactly how to get there, he or she may see the SIGA as one step toward returning to simplicity. Going home may not solve all of the patient’s problems; however, it may help him or her cope with the chaos that he or she is experiencing.

The subjects were more interested in the end result, which in this case is returning home, than they were with the means to get to the end. The subjects identified goals that would enable them to return home. For the most part, the subjects did not want to become independent; they just did not want to be a burden. A majority felt that if they met their goals, then they would be able to return home. When a subject was asked why she did not want to change her goals, she replied, “I think that those are the most important ones. If I can do those, I can go home.”

Although several subjects expressed a strong desire to return home, some subjects never spoke about returning home. Two of the subjects’ discharge environments were different from their prior living situation. The subject who was going from living in a house to living in an extended care facility did not express desire to return home. Was this because she did not view the extended
care facility as home? Or did she view her stay in the extended care facility as temporary until she was able to return home? Would she have expressed a desire to return home if she were returning to her prior living situation? Or was returning home just not important to her?

The question “Are these your own goals?” which was asked during the interviews, elicited a yes or no response from the subjects. A review of the summary of the subjects’ goals reveals an interesting phenomenon: even though a majority of the subjects felt that they had set their own goals, the goals for all subjects were very similar to each other, with several exact matches. For example 7 of the 11 subjects had the goal of increasing their strength. This suggests that the answer to this question may not be a simple yes or no answer. For example, one subject who said that the occupational therapist did not help him set his goals later said that the occupational therapist “gave me some choices [for goals] like multiple choice.” Although the occupational therapist did not help this subject set all of his goals, she did have some input into the goals that were set. Another subject said that she “more or less made them [goals] on my own.” However, this subject’s goals were almost identical to those of the other subjects in the study. Did the “more or less” mean that the occupational therapist contributed some to setting the goals?

Although the occupational therapist was seen as having the background to set realistic goals for the subject, patients saw their own ideas and input from the family as crucial because they are experts in what needs to be done so the subject can be discharged to the desired environment. One subject set the goal of wanting to dress herself because “I don’t like having some watching me [get dressed]. I sure do miss my privacy.” For this particular case, the occupational therapist may have thought that a home health aide could help the subject with dressing; however, the subject who is the expert on herself, felt that being able to dress herself was a high priority for discharge to home.
The results from this study are similar to the results from a parallel study conducted during the same time frame, but at a different skilled nursing facility. However, there are also some differences between the two studies to discuss. The diagnoses of the subjects in this study were varied, with both neurological and orthopedic disorders. However, in the parallel study, most of the subjects’ primary diagnoses were orthopedic. Having a variety of diagnoses in this study allowed for a more diverse population. Even though this population had a variety of diagnoses, overall, the purposes in this study were similar to those in the parallel study. For example, each subject expressed the desire to have a speedy recovery, despite his or her diagnosis.

Figure 1 in this study is similar to a figure in the parallel study. However, there are some differences between the two figures. The occupational form for the parallel study included other patients. Although there were other patients in this study’s facility, the occupational therapy evaluation took place in the subject's private room. Based on the interviews, the subjects in this study did not participate in groups where there would be opportunities to meet other patients. Therefore, the influence that the other patients had on their occupational form was minimal. Another difference is that the subjects in the parallel study had confusion as to what a goal is. None of the subjects in this study expressed confusion over the meaning of a goal. Why was there a difference in the understanding of a goal between the two samples? Did one receive a better explanation of a goal or was one explanation so detailed that it only confused the subjects?

Both facilities in the studies had the same religious affiliation. However, the facility in this study included units for independent living, assisted living, and extended care, all within the same community as the skilled nursing facility. The subjects had the ability to move from place to place within the same complex when they required more or less assistance with caring for themselves. The other facility was a stand-alone skilled nursing and extended care facility. The subjects there
did not have the option of moving to another place within the same complex when they required more or less care. Therefore, the subjects in the other study may have experienced more drastic changes in their occupational forms than the subjects in this study. Although the subjects in both studies expressed a desire to return home, the desire in the parallel study to return home was especially intense. In this study, the subjects who wanted to return home stated their desire once during the interview. On the other hand, several of the subjects in the parallel study expressed the desire to return home more than once during the interview.

Although both occupational therapists involved in the two studies were licensed in the State of Ohio and were working in skilled nursing facilities, there are important differences between the two therapists. The educational level of the therapists is different, with the therapist in this study having earned a Bachelors degree, while the therapist in the parallel study earned a Masters degree. Both therapists were trained in how to administer the SIGA; however, the goals that the therapist in this study elicited seemed less occupational than the goals elicited by the therapist in the parallel study. For example, in this study, one of the goals was “to walk better.” In the parallel study, one of the goals was “to walk to the bathroom by myself,” which is more occupational than the goal set in this study. The goals that the therapist in the parallel study elicited were more typical of the goals expected when using the SIGA.

The investigators in these two studies were both attending graduate school at the same occupational therapy school; however, there were differences in the investigators’ personalities. These differences might have influenced their interviewing styles. The investigator in this study did not conduct the initial approach of potential participants and administer the informed consent, while the investigator in the parallel study administered the informed consent. By administering the informed consent, the investigator may have been able to develop superior rapport with the subjects.
The Process of Identifying Goals

Also, the subjects in the parallel study may have received a better explanation of the study because the investigator was the one giving the explanation.

Limitations

Several limitations exist for this study.

1. Due to the limited time frame available for recruiting subjects, this small sample of convenience is not representative of all older adults in skilled nursing facilities.

2. According to Strauss and Corbin (1998), sampling should continue until “a) no new or relevant data seem to emerge regarding a category, b) the category is well developed in terms of its properties and dimensions demonstrating variation, and c) the relationships among categories are well established and validated” (p. 212). Given that most of the analysis took place after data collection, this rule of sampling was not followed. Another reason for the data collection not proceeding as planned was that the investigator had first sought permission to collect data at a different facility, but it was closed unexpectedly. It was time consuming to gain permission at a second site. Therefore, data collection was stopped at a set time period instead of at the point of data exhaustion.

3. According to the principles of grounded theory, prolonged engagement with the subjects increases the richness of the data collected. Due to time constraints, the investigator was not able to spend time with the subjects outside of the interview session. Subsequent, follow-up sessions were not practicable.

4. The experience that the investigator had with interviewing older adults was limited. According to grounded theory, the more experience the investigator has, the more valid the results.

5. The SIGA was designed to help clients elicit goals that are meaningful to them. However, the goals that were identified in this study appeared to be very similar, which is not typical of the goals
elicited by the SIGA in other studies (e.g., Melville et al, 2002). Therefore, the occupational therapist may have needed more instruction and/or practice on administering the SIGA in order to effectively for her to help her clients identify individualized, occupational goals.

**Future Study**

The results from this study are tentative. Suggestions for further research in this area include conducting the study with a larger sample size, in different skilled nursing facilities, and with different occupational therapists administering the SIGA. The central phenomenon for this study seems to be “to get back home.” Would this be found by another study? Although this study had subjects with cognitive problems, the special meanings and purposes for people with poor memory were not examined in-depth. Another study could focus on subjects with cognitive problems.

Does Figure 1 hold up as a description, or is modification needed? A grounded theory of patient goal setting is needed and possible, and the current study is a small, initial step in that direction.
References


Table 1. Characteristics of participants.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Diagnoses</th>
<th>Prior Housing</th>
<th>Planned Discharge Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>76</td>
<td>Cerebrovascular Accident</td>
<td>Condo (With spouse)</td>
<td>Condo</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Atrial Fibrillation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>77</td>
<td>Cerebrovascular Accident</td>
<td>Condo (Alone)</td>
<td>Condo</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>79</td>
<td>Hypertension</td>
<td>House (With spouse)</td>
<td>ECF</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hypothyroidism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>81</td>
<td>Cellulitis</td>
<td>Assisted Living (Alone)</td>
<td>Assisted Living</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Congestive Heart Failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>83</td>
<td>Phlebitis</td>
<td>House (With spouse)</td>
<td>House</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coronary Artery Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>85</td>
<td>Atrial Fibrillation</td>
<td>Assisted Living (Alone)</td>
<td>Assisted Living</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>85</td>
<td>Gastric Cancer</td>
<td>Condo (With spouse)</td>
<td>Condo</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>86</td>
<td>Pneumonia</td>
<td>ECF (Alone)</td>
<td>ECF</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chronic Obstructive Pulmonary</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>87</td>
<td>Great Vein Anomaly</td>
<td>Apartment (Alone)</td>
<td>Assisted Living</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Congestive Heart Failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>90</td>
<td>Coronary Artery Disease</td>
<td>House (With child)</td>
<td>House</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chronic Obstructive Pulmonary</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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?

<table>
<thead>
<tr>
<th>If yes:</th>
<th>If no:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why did you change your mind about your goals?</td>
<td>Why didn’t you change your mind about your goals?</td>
</tr>
<tr>
<td>How do you feel about your goals?</td>
<td>How do you feel about your goals?</td>
</tr>
<tr>
<td>When did you change your mind about your goals?</td>
<td>Did you talk about it with anyone? Who? When?</td>
</tr>
<tr>
<td>Did you talk about it with anyone? Who? When?</td>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
<td>Do you think that you will change your goals in the future?</td>
</tr>
<tr>
<td>Have you thought of any other reasons why you changed your goals?</td>
<td></td>
</tr>
</tbody>
</table>
Table 3. Participant's self-identified goals and ratings.

<table>
<thead>
<tr>
<th>Goal</th>
<th>SIGA Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase self-care</td>
<td>5</td>
</tr>
<tr>
<td>2. Increase mobility</td>
<td>5</td>
</tr>
<tr>
<td>3. Increase strength</td>
<td>4</td>
</tr>
<tr>
<td>1. Increase self-care</td>
<td>5</td>
</tr>
<tr>
<td>2. Increase balance</td>
<td>6</td>
</tr>
<tr>
<td>3. Increase strength</td>
<td>5</td>
</tr>
<tr>
<td>1. Walk by myself</td>
<td>4</td>
</tr>
<tr>
<td>2. Get my hands working</td>
<td>1</td>
</tr>
<tr>
<td>3. Make my balance better</td>
<td>6</td>
</tr>
<tr>
<td>4. Increase my self-care</td>
<td></td>
</tr>
<tr>
<td>1. Increase strength</td>
<td>5</td>
</tr>
<tr>
<td>2. Increase walking</td>
<td>5</td>
</tr>
<tr>
<td>3. Increase activities of daily living</td>
<td>5</td>
</tr>
<tr>
<td>1. Be able to walk</td>
<td>3</td>
</tr>
<tr>
<td>2. Increase balance</td>
<td>0</td>
</tr>
<tr>
<td>3. Increase strength</td>
<td>2</td>
</tr>
<tr>
<td>1. Increase strength</td>
<td>2</td>
</tr>
<tr>
<td>2. Increase endurance</td>
<td>5</td>
</tr>
<tr>
<td>3. Increase walking</td>
<td>5</td>
</tr>
<tr>
<td>4. Get better at bathing and dressing</td>
<td>5</td>
</tr>
<tr>
<td>1. Walk better</td>
<td>5</td>
</tr>
<tr>
<td>2. Get breathing and endurance better</td>
<td>3</td>
</tr>
<tr>
<td>3. Be better at getting dressed</td>
<td>4</td>
</tr>
<tr>
<td>1. Be able to walk</td>
<td>0</td>
</tr>
<tr>
<td>2. Do transfers better</td>
<td>0</td>
</tr>
<tr>
<td>1. Walk better</td>
<td>6</td>
</tr>
<tr>
<td>1. Decrease back pain</td>
<td>4</td>
</tr>
<tr>
<td>2. Stop getting out of breath</td>
<td>3</td>
</tr>
<tr>
<td>3. Increase strength</td>
<td>3</td>
</tr>
</tbody>
</table>
Table 4. Categories generated through open coding.

1. Influences on goal setting process
   a. Therapist influence
      i. Provide suggestions
      ii. “Expert”
      iii. Collaboration
   b. Family influence
      i. Support
      ii. Decision maker
      iii. Caregiver

2. Prior life
   a. Prior roles
   b. Previous medical history
   c. Living situation

3. Forward thinking about future living situations
   a. Living situations
      i. Home
      ii. Extended care facility
      iii. Children’s home
   b. Caregivers
   c. Limitations

4. Want to return home

5. Levels of knowledge about current situation
   a. Disease progression

6. Some have goals, but expect others (medical team) to do work
   a. “Sick role”
   b. Passivity

7. Influence of memory impairment
   a. Validity of answers

8. Time to process personal needs/wants
   a. During initial occupational therapy evaluation
   b. Prior to SNF admit
Figure 1. A structural model using the conceptual framework for therapeutic occupation in axial coding.

**Occupational Form**
- Influences on goal setting
  - Therapist influence
  - Family influences
- Current facility
  - Therapist
- Time to process wants/needs
  - During initial evaluation
  - Prior to SNF admit
- Future Living Possibilities
  - Home
  - Children’s home
  - Caregivers

**Developmental Structure**
- Orthopedic and neurological disorders
- Secondary diagnoses some of which are severe or chronic.
- Varying levels of memory impairment
- Varying levels of hearing impairment
- Varying levels of deconditioning
- Advanced age and frailty

**Meaning**
- Fear of being a burden
- Seeing therapist as an expert.
- Varying levels of understanding of disease progression
- Varying levels of knowledge of occupational therapy and rehabilitation.
- Forward thinking and imagination.

**Overall Purpose**
- To return home

**Instrumental Purposes**
- The SIGA goals are seen as instrumental to returning home (combination of self-care and mobility goals).
- Speedy/faster recovery
- Work for whatever they want to give me.
- To please therapist