



January 2016

A Phenomenological Study on the Perception of Occupational Therapists Practicing in the Emergency Department

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Recommended Citation

Chown, G., Soley, T., Moczydlowski, S., Chimento, C., & Smoyer, A. (2016). A Phenomenological Study on the Perception of Occupational Therapists Practicing in the Emergency Department. *The Open Journal of Occupational Therapy*, 4(1). <https://doi.org/10.15453/2168-6408.1126>

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A Phenomenological Study on the Perception of Occupational Therapists Practicing in the Emergency Department

Abstract

Background: The purpose of the study was to increase the scope of knowledge regarding the perception of occupational therapy (OT) practitioners working in the emergency department (ED). A literature review identified a gap in knowledge of OT practitioners working in the ED.

Methods: The 10 participants in this study were registered and licensed OT practitioners working at five acute-care settings with experience working in the ED in Pennsylvania hospitals. A qualitative phenomenological research study was conducted using semi-structured interviews of participants' lived experiences.

Results: Using qualitative data analysis program Atlas.ti 7®, the central themes discovered were discharge recommendations that ensure patient safety, the next step, lack of education, and factors affecting the future of OT in the ED. The roles identified by participants included performing safety assessments, recommending equipment, and education. The perception of OT practitioners regarding other health care professionals was that OT services were positive and beneficial to staff.

Conclusion: The OT practitioners reported a positive perception of their work, including quality of patient care with regard to patient safety and decreasing return visits to the ED. It is believed that OT in the ED will expand in the future; however, limitations include lack of education and physical organization of the ED.

Keywords

occupational therapy, emergency department, emergency room, qualitative, phenomenological

Cover Page Footnote

Neil Penny, Ed.D., MS, OTR/L and Lauren Buckley, MS, OTR/L and Karen Camero, Ph.D., OTD, M.Ed., OTR/L for providing us with valuable feedback and guidance.

Credentials Display

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DOI: 10.15453/2168-6408.1126

Background and Literature Review

As the occupational therapy profession advances to meet the changing needs of society, occupational therapy practitioners must pursue new practice areas to serve the needs of patients. Each year, over 136 million people visit the emergency department (ED) (Centers for Disease Control and Prevention, 2012). Emerging evidence shows that occupational therapy practitioners fulfill a variety of roles in EDs, including evaluation of functional mobility, performance of activities of daily living (ADLs), and coping abilities, and recommendation of home safety assessments (Carlill, Gash, & Hawkins, 2002). Lebec et al. (2010) found that occupational therapy practitioners have a positive impact not only on the patients in the ED but also on the multidisciplinary team. However, the exact role of occupational therapy services in the ED remains unclear and may vary based on the facility where the ED is located. The purpose of this study was to investigate the perceptions of occupational therapy practitioners regarding the roles and benefits of occupational therapy services provided in the ED.

Historically, 20% of Medicare patients are readmitted to a hospital within 30 days of discharge (Centers for Medicare & Medicaid Services [CMS], 2013). Seventy-five percent of these readmissions are considered preventable, and could potentially save CMS \$12 billion in spending. The Affordable Care Act (ACA) provides a financial incentive for hospitals to reduce readmissions. While this currently includes only a few diagnoses, the incentive will be expanded to include total hip and knee arthroplasties in the fiscal year 2015 (CMS,

2013). Occupational therapy evaluation and intervention in the ED is believed to decrease hospital admissions by focusing primarily on concerns of functional mobility, the inability to perform ADLs, deficits in coping skills, and recommendations for home safety assessments (Carlill et al., 2002). This in turn may reduce hospital spending and readmissions and create a vital role for occupational therapy practitioners on the ED team. Occupational therapy services are currently provided to patients in EDs in other countries, including Australia, Canada, and the United Kingdom (Carlill et al., 2002; Cusick, Johnson, & Bissett, 2010; Lee, Ross, & Tracy, 2001). While the scope of practice varies with each study, the evidence available indicates a positive view of occupational therapy interventions in the ED (Carlill et al., 2002; Cusick, Johnson, & Bissett, 2009; Cusick et al., 2010; Hendriksen & Harrison, 2001; Smith & Rees, 2004).

Carlill et al. (2002) conducted research in the United Kingdom to determine if the use of occupational therapy and social work providers in the ED would improve the number of safe discharges and reduce unnecessary hospital admissions. The researchers performed an audit through retrospective case-note analysis of the 209 patients referred for services in a six-month period. In the study, the occupational therapy practitioner was available full time and the social worker was available part time. After they were cleared for discharge, the occupational therapy practitioner assessed patients referred for services to determine what unmet needs still existed.

The most common services performed by the occupational therapy practitioner included mobility and ADL assessments (n = 165), liaison with a caregiver or agency (n = 128), and home visits (n = 52; Carlill et al., 2002). When appropriate, the occupational therapy practitioner also loaned adaptive equipment (AE) to the patients; in many cases, this equipment made the difference between a discharge to home versus a hospital admission. The researchers inferred that 48% of the patients involved in the study avoided hospitalization as a direct result of the occupational therapy or social work intervention provided in the ED. After occupational therapy intervention, only 18.7% of the patients required admission for continued rehabilitation, primarily because they were unable to transfer safely between surfaces or perform functional mobility; the remaining patients were safe to return home following occupational therapy (Carlill et al., 2002).

Smith and Rees (2004) explored the role of the occupational therapy practitioner in the ED. This audit study investigated 1,036 referrals to occupational therapy in the accident and emergency (A&E) department through three stages of data collection:

1. The collection of patients' details.
2. The collection of therapy details following discharge from occupational therapy services.
3. The collation of data for any readmission, such as "medical diagnosis, with classification as borderline admission or readmission, [were] reported and analyzed"

(Smith & Rees, 2004, p. 155).

Patients were "classified in terms of a perceived likely destination after immediate medical intervention, that is, discharge to home, borderline admission or admittance after discussion between the referrer and the occupational therapist" (Smith & Rees, 2004, p. 154). Smith and Rees defined borderline admission as a situation "where discharge was judged to be unsafe due to functional deficits, social or environmental reasons or slight confusion" (p. 154). In the borderline admission cases, after the initial occupational therapy assessment, an individual treatment plan was created.

Smith and Rees (2004) found occupational therapy service in the ED "remains responsive to patient need and appears to be effective in preventing unnecessary and inappropriate admission to acute hospital care" (p. 158). Over the course of the three-year study, 306 inappropriate admissions were prevented. In addition, Smith and Rees identified that only 5.8% (60) of total referrals (1,036) were admitted to the hospital in one month after receiving occupational therapy intervention and evaluation in the A&E, 83% (50) of which were "due to longstanding or acute-onset medical problems" (p. 156). Smith and Rees' study demonstrated the way in which the use of occupational therapy services in the ED considerably reduced the number of unnecessary hospital admissions, which illustrates the efficacy of occupational therapy.

No literature was found that focused on the occupational therapy practitioner's perception of roles for practicing in the ED. The majority of the studies reviewed were from countries outside of the

US and quantitative in nature. The lack of evidence indicated a gap in research for occupational therapy practice. To address this gap and determine whether practicing in the ED is a viable practice area, the following research question was formulated: What is the perception of occupational therapy practitioners who provide occupational therapy services in the ED regarding: the quality of patient care, the role of the occupational therapy practitioners, the opinion of other health care professionals, and the impact on the future of the profession of occupational therapy?

Method

Settings and Participants

To be included in the study, the participants were required to be practicing, registered, and licensed occupational therapy practitioners. The therapists worked in any department of their hospital, full time or part time, but were required to have experience in the last six months assessing or treating patients in the ED. Certified occupational therapy assistants were excluded from the study.

Procedures

After receiving IRB approval, purposive sampling and snowballing were used to identify the participants. The participants were recruited by calling and emailing occupational therapy supervisors at hospitals in Pennsylvania, Maryland, New Jersey, and Delaware where occupational therapy practitioners practiced in the ED. After receiving verbal approval from supervisors, the participants were contacted by telephone using a phone script. The participants selected the location and time of the interview according to their availability after informed consent was obtained.

The interviews took place in private, quiet rooms at the hospitals where the participants were working.

The participant interviews ranged in length from approximately 10 to 50 min, based on the responses provided to each question. The interviews began with closed-ended demographic questions to gain background information about the participants. The remaining questions were open-ended and focused on the participants' perspectives of the role of occupational therapy in the ED, how they felt other health care professionals view the role of occupational therapy practitioners in the ED, the perspective of how they affect patient care in the ED, and how working in the ED influences the occupational therapy profession. The interviews concluded with time available for the participants to add further information at their discretion.

Instruments

The researchers employed a study-specific, semi-structured interview questionnaire comprised of 30 items aimed at understanding the lived experiences of the participants practicing in the ED. The review of the literature and identified gaps were used to guide the formulation of the questionnaire items. Establishing credibility is an important factor of a research measure to determine the trustworthiness of a research study (Shenton, 2004). Face validity of the interview questionnaire was assessed by comparing each question to the research question. Furthermore, faculty members and colleagues reviewed the interview questionnaire (see Table 1).

Table 1
Interview Questionnaire

Sample Questions

Based on your experiences, what are your general thoughts on OT services in the ED?

How does your presence make an impact in the ED?

What are the limitations of OT services in the ED setting?

Do you believe an OT should be available full time and why?

How do you feel you are received by physicians, nurses, and other staff in the ED?

Do you feel that OT in the ED benefits other staff in the ED?

How do OT services in the ED benefit the patient?

What are the common recommendations or interventions you provide?

Do you believe your interventions decrease return visits to the ED?

What advice would you give to hospitals that are considering implementing the use of OTs in the ED?

Do you think there is a future role for OTs working in the ED?

Research Design and Data Analysis

We used a phenomenological approach to collect qualitative data to gain rich descriptions of the occupational therapy practitioners' lived experiences while practicing in the ED.

Phenomenology describes what all participants have in common as they experience a phenomenon, with the basic purpose to reduce individual experiences to a description of the universal essence (Creswell, 2007). An ontological philosophical assumption was employed to gain an understanding of the nature of reality for those participants practicing in the ED. Characteristics of an ontological assumption are that reality is not only subjective but also multiple, with researchers using quotes and themes from participants to provide evidence of different perspectives (Creswell, 2007). A principle of phenomenological research is to use a "minimum structure and maximum depth in practice

constrained by time and opportunities to strike a balance between keeping a focus on the research issues and avoiding undue influence by the researcher" (Lester, 1999, p. 2).

Data was gathered throughout the interviews using an audio recording device to record questions, responses, and body language; other non-verbal communication was recorded in a journal. The interviews were transcribed verbatim and the researchers checked the transcription records against the audio recording for accuracy. To ensure anonymity, a respondent identification code was used for differentiating interviews in place of personal identifiers. Data sources including transcriptions and audio files were saved on a password-protected hard drive. Participant and site locations, names, and contact information were stored in a locked box with only one researcher having key access. The information gathered was reviewed through the qualitative data analysis program Atlas.ti 7[®] to identify units of meaning and themes.

Themes are the fundamental building blocks found in research data (Bernard & Ryan, 2010) and are found both in the data and through prior knowledge of the research topic. Themes were found by reviewing and identifying the repetition of ideas, unfamiliar or familiar words, analogies, and gaps in data, and by categorizing the data obtained from the interviews (Bernard & Ryan, 2010). A large number of data categories labeled as units of relevant meaning were initially identified and then grouped to form four central themes. A unit for relevant meaning is a sub-theme that falls in the broader central theme. These central themes were

then combined to form the essence of the lived experiences of occupational therapy practitioners in the ED. All four of the researchers completed independent coding of the data, each of which were then compared and combined to create a single comprehensive codebook. Redundancies and eliminations were determined by considering the number of times the unit was mentioned as well as non-verbal communication data, which might have increased emphasis on certain units of relevant meaning and/or themes. Trustworthiness, the degree to which one can be certain that the data accurately portrays the lived experiences of the participants and the reality of the research topic (Lysack, Luborsky, & Dillaway, 2006), was maintained by member checking, reflective commentary, and triangulation. Member checking included researchers reviewing their themes and findings with the participants, as needed, to ensure that the data was reflective of the participants' lived experiences. Addressing bias through bracketing, in the form of reflective commentary, throughout the research process helped to enhance trustworthiness and reduce bias by allowing the interviewer, observer, and coders to remain aware of their changing opinions regarding the research topic and the participants.

Reflective commentary is "used to record the researcher's initial impressions of each data collection session, patterns appearing to emerge in the data collected and theories generated" (Shenton, 2004, p. 68). It was also used to help the researchers monitor their changing conclusions about the research topic, as well as monitor the efficacy of the research methodology. The

researchers all initially had a positive perception of the practice of occupational therapy in the ED. One researcher had a Level II fieldwork experience prior to beginning this study at a hospital in which occupational therapy was provided in the ED. Potential biases emerged when one participant was known to three of the researchers and another was known to one of the researchers. Addressing bias through reflective commentary throughout the research process of qualitative studies helped to enhance trustworthiness by being aware of these preconceived ideas and relationships. In addition, the researchers' opinions, thoughts, and feelings were recorded in a journal before and after each interview and transcription.

Lysack et al. (2006) define triangulation as "the use of two or more strategies to collect and/or interpret or analyze information" (p. 353). The researchers employed triangulation techniques by using multiple methods in recording and collating the verbal responses, body language, and perceived emotions of the participants during the interviews. Triangulation was also used while analyzing the data through multiple coders.

Results

The interviews for the research occurred at five hospitals with 10 participants. It was found that the lived experience differed at each hospital, providing researchers with a wide range of experiences. All 10 of the participants were located in South Central and Southeastern Pennsylvania and were licensed and registered occupational therapy practitioners. Two of the participants held bachelor's degrees and eight participants held master's degrees. Three of the participants were

male and seven were female. The participants ranged in age from 23 to 57 years with a mean age of 35.1 years. All of the participants had an acute care background, but none had any special ED training. The frequency of treating patients in the ED ranged among the participants from once every six months to three or more times per day.

Table 2

Demographic Information of Interview Sites

Site	PA County	Number of Beds	Designations
1	Delaware	300	Primary Stroke Center, Level II Trauma Center
2	Dauphin	400	Primary Stroke Center
3	Berks	647	Advanced Primary Stroke Center, Level II Trauma Center
4	Berks	180	Primary Stroke Center
5	Dauphin	551	Adult and Pediatric Level I Trauma Centers, Primary Stroke Center

Table 3

Participant Demographic Data

Age	Average 35.1 years Range 23-57 years
Education	Master's = 8 Bachelor's = 2
Gender	Male = 3 Female = 7
Mean OT experience	11.18 years
Mean ED experience	5.97 years
Mean frequency in ED	9.5 times per month

Common diagnoses the participants evaluated and treated in the ED included fractures, falls or fall risk, cranial bleeds, strokes, concussions, altered mental status, hypotension, ambulatory dysfunction, upper extremity injuries, and weakness or fatigue. Following data collection and transcription, four central themes were discovered on the subject of occupational therapy in the ED. The themes were: discharge recommendations that ensure patient safety, the next step, lack of education of the ED staff and inappropriate or premature referrals, and factors affecting the future of occupational therapy in the ED.

Discharge Recommendations that Ensure Patient Safety

The first part of the research question regarded the impact on patient quality of care when occupational therapy services are provided in the ED. The data gathered from the participants revealed a central theme for this question: providing discharge recommendations that ensured patient safety. This included recommending AE or durable medical equipment, providing patient education, home modification, and assessment of safety and functional level. The central theme is best described by one of the participants, who stated:

[I]t's a real benefit to get to see physical and occupational therapy because either the families can then get some education on ways to make caring for their loved one easier, or safer, . . . but the other side of that is, the patient can get the services they need to potentially improve their functional capacity.

Three of the participants stated that providing occupational therapy services in the ED would expedite the process of getting the patient to a rehabilitation facility or other appropriate placement. The occupational therapy recommendations for discharge helped to reduce wait times by determining the appropriate placement, which initiates the patients' transfer to that facility.

Two units of relevant meaning emerged, which included patient assessment and return visits to the ED. Regarding patient assessment, the participants reported that they assessed the patients seen in the ED through a rapid, but thorough, evaluation. Patients are evaluated and provided recommendations or equipment as necessary for their deficits, but are not provided with occupational therapy interventions in the ED. A participant stated, "The ED is not a place where you treat, you're basically doing a safety assessment, getting their basic needs met and sending them on their way, so that then they'll probably have a follow-up with outpatient or in-home therapy." Common recommendations provided to patients included education on modifications to the home environment to improve safety and decrease risk of falls or other injury. Depending on the hospital, the occupational therapy practitioner may provide appropriate AE or provide recommendations to obtain equipment and education on its use. Regarding the return visits to the ED, the practitioners had mixed feelings on whether their services decreased return visits to the ED and hospital re-admissions; some believed their role was beneficial while others felt their role had no effect.

The Next Step

Another question concerned the perspective of occupational therapy practitioners on the role of occupational therapy in the ED. According to the analysis of the results, the central theme for this question was the next step, which refers to the role of the occupational therapy practitioner helping ED staff decide a plan of action. Five units of relevant meaning emerged: availability, appropriateness, safety assessments, AE recommendations, and education. A participant stated, "When we're there, it's a positive experience because they [the ED staff] are waiting for us to help determine what's the next step for this patient." This includes determining if the patient should be admitted to the hospital, discharged for a safe return home, or transferred to a rehabilitation center.

The unit of relevant meaning of availability relates to the hours occupational therapy practitioners should be available to the ED. Nine of the participants agreed that it is unnecessary to have an occupational therapy practitioner available 24 hours a day, seven days a week, secondary to the low caseload in the ED. Appropriateness relates to the patient being an appropriate referral to occupational therapy. Many of the participants mentioned being referred to see patients in the ED that were not ready for evaluation because they were not medically cleared. Safety assessment refers to the evaluation provided in the ED; most of the participants interviewed referred to the evaluation in the ED as a safety assessment. One participant stated, "We get the chance to evaluate and see all the problems, then we get them in a safe situation." The majority of the participants also

commented that they would recommend AE if appropriate for a patient to go home independently, making this the fourth identified unit of relevant meaning. Finally, pertaining to this theme was the education of patients, families, and staff. The majority of the participants that discussed patient and family education in the ED felt it was beneficial in helping the patients return home safely.

Lack of Education of the ED Staff

The third part of the research question pertained to the occupational therapy practitioners' perceptions on how other health care professions receive occupational therapy in the ED. According to the results of the research, the central theme for this question was the lack of education of the ED staff. Four units of relevant meaning emerged: inappropriate or premature referrals, collaboration with ED staff, perception on how occupational therapy is received by the ED staff, and how occupational therapy benefits the ED. Many of the participants recommend providing more education to the ED staff, especially to the residents, on when it is appropriate to request an occupational therapy consultation. In response to the question of why occupational therapy is not being called to the ED more frequently, one participant stated that there is a "lack of education of what we do . . . lack of education to what we can do and what we can provide to a patient." In response to what changes should occur to improve practice in the ED, another participant stated, "I guess my biggest change would be the education piece and allowing [us] . . . to educate people on why we're there and what our purpose is."

Eight of the participants reported having been referred to the ED prematurely or for an inappropriate consult. The participants reported being consulted before a patient had received all of the required/recommended tests for the patient's diagnosis.

More than half of the participants reported being welcomed when called to the ED and stated that occupational therapy is received positively by ED staff. Three of the participants felt differently about how the ED staff received them, not necessarily negatively, but differently. The participants responded that the ED team may include doctors and residents, nurses, social workers or case managers, and physical therapy (PT) practitioners. According to the interviews, either a physician or a resident referred the occupational therapy practitioners to the ED. The nurses usually provided the background to the occupational therapy practitioners on the patient's status. The social workers or case coordinators worked closely with the occupational therapy practitioners in order to refer the patient to the most appropriate location, if not being admitted, and to request certain AE from the patient's insurance company, if needed. Most of the participants reported performing their evaluations in the ED with PT.

Regarding the participants' perceptions of occupational therapy benefitting the ED staff, eight of the participants reported being a benefit to the staff. One participant believed it is important for occupational therapy to be called down to the ED because they are able to see "the whole picture of a person" and decide whether a person is safe to go home. Two of the participants did not believe

occupational therapy benefits the ED staff. One of the participants mentioned there is no benefit because occupational therapy practitioners do not keep patients seen in the ED on their caseload after an initial assessment and are typically consulted to get a patient out of bed.

Factors Affecting the Future of Occupational Therapy in the ED

The fourth central theme that was identified was the factors affecting the future of occupational therapy in the ED. The majority of the participants mentioned that the changes in health care would likely contribute to the future of occupational therapy in the ED. When asked if there is a future role for occupational therapy practitioners working in the ED, one of the participants responded, “Yeah, definitely . . . We’re moving towards a more community-based health care system, we’re not admitting people as long, things like that.” Another participant stated, “It does help prevent admission to the hospital and I think that’s what hospitals are looking at today.” A different participant also referred to occupational therapy in the ED as an emerging practice area with health care changes: “As clinicians [we] need to recognize it as a growing practice area, and need to address it and need to start working toward best practices for treating patients in the ED.”

Other units of relevant meanings that emerged from this theme included organization and the physical layout of the ED as a limitation to assessing a person. A participant stated:

It is an ED, not an actual patient room, most of the time there are no bedside chairs, if a patient has to use

the restroom, we have to put them on a bedpan, which as occupational therapists is not functional. The beds are litters, not actual hospital beds, so it’s even one step further from their actual bed at home, so doing their functional mobility is difficult in the ED.

When asked their beliefs on why more occupational therapy practitioners are not currently practicing in the ED, five of the participants cited the lack of education, of both occupational therapy practitioners and other health care professionals, about the services occupational therapy practitioners could provide in the ED. One participant stated, “Probably lack of knowledge and the need for it.” While none of the participants reported receiving or being required to have any special training before consulting in the ED, five of the participants stated their hospital experience as being helpful.

Difficulties with billing for occupational therapy services in the ED was another area of concern. A participant relayed that billing sheets have to be completed, “within 24 hours, because that patient can be gone quickly and if they [went] out of the system, we lost that money, and it’s not just the money of us individually, but the accountability that we were there.” The final concern affecting the future of occupational therapy in the ED was the lack of protocol. The most common advice given by the participants to other hospitals considering implementing occupational therapy in the ED was to create a specific protocol or system for referrals. Six of the participants

mentioned organizing a system for the ED that would increase clarity regarding the occupational therapy role in the ED and decrease inappropriate or premature referrals.

Discussion

According to Fowles and Greenberg (2011), the population of older adults aged 65 years and older is expected to reach 55 million by the year 2020. As the population of older adults increases, the need for occupational therapy services in the ED may also grow. The role of occupational therapy practitioners in the ED is to ensure the patient is able to perform functional tasks safely. The occupational therapy practitioner may recommend that the patient be admitted to an acute hospital, an inpatient rehabilitation facility, or a skilled nursing facility, or be sent home with in-home services, home with outpatient services, or home without services. The occupational therapy practitioner is trained to evaluate functional ability, anticipate functional problems, and recommend adaptations to compensate for functional problems. This has a specific implication for the patient with regard to his or her discharge plan and safety.

The safety assessment is intended to give the occupational therapy practitioner and ED staff a comprehensive view of how safely the patient is currently functioning. If there are concerns regarding the patient's ability to function safely, the occupational therapy practitioner using the safety assessment can determine the level of assistance the patient needs in order to return home. A study by Burns (2001) found that of older people in the A&E department, many did not have information

and after discharge were found to be struggling to perform these activities.

For the patients that are able to pass the safety assessment but still struggle with performing certain tasks, the role of the occupational therapy practitioner is to recommend AE. Often, this equipment and the training of proper use are enough to allow an individual to return home safely. According to Carlill et al. (2002), loaning AE to patients frequently made the difference between the need for admission versus discharge to home. A participant stated that for patients who “just need a little bit of fine tuning,” such as AE, or education, the services are beneficial in allowing patients to return home safely.

An important idea that appeared in the data was the role of educating the patients. Educating patients is crucial in helping them to adapt to the sudden change that brought them to the ED. At times, educating a patient is the only adaptation the patient needs in order to return home safely. Education in the ED may also assist patients that have been experiencing a slow decrease in functional ability. This may help decrease the number of ED visits and possible hospital readmissions by addressing the functional decline of the patient.

The occupational therapy practitioners explained how they improved patient quality of care by providing recommendations that promoted safety. One of the participants reported that occupational therapy practitioners assessed what the “safety net is going to be at the time of discharge” to ensure that the patient will have the support that they need along with necessary AE. This, in turn,

may prevent the need for a return visit to the ED, or by providing the least restrictive placement potentially improve patient satisfaction and quality of care. Three of the participants mentioned that occupational therapy services provided in the ED expedited the process of admitting a patient or referring them to an appropriate rehabilitation placement. Moving patients more rapidly from the ED frees resources and space for other patients, thereby reducing the wait times. Cooke et al. (2004) named ED wait times as the most significant cause of patient dissatisfaction and made the connection that patient satisfaction is a strong indicator of the quality of care provided.

One of the participants mentioned during the interview that she listens to the concerns of the patients and their families before providing recommendations. This is in agreement with the American Occupational Therapy Association (2008), which states that a high quality of care is provided when care is individualized and considers all aspects of the patient, including client factors, performance skills, and activity demands. The participants believed that they met the psychosocial needs of the patients and their families, which had an impact on the quality of care. Attending to the psychosocial needs may include using active listening to hear the concerns of the patient and addressing concerns and anxiety.

One participant believed that occupational therapy practitioners in the ED address psychosocial needs by calming patients who are anxious and by attempting to make the area a calm, therapeutic setting for patients and their families, which may improve the perception regarding quality of care.

Kilcoyne and Dowling (2007) discussed the “unmet basic human needs” (p. 23) seen in patients treated in the ED. Nurses reported that they do not have the time or resources to see to the personal needs and concerns of the patients, and feared the patients would notice they did not seem to care about them due to their lack of time, which could result in a negative perception of the quality of care (Kilcoyne & Dowling, 2007). Another participant exemplified this concept by stating, “I like that we are consulted because it shows that they [the hospital staff] have a general concern for the patients and their well-being and leaving here.”

A majority of the participants had positive experiences collaborating with other ED staff and treating patients in the ED. The data found that occupational therapy practitioners in the ED collaborate with a variety of staff members, including physicians, nurses, physical therapists, social workers, and case managers. More than half of the participants reported feeling welcomed by the ED staff when occupational therapy was called to the ED for a consultation. The participants believed that the ED staff members received occupational therapy positively and that the opinions of the occupational therapy practitioners were respected and well received. The occupational therapy practitioners also felt that other ED staff members relied on their input regarding the patients’ care; whether the patient should be admitted, was safe to go home, or needed to go to another location for more rehabilitation. Three participants felt that occupational therapy was received in a slightly negative or neutral manner by the ED team members, mainly due to a lack of education about

the services occupational therapy practitioners could provide or by being sent to evaluate an inappropriate patient. Another participant felt that because occupational therapy consulted in the ED infrequently, there was minimal interaction with the ED staff and the experience was more neutral than positive or negative.

The occupational therapy practitioners believed that they contributed to the ED staff by discharging patients out of the ED safely and quickly. More than half of the participants reported feeling most beneficial to the social workers and case managers with regard to where the patient could be discharged. They also felt beneficial to the nurses because occupational therapy informed the nurses of what level of assistance a patient required. Two of the participants thought that occupational therapy was not beneficial to the ED staff. One participant reported that the ED staff only wanted to determine whether a patient could physically walk and be discharged home safely. Another participant stated that occupational therapy practitioners only went to the ED to get a patient out of bed.

When asked what advice they would give to other hospitals considering implementing occupational therapy services in the ED, the participants most often advised creating a specific protocol or system for referrals, staff assignment, and patient care in the ED. Six of the participants mentioned organizing a system for the hospital, which would increase clarity about the occupational therapy practitioners' role in the ED, decrease inappropriate or premature referrals, and increase the efficiency of occupational therapy staff

All of the participants agreed that there would be a future role for occupational therapy practitioners to provide services in some form in the ED. However, the occupational therapy practitioners engaging in the ED varied from nearly non-existent as a part-time consult service to a full-time position. Most of the participants felt that it was important for occupational therapy practitioners to be available in the ED at an on-call level. Half of the participants identified changing health care policies as the reason for occupational therapy services to be more in demand in the ED in the near future. The participants were also concerned with how occupational therapy in the ED would expand and become an emerging practice area if insurance companies continued to deny payment for this area of practice.

The majority of the participants, when asked if they would advocate for occupational therapy services to be provided in the ED if they worked at a location where this practice was not established, replied that they would advocate or at least support someone else who was advocating. This willingness to support occupational therapy in the ED illustrates that these participants have seen the worth of occupational therapy services for the patients, for other health care workers, and for the hospital. When asked why they believed more occupational therapy practitioners were not practicing in the ED, half of the participants cited both occupational therapy practitioners' and other health care professionals' lack of education. The participants believed that misunderstanding or misperception of the role of occupational therapy in

the ED led to decreased numbers of occupational therapy practitioners working in this area.

None of the participants received any specialized training before practicing in the ED. Training for health care professionals practicing in the ED could include increasing awareness of the role of occupational therapy practitioners in the ED, promoting physical navigation around the ED, and providing resources for use in the ED. Wilde, Starrin, Larsson, and Larsson (1993) discussed the physical-technical conditions of the ED, such as environment of the ward and availability of necessary medical equipment, as relating to and directly impacting patient quality of care. The participants in the study made this same observation, as they felt the cluttered and chaotic environment of the ED decreased their ability to relocate their therapy equipment as well as to complete a thorough and accurate evaluation.

From the four central themes, which included discharge recommendations that ensure patient safety, the next step, a lack of education of the ED staff, and factors affecting the future of occupational therapy in the ED, the perception of providing occupational therapy service in the ED was positive. The overall essence, or lived experiences, of the participants was that occupational therapy in the ED was a valuable practice and beneficial to the patients, hospitals, and communities. However, the participants shared a wide range of lived experiences in the ED. Many stated that they believed the practice of occupational therapy in the ED was necessary, but they themselves did not want to be the therapist treating patients in the ED secondary to difficulties

with the physical layout of the ED, billing concerns, a lack of a consistent protocol for referrals, inappropriate referrals for assessment, and a lack of education of other health care professionals in the ED regarding the role of occupational therapy.

The results of this study indicate that, for this sample of occupational therapy practitioners, the practice of occupational therapy in the ED may expand in the future due to health care changes. The profession of occupational therapy should be preparing practitioners to fill these potential openings in the ED. The provision of continuing education classes, feature articles, position papers, and the inclusion of occupational therapy in the ED as an emerging practice area will encourage the development of competent occupational therapy practitioners. Other steps that can be considered to further the practice of occupational therapy in the ED and the profession are for schools to include the ED as Level I and II fieldwork placements, to provide specialized training or orientation for occupational therapy practitioners working in the ED, to create a specialty certification for the ED setting, to develop a more accessible physical environment in the ED, to educate other health care professionals on appropriate referrals and the role of occupational therapy in the ED, and to educate insurance companies on the validity and efficacy of occupational therapy in the ED.

Patients, equipped with the knowledge and the AE provided by occupational therapy practitioners in the ED, may experience fewer falls and hospital admittances, which would increase their quality of life. Families would need to endure fewer hospital visits and intensive recoveries. The

hospital and ED would be less crowded with the prevention of readmissions, and insurance companies would be paying a significantly lower amount for a person to receive occupational therapy in the ED than what they pay for acute care services and/or rehabilitation admission.

Because of the lack of literature regarding the perceptions and experiences of other health care professionals working with occupational therapy in the ED, further research in this area is needed. Questions, such as do other health professionals believe that occupational therapists working in the ED improve quality of care, should be addressed. Furthermore, questions about how billing, the physical layout of the ED, and the environment impacts the lived experiences of working in the ED should be explored. Last, further research to better understand the experience of occupational therapists practicing in the ED may benefit from more participants being interviewed, and from interviewing participants working in different locations.

The major implication of this study relates to the growing need to prepare occupational therapy practitioners to work in the ED. The research found the perceptions of occupational therapy practitioners on the quality of patient care to be beneficial with regard to patient safety and decreasing return visits to the ED. The participants reported that their roles in the ED included performing safety assessments, AE recommendations, and education. The participants stated that the perceptions of other health care professionals was positive and that occupational

therapy is valuable to ED staff and may expand in the future secondary to health care changes.

References

- American Occupational Therapy Association. (2008). Occupational therapy practice framework: Domain and process (2nd ed.). *American Journal of Occupational Therapy*, 62, 625–683. <http://dx.doi.org/10.5014/ajot.62.6.625>
- Bernard, H. R., & Ryan, G. W. (2010). *Analyzing qualitative data: Systematic approaches*. Thousand Oaks (CA): Sage.
- Burns, E. (2001). Older people in accident and emergency departments [Supplemental material]. *Age & Ageing*, 30(3), 3-6. http://dx.doi.org/10.1093/ageing/30.suppl_3.3
- Carlill, G., Gash, E., & Hawkins, G. (2002). Preventing unnecessary hospital admission: An occupational therapy and social work service in an accident and emergency department. *British Journal of Occupational Therapy*, 65(10), 440-445. <http://dx.doi.org/10.1177/030802260206501002>
- Centers for Disease Control and Prevention. (2012, August 20). *Fast stats: Emergency department visits*. Retrieved from <http://www.cdc.gov/nchs/fastats/emergency-department.htm>
- Centers for Medicare & Medicaid Services. (2013). *Readmissions reduction program*. Retrieved from <http://www.cms.gov/>
- Cooke, M., Fisher, J., Dale, J., McLeod, E., Szczepura, A., Walley, P., & Wilson, S. (2004). *Reducing attendances and waits in emergency departments: A systematic review of present innovations*. Retrieved from University of Warwick Institutional repository <http://www.go.warwick.ac.uk/wrap>
- Creswell, J. W. (2007). *Qualitative inquiry and research design. Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.
- Cusick, A., Johnson, L., & Bissett, M. (2009). Occupational therapy in emergency departments: Australian practice. *Journal of Evaluation in Clinical Practice*, 15(2), 257-265. <http://dx.doi.org/10.1111/j.1365-2753.2008.00991.x>
- Cusick, A., Johnson, L., & Bissett, M. (2010). Continuing professional development for occupational therapy emergency department services. *Australian Occupational Therapy Journal*, 57(6), 380-385. <http://dx.doi.org/10.1111/j.1440-1630.2010.00874.x>
- Fowles, D. G., & Greenberg, S. (2011). *A profile of older Americans: 2011*. Washington, DC: Administration on Aging, U.S. Department of Health and Human Services. Retrieved from http://www.aoa.gov/Aging_Statistics/Profile/2011/docs/2011profile.pdf
- Hendriksen, H., & Harrison, R. (2001). Occupational therapy in accident and emergency departments: A randomized controlled trial. *Journal of Advanced*

- Nursing*, 36(6), 727-732.
<http://dx.doi.org/10.1046/j.1365-2648.2001.02038.x>
- Kilcoyne, M., & Dowling, M. (2007). Working in an overcrowded accident and emergency department: Nurses' narratives. *Australian Journal of Advanced Nursing*, 25(2), 21-27.
- Lebec, M. T., Cernohous, S., Tenborge, L., Gest, C., Severson, K., & Howard, S. (2010). Emergency department physical therapist service: A pilot study examining physician perceptions. *Internet Journal of Allied Health Sciences and Practice*, 8(1), 1-12. Retrieved from <http://ijahsp.nova.edu>
- Lee, V., Ross, B., & Tracy, B. (2001). Functional assessment of older adults in an emergency department. *Canadian Journal of Occupational Therapy*, 68(2), 121-129.
<http://dx.doi.org/10.1177/000841740106800208>
- Lester, S. (1999). *An introduction to phenomenological research*. Taunton, UK: Stan Lester Developments. Retrieved from <http://devmts.org.uk/>
- Lysack, C., Luborsky, M. R., & Dillaway, H. (2006). Gathering qualitative data. In G. Kielhofner (Ed.), *Research in occupational therapy* (pp. 341-357). Philadelphia, PA: F. A. Davis.
- Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22(2), 63-75.
- Smith, T., & Rees, V. (2004). An audit of referrals to occupational therapy for older adults attending an accident and emergency department. *The British Journal of Occupational Therapy*, 67(4), 153-158.
<http://dx.doi.org/10.1177/030802260406700403>
- Wilde, B. M., Starrin, B., Larsson, G., & Larsson, M. (1993). Quality of care from a patient perspective: A grounded theory study. *Scandinavian Journal of Caring Sciences*, 7(2), 113-120.
<http://dx.doi.org/10.1111/j.1471-6712.1993.tb00180.x>