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FEATURE ARTICLE

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Exploring occupational therapy practice in Australian residential aged care facilities: A cross-sectional survey

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Abstract

Introduction: Occupational therapy in residential aged care facilities (RACFs) can enhance residents' occupational engagement and wellbeing. However, industry reports suggest that occupational therapists in Australian RACFs have mostly provided physical therapies such as pain management via massage and not addressed residents' occupations. There is limited literature on what constitutes occupational therapists' practice in RACFs to inform policy and practice. The aim of this cross-sectional survey was to explore practice patterns of occupational therapists working in Australian RACFs and influences on their practice.

Methods: Occupational therapists working in Australian RACFs were invited from July 2019 to March 2020 to complete a self-report online questionnaire via email and advertisements on industry websites, newsletters, and social media. The questionnaire asked therapists about their caseload, referrals, assessments, and interventions. Data were analysed descriptively and presented as frequencies and percentages.

Results: A total of 214 occupational therapists completed the survey. Occupational therapists' daily practice largely focussed on pain management; other areas of practice included falls prevention, pressure care, and mobility. The Aged Care Funding Instrument in place at the time of the survey was identified as the leading factor influencing therapists' choice of assessments and interventions. Organisational policies and procedures were also perceived as key factors influencing occupational therapy practice.

Conclusion: This paper highlights the influence of government funding and organisational policies in limiting occupational therapists' scope of practice and their ability to fully address the occupational needs of residents. Occupational therapists and the profession in general should be aware of factors in aged care funding models, and their application, that restrict occupational therapy practice and inhibit residents' function and advocate for change where needed. With the introduction of the Australian National Aged Care

Classification funding model replacing Aged Care Funding Instrument, future research should explore potential changes to therapists practice following the implementation of the new funding model.

KEYWORDS

aged care, cross-sectional studies, occupational therapy, older adults, residential facilities, surveys and questionnaires

1 | INTRODUCTION

Key Points for Occupational Therapy

- Occupational therapy practice in RACFs under the ACFI model was largely focussed on pain management via therapeutic massage.
- Age care policy and RACFs need to support person-centred, occupation-focussed practice that optimises residents' function.
- Advocacy is required to highlight the full scope and value of occupational therapy services in residential aged care.

In 2020, 4.2 million Australians were aged 65 and above, comprising 16% of the total population (Australian Institute of Health and Welfare [AIHW], 2021a). Approximately 245,000 lived in permanent residential aged care (AIHW, 2021b), which provides continuous supported care for people who are unable to live independently at home (Department of Health and Aged Care, 2017a). Residential aged care facilities (RACFs) provide the highest level of aged care support services in Australia, which includes accommodation, personal care for activities of daily living, 24-hour nursing care, day-to-day support, and allied health services. RACFs are operated by non-profit, government, or private organisations (AIHW, 2022a), and while some RACFs have occupational therapists on staff, many source therapists from external organisations (Occupational Therapy Australia [OTA], 2019).

Older people residing in RACFs often experience frailty and complex health care needs as a result of chronic health conditions, including dementia and depression (AIHW, 2018). Despite their health, residents' continued engagement in everyday activities in RACFs remains crucial in maintaining their overall quality of life. In particular, their engagement in meaningful activities may reduce age-related decline and enhance functional capacity, life satisfaction, and social belonging (Cooney et al., 2009; O'Sullivan & Hocking, 2006). Yet, international studies have found that the majority of RACFs provides residents with limited opportunities for meaningful activities both within (Choi et al., 2008) and outside the facility's formal activities programme (Mozley, 2004). Residents have also reported that they miss carrying out household activities such as cooking and gardening and taking part in other activities outside of the facility, such as clubs and volunteer work (Choi et al., 2008).

Similarly, in Australia, relatives of those living in RACFs have reported that their family members enjoy a greater quality of life when they are engaged in meaningful activities that are of interest to them and suited to their physical and mental abilities (Russell, 2017). Household chores, interest groups, rehab exercise classes, and bus trips were suggested in preference to passive activities such as watching TV. Furthermore, the relatives valued skilled staff, such as occupational therapists, who they felt would be able to tailor the activities to the residents' individual interests and capabilities (Russell, 2017).

Occupational therapy as a profession is well-positioned to enhance residents' participation in everyday activities in RACFs, given its goal of promoting health and wellbeing through individually tailored occupational engagement (World Federation of Occupational Therapists, 2019). Occupational therapists are trained in both cognitive and physical assessments and, with their unique focus on the person and their life occupations, can tailor interventions directly to the person and their roles within the environment (OTA, 2019). Internationally, interventions implemented by occupational therapists working in RACFs have been found to mostly focus on engagement in occupations (Dancewicz & Bissett, 2020). Studies have included interventions to address occupations such as leisure (e.g., woodwork, gardening, and social dances), self-care (e.g., dressing and personal care), and productive occupations (e.g., mentoring students and making food items for the RACF) (Dancewicz & Bissett, 2020).

Similarly, while there is limited evidence on Australian occupational therapy practice in RACFs, a systematic review by Calderone et al. (2022a) found that the literature identified occupational engagement, important

for residents' health and quality of life, can be promoted by providing diverse occupational opportunities. Yet, a submission by Occupational Therapy Australia (2018) to the Australian government's inquiry into the care standards in RACFs revealed that occupational therapists in Australia were not providing this occupation-focussed care; instead, therapists at the time were largely delivering therapeutic massage for pain management. Given the profession's diverse scope of practice and residents' prevailing health needs, the high proportion of therapeutic massage and limited occupation-focussed care suggest that occupational therapists were underutilised in Australian RACFs.

The predominant use of therapeutic massage for pain management and the limited provision of occupation-focussed care were associated with the funding model of aged care at the time, the Aged Care Funding Instrument (ACFI). The ACFI was a tool used to assess residents' care needs, which then determined the amount of government subsidy given to RACFs based on the identified needs of residents (Royal Commission, 2019a). Under the complex health-care domain of the ACFI, RACFs secured funding for residents who received pain management via therapeutic massage or TENS machine by an allied health professional, including occupational therapists (Department of Health and Aged Care, 2017b). This ultimately influenced the scope and service provision of occupational therapy practice in RACFs (Calderone et al., 2022b). With no funding for targeted occupational therapy services, therapists in a qualitative study completed by Calderone et al. (2022b) reported that the ACFI restricted not only their practice but also the residents' opportunities to live occupationally rich lives (Calderone et al., 2022b). This pattern of care was also highlighted in a previous survey of 63 occupational therapists working in Australian RACFs, which found that therapists were constrained in their practice to deliver predetermined treatments in the ACFI such as therapeutic massage for pain management (Hubbard et al., 2019).

A new funding model, the Australian National Aged Care Classifications (AN-ACC), replaced the ACFI in October 2022 (Department of Health and Aged Care, 2022a). The model intends to have a greater focus on the broader needs of residents, with specific treatments such as massage for pain management no longer linked to funding (Department of Health and Aged Care, 2022b). However, there is no other specific funding to support the provision of allied health such as occupational therapy under the AN-ACC system.

Previous research has explored the constraints on occupational therapy practice in Australian RACFs and the experiences and perceptions of occupational therapists working under the ACFI. However, little is known about what constitutes occupational therapy practice in Australian RACFs overall. This research forms part of a larger research programme aiming to understand occupational therapy practice in RACFs in Australia over time, with this first study reporting on practice (including clinical caseload, referrals, assessments, and interventions) prior to the introduction of AN-ACC.

This study therefore aimed to describe occupational therapy practice in Australian RACFs under the ACFI funding system by exploring occupational therapists' practice patterns and influencing factors.

2 | METHODS

2.1 | Design

This study was a cross-sectional survey using an online questionnaire to explore the practice patterns of occupational therapists working in Australian RACFs 2019/2020 and influencing factors. The survey was part of a larger study investigating the delivery of occupational therapy services in RACFs in Australia over time, including the driving factors behind this, the implications for key stakeholders, and any gaps in service delivery. Ethics clearance was obtained from The University of Queensland Human Research Ethics Committee (ID 2019001011).

2.2 | Participants

To be eligible for inclusion in this study, participants were required to be occupational therapists working or having previously worked in Australian RACFs within the past 5 years. Their eligibility was determined by the second item in the questionnaire, which asked if they met this criterion and consented to proceed. If not, the questionnaire ended at this point. There were no specific exclusion criteria.

2.3 | Procedures

A convenience sampling strategy was used to maximise the number of participants. Occupational therapists were invited to participate in this study via four recruitment approaches. First, the study details and link to the online questionnaire were published on the OTA website in their newsletter. Second, an email was sent to RACFs in Australia and private allied health organisations that deliver occupational therapy services to RACFs. The email requested RACFs and organisations

to invite any eligible employed occupational therapists to participate in this study. The list of RACFs and private allied health organisations was identified through the publicly available My Aged Care website list of providers and the National Health Services Directory. Third, information regarding the study and the link to the questionnaire were posted on occupational therapy social media sites. Finally, the authors sent out email invitations to their existing occupational therapy contacts.

The email inviting occupational therapists to participate in this study included a Participant Information Sheet and a link to the secure online questionnaire. The information sheet explained that therapists could provide consent to participate in this study by answering the first question of the questionnaire. The questionnaire was made available from July 2019 to March 2020. Follow-up emails and advertisements on the OTA website and social media were distributed, reminding therapists who may wish to participate to complete the questionnaire.

2.4 | Measures

The online questionnaire for this study was developed using Qualtrics online software and was guided by past surveys that investigated the practice patterns of occupational therapists in different settings (Bennett et al., 2011; Koh et al., 2009). The questionnaire was initially pilot tested with a small group of occupational therapists working in Australian RACFs. Minor changes to the wording of a small number of questions were made in response to their feedback before the final questionnaire was sent out to potential participants. The final questionnaire consisted of 70 items and required approximately 30 minutes to complete.

The questionnaire included eight sections, four of which were reported in this paper. These included the following: (1) participants' demographics, clinical caseload, years of work experience, employer, and employment type; (2) referrals; (3) assessments, interventions, and factors influencing therapists' choice of use; and (4) ACFI. A specific section on ACFI was included in the survey as it was the aged care funding model at the time of data collection. Data were gathered using fixed response categories on a 5-point Likert scale, ranking, and open-ended questions. Likert response options for questions relating to how often referrals were received and assessments and interventions were used ranged from *never* to *always*. Likert response options for questions on influencing factors ranged from *not at all* to *a great deal* and, for ACFI questions, ranged from *strongly disagree* to *strongly agree*.

2.5 | Data analysis

Data from the online questionnaire were downloaded from Qualtrics into Statistical Package for Social Science Version 27 for analysis. Descriptive statistics and analysis using the Mann–Whitney U test were performed to compare groups of therapists employed internally by the RACF to those employed externally by private organisations. Descriptive statistics were presented as frequencies and percentages. During analysis, some questionnaire categories were collapsed due to small numbers and to enhance ease of analysis, interpretation, and reporting. Sections (2) referrals; (3) assessments, interventions, and factors influencing therapists' choice of use; and (4) ACFI were collapsed into three categories instead of five. The new categories for referrals, assessments, and interventions were 'never/rarely', 'sometimes', and 'always/often'. The questions on influencing factors were collapsed into 'not at all/a little', 'to some extent', and 'a considerable amount/a great deal'. The ACFI questions were collapsed into 'disagree', 'neither agree nor disagree', and 'agree'.

The Mann–Whitney U test was used to compare the interventions completed and the areas of occupational performance addressed by the two employment groups (those employed directly by RACFs and those employed by an external provider). This nonparametric test was chosen due to the nonnormal distribution of the data (Simpson, 2015). A significance level of $P < 0.5$ was used, and no adjustments were made for multiple comparisons due to the sample size (Rothman, 1990). Items chosen for comparison included all occupational performance areas, the five most and least used interventions, and cognitive interventions. Cognitive interventions were included in the analysis given the prevalence of cognitive impairment and dementia, within the RACFs population.

3 | RESULTS

A total of 214 occupational therapists completed all or part of the questionnaire. Due to the recruitment methods of the anonymous online questionnaire, it was not known how many therapists received the study invitation, and thus, a response rate was unable to be determined. As the survey did not require participants to answer all questions, the number of responses to individual questions varied across the survey. For instance, for the question on the types of occupational therapy groups being run in RACFs, for therapists who did not run groups, this question would be irrelevant and not answered. Therapists with incomplete responses were not excluded as missing data were inconsequential. The total number of responses gathered for each question is documented in the findings below.

3.1 | Participant demographics

Participant demographics are presented in Table 1. There was participant representation from all states in Australia except for the Northern Territory and Australian Capital Territory: Queensland ($n = 31/108$, 28.7%), South Australia ($n = 18/108$, 16.7%), Western Australia ($n = 17/108$, 15.7%), New South Wales ($n = 18/108$,

TABLE 1 Participant demographics and clinical caseload.

Participant characteristics		*n*	%
Gender ($n = 200$)	Female	192	96.0
	Male	8	4.0
Highest educational qualifications ($n = 108$)	Bachelor's degree	78	72.2
	Graduate entry masters	18	16.7
	Other	12	11.1
Region of practice ($n = 108$)	Metropolitan	65	60.2
	Regional/rural	42	38.9
	Remote	1	0.9
Employment[a] ($n = 119$)	Permanent full-time	55	46.2
	Permanent part-time	28	23.5
	Casual	9	7.6
	Contract	27	22.7
Employer ($n = 108$)	RACF	30	27.8
	External organisation	74	68.5
	Self-employed	4	3.7
Employer description ($n = 108$)	Non-profit	28	25.9
	Government	7	6.5
	Private practice	60	55.6
	Self-employed	4	3.7
	Other	9	8.3
Occupational therapy experience ($n = 190$)	≤3 years	107	56.3
	4–10 years	42	22.1
	>10 years	41	21.6
RACF experience ($n = 190$)	≤3 years	151	79.5
	4–10 years	29	15.3
	>10 years	10	5.3
Residents seen per day ($n = 161$)	1–5	33	20.5
	6–15	25	15.5
	16–20	36	22.4
	>21	67	41.6
Length of sessions ($n = 160$)	0–20 minutes	117	73.1
	21–40 minutes	37	23.1
	41–60 minutes	5	3.1
	>60 minutes	1	0.6
RACF type ($n = 107$)	Non-profit	45	42.1
	Government	12	11.2
	Private	49	45.8
	Other	1	0.9

Abbreviation: RACF, residential aged care facility.

[a]Participants were allowed to select multiple options for their employment.

16.7%), Victoria ($n = 21/108$, 19.4%), and Tasmania ($n = 3/108$, 2.8%). The majority of the participants was female ($n = 192/200$, 96.0.0%), had a bachelor's degree ($n = 78/108$, 72.2%), and worked in metropolitan ($n = 65/108$, 60.2%) areas. Despite having varying years of work experience as an occupational therapist in general, 79.5% ($n = 151/190$) had worked ≤3 years in RACFs.

Participants were largely employed on a permanent full-time ($n = 55/119$, 46.2%) or permanent part-time basis ($n = 28/119$, 23.5%) and in private practices ($n = 60/108$, 55.6%) or non-profit organisations ($n = 28/108$, 25.9%). Many of the therapists were employed by organisations external to the RACFs ($n = 74/108$, 68.5%). The majority of participants reported that there were one to two occupational therapists providing services in the RACFs where they worked ($n = 87/108$, 80.6%). Approximately half estimated that occupational therapy services have been provided in these RACFs for 2 to 5 years ($n = 58/107$, 54.2%).

3.2 | Clinical caseload

Participants had large caseloads, with many providing support for 21 or more residents daily ($n = 67/161$, 41.6%) (see Table 1). This is also reflected in the length of occupational therapy sessions, with almost 75% of participants reporting that sessions last for ≤20 minutes ($n = 117/160$, 73.1%). Participants ranked the five most common conditions experienced by residents whom they supported, as dementia, arthritis, chronic pain, depression/anxiety, and deconditioning. When asked about the percentage of time spent on tasks, the majority of participants spent more than 50% of their time on interventions ($n = 93/155$, 60.0%). Conversely, participants spent less than 25% of their time on tasks such as preparation ($n = 142/153$, 97.7%), goal setting ($n = 147/154$, 95.3%), and outcome evaluation ($n = 139/154$, 90.3%).

3.3 | Referrals

Participants were asked about the number of referrals they receive and how often they receive referrals for specific reasons. The reasons for referral are shown in Table 2. Approximately half received ≤10 referrals within a 4-week period ($n = 77/146$, 52.7%). Referrals were mostly for pain management, with 83.8% ($n = 119/142$) of participants receiving referrals for pain management 'often/all of the time'. Other common reasons for referral were mobility and transfers ($n = 93/142$, 65.5%) and falls prevention ($n = 81/142$, 57.0%). In comparison, participants 'never/rarely' received referrals for instrumental

TABLE 2 How often referrals were received for a specific reason.

	How often referrals were received					
Reason for referral	**Never/rarely**	**%**	**Sometimes**	**%**	**Often/always**	**%**
Falls ($n = 142$)	31	21.8	30	21.1	81	57.0
Pressure care ($n = 141$)	32	27.0	44	31.2	65	46.1
Pain ($n = 142$)	9	6.3	14	9.9	119	83.8
Mobility ($n = 142$)	21	14.8	28	19.7	93	65.5
Seating ($n = 142$)	37	26.1	48	33.8	57	40.1
Behaviours ($n = 141$)	91	64.5	33	23.4	17	12.1
ADLs ($n = 142$)	99	69.7	27	19.0	16	11.3
IADLs ($n = 142$)	129	90.8	10	7.0	3	2.1
Leisure ($n = 142$)	117	82.4	13	9.2	12	8.5
Rest ($n = 143$)	127	88.8	14	9.8	2	1.4
Equipment prescription ($n = 143$)	33	23.1	50	35.0	60	42.0
Environmental modifications ($n = 142$)	99	69.7	28	19.7	15	10.6
Anxiety/depression ($n = 143$)	119	83.2	15	10.5	9	6.3
Social ($n = 143$)	119	83.2	11	7.7	13	9.1
Family consultation ($n = 143$)	89	62.2	42	29.4	12	8.4
Palliative care ($n = 142$)	106	74.6	30	21.1	6	4.2
Other reason for referral ($n = 8$)	5	62.5	0	0	3	37.5

Abbreviations: ADLs, activities of daily living; IADLs, instrumental activities of daily living.

activities of daily living (IADLs) ($n = 129/142$, 90.8%), despite this being an integral part of occupational therapy practice. Referrals for anxiety or depression ($n = 119/143$, 83.2%), social engagement ($n = 119/143$, 83.2%), and leisure ($n = 117/142$, 82.4%) were also 'never/rarely' received.

3.4 | Assessments

The most common assessments completed were for pain, with approximately 78% of participants ($n = 111/142$) completing evaluations for pain 'often/all of the time'. Other assessment areas frequently evaluated were mobility and transfers ($n = 96/141$, 68.1%) and body function, such as range of motion ($n = 91/141$, 64.5%). IADLs again were 'rarely/never' evaluated ($n = 127/141$, 90.1%), as were mental health ($n = 106/142$, 74.6%), social engagement ($n = 110/142$, 77.5%), and leisure ($n = 105/142$, 73.9%).

When asked about the methods of assessment used by therapists, those that were used 'often/all of the time' were informal client interview ($n = 120/140$, 85.7%), gathering information from nursing or care staff ($n = 116/141$, 85.7%), observation ($n = 101/141$, 71.6%), and gathering information from other allied health staff ($n = 96/141$, 68.0%), while gathering information from family ($n = 61/141$ 43.3%) and gathering information from leisure/diversional staff ($n = 61/141$, 43.3%) were used 'sometimes'. The use of standardised assessment tools varied, with 49.3% ($n = 48/140$) of participants using them 'often/all of the time', 30.0% ($n = 42/140$) using them 'sometimes', and 35.7% ($n = 50/140$) using them 'rarely/never'. Funding and organisational procedures were the main factors that influenced participants' choice of assessment. Greater than 80% reported that the factors influencing choice of assessment 'a considerable amount/a great deal' were the government funding policy (ACFI) ($n = 124/138$, 89.9%), the procedure at the RACF ($n = 115/138$, 83.3%), and the procedure stipulated by the employer ($n = 114/139$, 82.0%).

3.5 | Interventions

The types and frequencies of interventions that participants used with residents are shown in Table 3. Overall, the interventions provided were largely focussed on functional status and physical health rather than occupations. The most common intervention used was massage/TENS or other physical therapies. This was identified by many participants ($n = 110/133$, 82.7%) to be provided 'often/all of the time'. Other interventions that were provided 'often/all of the time' were falls prevention ($n = 73/133$, 54.9%), prescription of pressure care equipment ($n = 67/133$, 50.4%), mobility training ($n = 67/132$, 50.8%), and prescription of mobility equipment ($n = 65/133$, 48.9%). Conversely, interventions that were 'never/rarely' provided were remedial strategies for IADLs (e.g., improving skills in community mobility) ($n = 125/133$, 94.0%), compensatory strategies for IADLs (e.g., technology use) ($n = 115/133$, 86.5%), and community activity participation ($n = 111/133$, 83.5%). Factors that influenced participants' choice of interventions 'a considerable amount/a great deal' were the procedure at the RACF ($n = 101/125$, 80.8%), government or funding policy (ACFI) ($n = 102/126$, 81.0%), and the procedure stipulated by the employer ($n = 95/124$, 76.6%).

In relation to interventions provided, participants were also asked how frequently they run specific occupational therapy groups for residents. Pain management again was the intervention most often provided in a group setting, with 32.8% ($n = 41/125$) of participants reporting that pain management groups run 'often/all of the time'. Physical exercise groups were also provided 'often/all of the time' by a smaller number of therapists ($n = 34/125$, 27.2%).

3.6 | Comparison of practice patterns between external and internal employed therapists

Analysis revealed a difference in practice patterns between therapists that were employed by an external organisation and those that were employed internally by the RACFs and embedded within the facility. Results of the Mann–Whitney U test comparing the areas of occupational performance addressed (e.g., self-care, productivity, leisure, rest, IADLs, body function, participation, and environment) and interventions (including cognitive and the least and most often completed) for the two groups are shown in Table 4.

The areas of occupational performance addressed by therapists were dependent on whether they were employed externally or internal to the RACF. While body function and IADLs were addressed at a similar rate of frequency across the two groups, all other areas of occupation were addressed more often by those employed internally by the RACF. In particular, self-care was addressed significantly more often by those employed internally by the RACF than those employed externally (median = 2.00 vs. 1.00, respectively; $u = 818.000$, $P = 0.024$) as was participation (median = 2.00 vs. 1.00, respectively; $u = 676.500$, $P = <0.001$).

The frequency with which certain interventions were completed by therapists was also dependent on whether

TABLE 3 How often specific interventions were completed.

	How often interventions were completed					
Intervention	**Never/rarely**	**%**	**Sometimes**	**%**	**Often/always**	**%**
Environmental modifications ($n = 132$)	49	37.1	44	33.3	39	29.5
Assistive devices ($n = 133$)	51	38.3	47	35.3	35	26.3
Pressure care equipment ($n = 133$)	32	24.1	34	25.6	67	50.4
Bathing equipment ($n = 132$)	72	54.5	30	22.7	30	22.7
Mobility equipment ($n = 133$)	30	22.6	38	28.6	65	48.9
Mobility training ($n = 132$)	34	25.8	31	23.5	67	50.8
Falls prevention ($n = 133$)	24	18.0	36	27.1	73	54.9
Massage/TENS ($n = 133$)	16	12.0	7	5.3	110	82.7
Hand splinting ($n = 133$)	120	90.2	12	9.0	1	0.8
Exercise ($n = 133$)	65	48.9	33	24.8	35	26.3
Cognitive retraining ($n = 132$)	107	81.1	21	15.9	4	3.0
Cognitive compensatory strategies ($n = 134$)	100	74.6	24	17.9	10	7.5
Reality orientation ($n = 133$)	106	79.7	21	15.8	6	4.5
ADL remedial strategies ($n = 133$)	99	74.4	24	18.0	10	7.5
ADL compensatory strategies ($n = 133$)	76	57.1	31	23.3	26	19.5
IADL remedial strategies ($n = 133$)	125	94.0	6	4.5	2	1.5
IADL compensatory strategies ($n = 133$)	115	86.5	13	9.8	5	3.8
Community activity participation ($n = 133$)	111	83.5	15	11.3	7	5.3
Reminiscence therapy ($n = 133$)	91	68.4	21	15.8	21	15.8
Pet therapy ($n = 133$)	108	81.2	13	9.8	12	9.0
Horticultural therapy ($n = 132$)	105	79.5	17	12.9	10	7.6
Driving cessation ($n = 131$)	121	92.4	9	6.9	1	0.8
Sensory modulation ($n = 132$)	103	78.0	20	15.2	9	6.8
Stress management/relaxation ($n = 132$)	102	77.3	22	16.7	8	6.1
Art/craft participation ($n = 132$)	100	75.8	23	17.4	9	6.8
Music/singing participation ($n = 132$)	95	72.0	24	18.2	13	9.8
Leisure activity participation ($n = 132$)	94	71.2	23	17.4	15	11.4
Social activity participation ($n = 131$)	84	64.1	31	23.7	16	12.2
Spiritual activity participation ($n = 131$)	105	80.2	19	14.5	7	5.3
Rest/sleep ($n = 129$)	116	89.9	9	7.0	4	3.1
Comorbidity rehabilitation ($n = 131$)	68	51.9	36	27.5	27	20.6
Psychosocial support ($n = 132$)	92	69.7	25	18.9	15	11.4
Technology recommendation and support ($n = 131$)	108	82.4	19	14.5	4	3.1
Environment adaption carer training ($n = 131$)	74	56.5	37	28.2	20	15.3
Environment adaption nurse training ($n = 131$)	78	59.5	35	26.7	18	13.7
Leisure adaption carer training ($n = 130$)	105	80.8	13	10.0	12	9.2
Leisure adaption nurse training ($n = 129$)	107	82.9	12	9.3	10	7.8
Repositioning carer training ($n = 116$)	42	36.2	32	27.6	42	36.2
Repositioning nurse training ($n = 107$)	41	38.3	33	30.8	33	30.8
Family education ($n = 111$)	64	57.7	31	27.9	16	14.4
Client education ($n = 104$)	30	28.8	35	33.7	39	37.5
ADL adaption carer training ($n = 130$)	130	100.0	0	0.0	0	0.0

TABLE 3 (Continued)

Intervention	How often interventions were completed					
	Never/rarely	%	Sometimes	%	Often/always	%
ADL adaption nurse training ($n = 131$)	131	100.0	0	0.0	0	0.0
Other intervention ($n = 11$)	8	72.7	2	18.2	1	9.1

Abbreviations: ADLs, activities of daily living; IADLs, instrumental activities of daily living.

they were employed externally or internally. Cognitive retraining (e.g., activities to improve memory skills) was completed more often by those employed internally than by those employed externally (median = 1:00 vs. 1:00, respectively; $u = 797.500$, $P = 0.001$), as was cognitive compensatory strategies (e.g., using routines and reminders to compensate for memory loss) (median = 1:00 vs. 1:00, respectively; $u = 785.000$, $P = 0.002$). Results also suggest that interventions focussing on activity participation were completed more often by those employed internally by the RACF than those employed externally, for example, community activity strategies (median = 1:00 vs. 1:00, respectively; $u = 890.000$, $P = 0.014$), leisure activity participation (median = 2:00 vs. 1:00, respectively; $u = 628.000$, $P = <0.001$), and social activity participation (median = 2:00 vs. 1:00, respectively; $u = 544.500$, $P = <0.001$).

3.7 | Aged Care Funding Instrument

In this section, participants were asked about the occupational therapy services and treatment modalities that were funded under ACFI at that time. The majority of participants ($n = 99/112$, 88.4%) reported that occupational therapy services in RACFs consisted mostly of pain management under the ACFI Complex Health-Care Domain. When asked about the pain management treatment modalities, over 60% of therapists reported that these were not evidence based or effective; 61.6% ($n = 69/112$) of therapists disagreed that they were in line with current evidence, while 66.1% ($n = 74/112$) disagreed they were effective. Participants were also asked if the ACFI was sufficiently oriented towards client-centred care, and 83.0% ($n = 93/112$) of therapists disagreed. Most therapists (87.5%, $n = 98/112$) also disagreed that the occupational therapy services funded under ACFI were consistent with the occupational needs of the residents.

4 | DISCUSSION

This study investigated the practice patterns of occupational therapists working in Australian RACFs and the influences on their practice in 2019/2020 under the ACFI funding model. The findings revealed that occupational therapy practice was largely focussed on pain management at this time. This was reflected in the results pertaining to referrals received, assessment areas, and the interventions provided. Outside of pain management, other areas of more frequent practice included support for mobility, falls prevention, and equipment prescription. This highlights an emphasis on physical function with minimal intervention targeting meaningful occupations or psychosocial, emotional, and spiritual factors under the ACFI model of aged care provision.

Tailored activities and occupation-focussed work were noted to be a small part of occupational therapists' day-to-day practice, with IADLs, leisure, and social engagement rarely addressed. This was surprising, given it is not consistent with the holistic nature of occupational therapy and the professions primary goal to enable people to participate in activities of daily living (World Federation of Occupational Therapists, 2019). Furthermore, engagement in meaningful activities is beneficial for the health and quality of life of people living in RACFs, including people living with dementia (Smith et al., 2018). Specifically, tailored psychosocial activity-based interventions are known to improve mood, behaviour, and quality of life for people with dementia in RACFs (Travers et al., 2016). Over half of all residents in Australian RACFs (approximately 132,000 people) are living with dementia (AIHW, 2022b), and similarly in this study, dementia was identified as the main condition experienced by residents. Given the professions' focus on occupation, the known benefits of tailored activities for residents, and older adults' rights to a dignified life which provides opportunities for participation (United Nations, 1991), a more occupation-focussed practice in RACFs was needed in 2020.

The choice of assessments and interventions used by therapists was largely reported to be influenced by the ACFI, along with organisational procedures which were inevitably influenced by the ACFI. Occupational therapists identified that occupational therapy in RACFS mainly consisted of pain management via therapeutic massage, which was reported as the most frequent intervention provided. This is consistent with the ACFI requirements of the time, which outlined the use of therapeutic massage and other passive modalities for pain

TABLE 4 Mann–Whitney U test results for comparison of practice patterns between external and residential aged care facility (RACF) employed therapists.

Interventions and areas of occupational performance	Employer						
	RACF		External provider				
	n	Mdn	*n*	Mdn	*u*	*P*	IQR
Interventions							
Environmental modifications ($n = 104$)	30	2.00	74	2.00	786.000	0.014	2
Assistive devices ($n = 104$)	30	2.00	74	2.00	800.500	0.018	1
Pressure care equipment ($n = 104$)	30	3.00	74	2.00	784.500	0.011	1
Bathing equipment ($n = 103$)	30	2.00	73	1.00	929.000	0.176	1
Mobility equipment ($n = 104$)	30	2.50	74	2.00	1058.500	0.691	1
Mobility training ($n = 104$)	30	2.00	74	3.00	970.000	0.274	1
Falls prevention ($n = 104$)	30	2.00	74	3.00	1009.500	0.427	1
Massage/TENS ($n = 104$)	30	3.00	74	3.00	977.500	0.130	1
Hand splinting ($n = 104$)	30	1.00	74	1.00	1026.500	0.219	0
Exercise ($n = 104$)	30	2.00	74	2.00	1077.000	0.798	2
Cognitive retraining ($n = 103$)	30	1.00	73	1.00	797.500	0.001	0
Cognitive compensatory strategies ($n = 104$)	30	1.00	74	1.00	785.000	0.002	0
Reality orientation ($n = 104$)	30	1.00	74	1.00	930.000	0.059	0
ADL remedial strategies ($n = 104$)	30	1.00	74	1.00	994.500	0.280	1
ADL compensatory strategies ($n = 104$)	30	2.00	74	1.00	870.000	0.057	0
IADL remedial strategies ($n = 104$)	30	1.00	74	1.00	1055.000	0.363	0
IADL compensatory strategies ($n = 104$)	30	1.00	74	1.00	1098.000	0.888	0
Community activity strategies ($n = 104$)	30	1.00	74	1.00	890.000	0.014	0
Reminiscence therapy ($n = 104$)	30	1.00	74	1.00	838.000	0.017	0
Pet therapy ($n = 104$)	30	1.00	74	1.00	816.000	0.003	0
Horticultural therapy ($n = 103$)	30	1.00	73	1.00	865.500	0.022	1
Driving cessation ($n = 102$)	30	1.00	72	1.00	900.000	0.000	0
Sensory modulation ($n = 103$)	30	1.50	73	1.00	715.000	0.000	0
Stress management/relaxation ($n = 103$)	30	1.00	73	1.00	829.500	0.008	1
Art/craft participation ($n = 102$)	29	2.00	73	1.00	538.500	0.000	0
Music/singing participation ($n = 103$)	30	2.00	73	1.00	673.500	0.000	0
Leisure activity participation ($n = 103$)	30	2.00	73	1.00	628.000	0.000	0
Social activity participation ($n = 102$)	30	2.00	72	1.00	544.500	0.000	1
Spiritual activity participation ($n = 102$)	30	2.00	72	1.00	608.000	0.000	0
Rest/sleep ($n = 100$)	29	1.00	71	1.00	863.000	0.011	0
Comorbidity rehabilitation ($n = 102$)	30	1.00	72	1.00	1079.000	0.993	2
Psychosocial support ($n = 103$)	30	1.00	73	1.00	1074.000	0.847	0
Technology recommendation and support ($n = 102$)	30	1.00	72	1.00	957.500	0.154	0
Environment adaption carer training ($n = 102$)	30	2.00	72	1.00	814.500	0.029	0
Environment adaption nurse training ($n = 102$)	30	1.50	72	1.00	937.500	0.233	0
Leisure adaption carer training ($n = 101$)	30	1.00	71	1.00	907.500	0.098	0
Leisure adaption nurse training ($n = 100$)	29	1.00	71	1.00	877.500	0.084	0
Repositioning carer training ($n = 91$)	28	2.50	63	2.00	683.500	0.069	0
Repositioning nurse training ($n = 82$)	24	2.00	58	2.00	633.000	0.496	0

TABLE 4 (Continued)

Interventions and areas of occupational performance	Employer						
	RACF		External provider				
	n	Mdn	*n*	Mdn	*u*	*P*	IQR
Family education ($n = 86$)	25	2.00	61	1.00	688.500	0.428	1
Client education ($n = 78$)	21	2.00	57	2.00	528.500	0.402	1
ADL adaption carer training ($n = 101$)	29	1.00	72	1.00	1044.000	1.000	0
ADL adaption nurse training ($n = 102$)	30	1.00	72	1.00	1080.000	1.000	0
Other intervention ($n = 8$)	0	0.00	8	1.00	[a]	[a]	1
Occupational performance areas							
Self-care ($n = 104$)	30	2.00	74	1.00	818.000	0.024	1
Productivity ($n = 104$)	30	1.00	74	1.00	832.500	0.002	0
Leisure ($n = 104$)	30	2.00	74	1.00	627.000	0.000	1
Rest ($n = 104$)	30	2.00	74	1.00	771.500	0.003	0
IADLs ($n = 104$)	30	1.00	74	1.00	1009.000	0.095	0
Body function ($n = 104$)	30	3.00	74	3.00	934.000	0.060	2
Participation ($n = 104$)	30	2.00	74	1.00	676.500	0.001	1
Environment ($n = 104$)	30	3.00	74	2.00	664.500	0.001	2
Other occupational performance area ($n = 11$)	3	3.00	8	3.00	9.000	0.364	0

Abbreviations: ADLs, activities of daily living; IADLs, instrumental activities of daily living.
[a]Unable to commute as RACF $n = 0$.

management, with a frequency of four 20-minute sessions per week for residents experiencing pain (Department of Health and Ageing, 2017b). However, this predetermined modality and frequency of pain management was contrary to best practice, which necessitates individualised treatment combining both physical and psychological strategies to cater to differing pain experiences (Pain Australia, 2010).

In this study, many of the therapists indicated the ACFI was not enabling client-centred care and that the pain management treatment modalities were not evidence based or effective. Similarly, a study by Holloway (2019) examining pain management practices in Australian RACFs identified that the ACFI was a barrier to the use of an evidence-based pain management approach. Holloway's study added that residents in RACFs frequently experience complex pain, which is difficult to address using passive strategies such as massage. Such inadequate and inappropriate management of pain may lead to unnecessary suffering for residents. Overall, this raises concerns regarding the quality of care that therapists were able to provide at that time.

The findings of this study confirmed that the ACFI played a large role in the delivery of occupational therapy services. The findings support Occupational Therapy Australia's (2018) submission to the federal government's inquiry into the care standards in Australian RACFs, which highlighted that the ACFI restricted the scope of occupational therapy services. In this study, this restricted pattern of practice was more often occurring with therapists employed external to the facility who appear to deliver mainly physical therapies such as pain management and address limited areas of occupational performance, such as body function. This could be attributed not only to the ACFI but also to the emphasis placed on these areas by the RACFs who may place basic physical care over the broader psychosocial needs of the residents (Ibrahim et al., 2020; Meagher et al., 2019). In contrast, therapists employed internal to the facility were found to complete a broader range of interventions more often, including those that address cognition and activity participation, and also addressed occupational performance areas such as self-care and participation more often. This may be due to more opportunities for therapists embedded within the facility to raise staff awareness of the scope of occupational therapy services and greater opportunity to identify residents' needs, which could facilitate a broader range of referrals. The results of this study indicate that internal services, as opposed to external contracted services, provide a greater scope of occupational therapy services in RACFs and may facilitate the ability of therapists to meet the occupational needs of residents.

The lack of therapists employed internally by RACFs can also be attributed to the ACFI and the application of the funding by RACFs. Under the ACFI, higher subsidies were paid to providers when residents' health declined; thus, there was no incentive for RACFs to provide services such as allied health that promote reablement (Russell, 2017). Consequently, many RACFs predominantly engaged external providers, primarily for the completion of funded interventions. This preference for funded interventions was observed in this study, where passive interventions such as massage that were linked to funding were completed more often and occupations that optimise function and wellbeing, such as IADLs, leisure, and social participation, that were not linked to funding were rarely addressed.

The new AN-ACC model responded to these findings and concerns within the industry, promising a more reablement focus than the previous ACFI. However, recent surveys of Allied Health Professionals (Allied Health Professionals Australia [AHPA], 2022, 2023), including occupational therapists, have revealed apprehensions. Therapists expressed concern that there has been a decline in the quality of care and no improvements to outcomes for residents since the introduction of AN-ACC (AHPA, 2022, 2023). In particular, therapists reported an inability to provide reablement/restorative approaches, due to a reduction in the number of allied health professionals employed by RACFs and a shift towards less individualised treatment (AHPA, 2022, 2023). Given these results, it appears the new funding instrument has not led to an improvement in meeting the residents' occupational needs. Moreover, there are worrying signs of a further reduction or inconsistent delivery of occupational therapy across the sector. Importantly for residents, this indicates that the current practice of funding-driven service provision is and will continue to result in residents' occupational needs and human rights being unmet, with limited participation in everyday activities that fulfil their interests and contribute to physical and mental health and wellbeing (Moilanen et al., 2021; United Nations, 1991).

With most residents in RACFs already experiencing significant occupational disruptions due to complex health needs, the lack of occupation-focussed care further perpetuates their inability to participate in valued occupations, which is a form of occupational injustice for residents (Stadnyk et al., 2010). This was observed in a report by The Senate (2019), a house of the Australian Parliament, where residents with dementia who display changes in behaviours were often treated with physical and chemical restraints, further restricting their ability to participate in everyday activities. Despite declining health, residents have still identified themselves as having high quality of life, attributing it to their participation in meaningful activities (Cooney et al., 2009). Activities such as getting outdoors for a walk or being involved in the RACF garden were identified as crucial to enhancing their QOL by residents in Ireland (Cooney et al., 2009). The AN-ACC funding model has made a shift towards a re-enablement model of care; however, early indicators suggest its implementation has not resulted in an increase to participation in meaningful activities for the residents (AHPA, 2022, 2023). Future research is needed to explore how the occupational needs of residents and occupational therapy practice, such as assessments and interventions used, have changed since the introduction of the AN-ACC.

Beyond exploring the occupations of residents and practice of occupational therapists in RACFs, additional investigation into the training and professional supports required by occupational therapists working in RACFs may be warranted. Most therapists in this study had less than 3 years of experience working in RACFs, likely reflecting the number of new graduates employed and known difficulties with attracting and retaining allied health staff in the aged care sector (Royal Commission, 2019b). Due to the restricted practice patterns seen in RACFs, new therapists in this setting may experience challenges such as reduced opportunities to practise and embed core occupational therapy skills. Furthermore, Calderone et al. (2022b) identified a lack of training and limited opportunities for professional supervision in RACFs, contributing to therapists' perceived lack of support. Research into the unique needs of occupational therapists, particularly new graduates, in RACF is needed to support job satisfaction and quality care.

The findings also demonstrated that therapists faced high caseloads and short sessions with residents, as well as spending a significant percentage of their time on providing interventions only. Similarly, therapists in the Calderone et al.'s (2022b) study experienced time constraints and competing priorities between ACFI-funded interventions and residents' needs, causing considerable angst for therapists. Bushby et al. (2015) identified that having inadequate time for quality practice, excessive caseloads, and an inability to uphold professional standards through delivering client-centred and evidence-based practice were common ethical tensions in occupational therapy practice. These ethical tensions, if unresolved, may cause therapist burnout, negatively impacting job satisfaction and contributing to therapists leaving both the aged care sector and the profession as a whole (AHPA, 2022, 2023; Calderone et al., 2022b). Future qualitative research to further explore therapists' perspectives, including what ideal practice would look like or where it works well, would be beneficial.

Despite changes to the aged care funding model, there are early reports that allied health, including occupational therapy, has been negatively impacted by these changes. While AN-ACC allows for greater scope of practice, there is minimal incentive or direction for RACFs in the implementation of reablement/restorative approaches or allied health services in general. It is therefore vital that the occupational therapy profession continues to play an active role in advocating for greater recognition of their practice in RACFs, to highlight the unique expertise occupational therapists have in delivering individualised and occupation-focussed services and the value their services bring to RACF. Considering that costs remain a top priority for RACFs, the provision of occupational therapy services may garner better support if proven to be cost effective in improving residents' health and wellbeing. As such, occupational therapists should be proactive in measuring the value of their services. Currently, there is limited literature regarding the benefits of occupational therapy in RACFs; for instance, in dementia care, much of the research is specific to community settings (Laver et al., 2017). Hence, further research investigating the benefits and cost effectiveness of key areas of occupational therapy practice in RACFs is required.

The results of this study indicate that RACFs should consider employing occupational therapists internally, to further utilise their skills and provide an environment that is rich in occupational opportunities for residents. Dorrestein and Hocking (2010) suggest a mixed advisory/practitioner role for occupational therapists in RACFs would benefit the organisation, staff, and residents, with occupational therapists providing services, including educating staff on how to improve occupational opportunities for residents as well as addressing environmental conditions and individual residents' occupational performance issues.

The issues identified in this study, such as funding restraints and excessive caseloads, are largely shaped by government policies and organisational factors. Therefore, it is important that occupational therapy professional bodies advocate for reviews of existing workplace procedures, and government, and organisational policies to ensure therapists are able to provide quality care in RACFs.

4.1 | Strengths and limitations

This study explored occupational therapy practice in Australian RACFs during the ACFI era of aged care.

The use of convenience sampling for the online questionnaire is a recognised limitation of this survey, as the voluntary nature of participation subjects the data to bias and reduces the representativeness of the sample. Additionally, the inability to determine the response rate due to the distribution methods of the survey further reduces the generalisability of results. Future studies involving audits or direct observations may be useful in further substantiating the findings of this study.

Another limitation is the potential for type 1 errors, with an increased risk of identifying statistically significant results by chance, due to the multiple variables (~20) tested in the Mann–Whitney U test. Therefore, caution is warranted when interpreting the specific statistical significance of the findings. A larger sample size and the adoption of correction methods like Bonferroni could mitigate the impact of type I errors in future studies.

4.2 | Conclusion

This study provides a national picture of the practice patterns of occupational therapists and influencing factors in Australian RACFs during the ACFI era of funding. The findings of this study quantified and built upon previous literature, including the submission by OTA (2018) to the government's inquiry into the care standards in Australian RACFs, the report by Hubbard et al. (2019) which highlighted that the ACFI restricted the scope of occupational therapy services, and the qualitative study by Calderone et al. (2022b) where therapists reported that the ACFI restricted not only occupational therapy practice but also opportunities for the residents to live occupationally rich lives.

Occupational therapy practice in Australian RACFs during this time was largely constrained by the prescriptive nature of the ACFI and the way it had been applied by RACFs, limiting therapists' opportunities in utilising their skills and the provision of best practice to address residents' needs. Recent surveys of allied health professionals (AHPA, 2022, 2023) provide early indications that changes since the introduction of AN-ACC, the new aged care funding model, have further debilitated occupational therapy in RACFs. Beyond the need to re-evaluate practice since the introduction of AN-ACC, important questions were also raised, with the need to explore the occupational experiences of residents and the training and professional support needs for occupational therapists working in this setting. The findings of this study call for greater attention to occupational therapy practice in RACFs, from government policymakers as well as RACFs, and for continued advocacy by the occupational therapy profession, to maximise the potential of the profession, allowing best care to be provided for residents and ultimately improving their health and quality of life.

AUTHOR CONTRIBUTIONS

D. R. led the research design and delivery, participant recruitment, and data collection. All authors contributed to data analysis, interpretation, and preparation of the manuscript. All authors read and approved the final manuscript.

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CONFLICT OF INTEREST STATEMENT

Dr Tammy Aplin is an associate editor for Australian Occupational Therapy Journal and a co-author of this article. T. A. was anonymised to the peer review process; management of the peer review process and decision-making for this article was undertaken by the Editor-in-Chief. The authors declare no further conflict of interest.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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