

# Understanding occupational therapy practice in residential aged care facilities under the Aged Care Funding Instrument: A qualitative study

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## Funding information

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## Abstract

**Introduction:** Australian occupational therapy practice in residential aged care facilities has been largely funded using the Aged Care Funding Instrument since March 2008. Literature indicates that the funding model constrains occupational therapy practice, impacting on therapists' and residents' experiences. In preparation for the implementation of the new funding model, the Australian National Aged Care Classification, it is timely to understand current practice. Therefore, the aim of this study was to explore occupational therapy practice in residential aged care facilities under the Aged Care Funding Instrument. The objectives were (1) to understand occupational therapists' experiences of working in residential aged care facilities under the Aged Care Funding Instrument; and (2) to explore occupational therapists' perceptions of how the Aged Care Funding Instrument influences residents' occupational performance and engagement.

**Methods:** A phenomenological research design was employed to understand therapists' perspectives. Data were collected from seven occupational therapists using a demographic form and a semi-structured interview. Data were analysed using a modified Colaizzi's descriptive phenomenological data analysis. Ethics approval was obtained.

**Findings:** Two themes emerged from the study's findings: a restrictive practice context that disables residents; and a restrictive practice context that inhibits occupational therapists. The first theme describes how the Aged Care Funding Instrument constrains practice and incentivises the disabling of residents. The second theme describes the challenges faced by occupational therapists throughout their journey of employment under the funding model.

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**Conclusion:** Occupational therapists perceived that the Aged Care Funding Instrument restricts occupational therapy practice and prevents residents from living occupationally rich lives. With the introduction of the Australian National Aged Care Classification in late 2022, it is crucial that national associations and employers advocate to policymakers to ensure future practice reflects the profession's unique knowledge and skills to optimise the health and wellbeing of residents.

**KEYWORDS**

Aged Care Funding Instrument, occupational therapy, older adults, residential aged care, residents

## 1 | INTRODUCTION

Occupational therapists have a long history of working in residential aged care facilities (RACFs) globally (Dancewicz & Bissett, 2020). Their unique role focusses on enabling engagement in occupations by promoting independence, providing occupational opportunities, recommending assistive devices, and implementing environmental adaptations (Dancewicz & Bissett, 2020). In Australia, RACFs are funded by the Commonwealth Government which introduced the Aged Care Funding Instrument (ACFI) in March 2008 to replace the Residential Classification Scale (Chan et al., 2014; Hamilton & Menezes, 2011). A proposed strength of the ACFI was that it streamlined application documentation and enabled increased attention to the health-care needs of residents (Chan et al., 2014; Thomas, 2008). A criticism of the ACFI is that it provides incentives for RACFs to accommodate residents with high needs rather than residents with low needs (Chan et al., 2014; Hamilton & Menezes, 2011). Additionally, some argue that there is little financial incentive to provide preventative health care under the ACFI (Chan et al., 2014; Hubbard et al., 2018), ultimately having negative consequences on residents' health and quality of life (Chan et al., 2014).

The ACFI also dictates the scope of practice for health professionals providing services within RACFs. For occupational therapists, this limits practice to chronic pain management, and only if modalities such as therapeutic massage and electrotherapy are used (Brett et al., 2018; Occupational Therapy Australia, 2019). Occupational therapists have expressed that the ACFI constrains their practice by not recognising their unique expertise and contribution to health and wellbeing (Hubbard et al., 2018; Occupational Therapy Australia, 2019). A recent survey of occupational therapists working in RACFs revealed that 75% believed their practice did not reflect their professional expertise (Hubbard et al., 2018).

### Key Points for Occupational Therapy

- National associations must advocate for full scope of practice for occupational therapy under the AN-ACC.
- The AN-ACC must support residents to live occupationally rich lives.
- Future research must investigate residents' occupational engagement from their perspective.

Therapists felt that the ACFI restricted evidence-based and client-centred therapy and constrained them from making their own professional decisions and recommendations (Hubbard et al., 2018). Occupational Therapy Australia (2019) has raised concerns regarding the consequences this restricted scope of practice has on residents' health and wellbeing. If occupational therapy within RACFs reflected practice true to the profession's core, it could improve residents' life satisfaction and sense of belonging (du Toit et al., 2019).

It can be argued, therefore, that the ACFI is at odds with the expectations of care described in the national Aged Care Quality Standards (Australian Government, 2021). For example, Standard 4 addresses residents' right to achieve goals and have meaningful roles that provide purpose to their lives. Occupational therapy, the profession concerned with meaningful and purposeful engagement, is currently restricted by the ACFI to support RACFs in upholding this standard. In recognition of the current challenges in RACFs, the Royal Commission into Aged Care Quality and Safety (2021) proposed that an alternative to the ACFI must be implemented at the earliest opportunity. The new funding model, the Australian National Aged Care Classification (AN-ACC), is set to commence in October

2022 (Australian Government Department of Health, 2021). The implementation of the AN-ACC creates a timely opportunity to explore current occupational therapy practice in RACFs and influence the future of the profession in this important practice setting. While both Hubbard et al. (2018) and Occupational Therapy Australia (2019) have identified several challenges for occupational therapists in this setting, and the consequences these challenges have for residents, the lived experiences of occupational therapists are yet to be examined in depth. Therefore, the aim of this study was to explore occupational therapy practice in RACFs under the ACFI. The objectives were to understand occupational therapists' experiences of working in RACFs under the ACFI; and explore occupational therapists' perceptions of how the ACFI influences residents' occupational performance and engagement.

## 2 | METHODS

A phenomenological design (Wright St-Clair, 2015), underpinned by the constructivist paradigm (Kivunja & Kuyini, 2017), was employed to understand the reality of occupational therapy practice in RACFs under the ACFI. This supported achievement of the research aim and objectives, as the research design and paradigm encouraged deep exploration of occupational therapists' experiences of working under the ACFI and their perceptions of residents' occupational performance and engagement. Ethics approval for this study was obtained from the Griffith University Human Research Ethics Committee (HREC; GU Ref: 2021/007).

### 2.1 | Participant recruitment

Convenience sampling was implemented to recruit Australian occupational therapists with a minimum of one year of experience working under the ACFI. Participants responded to advertisements on the Occupational Therapy Australia website and social media (Twitter, Facebook, and LinkedIn). Interested therapists were emailed an information sheet and consent form. Occupational therapists who agreed to participate were required to complete the consent form before data collection.

### 2.2 | Data collection

Seven occupational therapists participated in the study. Therapists were required to complete a demographic form and engage in one semi-structured interview. The

demographic form was sent to participants in advance of the interview, and it collected data, including participants' years of experience as an occupational therapist, years of experience practising under the ACFI, and geographical location of employment. Researchers reviewed demographic forms prior to the interviews to better understand the context of the therapists' practice experience.

An interview schedule was developed and pilot tested. No changes were made to the interview schedule, and so the pilot interview was included in the study. Each therapist participated in one semi-structured interview of approximately 60 minutes. Interviews were conducted in person or virtually, based on each participant's location and preferences. The interviews were audio-recorded and transcribed verbatim, with all identifying details removed. All participants were contacted again one week after the interview in acknowledgement that the interview may have raised professional issues or further discussion points. This check-in on participants did not result in any further action being taken by the research team.

### 2.3 | Data analysis

Data analysis was completed using a modified version of Colaizzi's descriptive phenomenological data analysis (Colaizzi, 1978, as cited in Wirihana et al., 2018). The research team followed a process of (1) reading transcripts multiple times; (2) extracting significant statements related to the phenomenon of interest; (3) formulating meanings from significant statements; (4) creating theme clusters and themes; (5) writing an exhaustive description of the themes which explored the investigated phenomenon; and (6) writing a description of the fundamental structure of the phenomenon (Wirihana et al., 2018). Upon completion of Stage 3, the research team agreed data saturation had been achieved. Therefore, a decision was made to cease data collection. To promote trustworthiness (Shenton, 2004) Stages 2–4 were initially completed independently by all authors. Analyses were compared at team meetings, and when consistency was achieved, the first author finalised the stage of data analysis under supervision. Stages 5 and 6 were completed by the first author, with frequent team meetings to discuss, review, and complete these stages of data analysis. Stage 7 of Colaizzi's method, participant validation (Colaizzi, 1978, as cited in Wirihana et al., 2018), was not completed. Although participants are experts in their own experiences, the data analysis process meant that the research team created a deep understanding of the underlying essence of the phenomenon (Giorgi, 2008), and so it would be difficult for participants to validate overall findings purely on the basis on their individual contribution.

As recommended for the Colaizzi method (Wirihana et al., 2018), the research team bracketed (as much as is possible) their personal biases relevant to the study. These biases arose primarily from their professional practice experiences and knowledge of existing literature about occupational therapists' experiences in this practice setting. While Colaizzi recognised complete bracketing is never possible, this was an important process for the research team to promote trustworthiness of the study's findings (Colaizzi, 1978, as cited in Wirihana et al., 2018). The research team challenged each other's assumptions during regular team meetings.

## 2.4 | Ethical issues identified during the study

In some interviews, therapists described potentially unethical and/or illegal practice. This was not anticipated and required the research team to temporarily suspend data collection until advice was obtained from the chair of the HREC and University Research Office. Guided by recommendations of the university HREC, three actions were taken: (i) minor amendments to the participant information sheet and consent form to further strengthen the informed consent process and participant awareness of the ethical and legal responsibilities of the researchers; (ii) further actions to protect the anonymity of participants, including use of a number to identify participants rather than pseudonyms and minimal disclosure of demographic information; and (iii) continuous reflection, debriefing, and discussion among the research team.

## 3 | FINDINGS

Six female therapists and one male therapist participated in this study. The participants had 2.5 to 31 years of experience as occupational therapists and 2 to 6 years of experience working in RACFs under the ACFI. All therapists were employed by private companies that were contracted by RACFs to provide occupational therapy services. Their shared experiences led to the development of two themes: a restrictive practice context that disables residents; and a restrictive practice context that inhibits occupational therapists.

### 3.1 | Theme 1: A restrictive practice context that disables residents

Occupational therapists articulated that the ACFI provides financial incentives to increase residents' care

needs, summarised by Participant 7 as 'ACFI promotes disability'. This occurs because RACFs receive increased funding for residents who have greater care needs, which impacts directly on occupational therapists' practice. Participant 3 explained 'we're encouraged to be as negative as possible in our reporting because that means the funding will increase for the facility'. This creates a system that prioritises funding over residents' actual abilities. Participant 5 stated 'It doesn't matter what they need. It just matters what the numbers add up to'. Participant 3 described a practice example:

I noticed that someone had been written down as needing one physical assistance for their mobility ... I didn't see why they might need help. I ... was pretty happy that they should just be able to get up and ... do what they are required or want to do, when they want to do it. So I changed that person's care plan ... and I got asked to change that back by the ACFI coordinator as that would have meant that they would have lost a portion of their funding ...

The ACFI has created a culture in which RACFs benefit financially from residents being dependent. Care plans reflect a resident's performance on a 'bad day' (Participant 1), thereby emphasising their difficulties, in order to maximise their documented care needs and the funding received by the RACF. Participant 1 reflected on a resident who was 'able to walk most of the time, but on that one bad day, she needs a wheelchair. So, basically, we had to say that she was on a wheelchair just so we could get that funding'.

Additionally, therapists believed the ACFI actively disempowers residents by not providing therapy options that align with their needs and wants. Participant 6 felt that, at times, therapists were required to 'force [themselves] upon' residents, referring to the way staff sometimes coerced residents into accepting pain massage treatment. Therapists explained this was just another way to increase funding. Because residents were disempowered, Participant 6 compared the RACF to a prison and stated there is 'not a lot of hope sometimes'. Due to the financial incentive for residents to be viewed and treated as having limited abilities, their opportunities for occupational performance and engagement are extremely limited. Participant 7 stated:

From a provider's perspective, there's no motivation for re-enablement/maintenance. Not that anyone would ever articulate it but it's in the provider's interest that [residents]

get worse ... So then when the resident wants to actively participate in things that are going to keep their cognitive, physical, occupations, needs satisfied, there's very limited opportunity to do so because of the structure of the whole beast.

Furthermore, therapists expressed concern that the pain massage program is not evaluated: 'there's no requirement for monitoring therapeutic benefit so, therefore, it just breeds this totally passive just doing it for doing its sake' (Participant 7). Based on their informal observations and subjective reports from residents, the majority of participants believed pain massage was not beneficial for residents. Therapists were of the view, therefore, that the ACFI does not support evidence-based practice. Participant 6 said pain management is 'narrowly defined under the ACFI', while other therapists suggested the ACFI ignores evidence that highlights the unique contribution the profession can offer by promoting health and wellbeing using occupation.

### **3.2 | Theme 2: A restrictive practice context that inhibits occupational therapists**

This theme maps the challenges experienced by therapists working under the ACFI throughout their employment. Therapists came to a gradual realisation of the true nature of the practice context as they became more enculturated into the practice setting.

#### **3.2.1 | 'A lot of things I just figured out on my own'**

Occupational therapy practice under the ACFI was characterised by a lack of support from the time therapists commenced their employment. This was seen through a lack of training and professional supervision. Therapists identified that their pain management role under the ACFI, specifically pain massage, was not taught to them during their occupational therapy education. They, therefore, felt ill-prepared, with some therapists feeling so incompetent they feared they were 'going to cause pain for a person' (Participant 1). Consequently, therapists identified that they needed to seek immediate training. For some, this was provided through online workplace modules or shadowing colleagues. One participant sourced her own informal training from a family member who was a physiotherapist. Interestingly, this lack of support and training seemed to not be of

particular concern at the time it occurred, but therapists recognised this as problematic with hindsight during the interviews.

Therapists recounted limited opportunities for ongoing professional supervision, further contributing to their perceived lack of support. Therapists identified that supervision was not valued or prioritised by their employers, due to time constraints arising from the high demands of the pain massage program. This was particularly challenging for less experienced therapists who often questioned whether they were doing enough to support residents. The lack of support experienced by therapists was so significant that Participant 7 worked with distressed therapists to reconcile their practice and challenged them to find ways to apply their occupational lens. Participant 7 recognised this was a 'constant struggle' in RACFs. The lack of support inhibited therapists from enacting their full scope of practice within the practice setting. Due to this, there was strong agreement among therapists that new graduates are vulnerable members of the profession who should not seek employment in RACFs.

#### **3.2.2 | 'We don't have much power'**

Alongside feeling unsupported in their role, therapists also faced significant power imbalances in the workplace. These were most commonly evident with ACFI coordinators and, in some settings, physiotherapists. Participant 6 referred to ACFI coordinators as the 'gatekeepers' of the funding instrument as their role is to maximise funding through increasing residents' care needs. Participant 1 experienced 'constant pressure' from ACFI coordinators, with several other therapists sharing the view that ACFI coordinators often influenced their practice to the point of discomfort: 'I have to be honest about this ... sometimes it does interfere much more than I'd like it to' (Participant 4). Therapists described a culture whereby conforming to ACFI coordinator requests made work easier: 'there are little things that are quite apparent. You do what the ACFI coordinator wants you to do' (Participant 5). As previously indicated, therapists were often challenged by requests to 'disable' residents to increase funding: 'I absolutely think there were always ethical questions about is this the right thing to do on a daily basis' (Participant 7). To mitigate this pressure, Participant 5 shared that 'you choose when to push and when not. It's a delicate balance to keep that relationship but then also protect your professional integrity'. A small number of therapists spoke about upholding their responsibility as the reporting therapist and disagreed with ACFI coordinators if the request was not

appropriate according to their professional judgement. These decisions were accepted by ACFI coordinators when strongly justified by therapists. However, therapists knew that ACFI coordinators could, and sometimes did, ask another allied health team member to complete the same review to align with their request.

Additionally, therapists lacked power when attempting to remove residents from the pain management program, explaining that ACFI coordinators largely dictated this client list. While therapists were aware of the implications this would have on funding, they felt they were encouraged to overlook residents' autonomy: 'it's [like] pulling out teeth if we need to remove someone from the list ...' (Participant 5). Therapists explained that ACFI coordinators have the power to remove a resident from or downgrade them in the pain management program once the maximum subsidy for the resident was reached.

Some therapists also spoke about a workplace culture where physiotherapists are valued over occupational therapists. In some circumstances, this manifested in some employers paying physiotherapists more than occupational therapists for the same job description: 'there are ... companies that have reputations who only hire physios or prefer physios, pay physios a ridiculously high salary and then OTs an insultingly low salary' (Participant 5). Participant 6 described another way this imbalance manifested: 'I work in a physio room ... that's really important for me. It's called a physio room'.

### 3.2.3 | 'I leave OT out of it'

In the context of limited support and a lack of power within RACFs under the ACFI, therapists appeared to struggle with their professional identities. Therapists agreed that the ACFI constrains occupational therapy practice, which extended to the point that some therapists recognised they were not delivering discipline-specific therapy and have, therefore, dropped occupational therapy as a role they identify with: 'I leave OT out of it because that's not what I'm there for' (Participant 3). Therapists believed that the ACFI restricts them from using their occupational lens and does not capitalise on their unique contribution to promoting health and wellbeing. Therapists felt devalued in this practice setting as it seemed they were only as valuable as their signature on a form because an allied health authorisation/confirmation was required for some activities and associated funding: 'they just needed that OT stamp' (Participant 1).

The barriers to practice described by therapists created a range of emotional responses, including frustration

and professional dissatisfaction. Therapists expressed frustration regarding practising under scope: 'it's the things we're not doing rather than the things that we perhaps are doing. So, it's the sins of omission' (Participant 6). As described by therapists, the sins of omission included having to overlook occupational needs and not supporting residents in their occupations. Restricting therapists from using their unique knowledge and skills to optimise residents' occupational performance and engagement led to professional dissatisfaction for all participants: 'there has never been something, in part of the ACFI process, that I have implemented and then been satisfied with' (Participant 3). Participant 5 described the role as 'defeating, when there's things that aren't just or fair', including not being able to support residents to transition into RACFs or those experiencing limited occupational opportunities. Practising under scope was so significant that one participant experienced professional dissatisfaction in supporting the recruitment of therapists into this setting for a role they no longer believed in.

Participant 6, who had experience working in RACFs before the ACFI was introduced, identified that practice in RACFs used to be very different than how it is under the ACFI: 'it was incredibly liberating'. Participant 6 said their role included supporting residents' engagement in occupations through providing direct and indirect interventions. It is clear that the ACFI inhibits occupational therapists from using their discipline-specific knowledge and skills, having detrimental outcomes on therapists' professional identities.

### 3.2.4 | 'There were always ethical questions'

Occupational therapists were faced with multiple ethical challenges on a regular basis due to the ACFI influencing their practice. First, due to time constraints, therapists were requested to action non-ACFI occupational therapy referrals during ACFI funded intervention time as the time they had available for non-ACFI referrals was very limited. The companies that employed the therapists were often paid for ACFI referrals and non-ACFI referrals, and the latter were funded entirely by the RACF and were not reimbursed by ACFI.

Second, in an attempt to feel a sense of professional satisfaction, therapists would use their pain massage sessions to provide activities to support residents to achieve their occupational goals.

I've worked with a resident, with his wife, the goal was determined that we really need to look at getting him to feed himself ... this

is post-stroke. So then in my [pain massage] time with this resident ... we were just focusing on [feeding]. (Participant 4)

Therapists reconciled their failure to adhere to the ACFI guidelines by justifying that their practice met residents' needs and wants. This enabled them to feel a sense of professional satisfaction in their practice. However, their failure to adhere to the ACFI requirements created another ethical challenge as therapists were required to document the session as pain massage: 'I guess the thing is, it's when I document it, we have to say we were doing a massage' (Participant 1).

Third, therapists spoke about the challenges for RACFs regarding a lack of funding and staff. This caused therapists to either overwork or compromise sessions to meet demand. Therapists explained that, at times, they were directed to provide shorter sessions of pain massage or provide none at all, with an expectation that the session would still be documented as pain massage of the required length. Participant 6 stated that 'it's very hard to get the manager to put that in writing', highlighting the ethically questionable nature of the request. Similarly, in some facilities when a resident refused intervention, it was still expected that therapists documented the session as completed.

Collectively, these unethical practices caused therapists to be fearful, particularly during ACFI audits. Therapists described that they were notified by the RACF via email regarding upcoming audits, with an implied message to strictly adhere to the pain management program as directed in the ACFI. Participant 2 explained these audits provoked fear as they did not want to get themselves, their employer, and/or the RACF into trouble. The unethical practice took a toll on therapists as Participant 2 explained they were 'constantly on edge'.

### 3.2.5 | 'I couldn't stay in a job where I wasn't happy to be there'

Occupational therapists appeared disconcerted by their practice and identified two options: resign or self-justify their practice. An inability to continue excusing unethical practice was a large contributor to therapists' decisions to resign from RACF practice. In addition, frequent experiences of professional dissatisfaction, a lack of professional development, an obscure professional identity, and perceptions that their 'own occupation had become meaningless' (Participant 4) were all reasons for resignation.

Occupational therapists who were currently employed in RACFs identified their motivators for staying. These included working with the residents,

friendship with colleagues, and being optimistic about change under the AN-ACC. However, these participants admitted to searching for other jobs during times of 'crisis' and would later acknowledge the rewarding aspects of their practice: 'I get lots of really positive things that help me reconcile ... things like, the residents really appreciate what you do' (Participant 6). Participant 6 believed the role can be rewarding for the right person and appreciates the clarity of the role and the learning opportunities from observing diagnoses change over time. However, this perspective was uncommon, as Participant 1 explained that there is high staff turnover, as for most therapists the negatives heavily outweigh the positives.

## 4 | DISCUSSION

The introduction of the AN-ACC simultaneously provides an opportunity for RACFs to improve care provision and for occupational therapists to re-position their role working with older adults in RACFs. The results of this study support previous findings that the ACFI inhibits occupational therapists and prevents residents from living occupationally rich lives (Hubbard et al., 2018; Occupational Therapy Australia, 2019). The profession, employers, and policymakers must learn from the ACFI and ensure that the AN-ACC allows authentic occupational therapy practice that will maximise the chance of the best possible outcomes for residents. The implications of the ACFI and recommendations for supporting the profession and residents under the AN-ACC are discussed in this section.

Occupational therapists are experiencing a professional identity crisis in RACFs. Therapists in this study described pre-ACFI practice as being occupation focussed, but the ACFI influenced a shift in practice. The ACFI creates challenges for occupational therapists to sustainably contribute to this practice setting, by emphasising residents' dependence, restricting opportunities for residents' occupational performance and engagement, and directing therapists to practise under scope. It appears that other professions are experiencing similar challenges in their practice under the ACFI (Brett et al., 2018; Rayner et al., 2020). Physiotherapists, who are more skilled and knowledgeable in pain management, using massage and electrical modalities, have noted that the ACFI is not consistent with the evidence and limits physiotherapists from making clinically based, client centred decisions (Brett et al., 2018). Additionally, nurses have identified that the ACFI inhibits their ability to provide high-quality, client-centred care (Rayner et al., 2020). It seems, therefore, that the issues

experienced by occupational therapists are not unique to them, but something more systemic impacting on a range of professions. Certainly, there is a fundamental issue in occupational therapists not being permitted to use their unique knowledge and skills, namely, understanding humans as occupational beings and enabling occupational performance and engagement, to benefit the lives of residents. In response, national associations (e.g., Occupational Therapy Australia and Allied Health Professions Australia) must lobby policymakers to restore occupational therapy's scope of practice in RACFs under the AN-ACC. This scope must reflect the knowledge, skills, and core values of the profession, including occupation-centred practice that is evidence based and client centred.

The ACFI seems to be contributing to an unstable and insecure workforce in RACFs. There is evidence of high staff turnover within multiple health professions in this practice setting, including occupational therapy (Brett et al., 2018; Occupational Therapy Australia, 2019; Rayner et al., 2020). One way to understand this poor retention is using the concept of moral distress. Moral distress is a concept in ethics that leads to a loss of meaning and purpose in work, an obscured professional identity, and resignation from practice or leaving the profession (Goddard, 2021). The findings from this study suggest that occupational therapists practising in RACFs might be experiencing moral distress. The ramifications of this are potentially harmful to residents, as they are receiving support from health professionals who are experiencing burnout and reduced professional satisfaction (Goddard, 2021). Goddard (2021) argues this may impact the quality of care and client safety. It is crucial that policymakers and employers address the moral distress of occupational therapists by providing a practice setting that promotes ethical practice and professional satisfaction. This may well encourage improved wellbeing among health professionals and higher retention rates.

Older adults living in RACFs experience detrimental outcomes, including a loss of meaning and purpose, a lack of occupational roles, and increased feelings of isolation and dissatisfaction (du du Toit et al., 2019). Arguably, the ACFI contributes to this by decreasing residents' abilities and limiting opportunities for occupational performance and engagement, which provide meaning and purpose to residents' lives. This approach contradicts the Aged Care Quality Standards that set an expectation that residents receive support to achieve goals and engage in roles that provide meaning and purpose to their lives (Australian Government, 2021). The ACFI provides a perverse incentive for RACFs to neglect these Quality Standards. National associations and policymakers must work collaboratively to invest in the development of practice consistent with these standards.

## 4.1 | Limitations

The participants of this study were all employed by private companies that provided services into RACFs. Therefore, this may not be representative of all occupational therapy practice in Australian RACFs. Furthermore, this study gained insight into residents' occupational performance and engagement from the perspective of occupational therapists. Therefore, this study has not gained insight into residents' occupational performance and engagement from residents' perspectives.

## 4.2 | Implications for practice and future research

Occupational therapy has much to offer in residential aged care, but the impact of the ACFI does not enable the profession to have a maximal impact on the lives of residents. There is, therefore, a crucial need for advocacy by national associations to policymakers to enable occupational therapists to work to full scope within this practice setting under the AN-ACC for the ultimate benefit of residents. The ACFI directs occupational therapists to practice under/out of scope, and this makes it difficult to develop an evidence base about the full scope of occupational therapy practice in RACFs. Additionally, as therapists perceived that residents were currently not permitted to live occupationally rich lives, future research should investigate the lived experience of residents in RACFs.

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## CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

## AUTHOR CONTRIBUTIONS

All authors contributed to the completion of this research study and article. This includes study development, participant recruitment, data collection, and data analysis. All authors are accountable for ensuring this manuscript answers the research aim and objectives that guided this study.


## DATA AVAILABILITY STATEMENT

Research data are not shared.



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