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Context matters: A national survey of Danish occupational therapists' practices related to observations of Activities of Daily Living in hospital settings

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Abstract

Background

Performance-based observation of activities of daily living (ADL) is central to occupational therapists' contribution to safe discharge planning in hospitals. Yet acute care conditions, rapid patient flow, time pressure, interruptions, and medically unstable patients may constrain how occupation-based ADL observations and standardised tools can be applied in practice. A national overview is needed to determine whether current approaches support consistent, transparent, and contextually feasible ADL assessment in Danish hospitals.

Aim

The aim of this study was to investigate current ADL observation practices among hospital-based occupational therapists in Denmark, including factors influencing the use of assessment approaches, as well as clinicians' perspectives on existing methods and future needs related to ADL observation.

Methods

A national cross-sectional survey study was conducted among occupational therapists working in Danish somatic hospitals. A study-specific questionnaire was developed and pilot tested, informed by the Consensus-based Standards for the selection of health Measurement Instruments (COSMIN) recommendations. Data were analysed descriptively, and open-ended responses were analysed using thematic analysis.

Results

A total of 148 occupational therapists participated. ADL observations were primarily used to assess functional ability (88.5%), rehabilitation needs (86.5%), and discharge-related decisions (70.9%). Observations were mainly conducted in bathrooms and patient rooms and focused predominantly on personal ADL activities such as dressing, washing, and personal hygiene, whereas more complex activities were observed less frequently. Most respondents who were certified in an ADL observation tool were calibrated in the Assessment of Motor and Process Skills (AMPS). Among certified respondents, many reported using knowledge derived from these assessments to inform clinical reasoning rather than administering them according to the manual. Reported barriers for applying performance-based observation of ADL included interruptions, organisational constraints, and mismatch between existing standardised ADL assessment tools and acute-care workflows. Respondents expressed a need for hospital adapted observation approach that combines clinically relevant information with feasibility in the hospital context.

Conclusion

ADL observation remains central to Danish hospital occupational therapy, but current practice appears strongly shaped by acute-care workflows, organisational priorities, and available hospital environments. Respondents reported challenges in applying existing assessment approaches within the organisational conditions of acute hospital practice. These findings support further work to determine whether better implementation, adaptation of existing standardised ADL assessment tools, or development of a hospital-adapted approach to ADL observation is warranted.

Background

Occupational therapists play a central role in discharge planning in hospital settings by assessing patients' ability to manage activities of daily living (ADL) (1–4). Acute illness and hospitalisation are often accompanied by declines in ADL performance, which have consistently been associated with adverse outcomes including, institutionalisation, hospital readmission, and mortality among older adults (5–8). Consequently, assessment of ADL performance is a central component of hospital occupational therapy practice and informs decisions related to rehabilitation, discharge planning, and post-discharge support.

Performance-based ADL observation is a distinctive feature of the occupational therapy assessment process. Rather than focusing solely on whether activities are completed, occupational therapists observe and evaluate how activities are performed, including aspects such as safety, effort, efficiency, process skills, independence, and the need for environmental support(9, 10). Such observations provide information about patients' functioning in everyday activities and support clinical reasoning regarding rehabilitation needs, discharge planning, and further services beyond what can be obtained from interviews or impairment-focused assessments alone(11)

Despite the central role of ADL observation, studies from acute hospital settings suggest considerable variation in assessment practices. Occupational therapists frequently rely on interviews, informal observations, and clinical judgement, whereas standardised assessments are used more selectively(4, 12–14). International surveys similarly report substantial variation in the use and implementation of standardised assessments across practice settings. Differences in assessment selection, administration, and clinicians' knowledge of available instruments suggest that local organisational conditions influence assessment practices alongside psychometric considerations(15, 16).

Similar organisational influences have been described across acute-care settings, where discharge pressures, limited time, and contextual constraints shape how ADL observations are conducted(10, 11, 14, 17). Australian studies have likewise shown that occupational therapists often adapt assessment approaches to local workflows rather than applying standardised procedures rigidly(18, 19).

In Denmark, Vinge et al. found that although many occupational therapists were trained and calibrated in the Assessment of Motor and Process Skills (AMPS), standardised use of the tool was inconsistent and

influenced by organisational and contextual factors(17).

However, existing research has primarily focused on specific assessment tools or selected clinical populations. Less is known about how ADL observations are conducted more broadly within contemporary Danish hospital practice, including which activities are observed, how standardised and non-standardised approaches are used, and which factors influence assessment practices.

A national description of current practice is therefore needed to establish whether observed variation primarily reflects differences in implementation, organisational conditions, local priorities, or limitations in existing assessment approaches. Such knowledge may guide future efforts to optimise ADL assessment in hospital settings, including implementation strategies, contextual adaptation of existing methods, and considerations of whether additional assessment approaches are warranted.

Aim

The aim of this study was to investigate current ADL observation practices among hospital-based occupational therapists in Denmark, including factors influencing the use of assessment approaches, as well as clinicians' perspectives on existing methods and future needs related to ADL observation.

Methods

Study design

A national cross-sectional survey study was conducted to investigate current clinical practices related to ADL observations among occupational therapists in Danish hospital settings. Reporting follows the Consensus-Based Checklist for Reporting of Survey Studies (CROSS) (20). The completed CROSS checklist is included as Supplementary File 2.

Participants and setting

The study targeted occupational therapists working in somatic hospitals across the five administrative regions of Denmark. All occupational therapy departments in public hospitals were invited to participate.

Eligible respondents were occupational therapists working with adult hospital inpatients and currently performing ADL observations as part of clinical practice. Occupational therapists who did not perform ADL observations, who worked exclusively in paediatric settings, or who worked solely with outpatients were excluded.

Sample size considerations

As no complete sampling frame of eligible hospital-based occupational therapists performing ADL observations was available, the sample size target was based on a pragmatic precision approach rather than formal hypothesis testing. National workforce data indicated that 775 occupational therapists were employed in Danish hospitals, but this figure included therapists working outside the target population, such as paediatric, outpatient, managerial, dysphagia-only, or other non-ADL observation roles(21). We therefore assumed that the eligible population was substantially smaller and likely in the low hundreds. Assuming an eligible population of approximately 400 therapists, a 95% confidence level, a 50% response distribution, and finite population correction, 196 completed responses would correspond to an approximate 5% margin of error. A pragmatic target of at least 150 completed responses was considered sufficient for national descriptive analyses, corresponding to an approximate margin of error of 6–7%, depending on the true eligible population size.

Survey

A study-specific questionnaire was developed to examine current ADL observation practices, standardised ADL assessment tools, and factors influencing their application in hospital-based occupational therapy.

The questionnaire comprised four sections: (1) respondent characteristics, (2) current ADL observation practices, (3) use of assessment tools and associated barriers and facilitators, and (4) perspectives on the adequacy of existing approaches and potential need for further development. Items were primarily structured as closed-ended questions (multiple choice, dichotomous items, and 5-point Likert scales), supplemented by selected open-ended questions. Conditional skip logic was applied to enhance relevance and reduce respondent burden.

Item generation was informed by the study aim, existing literature, and clinical expertise. Questionnaire development was informed by the COnsensus-based Standards for the selection of health Measurement INstruments (COSMIN) recommendations regarding relevance, comprehensiveness and comprehensibility(22).

The draft questionnaire was pilot tested with seven occupational therapists from three hospital sites representing different clinical specialties and levels of experience. Participants completed the questionnaire (9–20 minutes) and subsequently participated in individual cognitive debriefing interviews (12–18 minutes). Interview data were analysed by two authors (SMS and TH) using a structured matrix based on COSMIN domains (relevance, comprehensiveness, and comprehensibility).

Based on this process, minor revisions were made to wording and structure, and additional items were included to improve content coverage.

To enhance transparency and allow readers to assess the potential influence of question framing, the full questionnaire and participant information text are provided as Supplementary File 1. The study was informed by the researchers' clinical experience and observations suggesting that existing ADL

assessment approaches may not always align with the organisational and contextual realities of acute hospital practice. Rather than presuming a need for additional assessment approaches existed, the survey sought to explore whether clinicians' perspectives on current practices, the perceived usefulness of existing approaches, barriers and facilitators to their use, and perceived needs related to future optimisation of ADL observation in hospital settings.

Data collection

Data were collected over a six-week period from early March to mid-April 2026.

Participants were recruited using a combination of gatekeeper-mediated sampling and open convenience sampling. Survey invitations were distributed via email to managerial representatives of occupational therapy departments, who were asked to forward the invitation to eligible staff. Gatekeepers were additionally asked to report the number of staff members who received the invitation. Based on gatekeeper reports, invitations were distributed to at least 117 occupational therapists.

To increase reach, the survey was also disseminated through Danish professional networks on social media platforms (Facebook and LinkedIn), targeting occupational therapists. This strategy was chosen to maximise national coverage despite the absence of a complete sampling frame. Participation via these channels was based on voluntary self-selection. As the survey was distributed through both gatekeeper networks and social media, the total number of individuals exposed to the invitation could not be determined. Consequently, an overall response rate could not be calculated.

The survey was administered electronically using SurveyXact(23).

Data analysis

Data were exported from SurveyXact, processed in Microsoft Excel, and analysed in RStudio(24). Responses from ineligible participants and incomplete submissions were excluded prior to analysis. Potential duplicate responses were assessed based on response patterns and respondent characteristics; no duplicates were identified.

Descriptive statistics were used to summarise respondent characteristics and survey responses. Categorical variables are presented as frequencies and percentages. Current ADL observation practices (e.g., purpose, timing, duration, location, and types of activities observed) were analysed descriptively and presented graphically.

The use of ADL assessment tools and associated barriers and facilitators were analysed descriptively. For items allowing multiple responses, categories were analysed independently and reported as proportions. Perceived usefulness, as well as facilitating and hindering factors, are presented using frequencies, percentages, and 95% confidence intervals.

Responses concerning the perceived need for further development of ADL observation tools and desired characteristics were analysed descriptively and grouped into content-related and implementation-related aspects.

Open-ended responses were initially coded and analysed by co-author KMS using thematic analysis informed by Braun and Clarke to explore perspectives on existing ADL tools in acute hospital practice (24, 25). SMS subsequently reviewed coding decisions, theme development, and thematic interpretations at each stage of the analysis. Any discrepancies in interpretation were discussed until consensus was reached. Initial coding was informed by selected TDF domains, whereas final themes were developed through iterative interpretation across the dataset(25, 26).

Ethical consideration

The study was registered with the Danish Data Protection Authority (journal no. P-2026-20774) in the Capital Region of Denmark and adhered to regulations on secure data handling and storage.

Participants were informed on the survey landing page that participation was voluntary, that submission of responses constituted informed consent, and that data would be handled anonymously at the individual, unit, and hospital levels.

The study was conducted in accordance with the principles of the Declaration of Helsinki(27).

Results

A total of 26 occupational therapy departments across Danish hospitals were invited to participate. In total, 200 respondents initiated the survey. Of these, 148 provided complete responses, met the eligibility criteria, and were included in the main analyses.

The achieved sample was considered sufficient for national descriptive analyses. Participant flow is presented in Fig. 1.

[Figure 1 about here]

Figure 1 Flow of respondents

Characteristics of participants

Participant characteristics are presented in Table 1. Respondents represented all five Danish regions, with the largest proportion working in the Capital Region of Denmark (31.1%).

Participants had varied levels of professional experience, with 37.8% reporting more than 12 years since graduation. A similar distribution was observed for years of experience in hospital settings.

Participants worked across a range of clinical fields, most commonly neurological (53.4%), medical (37.8%), and geriatric settings (27.7%), with additional representation from surgical, orthopaedic, emergency, oncology, and other specialties.

The majority of participants reported conducting dysphagia assessments (89.9%) and ADL observations (79.7%) as part of their primary occupational therapy tasks. Other frequently reported tasks included rehabilitation planning for transition to municipal care (62.2%), patient interviews (53.4%), mobilisation (36.5%), and dysphagia management (35.8%).

Nearly half of the participants reported conducting 1–5 ADL observations per week (48.0%), while smaller proportions reported higher frequencies.

More than half (54.1%) were certified in an ADL assessment tool, most commonly Assessment of Motor and Process Skills (AMPS) (81.2% among those certified).

[Table 1 about here]

Table 1 **Characteristics of the participants**

Clinical practice of ADL observations

Table 2 displays the reported practice of ADL observations. ADL observations were primarily conducted to assess functional performance (88.5%), identify rehabilitation needs (86.5%), and inform discharge decisions (70.9%). These purposes were frequently reported in combination. Observations were most frequently performed early during hospital admission (48.6%) and typically lasted between 31–45 minutes (42.6%) or 46–60 minutes (33.8%). They were most commonly conducted in bathrooms (94.6%) and patient rooms (85.1%).

[Table 2 about here]

Table 2 **ADL observation practices**

Figure 2 displays reported ADL tasks across clinical specialties. Basic self-care activities, including dressing (93.9%), personal care (86.5%), and bathing (83.1%), were the most frequently observed tasks across all specialties. In contrast, more complex activities, such as meal preparation (30.4%), shopping (11.5%), and cleaning (5.4%), were observed less frequently. Neurological settings differed from this overall pattern, with respondents more frequently reporting observation of meal preparation (57%), shopping (22%), and cleaning (10%), whereas these activities were only rarely observed in other specialties (0–6%) (Fig. 2).

[Figure 2 about here]

Figure 2 ADL tasks by clinical specialties

Table 2 also shows that most respondents reported that they were able to conduct ADL observations involving activities that patients considered meaningful to some (51.4%) or a high extent (31.1%). Similarly, moderate to high levels of satisfaction with current practice were reported (Table 2). However, disturbances during observations were common, occurring often (31.8%) or sometimes (43.9%). The use of simulated ADL tasks varied across respondents, with no clear dominant pattern (Table 2)

The use of ADL assessment tools varied across respondents (Supplementary File 3).

Among respondents who were certified (n = 80), only 22.5% reported using assessment tools as intended (i.e., in accordance with the manual), whereas 68.8% reported not using the tools directly but applying knowledge derived from them in their clinical reasoning. A small proportion (8.8%) reported not using such tools at all.

Among respondents who were certified but did not use the tools as intended, commonly reported reasons included lack of time (67.3%), lack of access to required software (45.5%), and lack of implementation in the clinical setting (30.9%). Additional reasons included patients' functional ability (18.2%) and limited perceived benefit (14.5%).

Most respondents (70.3%) reported not using ADL observation tools that do not require certification, and only 16.2% indicated that a local method or tool was available within their department.

Reported barriers and facilitators for using ADL observation tools are presented in Fig. 3. The most frequently reported barriers were lack of time (40%), lack of implementation at the workplace (36%), patient-related limitations (31%), and lack of space or materials (24%). Facilitating factors were primarily related to perceived benefits of the tools, including improved quality of observations (55%), ease of use (45%), and support for documentation (43%).

[Figure 3 about here]

Figure 3 Facilitators and barriers influencing the use of ADL observation tools

Findings from open-ended responses

Analysis of open-ended responses identified three overarching themes: (1) The context defines the occupational therapy practice, (2) The impact of context on perceived meaningfulness, and (3) Adjustments to the occupational therapy expertise or the context (Table 3).

Regarding the possibility of conducting meaningful ADL observations, respondents described how patients' acute condition, hospital environments, and organisational constraints influenced both the selection of activities and opportunities to observe activities perceived as meaningful and relevant. While personal ADL activities were often considered meaningful and clinically relevant, respondents frequently reported that time constraints, physical environments, and patients' acute conditions limited opportunities to observe more complex activities.

With respect to current ADL observation practices, respondents generally expressed satisfaction within the constraints of hospital settings. However, several described how interruptions, shared patient rooms, competing clinical priorities, and limited opportunities for observing activities outside basic self-care influenced the quality and scope of ADL observations. Some respondents also reported that ADL observations were occasionally deprioritised relative to other occupational therapy responsibilities, including dysphagia-related assessments.

Finally, respondents highlighted several challenges related to existing ADL assessment tools. Existing standardised ADL assessment tools were often described as too time-consuming, inflexible, or poorly aligned with acute-care workflows. Respondents also expressed a need for a more shared framework, terminology and understanding of ADL observation, indicating that variation in assessment approaches may influence how ADL performance is observed, described, and communicated across settings.

[Table 3 about here]

Table 3 **Analysis of open-ended questions**

Exploring characteristics for ADL Observation Tools in Hospital Settings

Table 4 presents respondents' perceived need to develop an ADL observation assessment for use in hospital settings and the characteristics considered important for such an approach. Overall, respondents reported a moderate to high need for a new assessment approach adapted to hospital settings, with 62.9% indicating a high or very high need.

With respect to assessment content, respondents most frequently emphasised independence in ADL (79.1%), need for support during task performance (70.9%), and safety and risk (70.3%). Quality of performance (64.2%), process skills (63.5%), and assessment of physical and cognitive capacities (62.2%) were also commonly identified as important. In contrast, fewer respondents prioritised patient-reported experience (46.6%) or the inclusion of an overall performance score (28.4%).
When considering implementation characteristics, respondents highlighted the importance of applicability in hospital settings (82.4%), relevance for occupational therapists (72.3%), and compatibility with existing time constraints (68.9%). Ease of use (67.6%), an evidence-based foundation (65.1%), and applicability across different levels of patient performance (62.2%) were also frequently reported. Overall, respondents preferred an assessment approach combining clinically relevant information on ADL performance with feasibility in acute-care practice.

[Table 4 about here]

Table 4 **Perceived needs and characteristics for ADL observation tools in hospital settings**

Discussion

This study suggests that ADL observation remains a central component of Danish hospital occupational therapy practice. Respondents reported assessing not only whether activities were completed, but also aspects of task performance such as effort, fatigue, safety, process skills, and environmental influences. These findings indicate that ADL observations may support broader clinical reasoning regarding patients' functioning, rehabilitation needs, and discharge planning.

This is noteworthy given the organisational and time-related constraints that characterise contemporary hospital practice.

The findings align with previous studies from acute-care settings showing that occupational therapists primarily use observation to assess safety, discharge readiness, and rehabilitation needs (4, 14, 28). Like earlier reports, observations in the present study were predominantly conducted in bathrooms and hospital rooms and focused mainly on PADL activities such as dressing, washing, and personal hygiene, whereas more complex activities were observed less frequently. This pattern is consistent with previous research identifying time constraints, limited space, equipment availability, and organisational demands as barriers to occupation-based practice in hospital settings(11, 29). Together, these findings suggest that ADL observation practices are shaped not only by professional priorities but also by the organisational conditions under which assessments are conducted. Similar observations have been reported from Australian intensive care settings, where occupational therapists described organisational barriers including workload, limited resources, and service structures as major determinants of assessment and intervention practices(19). This interpretation is further supported by the higher use of more complex activities in neurological settings, where organisational conditions and rehabilitation trajectories may provide greater opportunities for broader performance-based assessment. Together, these findings support previous descriptions of acute hospital occupational therapy as a practice that is continually adapted to local organisational conditions and discharge-related demands(4).

The findings regarding ADL assessment tool use partly align with those reported by Vinge et al. Although most certified respondents in the present study were AMPS calibrated, only 22.5% of certificated respondents reported using their certified assessment as intended, while most reported applying knowledge derived from the assessment in their clinical reasoning instead of administering it according to the manual. Similar findings were reported by Vinge et al., where standardised AMPS use was also limited among calibrated occupational therapists. Direct comparison between the studies should, however, be made with caution. Whereas Vinge et al. investigated AMPS use among occupational therapists across a range of practice settings, the present study focused specifically on hospital-based occupational therapists and addressed the use of ADL assessment tools more broadly. Within this hospital context, lack of time was the most reported reason for not using a certified assessment as intended. In contrast, although time was frequently reported in Vinge et al., it was not identified as a statistically significant factor associated with standardised AMPS use. The greater importance of time in the present study may reflect the organisational characteristics of acute hospital practice, where short admissions, rapid patient flow, interruptions, and competing clinical priorities influence how occupational therapists conduct ADL observations and assessments. (2, 14)

Respondents reported a moderate to high perceived need for ADL observation approaches adapted to hospital settings. These findings indicate a perceived need for an assessment approach that combines clinically relevant information with contextual feasibility in acute-care practice. Emerging approaches to occupational performance evaluation such as Quality of Occupational Performance (QOP) may address some of the characteristics prioritised by respondents, but their feasibility, implementation, and measurement properties in Danish hospital practice require empirical evaluation before they can be recommended(30).

In the present study, many certified respondents reported using knowledge derived from standardised assessment tools while simultaneously expressing a need for assessment approaches that better fit hospital practice. This may indicate a perceived mismatch between existing assessment formats and the realities of acute-care workflows rather than disagreement with the value of standardised assessment itself. This interpretation is consistent with previous surveys demonstrating considerable variation in occupational therapy assessment practices across clinical contexts and heterogeneous implementation of standardised assessments across countries and practice settings (15, 16, 31). Together, these findings suggest that variability may partly reflect challenges related to contextual feasibility and implementation, rather than disagreement with the value of standardised assessment.

An additional finding was the perceived lack of a shared language and structure for ADL observation. Several respondents described ADL assessments as potentially becoming “fluffy” when clinicians did not share a common framework or terminology. This suggests that, beyond feasibility considerations, standardised or structured approaches may also support greater consistency in the observation, description, and communication of ADL performance.

One of the more distinctive findings concerned the relationship between dysphagia-related practice and ADL observation. A considerable proportion of respondents reported dysphagia assessment as part of their primary occupational therapy responsibilities, and several indicated that dysphagia-related tasks influenced the prioritisation of ADL observations. This finding is largely absent from the international literature discussed here and may reflect an important contextual difference, as dysphagia management in Danish hospitals is commonly undertaken by occupational therapists, whereas it is often managed by speech and language therapists in other healthcare systems(32). Taken together, these observations suggest that dysphagia-related responsibilities may compete with ADL observations for limited clinical resources during acute hospitalisation, highlighting the importance of considering local professional roles and service organisation when interpreting occupational therapy practice across healthcare systems.

A major strength of this study is its national scope and its specific focus on hospital occupational therapy practice. By including 148 occupational therapists from all five Danish regions, recruited through occupational therapy departments at 26 Danish somatic hospitals and supplemented by targeted professional networks, the study provides broad insight into current ADL observation practice across Danish hospital settings. Furthermore, combining quantitative and qualitative responses enabled a

broader understanding of how occupational therapists describe and experience ADL observation in acute-care practice.

Several limitations should nevertheless be acknowledged. The use of multiple recruitment channels increased national reach but precluded calculation of an overall response rate. The absence of a complete sampling frame and an overall response rate limits the ability to fully assess sample representativeness. Although the sample size was considered sufficient for national descriptive analyses, the findings should therefore be interpreted with appropriate caution regarding their representativeness and precision.

In addition, the study relied on self-reported data, which may not fully reflect actual clinical practice.

Although the questionnaire underwent pilot testing and revision, some survey items were based on five-point response scales in which only the anchor categories were explicitly labelled. As a result, respondents may have interpreted intermediate response options differently, which could have influenced the precision and comparability of responses related to satisfaction with current practice, perceived usefulness of existing standardised ADL assessment tools, and perceived need for new assessment approaches.

Respondents were specifically asked about the perceived need to develop an ADL observation assessment for hospital settings (question 27, Supplementary File 1), which may have oriented responses towards development-oriented solutions rather than implementation or adaptation of existing standardised ADL assessment tools.

Self-reported use of standardised assessment tools may have been influenced by differences in respondents' interpretation of standardised administration or by social desirability bias, potentially resulting in overestimation of adherence to manualised assessment procedures.

Selection bias may also have occurred, as occupational therapists with a particular interest in assessment methods may have been more likely to participate in the survey, potentially resulting in an overestimation of the reported use of standardised assessment approaches.

Although the questionnaire was revised following pilot testing, additional testing of the revised version could have strengthened evidence regarding its comprehensibility and the interpretation of survey responses.

Finally, findings related to dysphagia and occupational therapy roles may not be directly transferable to countries where dysphagia management is organised differently.

Conclusion

This study suggests that ADL observation remains a central component of occupational therapy practice in Danish hospitals. Respondents reported attending not only to task completion but also to aspects of

performance such as effort, safety, process skills, and support needs. However, current practice appears to be shaped by acute-care conditions and organisational priorities, with observations primarily focusing on PADL.

Many respondents were trained in standardised assessment tools, particularly AMPS, but reported patterns of use suggest that such tools may often inform clinical reasoning rather than being applied in fully standardised ways. The findings suggest that applying existing assessment approaches within acute-care workflows may be challenging because of organisational conditions and contextual constraints.

Respondents reported a moderate to high perceived need for clinically feasible approaches to ADL observation that are aligned with the constraints of hospital settings. Future research should investigate whether improved implementation, contextual adaptation of existing approaches, or development of a hospital-adapted approach to ADL observation most effectively address the challenges identified in the present study. Such work may contribute to more consistent and contextually feasible ADL observation practices in acute hospital settings.

Declarations

Author Contribution

Author contributionSabina Mette Staal conceptualized and led the study, developed the methodology and ques-tionnaire, collected and analysed the data, managed the project, and drafted the manuscript.Tina Hansen contributed to the study design, methodology, questionnaire development, supervised the project, and critically revised the manuscript.Kira Marie Skibdal contributed to the qualitative analysis and critically revised the manuscript.Gitte Johannesen contributed to the development and refinement of the questionnaire and critically revised the manuscript.Thomas Bandholm contributed to the study design and methodology and provided critical revision of the manuscript.All authors reviewed the manuscript and approved the final manuscript and agree to be accountable for all aspects of the work.

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Data Availability

Data are available from the corresponding author upon reasonable request. Data are not publicly available due to participant confidentiality.

References

1. Jönsson M, Appelros P, Fredriksson C. Older people readmitted to hospital for acute medical care - Implications for occupational therapy. Scand J Occup Ther. 2017;24(2):143–50. doi:10.1080/11038128.2016.1227367
2. Britton L L. Occupational therapy practice in acute physical hospital settings: Evidence from a scoping review. Aust Occup Ther J. 2015;62(6):370–7.
3. Wales K, Clemson L, Lannin N, Cameron I, Bayer A. Functional Assessments Used by Occupational Therapists with Older Adults at Risk of Activity and Participation Limitations: A Systematic Review. PloS One. 2016;11(2):2. doi:10.1371/journal.pone.0147980
4. Britton L, Rosenwax L, McNamara B. Occupational therapy in Australian acute hospitals: A modified practice. Aust Occup Ther J. 2016;63(4):4. doi:10.1111/1440-1630.12298
5. Junek ML, Jones A, Heckman G, Demers C, Griffith LE, Costa AP. The predictive utility of functional status at discharge: a population-level cohort analysis. BMC Geriatr. 3. januar 2022;22(1):8. doi:10.1186/s12877-021-02652-6
6. Cilla F, Sabione I, D'Amelio P. Risk Factors for Early Hospital Readmission in Geriatric Patients: A Systematic Review. Int J Environ Res Public Health. 2023;20(3):3. doi:10.3390/ijerph20031674
7. Thomas EM, Smith J, Curry A, Salsberry M, Ridgeway K, Hunt B, m.fl. Association of physical function with hospital readmissions among older adults: A systematic review. J Hosp Med. marts 2025;20(3):277–87. doi:10.1002/jhm.13538
8. Loyd C, Markland AD, Zhang Y, Fowler M, Harper S, Wright NC, m.fl. Prevalence of Hospital-Associated Disability in Older Adults: A Meta-analysis. J Am Med Dir Assoc. april 2020;21(4):455–461.e5. doi:10.1016/j.jamda.2019.09.015
9. Fisher AG, Marterella A. Powerful practice: a model for authentic occupational therapy. Fort Collins, Colorado: Center for Innovative OT Solutions; 2019. Located at: WorldCat
10. Occupational Therapy Practice Framework: Domain and Process—Fourth Edition. Am J Occup Ther. 31. august 2020;74(Supplement_2):Supplement_2. doi:10.5014/ajot.2020.74S2001
11. Aas MH, Bonsaksen T. Exploring occupation-based practice among occupational therapists in hospitals and rehabilitation institutions. Scand J Occup Ther. 2023;ahead-of-print(ahead-of-print):1–11. doi:10.1080/11038128.2022.2059564
12. Buurman BM, van Munster BC, Korevaar JC, de Haan RJ, de Rooij SE. Variability in measuring (instrumental) activities of daily living functioning and functional decline in hospitalized older medical patients: a systematic review. J Clin Epidemiol. 2011;64(6):6. doi:10.1016/j.jclinepi.2010.07.005

13. Pashmdarfard M, Azad A. Assessment tools to evaluate Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) in older adults: A systematic review. Med J Islam Repub Iran. 2020;34:33–33. doi:10.34171/mjiri.34.33
14. Robertson L, Blaga L. Occupational therapy assessments used in acute physical care settings. Scand J Occup Ther. 2013;20(2):2. doi:10.3109/11038128.2012.737369
15. Piernik-Yoder B, Beck A. The Use of Standardized Assessments in Occupational Therapy in the United States. Occup Ther Health Care. 3. juli 2012;26(2–3):97–108. doi:10.3109/07380577.2012.695103
16. Prieto-Botella D, Sanchez-Perez A, Sanchez-Moreno S, Hurtado-Pomares M, Peral-Gomez P, Espinosa-Sempere C, m.fl. Identification and Use of Assessment Tools in Spanish Occupational Therapists: An Exploratory Study. Healthc Basel. 2022;10(10):10. doi:10.3390/healthcare10101902
17. Vinge AFJ, Mondrup ME, Nielsen KT, Wæhrens EE. Assessment of motor and process skills in Danish occupational therapy practice. Scand J Occup Ther. 2023;ahead-of-print(ahead-of-print):ahead-of-print. doi:10.1080/11038128.2023.2220910
18. Griffin SD, McConnell D. Australian occupational therapy practice in acute care settings. Occup Ther Int. august 2001;8(3):184–97. doi:10.1002/oti.145
19. Rapolthy-Beck A, Fleming J, Turpin M. Occupational therapy service provision in adult intensive care units in Australia: A survey of workload practices, interventions and barriers. Aust Occup Ther J. juni 2022;69(3):316–30. doi:10.1111/1440-1630.12794
20. Sharma A, Minh Duc NT, Luu Lam Thang T, Nam NH, Ng SJ, Abbas KS, m.fl. A Consensus-Based Checklist for Reporting of Survey Studies (CROSS). J Gen Intern Med JGIM. 2021;36(10):3179–87. doi:10.1007/s11606-021-06737-1
21. Sundhedsdatastyrelsen. Beskæftigede på offentlige somatiske sygehuse fordelt på faggrupper i Danmark og pr. region [Internet]. 2026. Tilgængelig hos: https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fcdn1.gopublic.dk%2Fsundhedsdatastyrelsen%2FMedia%2F63911252598635 3187%2F2_beskaeftigede-paa-offentlige-somatiske-sygehuse-fordelt-paa-faggrupper-2019-2025-version-8-april-2026.xlsx&wdOrigin=BROWSELINK
22. Terwee CB, Prinsen CAC, Chiarotto A, Westerman MJ, Patrick DL, Alonso J, m.fl. COSMIN methodology for evaluating the content validity of patient-reported outcome measures: a Delphi study. Qual Life Res. maj 2018;27(5):1159–70. doi:10.1007/s11136-018-1829-0
23. Rambøll Management Consulting [Internet]. Aarhus: Rambøll Management Consulting. SurveyXact by Ramboll; cited 2026. Available from https://www.surveyxact.dk/produkter/surveyxact/. Danish.
24. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. januar 2006;3(2):77–101. doi:10.1191/1478088706qp063oa
25. Cane J, O'Connor D, Michie S. Validation of the theoretical domains framework for use in behaviour change and implementation research. Implement Sci IS. 2012;7(1):37–37. doi:10.1186/1748-5908-7-37

26. Atkins L, Francis J, Islam R, O'Connor D, Patey A, Ivers N, m.fl. A guide to using the Theoretical Domains Framework of behaviour change to investigate implementation problems. Implement Sci IS. 2017;12(1):77–18. doi:10.1186/s13012-017-0605-9
27. World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects. JAMA. 27. november 2013;310(20):2191. doi:10.1001/jama.2013.281053
28. Rogers AT, Bai G, Lavin RA, Anderson GF. Higher Hospital Spending on Occupational Therapy Is Associated With Lower Readmission Rates. Med Care Res Rev. december 2017;74(6):668–86. doi:10.1177/1077558716666981
29. Murray A, Di Tommaso A, Molineux M, Young A, Power P. Contemporary occupational therapy philosophy and practice in hospital settings. Scand J Occup Ther. 2021;28(3):3. doi:10.1080/11038128.2020.1750691
30. Anne G. F, Lou Ann G, Seokyeon J, Fernanda M S, Mette G. S. Quality of Occupational Performance: Administration Manual. 2026.
31. Roberts P, Ouellette D, Giles GM, Mroz TM, Furniss J, Malloy J, m.fl. Occupational Therapy Assessment Practice Patterns for Core Domains in Adult Populations. OTJR Occup Ther J Res. januar 2026;46(1):108–18. doi:10.1177/15394492251320089
32. Rivelsrud MC, Hartelius L, Bergström L, Løvstad M, Speyer R. Prevalence of Oropharyngeal Dysphagia in Adults in Different Healthcare Settings: A Systematic Review and Meta-analyses. Dysphagia. februar 2023;38(1):76–121. doi:10.1007/s00455-022-10465-x

Tables

Tables are available in the Supplementary Files section.

Figures

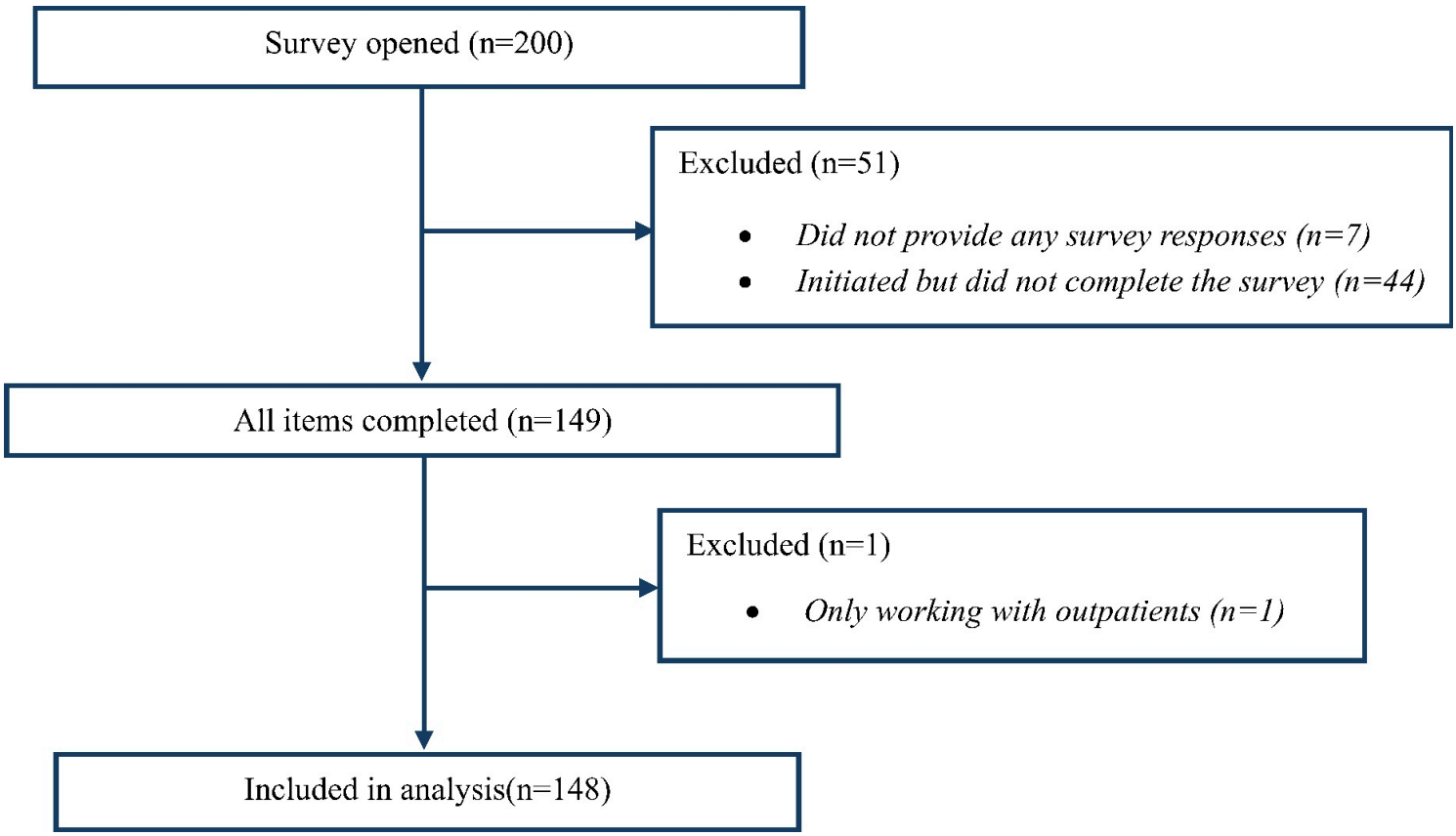


Figure 1

Flow of respondents

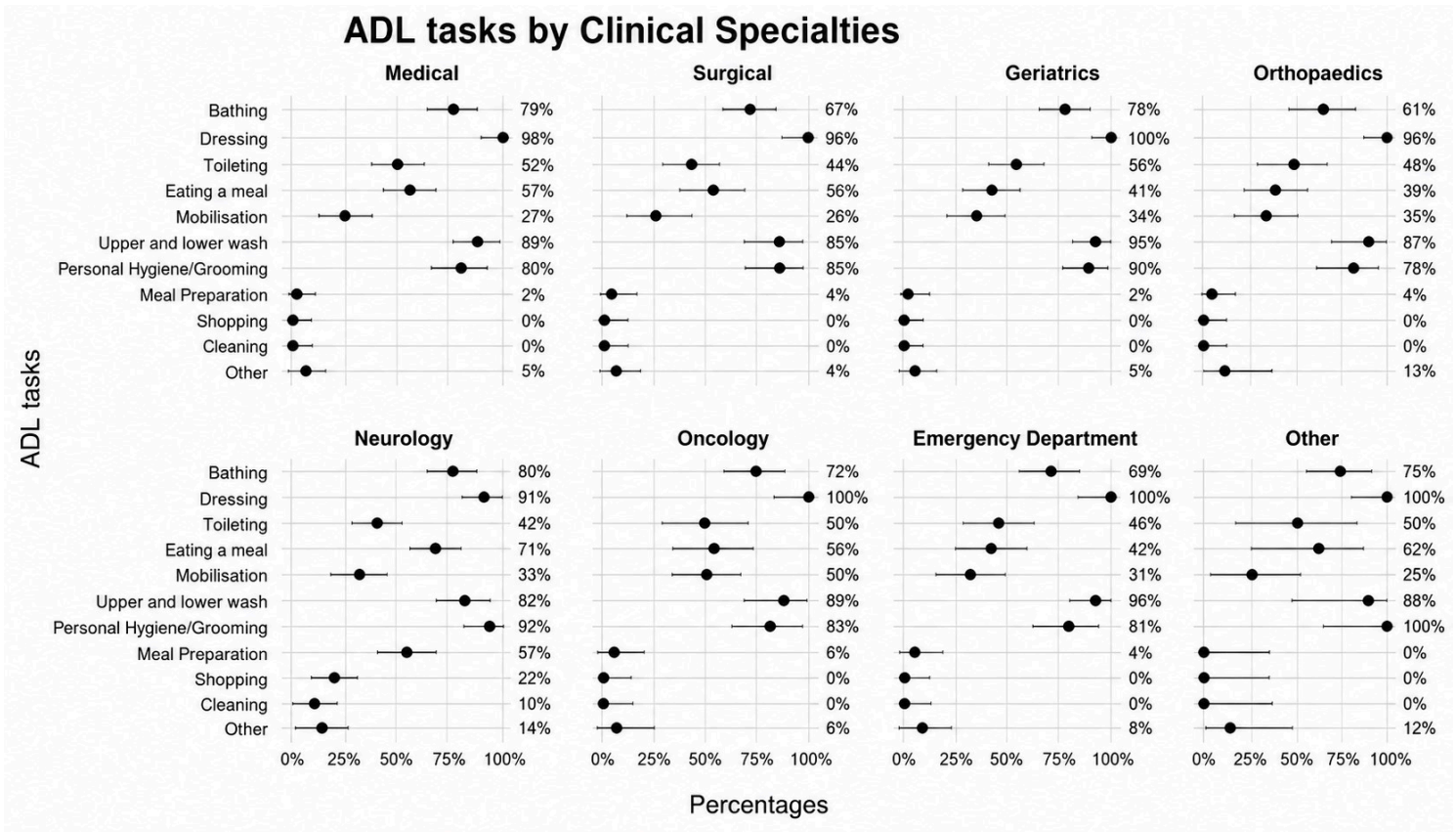


Figure 2

ADL tasks by clinical specialties

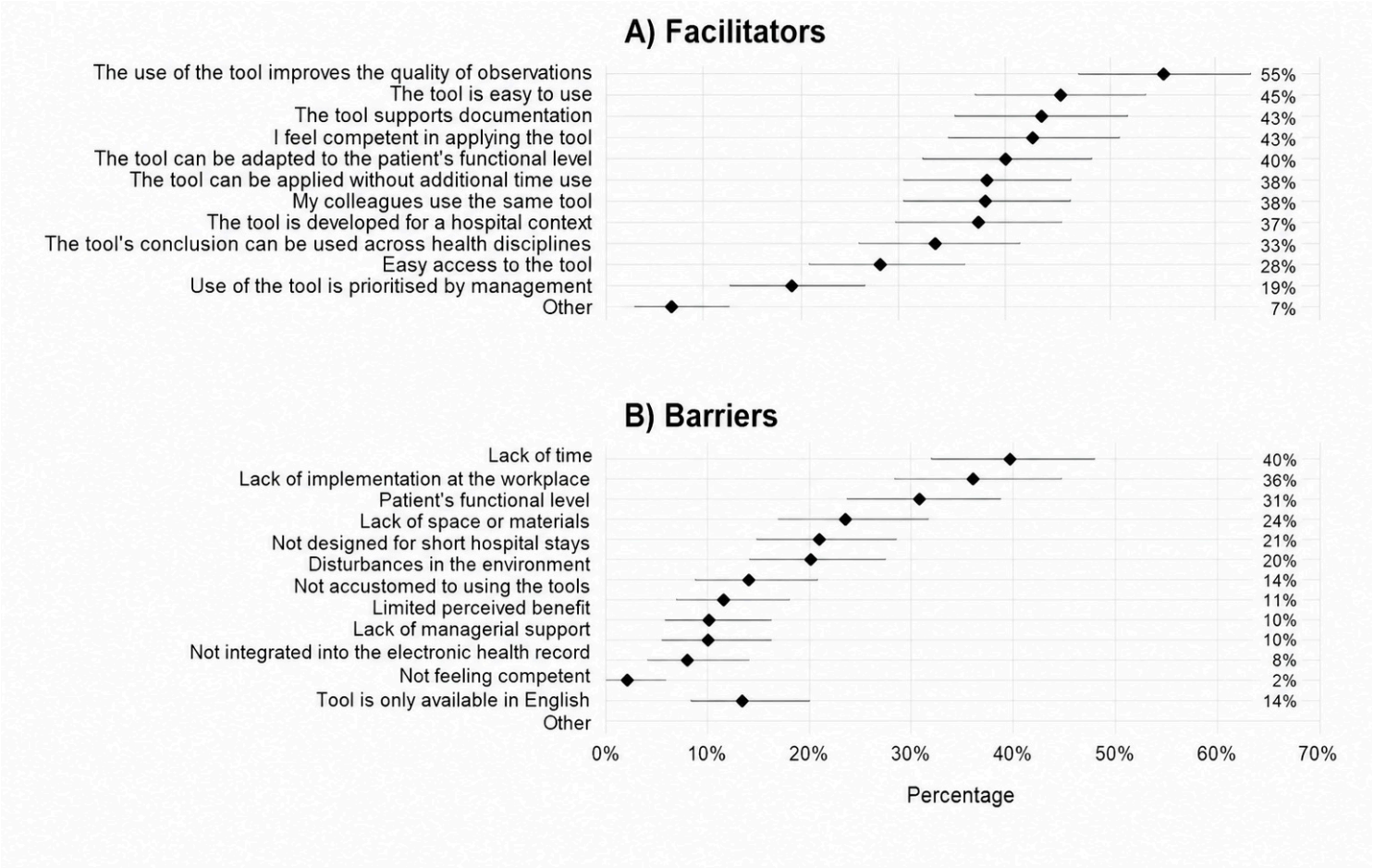


Figure 3

Facilitators and barriers influencing the use of ADL observation tools

Supplementary Files

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