Special Practice Settings Days 22–24

Section 8

9781284113242_CH31_543_556.indd 544 10/09/16 11:40 am

CHAPTER 31

Community Practice and Wellness

Susan Meyers

Learning Objectives

- Define community practice.
- Compare and contrast practice options as presented in this chapter.
- Describe considerations of safety that guide evaluation and intervention in community practice.
- Describe how the cultures of clients influence expectations of community practice.
- Describe the advantages of providing community therapy.
- Describe the three steps or processes that comprise intervention.

Key Terms

- *Community based*: Occupational therapy (OT) services that are focused on clients and families living independently within the home and community settings.
- *Health promotion*: Therapy aimed at improving control over behaviors that impact the health of individuals, both physically and mentally.
- *Prevention*: Therapy aimed at preventing or stopping illness or disability through promoting healthy lifestyle behavior modifications and practices.
- *Service delivery*: Standards and policies that guide consistent and quality healthcare services.
- *Wellness*: A healthy state, both physically and mentally.

Introduction

Community practice includes people of all ages and abilities being offered occupational therapy services in locations where they live, work, and engage in community activities of value and interest. Practice can be with an individual in their natural environment or services designed to meet the needs of an entire community. Practice is client-centered, focused on occupational performance in context, and based on best evidence (Scaffa, 2014). Independent living in the least restrictive environment is a component of occupational therapy practice that addresses client participation in everyday occupations regardless of disability (American Occupational Therapy Association, 2014).

Although there are different ways to define community practice, there is agreement that this practice occurs outside of an institutional setting and provides an OT with unique opportunities. Community practice is provided in a variety of locations: schools, homes, community centers, and work sites. Occupational therapists have an opportunity to learn about people in their natural environments rich with culture and interpersonal relationships. Engagement with an individual or agency may occur over a prolonged period enhancing understanding of challenges and their potential solutions (Shultz-Krohn & Pendleton, 2013). Therapeutic relationships usually extend to a client and a caregiver, teacher, and/or employer. An OT in community practice observes those who support or are in a position to facilitate positive outcomes, as well as those who may be barriers to the client's desired therapy outcomes. One of the most important

aspects of community practice is providing a safe environment for clients. An OT brings knowledge and skills to modify environments and provide education and advocacy to enhance safety in occupational performance for clients, families, schools, and employers.

Practice Options

Working with Children

Early intervention provides services to children from infancy to age 3 years with the purpose of enhancing a child's development in a natural environment (Stephens, 2005). Individual states are responsible for providing comprehensive services to children with an environmental or biological risk of developmental delay (Individuals with Disabilities Education Act of 2004 Amendments (P. L. 108-446), 2004). Occupational therapy services are usually provided in a child's home with the primary caregiver present. In an early intervention program, the OT may participate in an evaluation of a child, or may receive a referral for services from a developmental specialist if occupational therapy is needed to enhance the child's development. An OT arranges visits consistent with the needs of the child's caregiver in a home or preschool setting. Working closely with a mother or a teacher or both, and valuing their perspectives, an OT provides direct or consultative services (Lawler & Mattingley, 2014).

A preschool environment may be inclusive of children with differing abilities. An early intervention therapist may recommend a developmental preschool program to a parent whose child is "aging out" of early intervention. Preschool develops skills that help prepare a child for school with occupational therapy services aiding in the development of motor or social skills of a child with special developmental delays. Direct services may be provided in the preschool setting or via consultative services to a teacher who has the primary responsibility for fostering age-appropriate skills among his or her students.

Occupational therapists practice in schools that are inclusive of children with differing abilities. Both public and private schools employ OTs to work with children who have identified needs for occupational therapy services to enhance learning. A therapist may work in a single school or travel to serve multiple schools. Occupational therapy in schools is designed to facilitate a child's ability to learn through inclusion in a general education curriculum (Individuals with Disabilities Education Act of 2004 Amendments (P. L. 108-446), 2004). Provision of therapies is determined by local school districts to be most efficacious for their constituents. Some schools hire their own OTs while others contract with agencies to provide services. School OTs work with teachers, parents, other therapists, and school personnel to provide services needed to facilitate learning. Individual, group, and consultative services may be provided. Time constraints and high numbers of clients may challenge OTs working in school environments.

Working with Adults

There are many opportunities to work with adults in community settings including, but not limited to, the following: assisted living centers, community mental health programs, group homes, work environments, home health, and wellness programs (Meyers, 2010; Shultz-Krohn & Pendleton, 2013).

Assisted living settings help adults who need some help with either ADL or IADL skills or both while enabling them to maintain autonomy over much of their lives. The decision to relocate to an assisted living environment is often a choice made collaboratively between aging adults and their family members when independent living is no longer considered viable. The individual moves into an apartment or a single private room and remains "in charge" of many aspects of their daily living. Assistance is provided in areas such as home maintenance, transportation, and management of medicines. Meals and social activities are available on-site and community involvement is encouraged. Assisted living facility staff determines a person's eligibility for residence based on functional performance. An OT's focus with persons in independent living facilities is enhanced autonomy and safety. An OT most often is a consultant to an assisted living facility regarding safety factors that affect all residents or for assessment of an individual's functional performance. Persons living in assisted living may receive more traditional rehabilitation services from a home healthcare agency when challenges to their assistance level occur (Fisher, Atler, & Potts, 2007).

Community mental health services are provided to persons with chronic mental illness in their homes or day treatment centers (Shultz-Krohn & Pendleton, 2013). There are also a number of persons with chronic mental illness living in shelters and on the street. Assertive outreach is designed to take mental health services to the

client in their homes or other living environments with the objective of reducing hospitalization and increasing client satisfaction (Peterson, Michael, & Armstrong, 2006). Through assertive outreach, an OT visits with a client in the client's preferred location, which may be the client's home. Within the natural living environment, an OT gains a better understanding of challenges and barriers that influence a client's performance (Meyers, 2010). Community mental health centers provide day treatment including: meals, areas for performing ADLs such as hygiene activities, social and recreational activities, and assistance with the development of work skills.

The independent living movement has encouraged advocacy by parents of adult children unable to live without supervision in the community. As their children progressed through school programs that focused on skills that could be used for self-care and paid or volunteer work, living arrangements were sought to increase more independence. Group homes provide supervision as needed, while encouraging independence (Shultz-Krohn & Pendleton, 2013). Occupational therapists consult with the staff of group homes to develop individual programs to enhance residents' ADL and IADL skills.

Work Programs

Returning to work after an illness or injury or entering the workplace for the first time are important goals for many adults and provide motivation for rehabilitation (Johansson & Tham, 2006; Shultz-Krohn & Pendleton, 2013). Work is often associated with a person's identity, gives meaning and purpose to life, and provides structure for living. Sager and James (2005) studied injured workers and their rehabilitation process and found that injured workers wanted to return to meaningful, productive work roles. Although work hardening programs may reduce effects of injury and build strength and endurance, it may not address a worker's motivation to return to work (Loisel et al., 2005). Occupational therapy provided in a work site soon after injury that includes skilled intervention positively correlates with the worker's motivation to return to work. Rehabilitation in the workplace allows an OT to observe actual physical conditions and performance demands to facilitate a worker's transition from client to worker role (Shultz-Krohn & Pendleton, 2013). An OTs presence in a work site can help focus the attention of employers and insurers on the prevention of future injuries to clients and their coworkers (King & Olson, 2014; Lysaght, 2004).

Occupational therapists provide services in a client's home as a continuum of care following in-patient rehabilitation. There are many advantages to rehabilitation in the client's naturalistic environment including observations of physical and social supports or barriers to goal attainment. Services provided in clients' homes present opportunities for OTs to collaborate with clients and their family or caregiver. Therapy occurs in clients' homes and the community using naturally occurring resources for ADL and IADL skills and recommending modifications to facilitate performance and enhance safety. Occupational therapists providing services in clients' homes must understand that control of the environment remains with clients and their client's families. Changes in the physical environment or costs associated with enhanced safety recommendations or both may be unwelcome. Scheduling conflicts with clients and performance of tasks inconsistent with cultural preferences may need to be negotiated (Shultz-Krohn & Pendleton, 2013).

Wellness Programs

Maintaining and improving health contain the costs of health care (Folland, Goodman, & Stano, 2007). Occupational therapy has opportunities to focus on wellness as individuals and communities take greater responsibility for their health (Baum, 2007). Wellness encompasses a person's perceived need and responsibility for engagement in occupations that provide satisfaction. Some examples of programs that enhance well-being and self-control include the following: obesity management, backpack awareness, aging in place, safe driving, and life coaching (Reitz, 2014). All of these focus on needs and interests of an individual or a group, which give them greater control of the activities and roles that give life meaning.

Obesity-related chronic health challenges, such as diabetes and cardiovascular disease, often result in premature death or a lifetime of disability. These health challenges may interfere with job performance, participation in family and community activities, and lead to chronic depression. Obesity is no longer a challenge that impacts adults alone, and has encroached into the lives of children and adolescents, interrupting normal development. Occupational therapists collaborate with others in their communities to develop and implement programs that increase physical activity and stress reduction for individuals or groups contending with these and other health-related challenges.

Most aging adults prefer to live independently in their own home (Siebert, 2003). Aging in place is a movement directed to older adults who wish to remain in their homes throughout their lifespan but need assistance to evaluate the safety of their home and education to modify their performance of ADLs and IADLs to meet their changing physical capacity (Bowen, 2001). Reducing hazards in a home through physical modifications may be most effective in preventing falls in homes of older adults (Bonder, 2014). Services for older adults are often provided by community agencies advocating for independent living.

Driving safely is a concern that primarily affects older adults but may also relate to an adult of any age who has had an illness or disability that affects performance of driving skills. Occupational therapy has moved to the forefront of this area by developing practice guidelines for driving and community mobility for older adults (AOTA, 2007; Stav, Arbesman, & Lieberman, 2008; U.S. Small Business Administration, 2015). The American Occupational Therapy Association has collaborated with AARP and the Automobile Association of America in a program to recommend care modifications and driving services (Strzelecki, 2008).

Life coaching is offered by OTs in their communities with the goal of assisting clients to achieve wellness in challenging environments (Hawksley, 2007). An OT working as a life coach would assist a client to identify and plan steps to achieve goals, increase energy, and reduce stress (Yousey, 2001).

Community Considerations

There are two primary considerations that influence OTs working in community practice, including an appreciation of culture as a factor in occupational performance and safety for the client and for the therapist. Occupational therapy practice in the community occurs in contexts that reflect rich and diverse cultures. Culture is defined as a way of living that is reflective of values, attitudes, beliefs, ideas, and customs shared by a group of people (Black, 2014; Fitzgerald, Mullavey-O'Byrne, & Clemson, 1997). A client's culture influences occupational behavior standards and expectations (AOTA, 2014). Smaller communities may be composed of people aligned with a shared culture; however, as a community gets larger, cultural diversity expands. In larger urban centers, OTs encounter people of different races, ethnicities, religions, socioeconomic statuses, and other social locations; therefore, OTs must be prepared to engage respectfully with all clients. One of the greatest barriers to effective care in a multicultural environment is value conflicts between OTs and clients (Fitzgerald et al., 1997). For example, in some cultures aged adults are not encouraged in independent function since it is considered the responsibility of their children to provide such care.

An OT is a guest in a client's home and is advised to follow customs of the client and others living there (Black, 2014). Scheduling a visit in the community to gain maximum benefit to the client and OT will involve collaborations with caregivers (Solet, 2014). Occupational therapists working in early intervention know that a visit during regular nap time is generally not productive, and an OT working in home health will know that having a caregiver present will facilitate understanding the support or limitations available to a client. During the first visit in a new environment, the OT identifies cultural artifacts that are important to the client. Fashion of dress is relevant to the client and OT. After observing cues from the environment, an OT may choose to modify his or her appearance to be viewed as acceptable to the client. Methods of meal preparation also can present a new challenge to an OT unfamiliar with dietary restrictions due to a particular custom or religious requirement. Understanding gender roles and age expectations within a culture also will influence therapy outcomes. It is ineffective to focus on IADLs that will never be performed by a client because of cultural taboos. Cultural and religious rituals are an important part of belonging and participating in society. Understanding the meaning and performance demands of rituals to enable participation by a client may be a major focus of occupational therapy (AOTA, 2014). Observing and listening without personal bias can be difficult; however, failing to understand another person's culture can be an obstacle to effective community practice (Royeen & Crabtree, 2006).

Awareness of socioeconomic status is another factor that is a component of a client's culture and social locations. Understanding challenges to performance takes into account that some individuals or communities lack resources to provide environmental modifications to accommodate differences in abilities. Individual clients may understand that home modifications or adaptive devices may facilitate performance of ADLs and IADLs, but lacking financial resources, they may refuse or ignore

therapy recommendations. Understanding that financial limitations exist, and knowing if assistance would be acceptable to a client, marks the starting point for discussions about how best to meet a client's unique needs.

Safety

Living safely is an expectation for most people. Occupational therapy addresses safety of home and work environments through direct service and consultation and advocates for safe engagement through accessibility of public spaces, events, and transportation. Prevention of further harm through unsafe practices or environments is part of home health services. Working with older adults with a history of falls, OTs have been effective in assessing and reducing home hazards to prevent further injury (Rigby, Trentham, & Lotts, 2014). Occupational therapists assess safety hazards in homes by observing a client's caregiver performing ADLs and IADLs. Occupational therapists that usually travel to community sites by car may want to experience other modes of transportation to determine how easily their clients can move outside of their homes to the market, banks, medical and dental offices, and places of worship, for example. Discussion about valued roles will lead an OT to analyze performance demands and suggest modifications that may be made to enhance safety. A mother may value caring for a small child and need modifications to safely bathe her child. Shopping and money management are tasks where personal safety may be impaired by cognitive disabilities, and therapy can address these safety concerns (Tipton-Burton, McLaughlin, & Englander, 2013). Occupational therapists address safety through community programs such as backpack safety programs, applying ergonomic principles in the workplace, and offering programs aimed at the prevention of violence.

There are personal safety concerns for any healthcare worker providing services in the community. Personal safety begins with vigilance and a keen awareness of the surroundings when going to and from a client's residence. There are safeguards for an OT that include visual identification as a home health provider with a name or a car tag or both, uniforms or scrubs, and employing a cell phone to contact a client or ask for assistance. Occupational therapists manage their personal safety through knowledge of their clients and their communities, as well as possessing confidence in their ability to get help when needed.

Screening and Assessments

The greatest advantage of providing community therapy is the opportunity to evaluate occupational performance in the client's natural environment where performance demands exist and physical and social barriers are evident. In schools, OTs observe classrooms for sensory distractions and how well children interact with their peers and teachers. In a work environment, an OT observes performance challenges such as the physical layout of a classroom and task performance and support that is available from co-workers and employers. An OT working in community practice is concerned with factors that will empower clients and facilitate occupational engagement (AOTA, 2014).

Evaluation of context of a client's occupational performance includes cultural factors such as gender and associated roles, age, faith tradition, race and ethnicity, and socioeconomic status (AOTA, 2014). Occupational therapists practicing in home health begin the evaluation by observing the client's surroundings. How a living space is decorated is an opening to a client's history, beliefs, and values. An OT can engage the client and his or her caregiver and family members in sharing the importance of certain objects and how they relate to rituals and occupational performance relevant to client-centered care. Therapy in the community includes sharing of stories and ideas, as well as problem solving based on mutual respect. If an OT does not understand the values shared by a client and his or her family members, recommendations for therapy may be ignored.

Observation of the natural environment also takes into account physical structures such as internal space dimensions demarcated by walls and other physical barriers, objects (e.g., furniture and tools), and external space (e.g., entrances and walkways) (Shotwell, 2014). Discussing valued activities that include others and the client's access to these activities is an important component of evaluation in community practice. Most people get enjoyment and validation of themselves through social interactions. Evaluation of social interactions can be observed during usual social activities in a naturalistic context (Fisher & Griswald, 2010).

Occupational profiles give OTs information about clients' values, interests, and what they want and need to be able to do (AOTA, 2014). The Canadian Occupational Performance Measure (COPM) along with observation of the performance of ADL and IADL tasks provides

measures used for comparisons during intervention (Doig, Fleming, Kuipers, & Cornwell, 2010; Law et al., 2005; Shotwell, 2014). Integrating a client's functional performance, personal preferences, and community environment occurs through the process of activity analysis. The OT identifies assets and barriers that may advance or deter occupational performance. Sharing this information with a client and other persons of influence in the environment results in preliminary goals for intervention.

The exact manner of data collection is influenced by the needs of the client, the reason for therapy, and the frame of reference or model of practice or both that an OT employs. Formal and informal structured or unstructured assessment tools may also be used; however, standardized and criterion- or norm-referenced assessment tools provide objective data to support or justify continued need for occupational therapy services. Occupational therapists working with children utilize developmental assessments and observation of performance of age-appropriate tasks. Discussion with parents and teachers or surveys to be used at home may shed light on a child's performance deficits in different environments. Evaluation of adults using the Model of Human Occupation can identify current roles and those impaired or lost due to illness or injury and activities that support those roles (Solet, 2014; Tipton-Burton et al., 2013). These data paired with observation and performance in the client's natural environment help OTs to identify barriers that need to be addressed (e.g., home modifications to enable role performance). Evaluation in the community is multidimensional, continuous, and responsive to a client's developing achievement of desired occupations.

Interventions

Collaboration focused on clients' self-management, education, and environmental modifications is key to successful community practice outcomes. Depending on the service delivery model, interventions often are directed to individual clients and their family members or other caregivers, employers and employees, or groups and populations within a particular community. Intervention involves a three-step process of planning, implementing, and reviewing outcomes that is dynamic and cyclical until therapy services are concluded (AOTA, 2014).

Planning interventions begin with a process of clinical reasoning in which evaluation results are integrated with practice models, frames of reference, and evidence-based practice (Scaffa, 2014). Occupational therapists and clients that collaborate in planning interventions increase clients' level of commitment to achieve their established goals (Doig et al., 2010). A client may need activities to occupy time, increase independence in living skills, and improve relationships with others. Interventions are discussed with a client around discrepancies between functional performance and goals. In the planning process an OT may discover that a client is unable to recognize or accept that he or she may not return to former functional status or the client is resistant to an OTs recommendations (Wheeler, 2014).

In a continuum of care, a community-based OT addresses implementation of skills training along with assessment of naturally occurring barriers and available supports at the conclusion of an inpatient's therapy (Wheeler, 2014). Opportunity to modify the environment may be more effective to enhance client function than services directed at changing a client. Occupational therapists practicing in a community should be familiar with options to remove barriers that are acceptable and financially feasible. Universal design brings an array of products to retail stores for everyone to use to make their work safe and comfortable. Accessible design in new construction and added access to existing buildings and natural spaces eliminates barriers and enhances participation for persons of all abilities. Technology includes devices and products commercially available to make occupations easier for everyone. Using these devices opens opportunities for persons with disabilities to engage in activities at home, school, and work. Computers, smart pads, and phones have opened opportunities for clients and also to OTs who use these devices as therapy tools (Rigby et al., 2014).

During home care visits or other community services provided by OTs, home modifications are often recommended to enhance clients' safety (Bonder, 2014). Interventions may include durable medical equipment for performance of ADLs or reorganization of space for ease of performance of daily occupations. Challenges occur when a client or family member resists changes to their physical environment. A client can be tired, frustrated, and anxious about his or her future and be either actively resistant or passive about intervention strategies. These challenges can be managed within a therapeutic relationship. Occupational therapists must actively listen to client and family concerns, provide information, and negotiate a solution that satisfies a client's safety needs and family concerns (Taylor, 2014).

In community practice, intervention is reviewed as it continues and a client's functional abilities change. The dynamic process of intervention and disabling injury or illness requires an OT to continually observe performance and listen to a client or his or her caregiver and make modifications in intervention to satisfy goals or treatment.

Referrals and Discharge Considerations

Occupational therapists may provide community services through an organization that has multiple service providers, a structure for supervision, centralized billing, and routine methods of accountability. However, some OTs may opt for private practice as either a lone practitioner or with other service providers and will need to establish methods to monitor accountability. All practices must adhere to guidelines established by their funding sources such as Medicare or private insurance companies (Lohman, 2014). Independent practice requires understanding and compliance with all state and professional regulations for OT practitioners (Doherty, 2014). When a private practice under the auspices of an OT includes professionals such as physical or speech therapists, the manager of the practice also assumes responsibility for compliance with regulations affecting these practitioners. For example, if a third party identifies fraudulent documentation or billing by an OT, it is the responsibility of the practice manager to report this to the respective licensing boards of the person who has committed this breach.

Management and Standards of Practice

In community practice, most OTs are responsible for scheduling visits and delivering and documenting services provided without direct supervision. Therefore, organization skills to effectively manage time to include direct service, travel to sites of delivery, and documentation are essential. For example, grouping client visits by common locations and establishing a daily routine for documentation and billing contribute to effective practice. Community OTs must plan for their own continuing education in their areas of practice to stay up to date with therapy techniques and documentation and to maintain professional and state credentials.

Occupational therapy assistants (OTA) often are required by state regulations to have a specific amount and type of supervision by an OT. State regulations specify these requirements and it is the responsibility of both the OT and OTA to see that they are met and documented (Youngstrom, 2014). Community practice like all professional practices is guided by ethical considerations. In community practice where there may be little direct oversight, it is the OTs responsibility to adhere to a professional code of ethics.

Summary

Community practice and wellness include occupational therapy services delivered to persons with a variety of challenges at home, school, workplace, and community programs. The occupational therapy evaluation and intervention process can be most effective when delivered in a client's preferred environment where there are naturally occurring supports. Occupational therapists use their skills of observation and therapeutic use of self to establish a collaborative relationship with clients to create safe occupational performance in clients' preferred activities.

Chapter 31 Self-Study Activities (Answers Are Provided at the End of the Chapter)

Read the following case study and then answer the questions:

My first visit with Angie was a continuation of services from a community mental health program. Diagnosed with chronic severe depression, Angie was a regular participant in activities that provided socialization and volunteer work opportunities while living with her husband of eight years in a one-bedroom apartment. Medication effectively controlled most of Angie's symptoms of depression and she was satisfied with her life until she developed symptoms of multiple sclerosis (MS). Her family physician began medication to mediate her MS symptoms but this resulted in less efficacy of the medication she took for her depression. She decided that she would prefer to stop taking the medication for MS and live with her

symptoms, rather than fall into debilitating depression. My visit was to assess her function in her home and community since her gait had become unsteady and she feared falling.

Arriving at the entrance to her building, I observed that the exterior entrance had no steps or other barriers and her home was just past the main entrance. It was only upon entering her home that I observed her bathroom was located just inside the door but the rest of her living areas were two steps down from that level. Due to the placement of the bedroom door, there would be no possibility of a ramp to the bathroom; however, installing a railing and grab bars would make her home safer. During the first visit we discussed her valued roles as wife and homemaker. She had been independent in shopping and participating in community activities. I observed an open book and a full book case and we discussed our mutual love of reading. I asked her about her homemaking activities as we walked about her kitchen. Since Angie reported becoming fatigued as she cleaned her home and prepared meals, we discussed organizing her work space to conserve energy. Since Angie collaborated in problem solving her challenges, she was eager to implement changes to make her home safer and simplify her work.

Angie experienced a rapid escalation of her MS symptoms, including weakness and urinary incontinence. The most distressing outcome for her was an inability to exit her home independently to engage in social activities and reading discontinuance due to blurred vision. This was the point where, despite use of a cane and a wheelchair to go out with her husband to visit family, Angie decided to try medication to alleviate her MS symptoms. Her primary physician and psychiatrist agreed to work together to try and give her relief from both the MS symptoms and subsequent depression. There was success with ameliorating the MS symptoms; for example, her urinary incontinence abated; her vision improved and she began reading again; and her depression was lessened. Her gait remained unsteady; however. Durable Medical Equipment (DME) was provided for use while she was alone in her home, including a standard walker, bedside commode (i.e., to decrease the need to use the steps up to her bathroom), and a wheelchair for use outside her home. Her husband was supportive and helped with her use of the bathroom when he was home. Her mother who lived nearby visits, often helping Angie with some personal and home care tasks. Angie continued to prepare meals and do laundry and enjoyed weekend and evening outings with her husband.

The focus of Angie's intervention was safety and maintenance of valued roles, leisure, and work activities. Collaboration with Angie, her husband, and her doctors would need to be continued as Angie's symptoms change. Note: Questions 1-2 are related to the aforementioned case.

1. The OT was responsible to deliver services, which kept Angie safe in her home. Where will he/she begin Angie's evaluation?
   - **A.** With observation of the home environment
   - **B.** With a conversation with Angie about her concerns
   - **C.** With a conversation with Angie about her previous service providers regarding their concerns
2. The OT has determined that Angie will need adaptive equipment to be safe alone in her home. What should the OT consider in the recommendations?
   - **A.** Acceptance of the suggested equipment by Angie and her husband
   - **B.** The cost of the equipment
   - **C.** Ease of use of the equipment
3. An OT is working with a client learning to live alone in his own apartment for the first time. One therapy session focuses on meal preparation and clean up. At the conclusion of the meal, the client picks up the dirty pots and dishes and runs them under some cold water and sets them on the counter to dry. What is the next step the OT might take to improve health and safety for the client related to kitchen clean up?
   - **A.** Ask the client to describe any prior experience with kitchen clean-up either as a participant or as an observer.
   - **B.** Identify procedures to safely wash dishes and the importance of using soap and hot water.
   - **C.** Provide an opportunity to wash dishes with the client demonstrating safe dishwashing procedure.
   - **D.** Give the client a handout that describes procedures for safe dishwashing.

Chapter 31 Self-Study Answers

Question 1

Response "B" is the answer that stresses client-centered care. Angie's concerns relate to her needs

to continue to perform the roles and activities that she considers important to her well-being. Response "A" is also important since addressing the home environment may help Angie achieve her goals; however, the occupational therapist should *begin* the evaluation through a conversation with the client.

Question 2

- Response "A" is the most appropriate answer; unless equipment is accepted (and wanted) by the client, it is unlikely to be used.
- In review of response "B," the cost of equipment may also be a consideration, but community-based OTs are likely to know of resources to pay for equipment that a client is unable to afford.
- Response "C" is also important because if equipment is difficult to use, it may be abandoned by clients. For example, mobility aids that do not fit into the client's primary mode of transportation may not ease participation in activities throughout the community.

Question 3

While responses "A," "B," and "C" will give useful information, answer "C" is the correct response. That is, demonstration is the most effective method to improve safety in home management tasks. While working alongside the client to wash and dry dishes after a meal, the OT can provide important information about the process and also food safety. It does not put the client "on the spot" to answer that he has not done this task previously or has not seen it done correctly. Working collaboratively on this task, the OT has an opportunity to build rapport with the client and positively reinforce performance, which is likely to result in continued safe dishwashing practices.

Additional considerations

- It would be helpful to have a discussion with the client about concerns that an OT might have with the client's kitchen clean-up process (e.g., hygiene in the kitchen and other areas of the home, and food-borne illness).
- What information about this particular client might help the OT construct an intervention process that would result in meal preparation? Consider cognitive ability, interest in task, and motivation.
- Consider other methods the OT can use to improve this client's performance in food safety (e.g., local cooking groups the client may attend, use of technology to demonstrate and reinforce safe practice).

References

American Occupational Therapy Association. (2007). Board and specialty certification. Retrieved from From www.aota.org/practitioners/profdev.certification.aspx.

American Occupational Therapy Association. (2014). *Occupational therapy practice framework: Domain & process* (3rd ed.). Bethesda, MD: AOTA Press/American Occupational Therapy Association.

Baum, C. (2007). Achieving our potential. *American Journal of Occupational Therapy*, *61*(6), 615–623.

Black, R. M. (2014). Culture, race, ethnicity and the impact on occupation and occupational performance. In B. A. B. Schell, G. Gillen, & M. Scaffa (Eds.), *Willard & Spackman's occupational therapy* (12th ed., pp. 173–187). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Bonder, B. (2014). Providing occupational therapy for older adults with changing needs. In B. A. B. Schell, G. Gillen, & M. Scaffa (Eds.), *Willard & Spackman's occupational therapy* (12th ed., pp. 541–552). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Bowen, R. E. (2001). Independent living programs. In M. E. Scaffa (Ed.), *Occupational therapy in community-based practice settings* (pp. xxv, 414 p.). Philadelphia, PA: F.A. Davis Co.

Doherty, R. F. (2014). Ethical practice. In B. A. B. Schell, G. Gillen, & M. Scaffa (Eds.), *Willard & Spackman's occupational therapy* (12th ed., pp. 413–424). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Doig, E., Fleming, J., Kuipers, P., & Cornwell, P. L. (2010). Clinical utility of the combined use of the Canadian Occupational Performance Measure and Goal Attainment Scaling. *American Journal of Occupational Therapy*, *64*(6), 904–914. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/21218681.

Fisher, A. G., Atler, K., & Potts, A. (2007). Effectiveness of occupational therapy with frail community living older adults. *Scandinavian Journal of Occupational Therapy*, *14*(4), 240–249. doi:10.1080/11038120601182958

Fisher, A. G., & Griswald, L. A. (2010). *The evaluation of social interaction*. Fort Collins, CO: Three Star Press.

Fitzgerald, H. M., Mullavey-O'Byrne, C., & Clemson, L. (1997). Cultural issues from practice. *Australian Journal of Occupational Therapy*, *44*, 1–21.

Folland, S., Goodman, A. C., & Stano, M. (2007). *The economics of health and health care* (5th ed.). Upper Saddle River, NJ: Pearson Prentice Hall.

Hawksley, B. (2007). Work-related stress, work/life balance and personal life coaching. *British Journal of Community Nursing*, *12*(1), 34–36. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/17353810.

Individuals with Disabilities Education Act of 2004 Amendments (P. L. 108-446). (2004).

Johansson, U., & Tham, K. (2006). The meaning of work after acquired brain injury. *American Journal of Occupational Therapy*, *60*(1), 60–69. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/16541985.

King, P. M., & Olson, D. L. (2014). Work. In B. A. B. Schell, G. Gillen, & M. Scaffa (Eds.), *Willard & Spackman's occupational therapy* (12th ed., pp. 678–696). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Law, M., Baptiste, S., Carswell, A., McColl, M., Polatajko, J., & Pollack, N. (2005). *Canadian Occupational Performance Measure*. Ottawa, ON: Canadian Occupational Therapy Association.

Lawler, M. C., & Mattingley, C. (2014). Family perspectives on occupation, health and disability. In B. A. B. Schell, G. Gillen, & M. Scaffa (Eds.), *Willard & Spackman's occupational therapy* (12th ed., pp. 150–162). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Lohman, H. (2014). Payment for services in the United States. In B. A. B. Schell, G. Gillen, & M. Scaffa (Eds.), *Willard & Spackman's occupational therapy* (12th ed., pp. 1051–1067). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Loisel, P., Falardeau, M., Baril, R., Jose-Durand, M., Langley, A., Sauve, S., & Gervais, J. (2005). The values underlying team decision-making in work rehabilitation for musculoskeletal disorders. *Disability and Rehabilitation*, *27*(10), 561–569. doi:10.1080/09638280400018502

Lysaght, R. M. (2004). Approaches to worker rehabilitation by occupational and physical therapists in the United States: Factors impacting practice. *Work*, *23*(2), 139–146. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/15502294.

Meyers, S. K. (2010). *Community practice in occupational therapy: A guide to serving the community*. Sudbury, MA: Jones and Bartlett Publishers.

Peterson, M., Michael, W., & Armstrong, M. (2006). Homeward bound: Moving treatment from the institution to the community. *Administration and Policy in Mental Health and Mental Health Services Research*, *33*(4), 508–511. doi:10.1007/s10488-005-0013-3

Reitz, M. (2014). Health promotion theories. In B. A. B. Schell, G. Gillen, & M. Scaffa (Eds.), *Willard & Spackman's occupational therapy* (12th ed., pp. 574–587). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Rigby, P., Trentham, B., & Lotts, L. (2014). Modifying performance contexts. In B. A. B. Schell, G. Gillen, & M. Scaffa (Eds.), *Willard & Spackman's occupational therapy* (12th ed., pp. 364–381). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Royeen, A. M., & Crabtree, J. L. (2006). *Culture in rehabilitation: From competency to proficiency*. Upper Saddle River, NJ: Pearson Education.

Sager, L., & James, C. (2005). Injured workers perspectives of their rehabilitation process under the New South Wales workers compensation system. *Australian Journal of Occupational Therapy*, *52*, 127–135.

Scaffa, M. E. (2014). Occupational therapy interventions for organizations, communities and populations. In B. A. B. Schell, G. Gillen, & M. Scaffa (Eds.), *Willard & Spackman's occupational therapy* (12th ed., pp. 342–352). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Shotwell, M. P. (2014). Evaluating clients. In B. A. B. Schell, G. Gillen, & M. Scaffa (Eds.), *Willard & Spackman's occupational therapy* (12th ed., pp. 281–301). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Shultz-Krohn, W., & Pendleton, H. M. (2013). Application of the occupational therapy framework to physical dysfunction. In L. W. Pedretti, H. M. Pendleton, & W. Schultz-Krohn (Eds.), *Pedretti's occupational therapy: Practice skills for physical dysfunction* (7th ed., pp. 28–54). St. Louis, MO: Elsevier.

Siebert, C. (2003). Aging in place: Implications for occupational therapy. *OT Practice*, *8*, 16–20.

Solet, J. M. (2014). Optimizing personal and social adaptation. In M. V. Radomski & C. A. T. Latham (Eds.), *Occupational therapy for physical dysfunction* (7th ed., pp. 925–954). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Stav, W. B., Arbesman, M., & Lieberman, D. (2008). Background and methodology of the older driver evidence-based systematic literature review. *American Journal of Occupational Therapy*, *62*(2), 130–135. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/18390007.

Stephens, L. C., & Tauber, S. K. (2005). Early intervention. In J. Case-Smith (Ed.), *Occupational therapy for children* (4th ed., pp. 771–794). St. Louis, MO: Mosby.

Strzelecki, M. (2008). Driving the profession. *OT Practice*, *13*(5), 9–11.

Taylor, R. (2014). Therapeutic relationships and client collaboration. In B. A. B. Schell, G. Gillen, & M. Scaffa (Eds.), *Willard & Spackman's occupational therapy* (12th ed., pp. 425–436). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Tipton-Burton, M., McLaughlin, R., & Englander, J. (2013). Traumatic brain injury. In L. W. Pedretti, H. M. Pendleton, & W. Schultz-Krohn (Eds.), *Pedretti's occupational therapy: Practice skills for physical dysfunction* (7th ed., pp. 881–915). St. Louis, MO: Elsevier.

U.S. Small Business Administration. (2015). An official website of the United States Government.

Wheeler, S. D. (2014). Providing occupational therapy for individuals with traumatic brain injury. In B. A. B. Schell, G. Gillen, & M. Scaffa (Eds.), *Willard & Spackman's occupational therapy* (12th ed., pp. 925–935). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Youngstrom, M. J. (2014). Supervision. In B. A. B. Schell, G. Gillen, & M. Scaffa (Eds.), *Willard & Spackman's occupational therapy* (12th ed., pp. 1068–1087). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Yousey, J. (2001). Life coaching: A one to one approach to changing lives. *OT Practice*, *6*(1), 11–14.