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President's message

Susan Forwell

Have you every heard someone comment that a person looks younger than their stated age, as if there was some pre-conceived notion about what one looks like at any one age? Cunningham (2004) points out that we only think we know what old age looks like and have no idea what it feels like. She also says that the world an older adult inhabits is likely far different than the one we imagine. We can only guess that what seniors bring to each day is, in part, informed by a lifetime of experiences, relationships, habits and preferences that are accompanied by creeping sensory, physical and cognitive changes.

Essential ingredients for preserving quality of life are maintaining a sense of control over personhood and a choice of daily occupations within reasonable risk to self and others (Law et al., 2002; McKnight, 1989). Control and choice, however, are not necessarily coupled with independent participation. Rather, it is the confluence and interdependence with social, physical, cultural and societal structures and networks that may be preferable. Approaches to facilitate independent or interdependent participation may be accompanied by doing things a little differently. It is by using diverse solutions that occu-

pational therapists assist older adults to pursue chosen occupations to ensure participation in whatever manner that might take. The tenets of making active choices, maintaining a sense of control, engaging in daily occupation, whether it be independently or interdependently are essential imperatives that strike to the heart of occupational therapy. As we consider the wise thoughts in this issue, reflect on ourselves, our loved ones, clients and colleagues who are getting older and need to be assured these tenets are protected.

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Reflections on facilitating older adult's participation in valued occupations

Deirdre R. Dawson and Bianca Stern

*Age is opportunity no less,
Than youth itself, though in another dress,
And as the evening twilight fades away,
The sky is filled with stars, invisible by day.*
Henry Wadsworth Longfellow

Each day as we walk to our offices at Baycrest (our place of work and a health sciences centre focused on aging) we encounter various older adults. Mr. H., an elderly man, is packing his car with meals to deliver to housebound seniors, Mrs. S. is humming while she waters her plants and remarks, as we pass, on her thankfulness for another day, and Mr. P, a resident of our Home for the Aged is sitting in a wheelchair, well dressed, well positioned but staring off into space, occasionally shrugging in response to something said to him.

These snapshots beg the question: what enables some older adults to remain active and engaged, to find meaning, while others do not? Aging is variable and complex and we know it is not simply genetics, nor declining cognitive and physical abilities that determine how we age and live as older adults. Thus we ask: how do we, as occupational therapists, facilitate ongoing participation in meaningful occupations throughout the experience of aging?

What enables older adults to remain engaged?

Aging, unquestionably, results in mental and physical decline. Our memory slips increase (what did I go to the basement for?), and our joints become creaky. Yet the trajectory of decline is astonishingly variable. We all know of older adults in their 70s, 80s, even 90s who continue to work, pursue challenging hobbies, live independently, be physically active (even run marathons!) – that is they continue to enjoy and be actively involved in things that are meaningful to them.

There are a host of things we cannot change that significantly impact how we age (e.g., genes, years of education). Fortunately, there are also factors definitely or potentially amenable to change. For example, aerobic fitness training in older adults has been found to significantly increase brain volume (white and gray matter) (Colcombe et al., 2006). As well, some research suggests computerized brain fitness programs may provide cognitive benefit. Further, positive effects on cognition and overall psychosocial status in aging adults have been found in relation to multi-faceted programs and in rela-

tion to environmental manipulations. We ran a study combining strategy, memory and psychosocial training and found positive effects in each domain after only 12 hours of group training in normally aging older adults (Stuss et al., 2007). And in animals (old rats to be specific), an enriched external environment has been shown to offset some of the declines associated with aging.

While we do not advocate occupational therapists run aerobic fitness programs or prescribe computerized brain fitness programs, we believe that there is value in understanding some of the more basic research that relates to aging. Further, there are some interesting

“... how do we facilitate ongoing participation in meaningful occupations throughout the experience of aging?”

commonalities and differences across these studies. Although the activities are different (aerobics, computer programs, cognitive rehabilitation, moving in a complex environment), they lead to the hypothesis that the effort in being engaged may in and of itself be valuable and bestow positive benefit.

A second element is choosing meaningful activity. Our cognitive rehabilitation program included the research participants working on a self-selected goal. It could be argued that the animal study also included this. Within their complex environment, the animals select the activity they want to do – run on a wheel, hide in a box, etc. Although the level of consciousness is different in humans and adults, we hypothesize that the choice is important in facilitating participation in valued occupation.

Thirdly, it is possible to imagine in the human studies at least, an implicit belief on the part of the participants that what they were doing was of value. This may reflect positive self-efficacy, that is an individual's assessment of his/her ability to perform successfully specific behaviours in specific situations. A reduction of self-efficacy can have far-reaching effects. For example, an older adult forgets an important appointment or date and loses their belief (self-efficacy) that they will be able to remember the next important date. This may result in selecting a coping behaviour that is maladaptive (e.g., refusing to believe their memory has

changed). Participation becomes more unsuccessful and a downward spiral ensues. The individual may lose their sense of having control over their lives (their locus of control becomes externalized), choose coping behaviours that are avoidance-focused rather than problem-focused, become much less confident in their abilities with the result that participation deteriorates further.

However, even in the face of significant loss of autonomy (in memory or other areas), this downward spiral does not have to occur. A colleague doing research on locus of control, cognition and aging relates a story of Mrs. M., another resident at Baycrest. Mrs. M. was completely dependent physically but had rated her internal locus of control as very high (i.e., she felt she had control over her life). My colleague, surprised at this apparent incongruence, quizzed her. “Well, I can still decide if I want to eat, can’t I,” was her response.

Bandura’s (1982) landmark work showed that individuals with higher levels of self-efficacy engage in broader ranges of activities, direct more energy towards these and persevere more. Others have shown better memory performance, greater use of compensatory

memory devices and less functional decline in community dwelling elders is associated with greater self-efficacy (McDougal, 2004; Mendes de Leon, et al., 1996). This is consistent with the work of our occupational therapy colleagues (Griffith, et al., 2007). They asked eight older adults, all with substantial loss of physical autonomy, about what gave meaning to their participation in occupation. The older adults told them the following are important: openness to a range of experiences in daily life, a sense of being a participant in life despite loss of physical ability, appreciation of help from others, and acceptance of the future despite its unpredictable nature. Perhaps this openness and acceptance is linked to or possibly is the foundation of maintaining an internalized locus of control and positive self-efficacy about specific activities.

In our view, the findings of these studies are exciting and promising. But, and it is a big but, something is missing. In each instance in the human studies (other than Griffith et al.’s [2006] work), the investigators

either did not find, or did not report that the changes in body structure and function (brain volume, cognitive status, etc.) and abilities (test completion) were paralleled by increased engagement in or enjoyment of daily activities. Their research (and much health related research and practice) is embedded in biomedical models of health. These models assume a linear relationship between impairments (brain/body) and behaviour (meaningful occupation). Specifically, work is directed towards determining more and more precisely what the impairment is and targeting interventions accordingly. This is a reductionistic approach that while useful with regard to some health issues, does not fit well with our model of practice rooted in occupational enablement (Townsend & Polatajko, 2007). Nor does it fit with converging evidence from various fields showing that alleviating impairment does not have a consistent, strong, linear association with improving participation in meaningful occupations.

Factors impacting aging and amenable to change:

- Physical Fitness
- Cognition
- Environment
- Choice of activity
- Locus of control
- Self-efficacy
- Coping
- Openness
- Acceptance

The role for occupational therapists

Occupational therapists can and are enabling older adults to participate in meaningful occupations. We understand the highly personal and complex nature of aging and are able to see the various aspects of the environment that influence it. We recognize our goal is not that older adults are merely performing disjointed activities but that they are doing personally meaningful occupations that will in turn define their person. We consider how meaning is ascribed through occupation, through the environment and by the individual. We are involved in relevant and important research, education and social advocacy initiatives. But our work is not done. The numbers of people aged 65 and over in our population is growing and many older adults around the world do not receive needed interventions for the disability associated with aging.

A review of the work relevant to our role in enabling occupation in older adults is considerably beyond the scope of this editorial. Thus, we have unabashedly singled out some of our colleagues’ work for special mention to complement what is written in this issue. First, we applaud our Canadian colleagues for two excellent reviews related to the role of occupa-

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tional therapy working with clients with dementia. Egan and her colleagues (2006) recommend that we appreciate the fundamental role occupation has to play and that an ethnographic approach be taken to determine occupational performance issues with clients and their caregivers. Bier and her colleagues (2006) review the cognitive rehabilitation literature in relation to clients with mild cognitive impairment or Alzheimer's disease. They highlight the importance of utilizing preserved functions (e.g., procedural memory).

Although the well-elderly study was published 10 years ago, we highlight it here because it encourages broadening our focus beyond the individual. Clark and her colleagues from California developed a program for community dwelling elders with two components (Clark et al., 1997). The first was weekly group sessions focusing on managing changes associated with aging (e.g., finances, transportation), the second, one-hour individual sessions per month focusing on application of concepts to their particular experiences. The program ran for nine months. The group receiving this program improved on the measured outcomes whereas the control groups declined. Occupational therapy prevented health-related declines!

Our third special mention goes to colleagues in Norway who recently published work on the influence of the environment on participation in older adults (Vik, et al., 2007). Through focus groups, they found that older adults perceived pressure from their environments to perform their basic activities of daily living rather than focus on participation. In large part this pressure was perceived to be from societal (including health care) expectations that they be content and adapt their lives to fit in arrangements for services even if this meant disrupting valued daily routines, and by administrative issues (e.g., wait times for equipment, changes in staff). The authors challenge occupational therapists to consider whether we are part of the societal environment that is hindering rather than enabling participation. This comment is consistent with those made by Egan and her colleagues, with the approach in the well-elderly study and with comments made earlier. Choice, context and individualization are important to enabling participation in meaningful occupations.

Occupational therapists have and continue to play diverse roles in facilitating older adults' participation in valued occupations – we all know this and a quick glance through the table of contents of this issue attests to it. In this issue, are highlighted a variety of means of achieving this broad goal. We are providing compensatory devices (e.g., vision aids, locating devices),

working on specific body functions (e.g., memory, falls programs), and working with specific occupations (quilting, driving, story-telling) all to enable older adults

“Occupational therapists can and are enabling older adults to participate in meaningful occupations.”

to participate more fully in meaningful occupation. We are incorporating theory into our practice as illustrated in the article about the assessment of nursing home clients. Indeed, the principles of our practice are embedded in these articles. They confirm our *raison d'être* and hopefully inspire.

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Falls and older adults: Occupational therapists working in the community to facilitate participation

Mary Lou Boudreau

When an older adult falls, the impact can range from being quite inconsequential to a life-altering experience. A number of different interventions may assist an individual to cope with the aftermath of a fall or even prevent a fall from occurring. Occupational therapy can provide assistance to seniors if they have a fall; the primary goal of occupational therapy is to help the older adult regain their ability and confidence to return to their valued activities.

As well as working with individuals, occupational therapists are becoming involved in community development approaches to falls. Occupational therapy's focus on the integration of the environment, occupation and individual factors provides a strong framework for the development of population-based prevention programs. This article will begin with an overview of the topic of falls and older adults, followed by two examples of community occupational therapy initiatives for falls.

Impact of a fall

Each year, one in three Canadians over the age of 65 fall and the risk of falling increases as age rises (Raina, Dukenshire, Toivonen & Lindsay, 1997). Falls are

the most common cause of injury for older adults. These individuals have a greater risk for falls than other age segments of the population and these falls can result in serious injuries. Over 90% of hip fractures among older adults are the result of a fall (Zuckerman, 1996).

Furthermore, about 40% of nursing home admissions are the direct result of a fall (Rawsy, 1998). Increasingly, falls are a major public health concern.

Following a fall, there is a high cost to the independence and quality of life for older adults. Research has demonstrated that health and well-being are influenced by the ability to engage in life's occupations. Withdrawal or changes in occupation can lead to increased dependency, lack of confidence and depression (Canadian Association of Occupational

Therapists [CAOT], 2003). Older adults who have experienced a fall are at risk for subsequent falls and a decrease in engagement in activities of daily living and/or occupations.

The financial cost to the Canadian healthcare system is also considerable. The "Report on Seniors' Falls in Canada" states that a 20% reduction in falls would result in 7,500 fewer hospitalizations, 1,800 fewer permanently disabled older adults and a national savings of \$138 million annually (Public Health Agency of Canada, 2005).

Contribution of occupational therapy

Interventions by occupational therapists can take place in acute care hospitals, rehabilitation centres, day centres or in the community. An occupational therapy approach to fall prevention addresses personal, environmental and behavioural factors which influence older adults' participation in meaningful activities at home and in the community. The Canadian Model of Occupational Performance (CMOP) views the individual as an integration of physical, cognitive, psycho-social and spiritual compo-

Evidence on fall prevention

From the Cochrane Database of Systematic Reviews on falls and fall injuries (Gillespie et al., 2005; Lyons et al., 2005; McClure et al., 2005), the following approaches have demonstrated effectiveness with different populations of older adults:

1. Population-based interventions.
2. Individual-based interventions which include: multidisciplinary, multi-factorial, health/environmental risk factor screening/intervention programmes in the community.
3. Muscle strengthening and balance retraining, individually prescribed by a trained health professional.
4. Home hazard assessment and modification that is professionally prescribed for older adults with a history of falling.
5. Withdrawal of specific psychotropic medication; cardiac pacing for fallers with cardio inhibitory carotid sinus hypersensitivity.
6. Five-week Tai Chi group exercise intervention.

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nents (CAOT, 2002). Within the context of the CMOP model, the individual interacts with his/her environment through occupations. The environment includes physical (natural and human made), social (other people), cultural (commonly held beliefs) and institutional (laws, policies) components.

This dynamic view of the person, environment and occupation provides the optimal framework to address fall recovery and support, as well as fall prevention. Occupational therapy focuses on the effect of

the fall on the older adult's activities, including the ability to take care of him/herself, manage household tasks and continue with leisure activities. This view identifies how the individual might regain any lost function either by improving their abilities or through the use of adaptive devices. Through this occupational therapy approach environmental factors can be explored that assist in maintaining independence and participation in meaningful occupations.

The Steady as You Go program

Darla King

Clients are often referred to the Community Occupational Therapy Program at Western Health in Newfoundland after having sustained a fall or being recognized as being at a high risk for falling. This traditional occupational therapy service supports older adults through individual client assessment, treatment and consultation in their community. This program enables clients to maintain or improve their occupational performance within their home environments. These types of referrals are very common and high priority as there is a significant impact of a fall on an individual client's ability to participate in valued occupations. Through these referrals, it became apparent that the issue of falls and falls prevention was not an isolated problem, but a more global issue affecting older adults as a population. This realization helped to fuel the evolution of a community falls prevention program.

Evolution: In 1999, the International Year of the Older Person was proclaimed; in Newfoundland and Labrador the provincial government encouraged communities to plan activities that would celebrate and honour seniors. In Western Newfoundland and Labrador, the regional health board brought together a group of seniors and key stakeholders to plan a suitable celebration. This resulting group included provincial and federal government employees from various departments and agencies, as well as representatives from community partners such as the Victorian Order of Nurses, Humber Community YMCA and local seniors clubs. Once the event was successfully completed, the group recognized the power of their collaboration. Given their common interest in seniors, they decided to continue their collaboration and investigate opportunities to work together to

improve seniors' health in their region. The group became the Seniors Wellness Committee, with a mission to promote wellness among seniors by raising awareness, advocacy and education.

Around this time, there was a growing recognition of the issue of falls in older adults. The Western Injury Prevention Coalition, a separate regional body, recognized the need to address falls in seniors on a local level. Occupational therapy was represented on this coalition and recognized as skilled in the prevention of falls. It was decided that the occupational therapy representative (this article's author) on the coalition would approach the Seniors Wellness Committee to pitch a possible collaboration to address the local falls prevention needs. The pitch was successful and the occupational therapy representative became a member and eventually chair of the Seniors Wellness Committee and partnering with the Injury Prevention Coalition, began to investigate opportunities to pursue falls prevention initiatives.

Two years later and on a shoestring budget, the Seniors Wellness Committee had garnered support from its partners and piloted a small falls prevention project. The group chose to pilot the Steady as You Go (SAYGO) falls prevention program. This program was developed by Capital Health in Alberta and provided good evidence supporting its utility in rural areas (Robson, Edwards, Lightfoot & Bursey, 1999).

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Description: The overall purpose of this program is to reduce the number of falls for participating seniors by increasing their awareness of their risks for falls and encouraging them to make changes in their behaviors and environments. The Steady as You Go program is an excellent compliment to the services offered by local occupational therapy programs. Existing services targeted mainly secondary prevention and post falls support and were directed towards the frail elderly. The SAYGO initiative targets the primary prevention of falls in a well elderly population.

Implementation: To pilot the project, the Seniors Wellness Committee recruited 13 senior volunteers from six geographic areas of the region. The volunteers participated in a one-day workshop which provided basic information about falls prevention as well as the how-to's of delivering the Steady as You Go program. The volunteers then became senior facilitators and with the support of the committee, led the SAYGO program with their peers. Over a four-month period, approximately 50 seniors participated in the SAYGO pilot program. Participating seniors completed pre/post self-evaluations and participated in fitness activities. Seniors were also guided through a workbook that encouraged them to make changes to their behavior and environments to decrease their risk for falls. Evaluation results were positive, with participating seniors reporting increased knowledge regarding falls prevention and levels of physical fitness, as well as improved scores on their self-assessment tools.

Future endeavours: Following the pilot program, the Seniors Wellness Committee then focused on a

new goal: to find a way to deliver the falls prevention program on a larger scale throughout the region. This proved to be a challenge for the small committee as it struggled to find a source of funding. Four years and five proposals later, the group was successful in obtaining a Provincial Wellness Grant and coupled with funding from Service Canada was finally in a position to launch a regional falls prevention initiative. Now the committee has hired a falls prevention coordinator and has developed a work plan that will see approximately 500 seniors participate in the Steady as You Go program throughout Western Newfoundland and Labrador.

Conclusion: In Newfoundland and Labrador, the opportunity to work as a member of groups such as the Seniors Wellness Committee and the Injury Prevention Coalition has positioned occupational therapists to work in the less traditional role of community development. Working within a population health framework and using a community development approach facilitates occupational therapy to target populations and communities.

The SAYGO community falls prevention initiative and the Community Occupational Therapy Program at Western Health are a natural partnership. By investing resources into prevention of falls in older adults, both of these programs have the potential to impact the level of adult wellness in the community and the ability of older adults to continue to participate in valued occupations. This emerging role for occupational therapy helps to mobilize communities and build capacity to address issues of importance at a population level.

The Stable, Able and Strong program

Mary Lou Boudreau

Stable, Able and Strong is a three-year pilot program to test a support model and strategies for older adults who have experienced a fall. Using an occupation-based approach, Stable, Able and Strong builds on existing resources and local programs to provide post-fall support and future fall prevention. The goal of the program is to enable these individuals to maintain or resume their meaningful activities at home and in the community. This is accomplished by having older adult volunteers enable a peer who has

fallen. This approach helps the person to be more comfortable seeking help and offers an important role to the helper.

Background: Stable, Able and Strong is jointly sponsored by the CAOT and the University of Ottawa, occupational therapy program. The project is funded by the Population Health Fund, Health Canada. In September 2005, the program began with developing the program and resources. In August 2006, the

three sites agreed to host the program for its pilot period. The sites are the Seniors Active Living Centre in Charlottetown, Prince Edward Island; the Centre des aînés de Gatineau, Gatineau, Quebec; and the Confederation Park Senior Citizens Centre, Calgary, Alberta. Integration into the local health and community support system will help promote the program sustainability. When Stable, Able and Strong ends in October, 2007 the feedback from these sites will improve the model and materials. The program and resources will be posted on the CAOT website.

Program objectives:

a) Develop mechanisms for older adults to talk with peers about falls in a non-threatening environment. People have a tendency to seek out someone who has similar experiences, lifestyles and values. As well, older adults who have fallen may fear a loss of independence and not want to burden their children. They may need to speak to someone about their injuries and their concerns, but do not know who to approach. On the other hand, many older adults also have the desire to use the skills and experiences of a lifetime to assist others; they may be willing to volunteer their time to listen to people's experiences and help them learn more about the community services and supports that are available to them. Sometimes people already have the helping skills from past experiences; if not, these specific skills can be learned. This project brings these two groups together by offering training, resources and support.

b) Create awareness and knowledge of strategies and resources to maximize safety among older adults, caregivers and health professionals. Older adults can continue or return to their independence and participation in valued activities reducing the possibility of future falls. One of the best predictors of a future fall is a history of past falls (Public Health Agency of Canada, 2005). It is important that older adults who have fallen learn how to reduce the chances that they will fall again. Fear of falling can also make older adults feel overly cautious, restricting the activities that they used to enjoy (Ward-Griffin et al., 2005). The main goal of the services offered is to help older adults who have fallen find the balance between an independent and active lifestyle and the precautions that will keep them from further falls and injuries.

c) Create awareness of and promote access to local health care and community service agencies and resources through activities such as an easily accessible data base to identify the resources and programs available to them, as well as resources to enable older adults to discuss falls with their family physician. This will help to address the consequences of falls for older adults (e.g. physical injury, fear of falling).

A study of older adults who have fallen identified the lack of knowledge about existing resources as an issue that interferes with getting treatment and maintaining independence (Hobson, 2004). Caregivers reported experiencing fatigue providing assistance services that sometimes could have been accessed through community programs. Stable, Able and Strong has created a data base containing information on general resources, as well as local programs and agencies. This data base will be made available both to the program participants and to other older adults and their families through the Internet.

Stable, Able and Strong has also developed a brochure that helps the older adult who has fallen to identify key information to discuss with his/her doctor. This brochure will enable the senior to feel like they can take some control over the appointment while assisting the physician with diagnosing and treating relevant conditions.

d) Develop mechanisms to promote communication and integration of post-fall management services within the pilot site and develop plans to ensure the viability of continued post-fall management services for older adults and caregivers.

Each site has a site coordinator who lives and works in the community. Since the beginning of the project, they have been in contact with local agencies and resources. Local programs and resources are listed in the data base. They are encouraged to refer people to the program and may receive referrals from the program. The organizations who have agreed to act as sites have collaborated, sharing their space and resources. Ongoing communication strategies such as community meetings and newsletters are keeping agencies informed as the project continues. All of these factors help the program to promote the integration of post-fall management services and will increase the opportunities for the ongoing viability of the program beyond the pilot period.

References can be found on page 12

Driving and older adults: A focus on assessment by occupational therapists

Nicol Korner-Bitensky, Darene Toal-Sullivan and Claudia von Zweck

In the first article of this two-part series (Korner-Bitensky, Toal-Sullivan & von Zweck, 2007), we discussed the need for a national agenda focused on enhancing health professionals' awareness related to screening of individuals who may be at high risk for unsafe driving. In this article, we introduce the concept of the assessment of driving abilities by occupational therapists; this is the detailed assessment of an individual's driving safety. We also discuss recommendations arising from the National Working Group on Driving (expert clinicians and researchers in driving and gerontology) established by the Canadian Association of Occupational Therapists (CAOT). In December 2006, this group provided national recommendations regarding the process and structure by which driving assessment should be undertaken (CAOT, 2006).

Why the increased focus on assessment of older drivers?

For many older adults living in Canada, the ability to drive an automobile is a central aspect of independent living. In 2003, there were approximately 2.7 million

licensed drivers aged 65 and older, of which approximately 1.5 million were males (Transport Canada, 2004). The number of older drivers is expected to increase substantially in coming years for a number of reasons. First, people over the age of 65 are the fastest growing segment of the Canadian population, representing 13.1% of Canada's total population in 2004, and forecasted to increase to 22.6% by 2041 (Canada Safety Council, 2005). In addition, older females are driving in greater proportions, as shown by a 6.8% increase over a two-year period between 2001 and 2003. With life expectancy rising, and the increasing number of women who are driving, the proportion of older drivers is likely to exceed 4.5 million by 2041.

While it has long been believed that the older driver is actually the safest and most cautious driver on the road, statistical analyses of collision data from the past decade reveals otherwise. By the age of 70, the accident rate per miles driven rises, with an even more rapid increase at age 80 (National Highway Traffic Safety Administration, 2004). More specifically, individuals over 75 have a 3.5 times higher crash rate when the miles driven are considered, compared to 35 to 44 year olds (Canada Safety Council, 2005). To clarify, while crash rates reveal that older drivers' crash involvement is no greater than that of the overall population, once mileage driven is taken into account, fatal crash rates per 100 million miles traveled follow a U-shaped curve, with the rates for older drivers equaling those of the youngest and traditionally the highest, risk group.

What are the Canadian standards regarding driving assessments?

Currently in Canada there are no standards regarding driving assessment other than the "Recommendations of the Canadian Consensus Conference on Driving Evaluation in Older Drivers" (Korner-Bitensky, Gelin, Man-Son-Hing & Marshall, 2005). However, these recommendations focus specifically on the older driver, not on individuals with specific conditions such as a stroke or dementia. There is concern that the lack of standards results in large variations in clinician practices. Indeed, in both Canada and the US there is evidence of large variations in driving assessment practices (Korner-Bitensky, Bitensky, Sofer, Man-Son-Hing & Gelin, 2006).

Who performs the driving assessment?

Driving evaluation is a complex professional responsibility requiring advanced training. The outcome of these evaluations has serious implications for the individual and for society at large. In most Canadian provinces and in other countries as well, occupational therapists are responsible for performing these evaluations. The National Working Group on Driving recommended that CAOT, working in collaboration with the Canadian Ministry of Transportation, establish criteria that clearly identify the advanced training required of

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driving assessors who perform a comprehensive driving evaluation (CDE). In addition, recognizing that much of Canada is rural and may be under-served by occupational therapists who are skilled in performing a CDE, it is important to identify a reasonable method of insuring fair and equitable access for all Canadians who require assessment. One possibility is to provide training as a graduate level certificate that would combine e-learning instruction with short intense periods of on-site training available across the country. One such program has recently received graduate level certification status at McGill University's School of Physical and Occupational Therapy (for more information see the website: <http://www.autoeduc.ca/>)

Who is referred for a driving assessment?

The question of driving safety arises both from specific medical conditions and advanced age that may result in functional declines that affect driving. For example, for people with early Alzheimer's disease, stroke, traumatic brain injury, or specific psychiatric conditions, there are often changes in the prerequisite skills needed for safe driving. Advanced age, with its concomitant declines in visual processing speed, response time and increased physical limitations may also signal a concern that results in a request for a driving assessment.

What are the types of driver assessments?

Driver assessment is used to mean a number of different things and this can lead to confusion. To clarify, there are two types of driver assessments:

1. Medical assessment of fitness to drive
 - Performed by a physician and may also include reports by an optometrist or ophthalmologist.
 - Required by provincial legislation.
 - Necessitates completion of a standard medical form.
 - Indicates medical fitness to drive following a health event such as a stroke or because a person has reached a certain age.
 - Indicates medical fitness to drive at specified ages that varies from province to province.
 - Requires that the completed medical form be sent, typically with the client's knowledge, to the appropriate authority at the provincial Ministry of Transport.
2. Driving assessment of fitness to drive
 - May be referred to interchangeably as a comprehensive driving evaluation (CDE), driving assessment or functional driving evaluation.

- Entails a detailed evaluation of the client's prerequisite skills required for safe driving, along with actual real time driving abilities and driving safety.

The CDE typically includes two components:

In-house/pre-road assessment

The in-house (also referred to as pre-road, off-road or in-clinic) evaluation consists of some or all of the following components depending on the client's profile: medical and medication history, driving history and habits, physical assessment (motor and sensory), visual assessment of basic functions (not the detailed evaluation performed by an optometrist or ophthalmologist), visual - perception assessment, cognitive assessment and behavioural assessment.

On-road assessment

Typically this component of the assessment follows shortly after the in-house evaluation (a few hours or days later) and consists of an evaluation route that may include both city and highway driving and in some instances may begin with a closed-circuit traffic-free environment.

The CAOT National Working Group recommendations:

Regarding assessment of fitness to drive, the National Working Group recommends the following:

- On-road driving assessment ranging from 45 to 60 minutes to provide sufficient time to assess various on-road driving maneuvers and behaviours.
 - Standard assessment of specified behaviours and maneuvers during the on-road driving assessments. These are available to clinicians at <http://www.caot.ca/pdfs/Recommendation3.pdf>
3. Where there is a strong risk of danger to the occupants of the vehicle as judged by the driving assessor/driving evaluator, it is further recommended that the on-road portion of the CDE assessment be terminated early.
 4. On-road outcome be classified into 3 (rather than 2) categories:

Category One = Pass

- Drives safely.
- Recognizes that an individual may require periodic reexamination depending on the reason for referral, for example a health condition known to have a potential for deterioration such as early dementia, Parkinson's Disease or Multiple Sclerosis.

Category Two = Indeterminate

- Further steps are needed prior to making a determination of ability to drive safely.
- May include potential remediation/driver retraining or reevaluation based on a particular circumstance such as the introduction of a new medication, recent acute illness/new onset of a chronic illness such as stroke, or surgery that may result in changed functional status in the near future.

Category Three = Fail

- Unsafe/non-remediable.
- Not recommended for licensing.
- Unlikely that circumstances related to safe driving will improve in the future (eg. condition with expectation of negative progression).

Conclusion

Regardless of where they live, Canadians have the right to equitable and scientifically sound driving assessments provided by well-qualified health professionals. In recognition of the importance of driving as a human occupation, CAOT is working towards a National Driving Blueprint, a strategy that will focus on enhancing the screening, assessment and intervention processes aimed at keeping Canadian drivers driving safely for as long as possible. Given the great number of Canadians who will go into their retirement years driving, it is our responsibility to plan this

strategy aimed at reversing the current trend of increasing accidents and mortality in this age group.

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Column Editors: Roselle Adler and Josée Séguin

Occupational therapy and vision loss: Assistive technology for older adults

Linda Petty and Lizna Husnani

One of the major impacts of an aging society is the increasing experience of visual loss due to age-related eye diseases. Vision loss has a functional impact of decreased independence in living and quality of life among older adults (Gresset, 2004; National Eye Institute, 2002; Taylor, 2003). While vision loss has an obvious impact on personal mobility, driving and reading, the impact of vision loss extends to other areas of an individual's life (Virtanen & Laatikainen, 1993). Studies indicate that the incidence of admission to a nursing home is earlier, the number of falls is doubled and the incidence of depression is increased (A Clear Vision, 2004).

In the area of low vision and older adults, occupational performance in everyday tasks requiring vision can be supported with the provision of appropriate high technology aids. Occupational therapists have the expertise to assist individuals with selecting, training and using assistive technology, and to facilitate occupational performance in meaningful and purposeful activity (Canadian Association of Occupational Therapists, 2006).

At the Vision Technology Service (VTS) in Toronto, occupational therapists provide high technology vision aid assessments for clients of all ages, including individuals with physical disabilities requiring complex integration for alternative access equipment. The VTS is a Regional Assessment Centre with the Ontario Ministry of Health's Assistive Devices Program (ADP), and a service component of the Adaptive Technology Resource Centre at the University of Toronto (<http://atrc.utoronto.ca>). It is staffed solely by occupational therapists. Eligible clients are those who are unable to perform every day age-related visual tasks in spite of conventional medical, surgical and/or routine refractive interventions (such as glasses). To qualify a referral is needed from the eye or family doctor, or a vision report dated within the past six months. This referral must include a

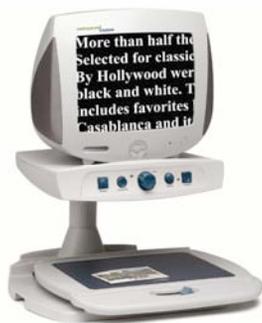


Figure 1: Merlin CCTV with 20" CRT, manufactured by Enhanced Vision

diagnosis of the person's condition and a record of their visual acuity. The provision of the equipment may be assisted through provincial programs.

As there are few occupational therapists presently working in this area of high technology aids for vision loss, we hope this article will provide information on the types of assistive technology which can improve occupational performance for older adults with vision loss in the areas of reading and writing.

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High technology reading aids

Many clients who have a slow progression of vision loss and significant remaining vision are recommended to use a Closed Circuit Television (CCTV) to magnify text to .5 to 6 or more centimeters high and increase the contrast to white on black or black on white (see Figure 1 and Table 1 for descriptions). With this aid, clients report that they can read food and medication packaging, leisure books, handwritten materials and more. For those with greater vision loss, a DAISY playback device is recommended, as it enables clients to listen to public library audio books, music, and books or magazines from the Canadian National Institute for the Blind (CNIB) library. A large number of older adults are computer users, surfing the web, sending and receiving e-mail. Many clients modify their computer with a larger monitor or flat panel screen and increase the font size. When this reading aid is no longer adequate, clients are assessed for the use of a screen magnification software, which increases the size of the material displayed from 1.25 times to 16 times, enhances the size and colour of the mouse or cursor and reads documents, web pages or e-mail out loud (see Table 1 on page 15).

Age Related Macular Degeneration (AMD) – Quick Facts

- Dry AMD is a gradual loss of central vision.
- Wet AMD is a sudden loss of central vision.
- 2.1 million Canadians experience blindness and irreversible vision loss due to AMD.
- More than the number of Canadians affected by glaucoma or cataracts combined.
- Each year, 78,000 Canadians are diagnosed with AMD.
- The incidence is expected to triple within the next 25 years.
- A cure or restoration for AMD is still under research.

Sample group of end stage AMD

As part of an informal study, we looked at the assessment data collected on 10 elderly clients with severe macular degeneration in 2006. The data was collected through an interview and included the environmental conditions and occupational performance issues identified using the Canadian Occupational Performance Measure. Among the ten clients, five clients were living alone in a house or apartment, three were supported by a spouse and two lived in a long-term care or an assisted living facility. The clients' age range was 76 to 93, with a mean of 84 years of age. As you consider a home environment and life's daily tasks, the reliance on vision for occupational performance is evident. However, the impact of vision loss is very individual; not all tasks areas are important or problematic for each elderly person with low vision. The following data highlights the common, most important occupational performance issues.

Occupational performance issues	Clients affected out of 10
Read financial statements/ bills/writing cheques	9
Read mail	7
Read medication information and packaging	6
Read local newspaper	6
Read books, or magazines	6
Read recipes	3

Technology for clients with early stage AMD

The case study of Mrs. P. provides an example of how technology can impact an individual's ability to participate in meaningful occupations. Mrs. P. is an 81-year-old client who lives with her daughter and her family, but is alone for much of the day. She has received medical care for her vision during the course of her macular degeneration, but has experienced progressive vision loss. Mrs. P. had low vision services through the CNIB including the prescription of a magnifier for spotting and small volume reading. She also had the donation of a DAISY playback machine and listens to novels from the CNIB Library. Mrs. P.'s family purchased a new computer for her with a 19-inch screen and ZoomText screen magnification and reading software, which she uses for e-mail, online banking and games. At the assessment for high technology vision aids at the VTS, the additional unmet reading and writing needs were identified as an inability

to read mail, financial statements, the local newspaper, food/mediation packaging, as well as write cheques.

Trials were done with CCTVs and it was determined that a 17-inch flat screen system with a height adjustable display and easy to use controls best met her needs. Comfortable letter recognition for reading was obtained at seven times magnification or 1.2 centimeters high letters. On a 17 inch screen, Mrs. P. was able to read at a functional rate and view 35 letters across the screen, from a working distance of 40 centimeters. As Mrs. P. was of short stature, the screen was lowered to ensure that the daily, repeated use of the equipment did not result in neck strain or postural fatigue.

Technology for clients with end stage AMD

Mainly due to AMD, VTS has noted increasing numbers of older adults with more severe low vision than Mrs. P. with reported acuities of 20/400 or worse. Most of these individuals are living in their own homes, some with family support. A number of these clients were noted to have difficulty managing everyday living tasks using the CCTVs funded by the Assistive Devices Program of the Ontario Ministry of Health prior to 2006. The maximum magnification level on these CCTVs with automatic focus and with a 17 or 18 inch viewable display was only 50 times magnification. These clients generally require text size of eight to 12 centimeters, which results in only five or six letters viewable on the display at any one time. In 2006, the provincial program approved funding for a 20 inch Merlin Black and White CCTV, with a 20.5 inch viewable CRT display and magnification level to 66 times (see Figure 1). Looking at the sample group, these clients were provided with 20 inch Merlin black and white CCTV. Seven of the 10 clients provided with this system were available for follow up at VTS whereby the COPM was re-administered. Their scores for each occupational performance task were recorded and the total changes in performance and satisfaction scores were averaged for each client. As a group, the scores were then averaged to show the change in performance and satisfaction with doing similar tasks with this device. The clients rated their change in performance as improving by a mean of 7.1, with a range of 3.3 to 9. These clients rated their satisfaction with their performance on these occupational performance tasks as improving, with a mean of 7.9 and a range of 5.5 to 9 among the clients. These data indicate that while the clients' visual impairments were severe, a large display, high magnification level CCTV is an effective tool to accommodate the reading and writing needs most important to the clients.

Table 1 – Adaptive technology for low vision
 Refer to <http://atrc.utoronto.ca> for more information regarding these products.

Adaptive Technology	Description
Closed Circuit Televisions (CCTV)	A video magnifying system that uses a stand-mounted or handheld video camera to project a magnified image onto a video monitor, television screen or computer monitor. Include the option of viewing black letters on a white or white letters on a black background, false colour and natural colours. Controls for contrast and brightness are standard. Many video magnifiers provide other special on-screen features and controls including underlining text options or masking. Some systems work jointly with a computer, offering the option of sharing the computer monitor.
Screen magnification software	Provides a magnified view of the computer screen and must also have screen reading components. For example, ZoomText by AI Squared manufacturer enlarges and enhances everything on a computer screen. This software features pointer and cursor enhancements to make it easier to locate these features; color settings to easily change screen colours to improve clarity and reduced eyestrain; and Desktop, Web and Text finders for easier location and navigation of documents, web pages and e-mail. ZoomText's integrated screen reader feature narrates the actions as you type text, navigate your programs or use the mouse.
Large monitor	Provides an expanded view of each item. The viewable area of a monitor or flat panel display may be less than the advertised size and should be checked. Monitors from 19 inches upwards can be considered large. Large monitors used along with magnification software enable more of the 'full' screen to be seen at once.
Large print keyboard	Each key is easy to see with options of different colour schemes including, white letters on black, black letters on black and yellow letters on black background.
Daisy playback devices	DAISY playback devices use the audio format known as the DAISY standard (also known as the Digital Accessible System). The DAISY format is the standard for digital talking books.
Hand held magnifiers	Available in many shapes and sizes, and provide magnification between 1.5 and 20 times. Some styles can be folded up for easy transport in a pocket or handbag, and some are equipped with battery-operated lights. Hand-held magnifiers may be difficult to use if your hands tire easily or tend to shake.
Telescope	Improve distance vision. A hand-held telescope, also called a monocular, is common. Hand held telescopes work best to quickly view a distant object, such as reading a sign or locating an object. Clip-on telescopes allow the user to slip the telescope over his or her glasses for hands-free use.
Corning lenses	Corning lenses help those individuals with light-sensitive eyes. Depending on the filter chosen, these coloured lenses assist with controlling glare and enhancing contrast.

Conclusion

This case study and larger sample group highlights the importance of reading and writing for older adults with low vision to carry out essential everyday activities and for overall quality of life. Older adults can compensate for visual loss through high vision technology such as CCTVs, larger computer monitors and screen magnification and reading software. Provision of such technology can prevent abandonment of valued activities such as reading and writing.

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Occupations from home: Continuing to have a purpose in long-term care

Joanne Gillis

For most individuals, home is a place of comfort and safety. Home is where people perform most of their daily occupations. For older adults, the ability to continue with these occupations and to remain at home is often challenged as a result of declining physical and/or cognitive abilities. Admission to a long-term care facility or nursing home is often the only option for the individual to remain safe. However, in these facilities they often lack the opportunity to continue to participate in valued occupations. To address this need and create a link to their prior home life, a quilting group was developed at The Agnes Pratt Home, 128 bed long-term care facility in St. John's, Newfoundland.

When people move to a long-term care facility, they must face a foreign environment where strangers live and follow an unusual routine of daily activities. More often than not, the staff dictate these activities. Meals are served at set times, which those living in the home do not prepare, serve or clean up afterwards. Laundry is done in a separate area of the home and again residents do not participate in this activity. Housekeeping is a visible activity within the home. Unfortunately due to staffing, schedules, infection control policies and union issues, residents do not participate in this activity either. Suddenly individuals, who have spent more than 50 years carrying out tasks with a sense of pride and purpose, are placed in a new home where they have few opportunities to perform meaningful activities.

In Newfoundland, as in many other areas of the country, the activities that are meaningful for many ladies and gentlemen who are 80 years of age or more include vegetable and flower gardening, fishing, cutting wood, quilting, as well as household activities. During the winter months, many of the women would spend days sewing and quilting. Often the men would assist with tearing scraps of materials for making rugs or mats for the house. During the rest of the year, gardening and fishing would be part of their daily routine. For residents with mild to severe dementia, these times are fresh in their minds. Although many of these activities would be challenging to recreate in a long-term care environment, others such as gardening and quilting would not.

The quilting guild

In November 2005, the occupational therapist and recreation specialist combined forces due to staffing availability and interest and gathered a small group of ladies to help make a quilt for the unit. The ages of the members ranged from 82 to 93 years and there were varying degrees of cognitive abilities. The purpose of the program was to enable residents with mild to severe dementia to participate in a meaningful, purposeful activity. The program was directed to residents who seldom participated in other recreation activities. Each of the residents had been identified by the recreation specialist as having a previous interest in sewing.

"Suddenly individuals ... are placed in a new home where they have few opportunities to perform meaningful activities."

The initial project was a crazy quilt, which would allow a large margin of error with the pattern and ensure a successful experience. Each week, the group co-leaders arranged the set up of the activity. Residents selected fabric of many colors, often given choices between 2 to 3 fabrics and would reminisce of sewing days gone by. Cutting of the fabric would be demonstrated to the residents. Assistance with this task ranged from providing dark lines on which to cut, to hand-over-hand assistance to cut the material as needed. Residents were asked to assist with ironing the materials in preparation for sewing, with supervision provided to ensure safety. Once the material was ready for sewing, residents were provided with needles already threaded with sewing cotton. The fine motor task of threading the needle was determined prior to the program to be too difficult.

Verbal cueing was provided each week to remind the residents of the activity and invite each one to participate. Redirection to the task at hand or reassurance of performance was frequently provided. Physical cues were provided such as placing dark lines on the fabric for guidance when sewing, as well as providing contrasting colors of fabric and thread to assist those with visual deficits. The environment where this activity takes place contains similar furnishings to a kitchen environment with items such as

a large table and chairs, cupboards and a sink. The environment facilitates reminiscence of days gone by and provides a sense of comfort as evident when several residents hum or sing a tune while sewing.

Staff was greatly surprised, including the co-leaders, when observing the residents' abilities. Residents dependent for their personal care demon-

"The greatest benefit though is the opportunity to re-live the true memory of life at home that is associated with comfort, familiarity, pleasure and purposeful activity."

strated the ability to hold the scissors safely and cut the material for the quilt. Others demonstrated holding the needle and fabric in sewing as done in days gone by. Stitching was observed to be fine and precise by all. Changes in performance, such as the stitching, have been consistent with resident disease progression, acute illness or decreased vision.

Seasonal transition

In May 2006, the residents completed their first crazy quilt. The large quilt was divided in half, with one portion left on the unit for resident use and the other on display on a quilting rack outside of the unit. At this time of year, it was decided that gardening would be provided as a seasonally appropriate activity relevant to the residents. At this time the group became larger as male residents assisted with planting seeds in planters, watering them and then placing them outdoors. On fine days, the residents would go outdoors to remove weeds or deadhead the plants.

Once autumn returned, quilting was resumed again for the season. This time the male residents continued their participation in cutting material for the ladies. One male resident demonstrated the ability to sew, as it was identified to be similar to mending fishing nets. The pattern selected for the second quilt was a basket weave pattern, which would allow for cutting and sewing along straight edges. As the crazy quilt neared completion and required fitting together the many odd pieces, the task became too complicated. The basket weave pattern quilt, which consists of blocks made from four rectangles in alternating colors, was completed in less than half the time of the first quilt and was sold in the November fair at the home to raise money for sewing supplies. This was seen as important to the oldest lady of our group as she often relayed the making of quilts and mats to sell to

raise money for the church or her family.

It has been difficult to gain verbal feedback from the residents participating in the group given the degree of cognitive impairment. Several brief comments have included "it's nice to do something useful", "I used to sew dresses for my daughters" and "I used to make quilts and sell them." Much feedback has been non-verbal in the residents' smiles, being agreeable to participate and asking the group leaders for more thread or material to continue the task at hand.

Benefits of familiar occupations

Currently the residents are working on a large block pattern quilt for the unit. The lone male resident who remains in the program continues to assist in cutting fabric. Resident turnover and disease progression remain challenges to maintain the program, as well as residents' daily abilities to concentrate and participate in the project. Benefits to the program drastically outweigh the challenges faced. Residents usually are involved in personal care activities during the morning. This often results in agitation that is demonstrated by behaviors such as pacing, crying and resistance to speak to staff. Residents have been able to participate in the quilting activity despite just having had a tub bath or been given medications that they would prefer not to take. Occupation that is a familiar, relaxing task in a supportive environment has proven beneficial to decrease resident agitation, especially during the morning care hours.

Residents reminisce about times when they sewed clothes or made quilts for their families, drove into town to get material or thread or waited for the boat to arrive delivering supplies to the community. For some, this is not reminiscing but chatting of things they believe to be true today. It has been observed that if one or two residents share a laugh, then others often join in. There are comments about the pretty colors of the fabrics and color combinations that they are encouraged to select.

The environment, as well as the activity, provides visual, auditory and tactile stimulation. The greatest benefit though is the opportunity to re-live the true memory of life at home that is associated with comfort, familiarity, pleasure and purposeful activity.

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Column Editor: Sandra Hobson

Discharge planning for older adults: The added value of occupational therapy home visits

Rene Taylor, Linda Kurytnik and Kerrie Pain

Occupational therapists feel strongly that home visits provide unique functional information that assist teams to make appropriate discharge plans for clients aged 65 and over who are leaving the hospital after a prolonged admission (Nygård, Grahn, Rudenhammar, & Hydling, 2004). In most cases, the successful reintegration of seniors into their home environment represents the lowest cost resolution on both a personal and societal basis. Effective discharge planning enables them to participate with the highest level in valued occupations.

As home visits are identified as a time and resource intensive activity, it is important to examine their added value for discharge planning. Presently,

hospital discharge decisions are heavily biased towards client's self-report and functional assessments within a simulated and unfamiliar environment. The literature has discussed the risk of overestimation of a client's abilities and the underestimation of barriers and safety risks in their home using hospital based assessments (Edwards, 1990). There has also been a lack of research pertaining to the value of an occupational therapy home visit for discharge planning.

The use of informal non-standardized home visit assessments, home visit check lists and narrative summaries have been a common discharge planning occupational therapy practice in various settings. Current practice on the 50-bed inpatient Specialized Geriatric Services (SGS) rehabilitation program in

the Calgary Health Region (CHR) is for the occupational therapist to complete a discharge home visit using a non-standardized environmental and functional performance assessment.

Occupational therapy literature strongly advo-

cates home visits for discharge planning as these visits provide information about the client's functional capabilities within their environment and about the informal support structures that the client may have in place (Edwards 1990; Letts & Marshall 1995; Patterson & Mulley 1995). However, there is little available data to support this view and guide informed decisions; occupational therapy research has primarily focused on falls prevention and home safety (Pardessus et al., 2002). This program evaluation study was designed to address these gaps in available data.

Study purpose

This study was designed to: 1. Systematically investigate the added value provided by occupational therapy home visits to the discharge planning process for seniors; 2. Establish best practice guidelines by standardizing the home visit protocol.

Study design

(a) Sample - Clients admitted to the inpatient senior's rehabilitation program (specialized geriatric, acute care rehabilitation program) at the Rockyview General Hospital in Calgary, Alberta participated in the study. Inclusion criteria required that they returned to their home environment either alone or with family members. Sample size was 26 clients (20 females and 6 males); the age range was 68 to 96 years with an average age of 88.6 years and an average Mini Mental Status Evaluation (MMSE) score of 27.6 (with a range of 22 to 30/30). Clients were seniors with complex, medical co-morbidities.

(b) Data collection - Data were collected using the Safety Assessment of Function and the Environment for Rehabilitation (SAFER) tool which provided a framework for systematic assessment of the client's functional performance for both the hospital and home situations (Chui, Oliver, Marshall & Letts, 2001). Permission was obtained through the publisher to use the SAFER tool in the interview and hospital settings, as well as in the traditional home situation for which the tool was designed. The SAFER is a reliable, valid and comprehensive functional assessment tool. The tool

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was used to standardize the home visit protocol and establish best practice guidelines within the inpatient program.

This comparative study gathered SAFER tool information from three different data sources. The interview and in hospital assessment were carried out by an occupational therapist with no previous knowledge of that client. The third home based assessment was completed by the primary treating occupational therapist.

1. Client interview (self-report of functional ability and perceived safety issues): The only information available at the time of the interview was related to their diagnosis.
2. Hospital assessment (simulated assessment made in a hospital setting): The assessment of client function included observing performance in the kitchen, bedroom and bathroom.
3. Home visit (assessment completed in the home): The assessment included observing functional performance throughout all relevant areas in the home and could include all transfers, stair management and meal preparation if appropriate.

An initial pre-study pilot was completed with eight clients and four therapists. Additional pilots were completed in response to staff turnover and included 6 clients and 2 therapists. This established and assured continued inter-rater reliability and validity. The following steps were taken for the primary objective concerning the added value of completing a home visit:

- The total number of problems identified through the two types of data collection were tabulated and compared using the ANOVA statistical analysis tool.
- The total number of matching check marks for the two assessments in the three categories (problem, not appropriate [N/A], no problem) was calculated. Descriptive information was generated about the items where there were disagreements.
- The similarities between recommendations were rated post pilot, with inter-rater reliabilities and a point-to-point accuracy of > 80%.

Study limitations included recognition that the multiple recommendations were hard to code and group, the interview portion did not include family members, the hospital simulation was artificial and the SAFER was not designed as an interview tool.

Study results

There was no statistical difference found in the aver-

age number of problems identified between a hospital assessment and home visit assessment, but there was statistical significance in the average number of problems identified between the client interview and home visit assessment. The use of the SAFER tool resulted in an increased number of identified problems and recommendations for both the hospital and home visit assessments. A significant difference was noted with the increased level of specificity of the recorded recommendations obtained during the home visit when compared to the hospital assessment. The home visit in combination with the standardized SAFER format allowed for individualized and effective provision of equipment and resources when planning for discharge.

The study recommendations were a challenge to categorize and analyze for several reasons. First, a larger than anticipated number of recommendations were generated per client/ assessment situation (range was 1 to 45 differing recommendations). Second, different therapist's wording hampered clear categorization of recommendations. Third, the SAFER tool included areas of overlap and redundancy; consensus was reached only after multiple codings.

Discussion

The data supported the perception that clients overestimate their abilities and underestimate problems when discharge planning from hospital. The impact of this may be a mismatch of resources, under-utilization or missing required services, especially if discharge planning is based only on client self-report. Areas where this was frequently observed included home accessibility and transfers using bathroom equipment. An example of the former occurred when a client did not identify a problem with home access during both the client interview or hospital assessment. However, at the time of the home visit problems included a greater number of steeper stairs with an unsafe surface, resulting in the need for one person assistance. An example of the latter included client's report of inaccurate set up of bathroom equipment. This resulted in the need to reposition and adjust equipment and modification of the transfer technique used to increase safety.

The SAFER tool provided a framework that promoted a more client-centred and inclusive approach to discharge planning and assisted in standardizing the communication within the occupational therapy group involved in the study. It is anticipated that the use of the SAFER tool with visits to a non-institutionalized

settings (i.e. home vs. assisted living or lodge) will assist in a more consistent approach to discharge planning for this population. A qualitative outcome was in clearer communication between program occupational therapists to maintain best-practice norms within the program.

Conclusion

The research confirms the belief that functional assessments in the home environment are more effective for senior's discharge planning than either hospital based functional assessments or client self assessments. Also, home assessments provide a broader scope and level of specificity for problem and personal needs identification. The opportunity to observe functional performance within the home environment allows for timely, cost effective and appropriate provision of equipment and services.

The study also demonstrates the added value of using a systematic tool such as the SAFER for functional performance evaluation. The tool ensures that the discharge home visit assessment was comprehensive and consistent and significantly contributed

to a thorough discharge plan for a successful transition from acute care to home.

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THEORY MEETS PRACTICE



Column Editor: Heidi Cramm

Assessment of older adults health needs with the Canadian Model of Occupational Performance

Michèle Hébert, Rachel Thibeault, Thomas Brind'Amour and Jean-Pascal Beaudoin

Occupational therapists may be asked to assess the health needs of a community or a population to develop a new health program, plan new services or evaluate an existing program. The field of health services management offers us models and documentary procedures applied in strategic analysis that can be used for such assessments (Pineault & Daveluy, 1995). These models and methods enable us to determine the information that needs to be researched, information sources (studies, personal accounts, experts, etc.) and how those data have to be organized in order to identify the needs of a population, design programs that can solve problems or measure the appropriateness of services offered (Contandriopoulos, Champagne, Denis & Pineault, 1992). In occupational therapy, this organizational outlook must be supplemented with a concept of health which is reflective of our profession.

From this perspective, an assessment was completed to determine the health needs of older adults living at the Maison Fleur-Angé using the Canadian Model of Occupational Performance (CMOP) (Canadian Association of Occupational Therapists [CAOT], 2002). The project had three objectives: (1) to inform staff and management about the health needs of residents in order to improve their quality of life; (2) to identify needs that could be appropriate for occupational therapy interventions; (3) to explore the usefulness of the CMOP to assess the health needs of a community.

Needs assessment: From theory to practice

The ultimate purpose of a needs assessment in health care is to bring about changes beneficial to the health of a population (Stevens & Gillam, 1998). The health

indicators that should be documented in such a process can be related to health status, quality of life, functional impairments, socio-economic conditions or the appropriateness of offered services (Congdon, 2001; Okamoto, 1997; van den Bos & Triemstra, 1999). The CMOP offers a perspective on the quality of life of individuals based on the aspects of persons, their occupations and environments, in order to better understand the meaning they give to their lives and what elements give their lives that meaning (CAOT, 2002). From the perspective of the CMOP, the health needs assessment of a population would require the documentation of all these elements and would permit the occupational therapist to carry out the needs analysis to determine the current health situation and the desired state, as well as to identify the issues and priorities in order to determine the services required or the appropriateness of the services already offered (Rouda & Kusy, 1995).

Population

The Maison Fleur-Angé, administered by the Société Alzheimer de l'Outaouais Québécois (SAOQ), is a community agency that provides permanent housing for seniors with Alzheimer's disease or related diseases (SAOQ, 2006). The mission of the Maison Fleur-Angé staff is to provide a suitable environment that meets the resident's needs, demonstrates concern for their quality of life, their dignity, and recognizes the potential of each resident in all aspects of their daily life (SAOQ, 2006). The Maison Fleur-Angé provides a housing service to nine seniors to help them make the transition between living at home and long-term care facilities for as long as possible, given available resources.

Data collection

To assess the needs of the Maison Fleur-Angé residents, the CMOP was used to determine the required information, how to organize this data and what analyses should be done. The collection of information that was carried out over four months by an occupational therapy student at the University of Ottawa, working one day/week, consisted of the following:

- Observations and consultations of the residents health files to determine the physical function, observation and informal meetings with the residents for the assessment of emotional function, assessment of the cognition using the Cognitive Assessment Scale for the Elderly (CASE) (a protocol for the evaluation of 10 cognitive competen-

cies by Geneau & Taillefer, 1996).

- Observation and meetings with the residents, families and staff to document the nature, frequency, duration and appreciation of personal care, leisure and productive activities, supplemented by consultation with the schedules for activities and tasks.
- Review of the documentation regarding the Maison, observation and informal meetings with residents, families and staff to document the different aspects of the environment.

The information was compiled and presented, using the CMOP, in a "Rapport d'évaluation des besoins à la Maison Fleur-Angé" (Brind'Amour, 2004), and included a description of: the context of the project, environment, activity areas, personal factors of meaning and quality of life of residents, strengths observed and recommendations.

Results

The use of the CMOP to complete the assessment of health needs at the Maison Fleur-Angé made it possible to form an overall picture that was very informative about the quality of life of the residents and potential avenues for improvement. For example, it was noted that the physical environment was free of architectural barriers, but it had few reference points for spatial orientation; the expression of the residents' culture was strongly encouraged and respected in the private spaces; the "carpe diem" philosophy (seize the day) was valued; occupations related to the personal care activities and the productive activities were appropriate and meaningful for the residents. On the other hand, there were areas which could benefit from improvement. These areas included the irregular presence of families, underestimation of resident's functional capacities, lack of success for a few initiatives to improve mobility and insignificance of leisure activities.

These results have provided a new perspective for management and staff. They found the process respectful of the complexity of the lives of seniors liv-

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ing with cognitive impairment and in a residence. The documented facets of their circles of influence have, secondly, made it possible to clearly identify the strengths at the Maison Fleur-Angé and the aspects requiring attention. For example, the "carpe diem" philosophy seemed to be reassuring and stimulating for the residents and needed to be reinforced by ensuring that residents participated in activities that were meaningful for them. The staff were competent and devoted, and their desire to encourage full participation and inclusion of all residents in all daily activities needed to be adjusted on the basis of a better understanding of the capacities and desires of the residents. The question of meaningfulness needed to be appreciated to increase the motivation of residents regarding participation in the daily activities of the Maison. This observation made it possible to make a few recommendations which included: training staff regarding meaningful activities and their connection to health, establishment of a council of elders made up of residents with the mandate to express views on daily life in the Maison, design of a directory of daily activities and special activities and identification of individual and group activities that are meaningful for residents.

When the project was completed, the overall recommendations resulting from the needs analysis were wide ranging and included the following: orientation clues for residents in the Maison, safe movement?, management of disruptive behaviour, importance of families involvement, importance of routines, regular assessment of functional autonomy and importance of communication between residents. The procedures and resources required to implement these recommendations have also been identified both within the Maison and outside the facility through the development of alliances.

Occupational therapy outcomes

The resident's health needs assessment at the Maison Fleur-Angé undertaken from the specific perspective of the CMOP met all expected outcomes. The results were welcomed favourably by management and staff who emphasized how much this innovative, positive perspective was helpful to assess the appropriateness of the services offered. The results led to adjustments to improve the resident's quality of life and enable them to fully participate in activities that were meaningful to them.

The needs assessment was used to generate internship objectives for occupational therapy stu-

dents at the University of Ottawa. Under the supervision of a professor in the program. These internships provided excellent conditions for learning and the application of knowledge since they were designed entirely on the basis of the CMOP. They encouraged autonomy of student's while offering them a wide range of interventions related to individuals, their activities, environment, and the question of meaning for residents and training of staff.

Finally, in spite of the fact that the potential for generalizing the results of the project is limited, the different stakeholders (residents, staff and management of the Maison Fleur-Angé, students and teachers in the occupational therapy program) all appreciated the process. Everyone has utilized the data generated by the project, both for the health of the residents and for the learning needs of the staff, students and professors who observed, once again, that moving from theory to practice brings meaning to occupational therapy.

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Life storytelling, occupation, social participation and aging

Barry Trentham

Occupational therapists have long appreciated the value of life narratives, occupational histories and life reviews as a means for client assessment and therapeutic interventions (Burke & Kern, 1996; Frank, 1996; Kirsh, 1996; Mattingly, 1991). In this article I further consider life storytelling as a powerful health promoting and shared occupation. As an occupational therapist and gerontologist, I am convinced of the value of doing life storytelling as a meaningful and purposeful occupation that helps make sense of our lives as we adapt to the challenges associated with aging. It is an occupation that may be most important for older adults who are adjusting to the identity threats associated with chronic illness or changes in living environments.

I pose the question, how does the doing of life storytelling foster well-being, community engagement and participation? My response considers life storytelling as an occupation through which older adults engage with family, friends and community, fostering identity development while promoting adaptive mental health functioning.

Definitions

What do I mean by life storytelling? The term life story is often used interchangeably with life narrative or life history and is a written or oral account of a life or a segment of a life as told by an individual (Cole & Knowles, 2001). Life storytelling is the process or occupation of sharing one's life story with others. Life review and reminiscence reflect similar processes, but denote a particular therapeutic process, form and purpose. Life stories may be shared orally and often make use of creative or artistic approaches such as photography, theatre or video. As narrative constructions life stories are not mere chronological accounts but convey the motivational links between life events. In so doing, the stories convey the meaning-making process, worldview and value system of the storyteller.

Occupational perspective

Occupational therapists often speak of the need to take thorough occupational histories by engaging the

client in occupational storytelling as part of the assessment process. An occupational history, as formalized in the Occupational Performance History Interview - II (Kielhofner, 2002) can be considered a form of life storytelling that focuses on occupational events, choices, achievements and challenges throughout one's life. However, life storytelling is not just a means to gather information but can be reframed in terms of a powerful occupation to be enabled. Not only does storytelling serve as a means to help us understand our lives, but it also assists older adults to adjust to identity threats associated with aging.

I believe that the stories we tell about ourselves reflect the larger cultural and social narratives within which we live; that is the ethno-cultural, mainstream or religious scripts, which may often unconsciously guide occupational participation choices. For example, one culturally accepted script, often conveyed in the stories of older people in this country, is that hard work dedicated to the well-being of others leads to a satisfied life. I also believe that by telling our life story we participate in a social process that engages both storytellers and story listeners, providing a means to share wisdom, humour, encouragement and histories. For anyone who has had the opportunity to tell their story publicly or to have it told (think of all those birthday, wedding, anniversary slide shows and family scrapbooks), to tell one's story publicly is to participate meaningfully in family and community building.

Insights from the field of narrative gerontology

The growing field of narrative gerontology has generated support for these beliefs (Chapman, 2005; Gubrium, 2001; Kenyon, Clark & de Vries, 2001; Randal & Kenyon, 2004) and has highlighted the value of the occupation of life storytelling in promoting well-being in old age. Jaber Gubrium (2001) a sociologist, states that meaning is created by how we link together the different experiences of our lives. It is in the telling of a life story that sense is made of it. Storytellers create the characters they see themselves

to be through their interpretation of past events and then reconstruct coherent plots that create meaning and guide future actions and life decisions.

Though few lives reflect coherent Hollywood-like plot lines, we may attempt to make them so in our telling of them. At the time of the telling, life stories may change depending on the audience or the particular salient conditions in the life of the teller. However, minister, adult educator and gerontologist, William Randall (2001) also cautions that the stories we tell ourselves about ourselves have the power to positively or negatively influence our lives. In the same vein, life storytelling may also help individuals to realize the extent to which they absorb the larger social norms, expectations and cultural constraints in which they live. The grand narratives, such as theories and socio-cultural scripts can just as likely be the means by which individuals are de-storied or silenced. This may happen when dominant and expected life course norms leave little space and few venues for the expression of minority voices or alternative life course story lines.

Stories never told

Not everyone may want to tell their story, nor do all those older adults who wish to engage in life storytelling have equal opportunity to do so. Many life stories are left untold and uncelebrated. Such silencing has the potential to limit how people engage with and participate in the world around them. Many older persons may be prevented from the full telling of their life story due to living situations, lack of story listeners, disability as well as culturally insensitive, discriminatory or unsafe environments that dissuade elders from sharing stories that do not fit accepted and dominant cultural story lines. For example, how comfortable do older adults who identify as minority members based on ethnicity, sexual orientation, religion or socioeconomic factors feel about sharing their life stories, particularly when living in potentially vulnerable situations such as supportive care environments?

The creation of non-judgmental venues for reflective and transformative life storytelling can enable individuals to become more aware of the patterns and cultural scripts that influence how they live their lives. These venues can also enable the development of more authenticity in their lives (Mezirow & Associates, 2000) through the occupational choices they make. A goal of occupational therapy is to enable engagement and participation in organiza-

tional, family and community roles. Considered as an occupation, life storytelling can be an effective connector for linking occupation to these roles. True to the occupational enablement process, occupational therapists need to first assess the person and environment factors that impact on their clients' ability to engage in life storytelling and then determine ways to modify these factors to enable full participation in life storytelling occupations.

Theories of aging and life storytelling

Many theories on aging support the mental health benefits of life storytelling, though largely with respect to the process of life review. For example, developmental psychologist, Erickson (1963) viewed life review as a means to avoid despair in preparation for death with the aim of reaching a final state of personal integrity. Continuity Theory (Atchley, 1989) explains how life review provides a means of maintaining a sense of one's identity in light of declining abilities. Disengagement theory (Cummings & Henry, 1961) has also been (mis)used to understand how individuals disengage from the present and immerse themselves in memories of better times. Jeffery Webster (2001) challenges these individualistic theories as not sufficient for considering the manner in which individuals "negotiate an environment in flux" (p.162) and calls for a more contextual understanding of life storytelling. Psychologist, Laura Carstensen (1995) considers contextual features and provides evidence to support the Socioemotional Selectivity Theory, which explains how those in later life tend to put a more positive spin on autobiographical memories than do younger people and use mutual life review as a way to regulate their emotions and build social links. These broader social narrative theories lend support for an expanded practice related to life storytelling beyond that of life review, to a view of life storytelling as an occupation that links and engages individuals with family and community occupations.

Going broader: New understandings about life storytelling occupations in later life

The gerontological literature, though predominantly focused on the individual functions of life review and storytelling, has begun to consider the value of life storytelling at the community participation level. Particularly, this literature is focusing on to how sharing life stories is an important way for individuals to link with others, by passing on the wisdom gained through life reflection (Edmonson, 2005; Kivnick, Stoffel & Hanlon, 2003; Randall & Kenyon, 2004).

In making the links among life storytelling, the individual and society, psychologist Peter Coleman (2005) reminds us that, “healthy psychological functions are those that are beneficial not only to the individual but also to society and to future generations” (p. 293). The social nature of life storytelling has been referred to by several gerontologists (Cruikshank, 2003; Edmondson, 2005; Holstein, 1999; McKee & Barber, 2001) to explain the social role that life storytelling offers older adults in providing problem-solving guidance for current social challenges faced by younger generations and often expressed in terms of wisdom.

At the small group level, storytelling groups have been used with reportedly good success in developing a sense of belonging and connection amongst potentially isolated individuals (Pohlman, 2003; Birren & Cockran, 2001) and to create what Gary Kenyon (2003) calls wisdom environments. Others have described the use of life storytelling at much broader levels including efforts to bring together historically alienated groups including seniors from various European countries (Coleman, 2005) and cultural groups in conflict, for example Catholic and Protestant groups in Northern Ireland (Gibson, 2004).

The humanities literature reminds us of the value of effective storytelling in passing on important life messages to current and future generations and in fulfilling the generativity (Erickson, 1963) or social contribution functions associated with old age. Some have even suggested that the importance of good storytelling in relation to effective social functioning is greater today than ever before for all ages; therefore it behooves society to create adequate enablers and opportunities for storytelling skill development (Nelson, 2003).

Of relevance to cross-cultural discussions, aging and life storytelling, psychologist Katherine Nelson (2003) has noted variations across gender and culture in terms of how groups develop and share their autobiographical memories. Noticeable differences have been found between Eastern cultures, which downplay the significance of the individual in the story and Western cultures, which have been shown to encourage individual autobiographical memories at relatively early ages and continue to reinforce such storytelling until much later (Nelson, 2003). Some cultures, most notably Aboriginal cultures, place a high value on storytelling as a forum for learning and passing on cultural traditions. Elders, a title afforded those who are recognized as leaders by community

members, play an important role in passing on cultural teachings and wisdom through life stories that are modified as needed for the given context or teaching purpose.

Given the many cross-cultural challenges to optimum health care delivery, occupational therapists might ask critical questions about whose life storytelling is being enabled and whose stories are being silenced. This would seem particularly important if, as the literature suggests, life storytelling supports individual mental health functions and offers a means for family and community occupational engagement and participation. Through the sharing of life stories older adults from all backgrounds, abilities and circumstances can offer themselves and others opportunities for guided problem-solving, mutual support, humour and the potential for discovery and transformation. Occupational therapists have much to offer older adults by enabling the doing of life storytelling and to ensure that the rich and unique stories that reflect the diverse nature of our society are heard, celebrated and harvested for their social wisdom.

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Occupational therapists connect with the community to help develop Memory P.L.U.S.

Kathy Gallagher

Occupational therapists working at the Geriatric Outpatient Clinic in Victoria, British Columbia recognized an unmet need for their clients with early dementias, including Alzheimer's disease. What was missing for these individuals was a place to go for education, support and socialization as they no longer felt comfortable attending many of their regular activities due to their cognitive changes. The occupational therapists partnered with a community agency and the Memory P.L.U.S (Practice, Laughter, Useful Strategies) program was launched.

The program has been running for over five years and has met with great success in three different centres located on southern Vancouver Island: Victoria, Saanich and Sidney. The program is sponsored by the community organization Silver Threads (www.silverthreads.ca). People attend their local centre once a week for a 12-week session. Each week participants are involved in a variety of activities, including working on a personal memory book, exploring their leisure resources, as well as discussions concerning their

memory, strategies and coping skills to manage their memory loss.

Occupational therapists have not only been involved with program development, but also will help in revamping the program to accommodate the needs for people with later stages of dementia and developing a training manual. The program is run by recreation therapists, with the occupational therapists in the outpatient department of the clinic serving as a primary source of referrals. The therapists see the program as an integral part of their community resources, as it provides a valuable social network and support for their clients. As well, the completion of their personal memory book while attending Memory P.L.U.S., the program provides a valuable occupation; it connects people to their past and enables them to share their history with others as their dementia progresses.

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Column Editors: Roselle Adler and Josée Séguin

The brave new world of locating technology and the role for occupational therapy

Elizabeth Steggles

Locating technology has been used for years to track animals, packages, vehicles and for military applications. In the last few years, manufacturers have recognized that the technology may also be useful for people who are at risk of wandering and are marketing to this segment of the population, primarily older people with Alzheimer's disease. The technology is developing at a rapid pace and is widely advertised particularly on the Internet. There are a plethora of options for locating technology and occupational therapists need to be aware of how to best meet the needs of their clients from the available options for locating technology.

In 2005, I first became aware of this application of locating technology when I was working with a man whose participation in independent occupation was severely restricted because of his behaviour and need for constant supervision. He desperately wanted to take his dog for a walk without an attendant but he was concerned about his ability to remain on the chosen path. He and his family agreed to take part in a small informal trial of locating technology. Coincidentally, one year later the Ontario Ministry of Community and Social Services expressed a desire to

cerned that they may become lost or encounter difficulties. At the outset of the project, the investigators had concerns about the ethical issues of using locating technology which included the stigma associated with the use of equipment that has been used to track animals and criminals and also the potential for invasion of privacy. However, consumer panels indicated that the benefits of a decrease in supervision, locked doors and drugs and an increase in independence and security outweighed any perceived ethical issues.

The occupational deprivation and loss of autonomy that result from wandering behaviour became apparent from the consumer panel. Many people who wander are often constantly supervised, limited in their ability to participate in chosen activities and they may be confined to locked environments or given sedating medication. Caregivers also face a negative impact on their own occupational performance needs as their time is focused on the people for whom they provide care.

During the course of the project, it became evident that no one system of locating technology provides a fool proof solution. One of the outcomes of the project was the recognition that there are different types of technology being used, primarily Global Positioning Systems (GPS) and radio, with a range of different features. Also, the technology takes different forms such as cellular phones or wristbands that transmit and/or receive signals. We found 26 products or services on an Internet search.

In order to assist consumers and occupational therapists in identification of needs and consideration of available features and to enhance meaningful occupation, please refer to page 29 of this issue to see answers to frequently asked questions about locating technology.

About the author –

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"...no one system of locating technology provides a fool proof solution."

evaluate the utility of locating technology for people at risk of wandering. My colleagues and I (three occupational therapists and a rehabilitation technologist) at Accessibly Yours, a service arm of the School of Rehabilitation Science at McMaster University, approached the Ministry and ultimately entered into a partnership to conduct the evaluation through equipment trials and a qualitative study. The full report of the Locating Technology Project is available at <http://www.fhs.mcmaster.ca/rehab/locatingtechnology/>

The participants were anxious to find equipment that meets two very specific needs: to help families and caregivers locate people who have wandered or run away and assist people who would like to be more independent in the community but are con-

Frequently asked questions about locating technology

Elizabeth Steggles, James Leslie and Sue Baptiste

What is locating technology?

Locating technology usually involves an electronic device which allows caregivers to locate people who are at risk of wandering or getting lost. Generally, the person at risk wears a device such as a wristband or cell phone as part of the system. Some devices rely on the caregiver to find the wearer, while others use a monitoring service such as a call centre. One system relies on police services. The technology generally uses global positioning systems (GPS) or FM (radio) and various features may be offered.

Who may use locating technology?

Candidates for this technology may include those with Alzheimer's disease or other dementias, autism or a developmental delay. Locating technology may help find a person or provide increased independence for a person who wishes to go out alone.

What are the details about locating technology?

1. Ethical issues:

- May carry the stigma associated with tracking animals and criminals.
- Could infringe on a person's right to privacy, dignity and freedom.
- Potentially indicates to the general public that the person has a disability. This may make them vulnerable or socially isolated.
- There are currently no guidelines regarding who should provide consent to use the technology.
- Coercion may be used to make a person use the technology.
- The use may lead to less supervision or human contact.
- The technology may be used to restrict people from going where they wish.

2. Considerations for the person at risk (wearer):

- Is the locating technology attached or carried?
- Can the wearer tolerate wearing a device?
- Are the characteristics of the device important e.g. size, weight and aesthetics?
- Can the wearer remove the device?
- Does the device include a "help/call" button?
- Does the wearer need to identify his/her own location?
- Is there more than one wearer? How many?

3. Considerations for the caregiver(s):

- Who needs to track/locate the person? e.g. a caregiver, agency, call centre or police?
- Is two-way communication needed with the person who wanders?
- Are special skills/training needed to use the locating technology?
- How easy is it to maintain the system e.g. charging, cleaning?
- Is a map required in order to locate the user?
- Is the system flexible to changing needs, e.g. a person going on a vacation?

4. Technical factors:

- Is the technology waterproof or water-resistant?
- Where must the wearer be? Not all technology works in all locations, e.g. in a building, forest, outside the immediate community or in or near water.
- How long should the battery last?
- Does the locating technology need other equipment, such as a computer, Internet access, cell phone or a charging bay, in order to function?
- Is an alarm/alert required:
 - When the locating technology is removed?
 - When the wearer falls?
 - When the wearer is near/in water?
 - When the wearer is out of a specific area?
 - When the wearer leaves a building?
 - When the wearer is near traffic?
- Where will the locating technology be used? E.g., in a long term care facility or school, residence, neighbourhood or everywhere.

With this rapidly changing technology, other questions may arise when you look for a system that will meet your needs. Locating technology is only one strategy for coping with wandering behaviour or helping people who get lost and is not appropriate for everyone. It is important to work with the health care team to determine the most appropriate strategies.

*This "Frequently Asked Questions" is only intended as a guide and does not necessarily address all of the issues related to locating technology. It was developed in October 2006 by The Locating Technology Project Team, School of Rehabilitation Science, Institute of Applied Health Sciences, McMaster University. For more information contact Elizabeth Steggles: Tel: 905-525 9140 x21096 or E-mail: steggli@mcmaster.ca

