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The Occupational Therapist's Roadmap to Safety for Seniors

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Times are changing. Our society relies on community mobility much more than it ever did in the past. Also, the number of citizens over 65 years old is steadily rising. John Eberhard, a senior research psychologist at the National Highway Traffic Safety Administration in Washington, DC, said, "Today 35 million Americans are 65 years old or older... By 2030, one in five Americans will be 65 years old or older." (Eberhard, 2001) Because occupational therapists will be very involved with this age group in the next century, they must prepare to address the community mobility issue of driving for this clientele. An occupational therapist does not need to be a certified driver rehabilitation specialist to be involved with the issue of safe driving or transportation. This article proposes a "roadmap" for the occupational therapist who works with older adults in a variety of settings. This guide is intended to assist occupational therapy practitioners in their efforts to adequately address driving and transportation throughout the continuum of occupational therapy treatment programs.

Driving is an activity of daily living (ADL) listed under community mobility in the American Occupational Therapy Association's Practice Framework (AOTA, 2002). Occupational therapists need a guide to address this issue that is specific to the over 65 years old population. Occupational therapists must examine the age-related issues and the newly acquired disability issues because they can affect this population's safe driving and transportation goals. Occupational therapists are in the best position to address the issue of safe mobility in the senior community because of their understanding of ADL, and their understanding of quality of life issues, and their holistic view of the whole person.

Regardless of the practice setting, all occupational therapists who work with the senior community should address the issues of driving, transportation, and safe mobility in the community. The specific roles and responsibilities of the clinician will change depending on the stage or stages at which the therapist is involved with the person. These stages include: 1) Fact finding/Information Stage; 2) Predriver Clinical Screening Stage; and 3) Formal Driver Evaluation Stage. In some settings, the occupational therapist may follow the client through only one or two stages or through all stages. In all stages, the occupational therapist must keep in mind the importance of independent driving or transportation for each person and its affect on his or her quality of life. The therapist must be compassionate and patient and do everything he or she can to help the client continue driving if possible. Occupational therapists must realize that clients associate their ability to drive with independence. If the person can no longer drive, the therapist must evaluate other transportation options and assist in creating a new transportation alternative that is viable for the person in their community.

The most basic level is the **fact finding/information stage**

when the occupational therapist is in a resource position to simply address driving in the same context as all other ADLs are initially addressed with a client.

At this stage, the occupational therapist determines if driving is a goal for the client and if not, what other transportation alternatives are being considered. If driving is the client's ultimate goal, then the occupational therapist can provide information to the client and his or her family on how and when the client's driving skills will be formally evaluated. At this stage, the occupational therapist can address how the age-related and/or newly acquired issues may affect driving performance skills and then create a plan of action with the client to address these issues. To educate the client properly, occupational therapists must know the accepted process for completion of a driving evaluation in their geographical area. Then they will be able to explain clearly to their clients how the person will move through stages two and three.

The second level is the **predriver clinical screening stage** performed in conjunction with the typical ADL assessment. At this point, more details of the client's driving history and typical driving pattern must be known. A "picture" will begin to form of how driving interweaves into the client's lifestyle. The purpose of the clinical screening at this stage is to assess the client very specifically for all performance skill areas that are needed for driving. These performance skills include physical, visual, visual-perceptual, and cognitive skills. Many of these areas will be the same as for other ADL. However, there will be some areas that are different or more complex because driving is a dynamic, multidimensional activity that is performed in an ever-changing moving environment. A hierarchy of skills dictate the order in which each area is addressed. Mobility in basic activities of daily living (BADL) is first, followed by mobility in instrumental activities of daily living (IADL) (Pierce, 2002).

The occupational therapist will use clinical tools common to other occupational therapy assessments with perhaps a few additional tools that may be more specific to driving (See Resources). The physical, visual, visual-perceptual, and cognitive areas are screened in the typical way with addition of some tests that involve dynamic visual and cognitive skills such as the Elemental Driving Simulator, Driver Performance Test, and Useful Field of Vision Screener. As the occupational therapist is performing these assessments, she or he will begin to draw conclusions of how the deficits that are seen, if there are any, may interfere with the client's driving skills. For the visual assessment of a client over 65, it may be important to add a few visual screening tools that can assess visual acuity, contrast sensitivity, peripheral vision, and eye mobility. The client must have at least 20/40 in one eye and at least 130 degrees of uninterrupted peripheral vision to meet most states' visual requirements by the driver licensing authority. (These may vary in your own state so check with your state's department of driver licensing). Quality of vision is very important particularly for the older client who is prone to cataracts, glaucoma, diabetic

retinopathy, and other age-related visual deficits. Obtaining an eye examination report from the client's eye doctor or referring the client to the eye doctor for a full examination if he or she has not been seen in the past 12 months, will provide the best information in these areas. There are a few good tabletop visual screeners that can be used by the occupational therapist to screen for visual acuity, fusion, stereopsis (three-dimensional depth perception), contrast sensitivity, and horizontal perimeter vision. A handheld perimeter disc can additionally screen for peripheral vision in all quadrants. A night sight meter can objectively assess for night vision and glare recovery.

As the occupational therapist begins to identify the client's occupational deficits, a treatment plan is developed to work on each basic performance skill in relation to each ADL pertinent to the client. The client will provide the information regarding the importance of driving in his or her life and specify the frequency, the personal needs to be met, and the driving required to fulfill the needs. Driving is an ADL and based on this author's experience and expertise it is one of the most complex ADL that the person 65 years or older will perform. Driving should be formally addressed as one of the last goals in the instrumental activities. The occupational therapist at this second stage will determine readiness for referral to the third stage at which the client participates in a **formal driver assessment** on the road by a driver rehabilitation therapist. A driver rehabilitation therapist has an allied health background and is usually an occupational therapist with special training in the field of driver rehabilitation. This therapist understands medical diagnosis, implications, how to relate deficits to driving performance skills, and how to plan an appropriate on-road route specific to each client and the suspected issues. A driver rehabilitation specialist should not be confused with a commercial driving school instructor who has no medical background and little working experience with visible and nonvisible medical issues that may affect a person's driving skills. While the Association for Driver Rehabilitation Specialists can provide a listing of its members and those who are certified driver rehabilitation specialists, they do not distinguish the therapists from the driving school instructors.

Typically, most clients with a new diagnosis such as cerebrovascular accident, traumatic brain injury, cerebral hemorrhage, or post-surgical removal of brain tumor should be referred to the driver rehabilitation therapist 2 to 3 months postdischarge from a hospital or rehabilitation setting. Persons living in independent or assistive living facilities, or being seen through an Alzheimer's resource center, or senior citizen community center can be screened annually, if he or she drives, for the performance skill areas needed for safe driving. Appropriate referrals can then be made to the driver rehabilitation therapist when necessary. Often, driving becomes a focus with older adults only when the person experiences or acquires an acute medical condition; however, age-related issues must also be screened for in all settings as these issues can greatly impair performance skills for driving, in the absence of or in addition to any acute medical changes.

Before recommending the client to a driver rehabilitation therapist, the occupational therapist should collaborate with his or her colleagues to ensure that each person on the rehabilitation team is in

agreement that the person is ready for the road test. The occupational therapist should always talk with the family or significant others to gather important information that will assist in making the right decision. When the client is ready for the road test, the therapist at the second stage should know whom and where the correct professional is and what the therapist will be doing so this can be explained to the client and the family. To protect the occupational therapist from liability, the referral should be made to a driver rehabilitation therapist with an allied health background who has specialized training and experience in driver rehabilitation as well as an appropriate evaluation vehicle. Caution should be used if referring a client with a disability or performance deficits to a commercial driving school instructor or to a certified driver rehabilitation specialist who does not have an allied health background. To find a qualified driver rehabilitation therapist near you, use AOTA's driving network Listserv or contact Adaptive Mobility Services, Inc.

In conclusion, occupational therapists should be addressing driving issues with clients over 65 years of age. Our profession must begin to take an active role in developing procedures for all settings for stages one, two, and three. By 2030 the demand for our involvement will be tripled! The role of occupational therapy at each stage will vary according to the setting and the functional level of the client. By addressing the driving issue at an early stage, by working on driving skill areas in your treatment program, and by educating the elder driver and his or her family to the process and resources, they should be more active, supportive, and willing to participate with the formal driving evaluation when needed. The goal is to keep elder drivers on the road if possible, and to assist those who can no longer drive with finding viable alternative means of transportation in their own community. ■

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Resources

Commonly Used Clinical Tools for Assessment of Performance Areas for Driving

Trailmaking Parts A & B	WAIS Digit Symbol
Gardner Test of Visual Perceptual Skills	WAIS Picture Completion
Motor Free Visual Perceptual Test - 3	WAIS Digit Span
Double Letter Cancellation Task	WAIS Block Design
Driver Performance Test*	Mini-Mental Exam
Cognitive Linguistic Quick Test	Unilateral Neglect Test
	Road Smart Judgment Test
	Useful Field of Vision
	Clock Drawing Test

Optec 2000 Visual Screener
 Minnesota Rate of Manipulation
 Night Sight Meter & Glare Recovery
 Elemental Driving Simulator
 Cognitive Behavioral Driver's Inventory
 Vericom Braking Reaction Timer
 *Indicates dynamic visual or cognitive components.

Resources for Clinical Assessment Tools

Bernell Corporation 4016 N. Home St. Mishawaka, IN 46545 800-348-2225	Stereo Optical Co. 3539 North Kenton Ave. Chicago, IL 60641 800-344-9500
Visual Resource, Inc. PO Box 51524 Bowling Green, KY 42102	Academic Therapy Publications 20 Commercial Blvd. Novato, CA 94949-6191
The Psychological Corporation 1-800-872-1726	Vericom Computers, Inc. 1-800-533-5547

Resources for Information and Specialized Training in Driver Rehabilitation Issues

Adaptive Mobility Services, Inc. Dept. of Continuing Education 1000 Delaney Avenue Orlando, FL 32806 407-426-8020 www.driver-ed.org www.adaptivemobility.com	Association for Driver Rehabilitation Specialists 711 S. Vienna Ruston, LA 71270 800-290-2344
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Occupation at Home in Long-Term Care

■ Mary Lou Leibold, MS, OTR/L

My Story

I had been working full time as an occupational therapist (OT) for 17 years when I encountered my first work experience in a 150-bed skilled nursing and long-term care (SNF/LTC) facility. Prior to this, my working background focused on adult physical disabilities in a hospital setting, a freestanding rehabilitation center, and a brief stint in home care.

I felt confident with my abilities, so I thought how different could this be? I did not anticipate any challenges in my new job. What I quickly learned was that the acute and skilled patient area of the facility felt very comfortable and was similar to my former position at the rehabilitation center, but at a slower pace. However, the residents in the LTC area of the facility were a different story. With these clients, I wasn't really sure of my role.

Six years have passed since that time and I believe that through my direct care experiences, I've come to recognize and understand the contribution of occupational therapy for those residents who call these LTC facilities their home. I wrote this article for practitioners at all levels of practice experience, from novice to expert, in hopes of generating further discussion and reflection about the critical role of occupational therapy for the LTC residents.

Occupation as a Foundation

Let's start with the word occupation in occupational therapy. I believe in it, and I think we should use the word occupation when we talk with residents, families, physicians, team members, and everyone else so that they "get it!" I like to ask the residents what their occupations are after explaining what it means and after giving examples of some of my occupations for clarity. Residents typically respond well to this approach, and I can quickly learn a lot about them. For those who cannot respond, I learn about their occupations from family members and the nursing staff. Residents in LTC report occupations such as crafts, playing cards, attending religious services held in the building, and visiting with their friends.

Occupation provides a foundation for our practice. Regardless of the population we serve or the setting in which we work, the use of occupation is our unique contribution in our clients' intervention programs. This concept helped me to recognize that providing occupational therapy in LTC is, and should actually be, similar to providing occupational therapy in home care because the facility is the resident's permanent home. Thus, treatment can and should be meaningful, using the client's own "props and tools" in the true and appropriate context. Providing intervention where the occupation actually occurs seems to elevate understanding of the meaning and purpose for the residents, families, and staff. This enables them to make the connection and see immediate results while not having to guess at the generalization of skills learned elsewhere.

The Use of Occupation

There are many different ways that clinicians choose to describe and capture the essence of occupation. For me, it helped to review Catherine Trombly's 1995 Eleanor Clarke Slagle Lecture entitled "Occupation: Purposefulness and Meaningfulness as Therapeutic Mechanisms." (Trombly, 1995). Trombly discussed two ways in which the word occupation is used and calls them occupation as ends

and occupation as means. Trombly described occupation as ends as instances in which occupation (is) the goal to be learned (Trombly, p. 963). On the other hand, Trombly explains occupation as means as referring to occupation acting as the therapeutic change agent to remediate impaired abilities or capacities (Trombly, p. 964). I like this description because of its all-encompassing nature which gives me a lot of flexibility in using occupation with my residents. For example, I can use the act of dressing as a goal or an intervention. I may have one resident working toward the goal of independence in dressing and I help him reach his goal by teaching him one-handed skills, challenging the limit of stability to increase dynamic balance, and incorporating pacing techniques to prevent fatigue. At the same time, another resident might engage in self-dressing as an intervention, working toward the goals of improved upper extremity functioning, dynamic balance, and functional ambulation to become independent in gathering clothes and self-care sequencing. Thus, I can use occupation as the ends or the means to help residents accomplish whatever occupational goal they have determined to be meaningful.

Types of Occupational Therapy Intervention

Next I want to address the types of occupational therapy interventions outlined in the new Occupational Therapy Practice Framework: Domain and Process (American Occupational Therapy Association [AOTA], 2002). This helps me to think about what I am actively doing and what intervention looks like. The Framework describes three types of activities to be used in occupational therapy practice. First, the purpose of occupation-based activity is to "allow clients to engage in actual occupations that are part of their own context and that match their goals." (AOTA, p. 628). Examples in LTC would include putting on clothes with some assistance, playing Bingo, and propelling a wheelchair to the dining room for meals. See Table 2 for additional examples. Second, the purpose of purposeful activity is to "allow the client to engage in goal-directed behaviors or activities within a therapeutically designed context that lead to an occupation or occupations." (AOTA, p. 628). Examples in LTC would include playing cards for fine motor coordination when the resident is not a card player and making pudding to improve sequencing and direction following abilities when the resident does not typically engage in food preparation. Third, the purpose of preparatory methods is described as "prepares the client for occupational performance; used in preparation for purposeful and occupation-based activities" (AOTA, p. 628). See Table 3 for examples.

All of these are appropriate types of occupational therapy intervention when used in the context of occupation. So, once again,

Table 1. Residents and Their Occupations

- Mrs. B**, 90 y/o, was very concerned about her appearance and spent time each morning making sure that she looked "just so." In particular, she owns drawers full of jewelry; something to complement each outfit. It was important to her that her jewelry was organized, accessible to her at wheelchair level, and that she could fasten the clips and remove the jewelry herself.
- Mrs. L**, 85 y/o, is determined to be as absolutely independent as she can and has one of the few rooms with an accompanying bathroom with a tub. In the tub, she has her transfer tub bench, hand held shower and supply organizer. She requests her privacy for bathing and wants assistance only for the transfer out of the tub.
- Mrs. E**, 72 y/o, was a music teacher for 50 years. Now with Alzheimer's disease, she needs 24-hour supervision and assistance. Everyday before lunch she sits down in the dining room and plays her repertoire on the piano which typically ends with the grand finale of "I've Been Working on the Railroad." The other residents expect and wait for her to play. Often it results in a sing-a-long (and sometimes from residents you least expect!).
- Mrs. R**, 66 y/o, made rosaries in her spare time and donated them to local churches in the area. Her left arm was nonfunctional after her stroke and she wanted to continue making the rosaries. A work area was set up in her room with adaptations needed to complete her task one-handed.
- Mr. R**, 73 y/o, a very social man, is constantly on the go and loves to meet and greet the other residents. His "job" as he sees it, is to deliver the mail to the other residents each afternoon. He has a specially designed carrying case for transporting the mail as he propels his wheelchair with both feet.
- Mr. T**, 78 y/o, worked in housekeeping until he retired. He has advanced dementia but is physically very mobile. He spends several hours each day "cleaning" the handrails in the facility. He makes several trips around the building each day mobilizing his wheelchair with both legs as he wipes the handrails. Everybody knows him and greets him and expects to see him on his travels.

Table 2. Occupation-Based Activities

- Operation of tape recorder, TV, CD player, talking books
- Bed control and nurse's call bell use
- Making own appointments for the beauty shop
- Menu selection
- Clean/organize dresser drawers
- Put away clean laundry
- Prepare evening snack – (e.g., pudding, peanut butter crackers, fruit salad)
- Dining in the least restrictive environment—social interaction, walk to dine, motor to meals, food texture management (dysphagia) with speech therapy, monitor and facilitate oral intake with dietitian, positioning, equipment, compensatory techniques
- Placing clean table cloths on dining room tables, pass out cover-ups
- Toileting independence, including incontinence protection aides
- Putting on a sweater when cold
- Using a reacher for anything (e.g., closet, drawers, bathroom medicine cabinet)
- Arrange room furniture for accessibility
- Topographical orientation
- Transfer to chair in beauty shop as well as appropriate seating in chair and best approach for washing hair
- Transferring to sofa or wing-back chairs in lobby area
- Greeting guests in lobby
- Decorating building for holidays
- Adaptations and positioning needed for inclusion in Bingo and other leisure activities (e.g., large font Bingo cards, grasp of Bingo dauber)
- Operation of remote control for big screen TV in activity room
- Operation of VCR for movies
- Adaptations and positioning needed for inclusion in religious services (e.g., large font in church bulletin and hymnal)
- Planting and maintaining vegetable garden in elevated beds in enclosed outside garden area
- Watering plants in facility

occupation is the core of our intervention programs and we can use occupation-based activity, purposeful activity, or preparatory methods, or all, as long as the obvious goal is to promote the resident's participation in occupations that they want, need, and/or are expected to participate. Allow me to share the stories of six residents I've met along the way. These stories are listed in Table 1. Involvement in the occupations that they identified as being important to them is of high value and is part of their everyday lives in the LTC facility:

In all of these examples, occupation was the common thread.

Table 3. Preparatory Methods (Keeping the Occupation in Mind)

- Splints
- Bed and chair positioning—for comfort, skin integrity, engagement in any occupation
- Safe eating methods, in collaboration with speech language pathology
- Skin care management—foam, bed bumpers, wheelchair, cushions, elbow and heel protectors
- Family education—positioning, safe eating
- Accessibility of room to ease burden of care on nurses and decrease work injuries to staff

Conclusion

My closing thoughts about occupation and the LTC resident are as follows: it works, it is our identity, it can be the ends or the means, or both, it is universal—everyone has occupations, it motivates, it is individualized for each person, it can be addressed using preparatory methods, purposeful activities or occupation-based activities, or all, it should be “talked” about, and it makes us unique. ■

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